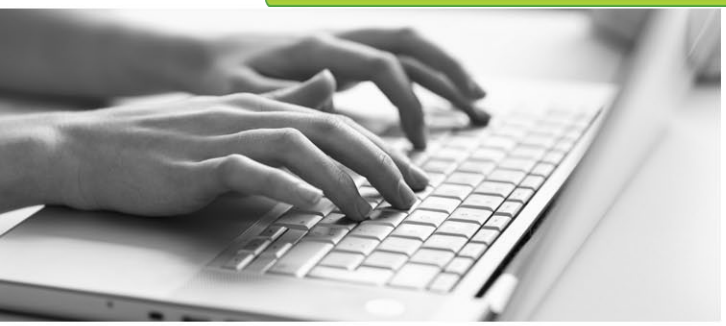
CLICK ABOVE FOR EMBEDDED VIDEO

CLICK HERE FOR FULL RESOLUTION VIDEO



Approach to Fiscal Agent Operations Statement of Work

Approach to Fiscal Agent Operations Statement of Work

RESPONSE 40

RESPONSE 40: Using the format provided in Section D.3.6.2 above, the Offeror shall provide a description of how their proposed solution will meet each of the Fiscal Agent Operations technical and business services requirements provided in Section 9 of the RFP Body and Appendix A – Requirements and Performance Standards Matrix. The Offeror shall provide video, screenshots, and/or process documentation to support any statements regarding features and functionality that are already "In Production." In addition to providing narrative describing the specific functions and features in each component above, in the section provided in the response format, the Offeror shall make a direct correlation to the detailed requirement(s) in Appendix A – Requirements and Performance Standards Matrix that is being addressed. The Offeror shall also describe the licensing process, if any, for the proposed solution as part of their response.

As we move from discussions about our technical solution and into discussions of operations, the Department should have a clear image of HP's dedication and commitment. Just as we are driven to deliver a proven MMIS to the Department, we are driven to provide service excellence in the fiscal agent operations.

During fiscal agent operations, the Department, clients, providers, and other project stakeholders realize the benefits of the guiding principles the State established, including the following:

- A flexible solution with enhanced decision-making and increased management efficiencies
- Accurate, real-time data and reporting to meet changing business and management needs
- An enhanced customer service experience for providers and clients
- Performance-based service levels
- Easy and comprehensive access "one-stop-shop" for providers
- Successful implementation of contracted services and supporting technology

We will remain focused on these guiding principles throughout fiscal agent operations. HP stands ready to help the Department successfully realize the benefit of its successful transformation journey through improved outcomes and access to care for its clients during fiscal agent operations.

HP describes our approach to the Department's fiscal agent operations statement of work in the following responses:

- 9.2 – Fiscal Agent Operations Business Requirements (RESPONSE 40a)—The Department's view into the status of the project depends on the quality and transparency of the reporting. To that end, HP's solution includes bringing our innovative enterprise product, HP Project and Portfolio Management (PPM), which is repeatedly rated as a best-in-class product by Gartner and Forrester.
- 9.3 – Claim/Encounter Related Services (RESPONSE 40b)—Comprehensive claims and encounter processing solutions are at the core of the Department's ability to manage multiple payer groups, provide timely processing for the provider community, and safeguard the State's funds. Our claims and encounter processing solutions are customized, flexible, and backed with experience processing Medicaid transactions in 20 states, providing the Department and stakeholders with convenient, online, and secure access to their information.
- 9.4 – Prior Authorization Services (RESPONSE 40c)—Providers have fast and easy access to PA data through the provider portal. We consulted physicians, nurses, pharmacists, and other portal users for information and input into the creation of these features.
- 9.5 – Provider Management Services (RESPONSE 40d)—HP supports the Department's desire to improve and enhance services to the provider community. To this end, our approach includes a standard suite of services and increased emphasis on self-service, education, and access to information. These services are delivered through a well-organized operational structure supported by proven technology, proven best practices and a strong foundation of continuous improvement.
- 9.6 – Third Party Liability Support Services (RESPONSE 40e)—HP's extensive experience with other states demonstrates that the Colorado interChange can capture and display cash collections, post-payment recoveries, cost-avoidance data, Medicare Buy-In, and HIBI to provide the data needed for reporting and increased cost avoidance.
- 9.7 – Program Integrity Support Services (RESPONSE 40f)—HP will use LexisNexis to meet the requirements of Rule 6028 of the ACA for provider credentialing and background checks. This service aids in the investigation process by quickly identifying fraud and other incidents within the last five years that involve the owners, indirect owners, and managing employees.
- 9.8 – Client Premium Management Services (RESPONSE 40g)—The Colorado MMIS will be fully equipped to handle Medicare premium processing and the application of different types of cost share to client claim and encounter transactions.
- 9.9 – Electronic Document Management Support (RESPONSE 40h)—HP understands the rigorous demands of document management in the Medicaid industry and provides a robust,

fully integrated document management solution to allow the Department to focus on the business of running the Medicaid program.

- 9.10 – Workflow Management Support (RESPONSE 40i)—Standard application workflows will not suffice for the type of transformation Colorado requires and as such, we have focused on integrating high-quadrant. For the COMMIT project, we will use K2 blackpearl as the COTS workflow engine fully integrated with the Colorado interChange.
- 9.11 – Call Center Services (RESPONSE 40j)—HP supports multiple interaction channels for both voice and non-voice, chat, instant messaging, and monitoring social media as a feedback channel. We have extensive healthcare and eligibility experience and have operated Medicaid-specific contact centers for more than 40 years.
- 9.12 – Help Desk Services (RESPONSE 40k)—HP state and local healthcare industry team has more than 20 installations throughout US where plan clients, providers and relevant stakeholders receive call center/help desk support.
- 9.13 – Mailroom Services (RESPONSE 40l)—The OPEX and HP Exstream solutions vastly reduce the amount of manual effort in the mailroom.
- 9.14 – Online Document Repository (RESPONSE 40m)—Our electronic document management support (EDMS) solution provides an online, real-time communications tracking tool with role-based access to monitor and document system updates, daily business, and exchanges between organizations and the Department.

As you read these responses, we hope we have achieved our goal of explaining why we are the best vendor to help you achieve your goals.

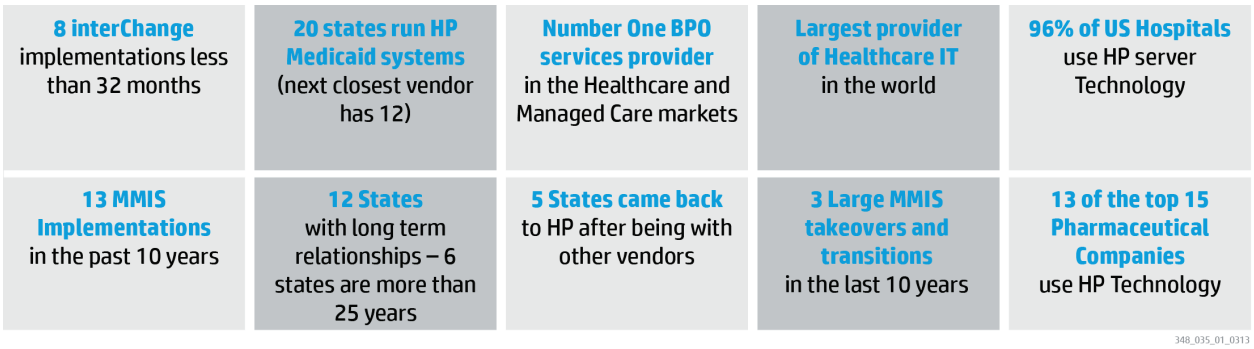
RESPONSE 40a

9.2 – Fiscal Agent Operations Business Requirements	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1016, 1224, 1225, 1227, 1369, 1413, 1478, 1678, 1679, 1687, 1693, 1778, 1786-1813	**YES**

HP has supported Medicaid operations for more than 40 years, and we serve customers in 20 states. We are committed to meeting RFP requirements in every state we support. HP has a successful track record of doing just that by using our proven operational processes developed through the years of continual improvement providing fiscal agent services. Our years of experience and the many states we have supported with Medicaid operations uniquely position us to deliver outstanding performance. No other contractor has the depth of experience and success we bring to fiscal agent operations as illustrated in the following figure.

For the Department, this means a contractor that can act quickly and implement corrective action proactively to prevent failures that could negatively affect the Department, its clients, or providers. Instead of "reacting" and fixing a problem, our extensive experience allows us to recognize signs that something is veering off course and make the appropriate changes necessary to remain on track.

Extensive Experience



We bring this extensive experience directly to the Department through key personnel and staff familiar with HP's fiscal agent operational processes, lessons learned, and tools. Our HP team on the ground in Colorado also will benefit from the years of experience and oversight of HP's Capability Leaders who have led successful fiscal agent operations themselves and who now oversee functional teams (for example, in claims, provider relations, and finance) deployed across our Medicaid projects in 20 states.

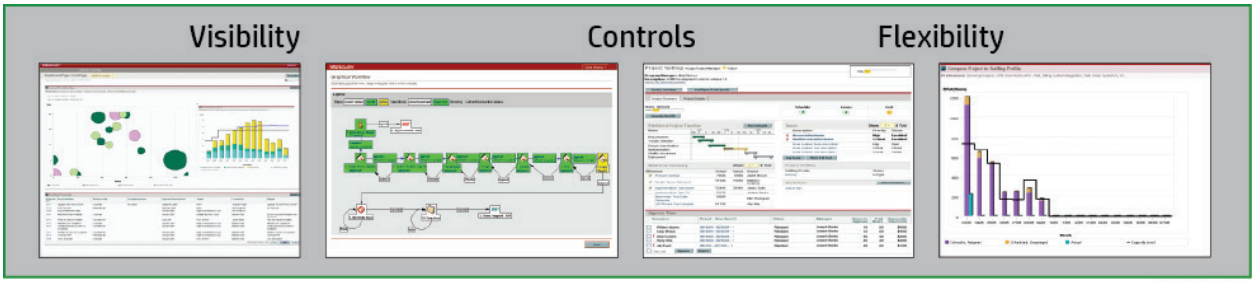
To describe our responses to "Fiscal Agent Operations Business Requirements" from Appendix A, we grouped them by topic below, each identifying the applicable unique ID.

Operational Reporting (Unique IDs 1369, 1789, 1790, 1791, 1792, 1800)

TECHNOLOGY HIGHLIGHT

(1369, 1789) The Department's view into the status of the project depends on the quality and timeliness of the reporting provided by the contractor. To that end, HP's solution includes bringing our innovative enterprise product, HP Project and Portfolio Management (PPM) tool that is repeatedly rated as a best-in-class enterprise commercial off-the-shelf (COTS) product by Gartner and Forrester. HP PPM is a web-based system that can transform project management information sharing between the Department and HP by providing real-time access to scope, issues, risks, quality, deliverables, schedules, critical path, resource management, and performance dashboards as seen in the following figure.

HP PPM Dashboards



Through this state-of-the-art tool, the HP project manager can maintain real-time and regular communication with the Department's project manager, leaders, and project team. This tool will provide the ability to regularly and accurately produce operational reports using System data. Our experience has taught us that constant communication between the project team members builds trust and develops a team attitude that promotes project success.

(1790) Each week, project managers and team leads will review metrics on schedule, cost, risk, and quality and create corrective action plans when we identify problems. The tool enables development of weekly and monthly status reports that include dashboard reporting, key metrics, and numerous graphs or charts to give a quick, visual view into project health. The weekly project status report will include information on project progress (indicators for scope and schedule), deliverable and milestone status, risks, issue, action items, and change information. We will finalize the format for the project status reports and gain Department approval after project kickoff.

HP PPM will serve as the primary documentation and communications tool. Besides providing for formal status reporting at the various work groups and boards, HP PPM provides escalation information to appropriate users at any time. This transparency and flexibility increases control for interested users by making current information available at any time and pinpointing exactly where any issue or risk is in the process.

(1791) Weekly operations status meetings are an excellent way to communicate status on operational performance and system maintenance activities. HP operational and technical leaders

will be active participants in these meetings. HP will meet with the Department for a weekly operations status meeting to discuss progress, issues, problems, and planning. HP will report current operations status, progress on System maintenance, claims/encounters inventory balances, claims/encounters backlogs, data entry backlog, and suspense file status, and modification activities separately. At least 24 hours before status meetings, HP will provide the agenda and current project status report to meeting attendees. This will allow participants an opportunity to prepare for the meeting by reviewing the materials in advance. HP will take minutes to document discussions and decisions made during the meeting. The draft minutes will be provided to the Department, for their review and approval, no later than close of business on the third business day following the meeting. Minutes approved by the Department are stored on the project's SharePoint Enterprise site along with system documentation and user manuals.

Through the deliverable creation and submission process, HP will define the key metrics to include on the weekly status report and weekly call center report. The status report will include information about interactions with clients and providers, including program statistics, call center and claim processing performance metrics, and other pertinent metrics relevant to each phase of the project. The MMIS produces reports containing information on processing that occurred in the prior week's cycle. This data will be the source for populating many of the items on the weekly status report.

(1792) Besides the call center metrics described in Appendix A, requirement 1792, HP has found that including items like the top-five most frequent reasons for calls from clients and providers supplies insight into the key issues stakeholders are experiencing. This allows the Department and HP to be more service focused by developing specific communications or training to offer an enhanced customer experience.

An innovative feature within our Contact Tracking Management System (CTMS) allows HP call

center supervisors to quickly create new call types so items of importance to the Department can be tracked. For example, when a new policy is implemented, if the Department would like to collect information on whether there is an increase in calls related to that policy, our call center supervisor can create a new call type and that data would then be included on the next weekly status report. This feature enables the Department and HP to quickly and efficiently adapt provider and client support to areas of greatest need.

Cross Contractor and Department Operational Status Meetings (Unique ID 1800)

As needed, HP will coordinate operational status meetings that include the Department and other contractors. These group status meetings can be incorporated into the regularly scheduled weekly operations meeting or held as a separate meeting. We will organize agenda items to maximize the use of the attendee's time and include start times for each agenda item. This will allow other contractors to join the meeting for those items that affect them.

Documentation and Communications (Unique IDs 1016, 1687, 1796, 1799, 1800, 1801)

In the communications management plan, HP will work with the Department to define the types, frequency, and channels of communication that allow us to work effectively with project stakeholders. As we work together and receive feedback from the Department, we will refine the communications management plan as part of our continuous improvement process.

Communication and feedback channels fall into three broad categories—face-to-face, paper-based, and technology-based. Effective channels of communication may include websites, briefings, overview sessions, newsletters, broadcast emails, and user group meetings. Some channels will be more suitable for different audience groups and different communication objectives. HP's open and comprehensive communications approach will enable the team to transmit information among multiple stakeholders, thus building mutual accountability and aligned expectations.

Desk-Level Procedures Documentation (Unique ID 1016)

Thankfully, the days of bulky user manuals on a staff member's desktop are gone. Through our SharePoint Enterprise site, staff members can view the most current information at any time from their desk by accessing their web-based user documentation. This one source of information remains current, so that users—such as resolution clerks, call center agents, or analysts—will not have to worry about using outdated documentation to make work decisions or share information with providers or program clients. The time previously spent thumbing through manual pages or looking for the right sticky note attached to their computer monitor can now be used to process claims or complete other time-sensitive work functions.

HP provides comprehensive, well-organized user documentation—written in a procedural, step-by-step format—that promotes usability. For each business process major program functional area, we prepare manuals that help users understand the purpose and operation of the functions and further support documentation accessibility to process owners and key stakeholders.

We understand the importance of accurate, current documentation to support the smooth, consistent running of a fiscal agent operation. We document and define acronyms, transaction codes, terms, and field identifiers consistently with the interChange panel, report, or data dictionary descriptions. Our web-based user documentation covers system navigation, online help, and policies and procedures.

We frame documentation during design and draft it during development, along with testing and training preparation following the established deliverable approval process. Our approach allows flexibility in developing and delivering content. By tying the training content to documentation, users can realize efficiencies in time, effort, and costs.

Provider Documentation (Unique ID 1687)

With the new and complex changes affecting the healthcare industry, communications management is critical to verify stakeholders' complete understanding of the ongoing and

upcoming requirements and the needs of the affected parties. Our publications manager works with the Provider/Client Services group and the Department on the creation, approval, and posting of provider education material and public-facing documents. We address recommendations received from the Department and incorporate the information into the provider materials.

Our modern Healthcare Provider Portal is an easy to access and comprehensive "one-stop shop" for providers, giving them 24 x 7 electronic availability of "static information" such as bulletins, announcements, and provider manuals or instructions.

Additionally, providers can download or upload information—such as their remittance advice, claim or claim attachment, and prior authorization submissions—through easy access. By using the point-and-click web technology to find numerous resources in one site, providers can view various documents without having to scramble to find last week's mail filed away someplace in their office. These self-service functions minimize providers' time spent searching for information and gives them time back to spend with their clients which may lead to improved outcomes.

The following are sample types of documentation HP prepares, maintains, and posts to effectively support providers:

- Provider bulletins
- Provider reports
- Provider manuals
- Online listings
- Forms

We also prepare, maintain, and post training documentation, including online training materials offerings and virtual training opportunities for providers. Providers benefit from web-based training, such as learning new program and system services at their convenience without having to rely on in-person training events, which can be costly and time-consuming.

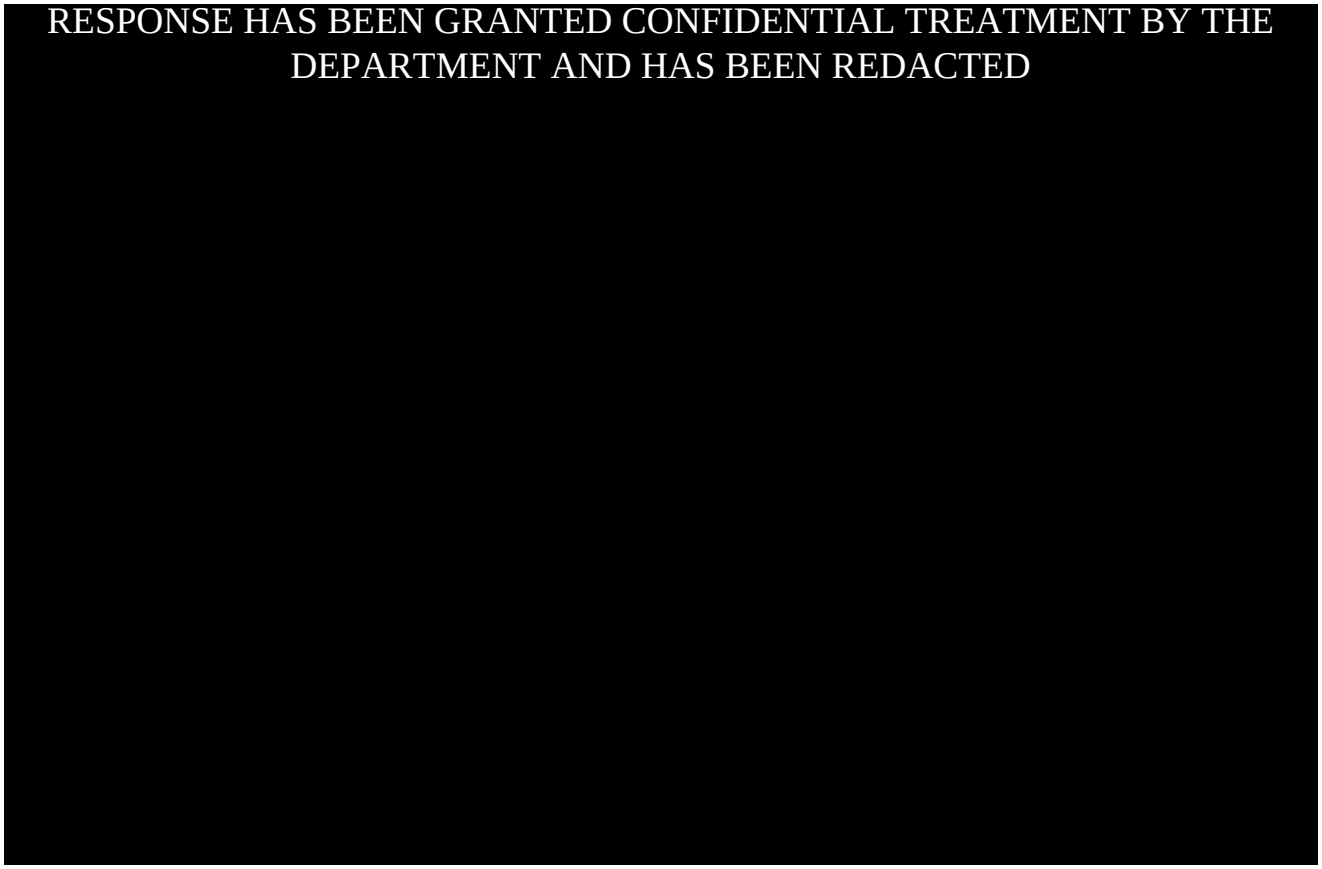
Deliverables Process (Unique ID 1796)

As part of the Start-Up Phase, our project manager works with the Department to define deliverable development, template format, review, and approval processes including criteria that can be used to measure deliverable acceptance. The Department's involvement in these early activities sets the stage for an efficient and straightforward process. Before the start of the first review period, we conduct a work product review of major deliverable documents. Our experience shows that a deliverable work product review allows for dialogue, questions, and thorough explanations of the document's content.

After the Department and HP have agreed on the acceptance criteria for key deliverables and documents, the work plan serves as a baseline for measuring the achievement of milestones and deliverables throughout the project.

In a transformation of deliverable management, the process is set up as an automated workflow within the HP PPM tool as shown in the following figure.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED



After the development and HP quality review of a draft or new deliverable, the deliverable is ready for the Department to review. The project manager notifies the Department and posts the deliverable on HP PPM. Based on our standard deliverable management process, the first draft review allows 10 business days for the Department to review and provide comments. After the first draft review is complete and no comments are received by the end of the 10 business days, the deliverable is considered accepted and the HP project manager requests signatory approval from the Department. If the Department returns comments or rejects the deliverable, the author completes the Department's requested updates to the document and a second review process begins. The second review process allows five (5) business days for the Department to review and provide comments on the updates. The time frames for the first and second reviews should provide the Department adequate time for review of the deliverables.

The project manager submits a final version of each deliverable to the Department after the reviews are completed. If a second review is not required, the project manager uses HP PPM to prepare and submit the final deliverable document for Department approval. We provide five (5) days for the review of the final deliverable including the format for signature approval by the Department. This proven approach has contributed to our previous successful projects. HP is pleased to bring the same processes and tools to support this project. The following figure illustrates the deliverable process.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Production Reports and Retention

The detailed system design (DSD) deliverable includes a list of standard production reports and their intended use. This document is stored on the SharePoint Enterprise site for easy reference. This site is a repository for system-related documentation including reports. The Department will have access to descriptions, layouts, data elements, calculations, and balancing information for the reports produced by the interChange MMIS. Additionally, the HP staff will be available to respond to Department requests for general information about the reports within four business hours of the request.

HP uses IBM's OnDemand to store and archive digital records such as reports, letters, and scanned images such as claims, attachments, and provider enrollment applications. OnDemand assigns each object within its repository a unique identifier and metadata attribute used for retrieval. Users can view assets within OnDemand through a web browser, or application service interfaces.

During implementation, operations, and turnover, data and records progressively move down storage tiers from production hard drives (online access) to backup tapes according to Department-approved schedules. Archives are at the bottom of the storage tiers. HP never purges data without a specific request from the Department and retains data and records online for at least four years or the minimum time specified by the Department. HP stores archived hard-copy documentation, backup tapes, and other media using Iron Mountain's secure storage services.

Forms Development (Unique ID 1801)

The HP publications manager will collaborate with the Department to assist in the development of internal processing forms and their corresponding instructions. Our publications manager will provide recommendations for possible improvements to the forms, if needed, based on our experience in other states.

Defect Notification (Unique ID 1799)

HP will notify the Department as soon as errors or discrepancies are identified in the MMIS. Initial notification will be handled through email to the appropriate Department contacts. If the error is caused by a system issue, a defect change order will be written to document the error and the system update needed to rectify the problem. If reprocessing is required to correct the issue, the details of the reprocessing requirements will be noted in the defect change order. The approach to notification for these types of incidents will be documented in the communications management plan submitted for the Department's review and approval as part of the deliverable submission process.

Resource Management (Unique ID 1798)

HP minimizes risk by supporting the Department with team members who have experience with the proposed interChange solution, who can effectively support testing, validating, and documenting the operational impacts of changes to the interChange MMIS. Our business analysts responsible for testing system changes will have the necessary knowledge to test each aspect of the change.

We also understand there will be times when the project may require additional staff members. Under these circumstances, we may bring in temporary staff members to supplement our existing trained and readied personnel. We have access to HP's technical support and BPO capabilities to provide additional employees, as needed. These groups are well-versed in Medicaid processing and already supporting the interChange system. Our work force planning program across HP healthcare helps us respond to staffing demands by having the right employees available to support crucial deliveries, such as the Colorado MMIS project.

CMS and T-MSIS Reporting (Unique IDs 1224, 1225, 1227, 1808)

With the HP solution, data from the client, provider, reference, financial, and claims functions will be brought together and passed to BIDM to facilitate the creation of monthly, quarterly, annual, and on-request reports. HP recognizes that federal reporting guidelines change

periodically. When this happens, we will work with the Department to incorporate the changes necessary to comply with the most current guidelines.

(1808) We recognize that obtaining accurate information to produce the CMS-64 report is crucial. The HP MAR solution will provide to the BIDM contractor, on a specified schedule, the data necessary to accurately complete the administrative portion of the CMS 64. This will include data such as claims paid by service—for example, abortion services claims and sterilization services claims to support the respective CMS64 and T-MSIS data requirements.

(1225, 1808)The MAR solution provides data for medical assistance payments supporting the preparation of those sections of the Department's CMS-37 report. HP will provide the data and support to the BIDM contractor for the CMS-37. HP also will provide data for the CMS 372 and the "lag" report, generated on the schedule and in the format specified, with format and frequency adjustable as requirements change. This report is designed to determine program participation, expenditures, services, paid and billed amount, eligible clients, unduplicated client counts, total cost of care by date of service, and expenditures for parallel populations.

(1227) HP will supply information to the BIDM contractor 90 days before the federal due date of the CMS-416 report. This will include data relating to EPSDT services, referrals, and follow-up treatment, using fee-for-service and encounter claims information. HP understands that CMS uses the CMS-416 report to identify the number of individuals eligible for EPSDT services and those participating in EPSDT periodic screenings. We also will include the number of screenings performed during the report period, referral activity for treatment services, and the number of clients who received vision, dental, and hearing screens within each age group.

(1224) The interChange MMIS provides the claims data for the CMS-required Transformed Medical Statistical Information System (T-MSIS) files. These files include data for client eligibility, inpatient claim activity, long-term care claim activity, other claim, and pharmacy claim activity. The MSIS summary process produces these files quarterly. Data is delivered to the BIDM contractor through electronic file exchange. We will update the MSIS files per the T-MSIS files specifications and data dictionary document. Because federally mandated requirements affect each of the states we support, we collaborate to share ideas and solutions. With each of our Medicaid accounts represented, the HP T-MSIS Leveraging Workgroup provides an online forum, along with routine meetings, for team members to pose questions, seek advice, and provide ideas for an effective transition. At these meetings, our account leaders discuss implementing new federal mandates and collaborate on how best to implement the mandates, sharing ideas and potential issues.

Registration and Attestation (Unique IDs 1778, 1786, 1787, 1788, 1806, 1807, 1809, 1810, 1811, 1812, 1813)

As part of the 2009 American Recovery and Reinvestment (ARRA) Act, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) established Medicare and Medicaid Electronic Health Records (EHR) Incentive programs. These incentive programs began

January 1, 2011, and provide incentive payments to eligible professionals and eligible hospitals for the adoption, implementation, and upgrade of meaningful use of certified electronic health record (EHR) technology.

State Medicaid programs are responsible for making the incentive payments to providers. Thirteen states, where HP serves as the fiscal agent, collaborated to develop an incentive payment application—the Medical Assistance Provider Incentive Repository (MAPIR).

(1778, 1786, 1788) MAPIR collects and tracks provider applications, evaluates eligibility, collects attestations and meaningful use measures, and makes payments. MAPIR interfaces with the CMS Registration & Attestation (R&A) system, as well as an individual State's MMIS. Pennsylvania was the first state in the 13-state collaborative to go-live with MAPIR in June 2011. HP will bring MAPIR to Colorado to support the registration and attestation requirements.

For the eligible hospital or eligible professional to attest to the EHR incentive, they must attest at the CMS R&A site using their personal data. An email will then be sent to the provider with a link to the secure Healthcare Provider Portal. Providers can only access this site using their secure username and password. The provider is then directed to the EHR link on the secure site to access the attestation page.

As the provider progresses through each topic, the number of completed requirements or measures will be displayed in the ***Progress*** section of the Attestation Meaningful Use Measures page. When the topic is completed, a check mark will be displayed in the ***Completed*** section of the screen.

As seen in the following figure, the Attestation Meaningful Use Measures page illustrates this capability.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

(1806) Online help is available in the MAPIR solution, including field-level help and "hover bubbles." The MAPIR user manual will be posted on the Healthcare Provider Portal. The user manual will include a table of contents, glossary, program background, and application assistance.

(1807) As part of our Customer Service team, HP will provide Tier 1 help desk support for the MAPIR solution. Staff members will be trained on the MAPIR system and the process for submitting an EHR application. They also will be trained to troubleshoot Tier 1 technical issues.

(1809) HP will support appeals from providers per the Department's established appeal process. Examples of appeal reasons include the following:

- Applicant is determined ineligible for the EHR Incentive Program.
- Applicant has received an overpayment for the EHR Incentive Program.
- There is an appeal of the incentive payment amount (such as a pediatrician payment).

If an appeal is upheld, the application will be re-reviewed with re-application by the provider, if necessary. If the appeal is denied, the application process ends but the provider may reapply. If the completed application is not denied, the provider will be notified and the process will continue from MAPIR to the CMS R&A system.

(1810, 1787) As a link on the Healthcare Provider Portal, the Provider Outreach page will include information related to the Colorado registration and attestation process. The portal pages will include specific branding for Colorado. The Provider Outreach page will include a separate path for eligible professional providers and eligible hospitals. Besides links to relevant State, Department, CMS, ONC, and other program pages, the pages will contain information such as the following:

- Background info
- Quick reference guides
- Frequently asked questions
- User guides
- Client volume calculator
- Links to interactive webinars
- Link to start an application

(1811) Our EHR department is in constant contact with the provider by telephone and email. Providers can access the EHR team through our toll-free customer service line. Additionally, we will establish a dedicated EHR email box for providers who prefer to communicate in that manner. Email communication to the provider that contains PHI/PII is encrypted using ZixMail to verify security.

Audits are done quarterly based on the quarter in which the provider was paid. Audits use the following audit criteria:

- High out-of-state client volume
- Low Medicaid client volume
- Group applications containing different client volumes
- Free or low-cost EHR
- Audit by Medicare

- Fraud and abuse complaints against the provider
- Previous sanctions

(1812, 1813) HP understands the importance of protecting confidential data. We will comply with the security and confidentiality requirements of this RFP and the HIPAA Business Associate Addendum. Information will not be retained or used in any way except as authorized by this contract or as required by law. We acknowledge that disclosure of such information may be cause for legal action against HP and defense of such action will be the sole responsibility of HP. HP acknowledges and will comply with the requirement.

We discuss our MAPIR solution in more detail in RESPONSE 39m.

Data Maintenance (Unique IDs 1478, 1678, 1679, 1693, 1793, 1797)

Accurate, accessible, and easily maintainable reference data is the critical link between the interChange MMIS and state healthcare policy. interChange reflects one of HP's newest rounds of innovation, @neTouch—a family of features designed to streamline working with interChange. Users can apply and maintain complex policies with maximum efficiency, exceptional productivity, and personalized flexibility. The following figure highlights the capabilities of @neTouch.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Serving as the central component to the Department's reimbursement policy, the interChange reference business function is a flexible and reliable solution maintaining the data files required to accurately process claims. Frequently impacted by changing business needs and state and federal changes, the reference database is easily updatable and reflects the most current reference data while minimizing the effect to real-time claims adjudication.

CLICK FOR VIDEO

A video demonstration of @neTouch is included in RESPONSE 47.

The interChange reference functional area will enable authorized users to flexibly, quickly, and easily update the data tables through intuitive and user-friendly online panels and automated batch updates, and administer policies governing the Colorado Medicaid Program. (1793) The reference business process will contain tables of information needed to process approved claim types and support associated assistance programs and various reimbursement methodologies. These reference tables will store service, revenue, diagnosis, and other codes and data elements required to price claims based on specific procedures, providers, and other criteria the Department defines. The following table includes some of the benefits and features of the reference files interChange maintains.

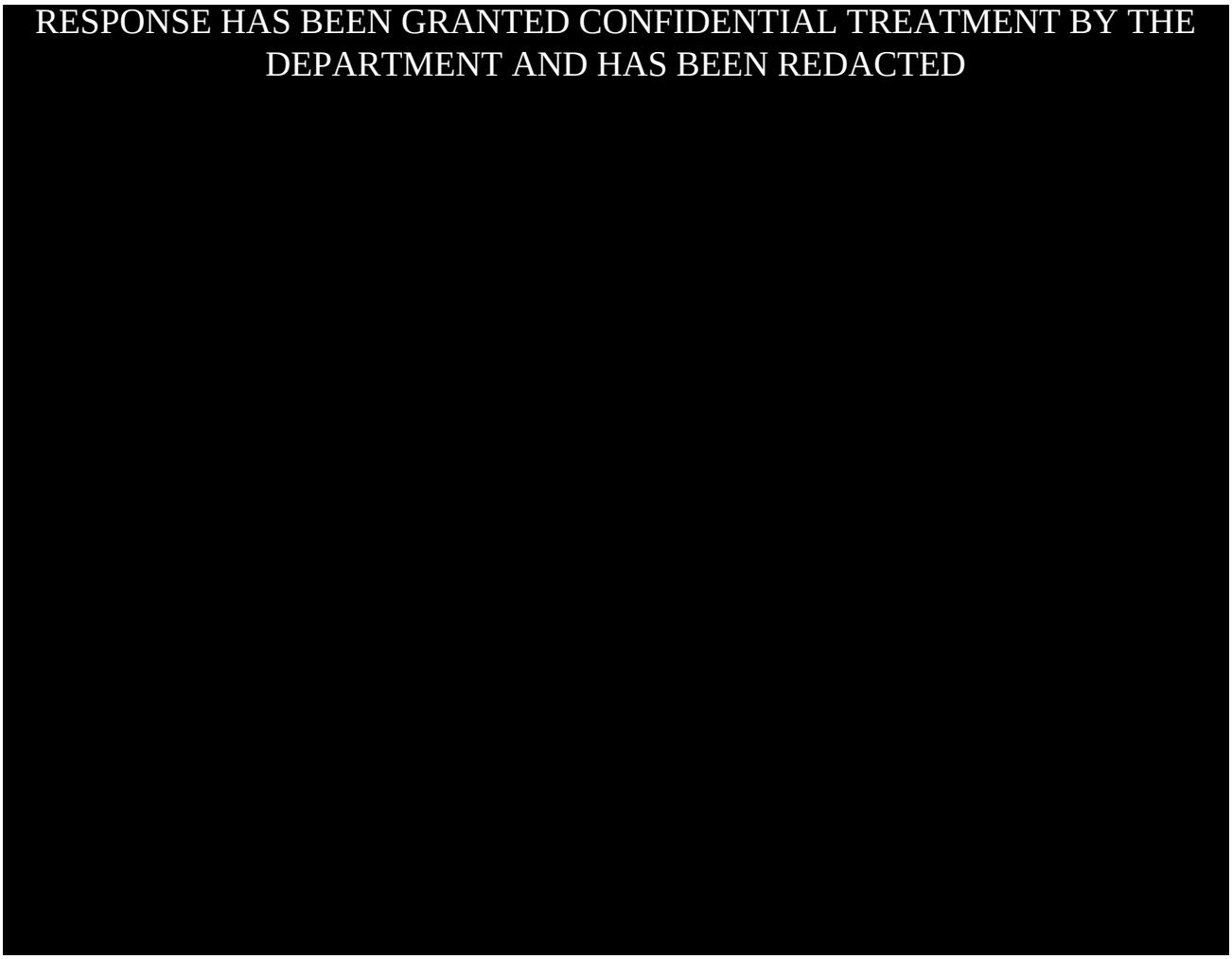
Reference Key Features

Benefit	Feature
Reliable system performance, integrity, and flexibility	• Provides the Department the benefits of investments made by HP to establish user-configurable functions that reflect HP proven practices • Flexible rate-setting configuration that allows effective disbursement of funds and overall cost containment coordinated and tailored for Department policy objectives, and enables greater flexibility in the customization of rates for services based on provider types, benefit plans, and other criteria
Ease of use	• interChange @neTouch simplifies tasks, enabling users to make and apply complex updates intuitively and simply without unnecessary steps or complications.
Reduces administrative time and expenses	• Online, real-time web panel reference changes reduces program costs and contributes to accelerated implementation of new or changed policy. • Maximum user configuration capabilities are provided without technical intervention, which reduces implementation time and cost. • Online audit trails capture changes made to reference data records by user ID, date, and time stamp for future research and reference. • Linking related and historical data within the system increases ease of use by reducing search and policy evaluation time. • Providing one set of reference tables for the processes to access in real-time mode allows updates to be used immediately, enabling the Department to realize the maximum fiscal effect of changes made. • By allowing accelerated implementation of policy changes in claims processing administration, this feature incorporates the use of interface update files including ICD-9 codes from CMS, ICD-10 codes, DRG data, HCPCS updates, and revenue codes.

(1679) The interChange solution accepts and processes online updates. Authorized users—whose role provides access to the reference database and permission to add, delete, or change information at the Department's request—complete online updates that are smaller in volume. To protect the integrity of the data, these updates go through an online edit process. A reference data maintenance analyst verifies the additions, deletions, or changes to the reference database. To complete this task, the analyst reviews the online web panels or a reference file update report. If information is incorrect or needs to be changed, the analyst or user with update authority on the Reference team makes the correction and verifies the changes. Within the interChange web panels are "notes" sections that allow for the tracking of changes entered by a user. The

following figure provides an example how users document the reason for the update. HP selected the authorization code web panel to illustrate this feature.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED



An audit trail tracks reference file updates to support the Colorado Medicaid Program and is available for Department review. Additionally, updates are end-dated, not deleted, preserving the data integrity while archiving historical information for claims processing and the Department's reference. The following figure provides an example of a diagnosis code reference web panel that illustrates information stored on interChange.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Whenever possible, automated batch updates allow for fast and accurate application of large volumes of reference data, such as quarterly and annual HCPCS, annual APR/DRG, and NCCI updates. For batch updates, the HP team obtains the data to be loaded from the Department, CMS, or other approved outside entities and uses automated processes to update the appropriate data within the reference tables.

The HP team maintains the reference files in interChange and assists in verifying that claims are checked against the most current and accurate information. The volume of data stored within interChange reference tables and the constant change of healthcare programs necessitates an approach that can accept automated batch updates on a frequency the Department approves. We also will subject the updates to strict data validation editing and track changes through online web panel audit trails. Audit trails contain the updates to the reference files and are easily accessible through online web panels.

We will complete batch updates daily, monthly, quarterly, annually, or at the Department's request. As in other states using interChange, the system will perform a comparison from existing reference information to new information loaded to the database. interChange will generate a report listing the differences and provide it to the Department to approve additions, changes, or deletions. After receiving the Department's approval, we move the changes to the production environment.

The Correct Coding Initiative (CCI) developed by CMS promotes national correct coding methodologies and controls improper coding, leading to inappropriate payments on claims. The interChange solution will apply Medicare CCI edits to defined claims. Other HP Medicaid state accounts developed rigorous procedures to confirm updates to the production files are accurate.

(1678) With years of experience in working with MMIS reference files, HP has the expertise to perform mass updates from multiple sources using industry-proven update procedures. The HP team will follow these proven procedures when accepting and processing mass updates to the reference files:

- The reference file updates specified by the Department are loaded systematically or manually into a test environment.
- HP produces reports listing new reference file updates for the Department and the HP team to review.
- When we receive Department approval, we move the updates to the production environment on a schedule approved by the Department. interChange sequentially reads the reference file and applies the updates to accurately update the master reference files.
- Quality assurance analysts from the HP team will complete postproduction verification of reference file updates through the online web panels or by reviewing the reference file update reports. When new updates are added, historical information is end-dated and not deleted from interChange.

Data will be available online for a minimum of six years and retrievable from storage after being archived. (1693) The Department will have access to the data elements stored within the interChange MMIS, including the following:

- Data captured and related to claim or encounter record, including reference files, edits and audits, and associated claims processing tables in effect at the time the claim or encounter was processed
- Inbound prior authorizations records captured, and reference files, edits and audits, and other associated claims processing tables in effect at the time that the prior authorization records were processed
- Once-in-a-lifetime procedures and data associated with audits or lawsuits

Client Data Maintenance

(1797) The interChange MMIS maintains client records for use in processing claims, prior authorization requests, and eligibility verification. Providers can inquire on claims, client's services, or benefits through the Interactive Voice Response System, the Healthcare Portal, written correspondence, or by calling the HP call center.

Provider Data Maintenance

The interChange MMIS' provider data maintenance function maintains comprehensive current and historical information on providers eligible to participate in the Colorado Medicaid program.

(1478) HP's solution brings a robust system and offers a single provider data repository with current provider demographic, certification, rate, and summary financial information. Ownership information is obtained through the provider enrollment process and stored in the provider database tables. The provider enrollment process requires the disclosure of ownership and the percentage of ownership. This includes individual owners, entities, subcontractors, board of directors, and management companies. The web application provides an easy method for providers to update the ownership information. During processing of the web application, the tax ID is used to verify if an owner already exists or if a new segment should be added.

Eligibility Verification System (EVS) (Unique ID 1413)

Providers can submit eligibility verification requests and receive an immediate response through the Interactive Voice Response System, the Healthcare Portal, or by swiping the client's ID card using the provider's point of service device. Benefit information pertinent to the client will be returned, including current eligibility, third-party liability (TPL), managed care provider information, spend-down data, and any other eligibility restriction data.

Providers rely on the Eligibility Verification System (EVS) to verify that they will be paid for rendering services to the Department's clients. They value high availability and various options for accessing eligibility data. The EVS solution developed by HP offers many features and benefits to effectively and efficiently supply client-related information to providers as illustrated in the following table.

Benefits to the Department

Solution Feature	Benefit
Improved access to eligibility. Providers receive real-time responses through multiple access methods that are available 24 x 7.	Increased provider satisfaction
Web-based capability with multiple inquiry field combinations eases provider access in finding client eligibility information and boosts providers' efficiency.	Efficient search capability
A centralized process retrieves data from one current database for access methods. This approach helps control benefit usage and provides the same response information regardless of the inquiry method.	Client information updated in near real time
We offer providers a choice in access methods, including the IVRS, Internet submission, point-of-service (POS) networks, and VANs.	Multiple access options
HIPAA-compliant security measures for electronic eligibility transactions protecting confidential information	Secured confidentiality

Solution Feature	Benefit
The real-time, transaction-based request and response processing is delivered using Extensible Markup Language (XML) transaction services and processed using common eligibility and claim status routines for inquiries including IVRS, web, and ANSI X12N for consistency and reduced maintenance costs.	Fast, accurate answers
A centralized process retrieves data from one current database for access methods. This approach helps control benefit usage and provides the same response information regardless of the inquiry method.	Uniformly current client information updated in real time

The EVS maintains an audit trail of inquiries and verification responses made, the information conveyed, and to whom the information was conveyed. Providers can inquire on clients by using the following information:

- Client identification number
- Case number
- Full name and date of birth
- Partial name and date of birth
- Social Security number and date of birth

HP will include additional response data elements as deemed necessary by the Department. The Healthcare Portal eligibility response gives the provider a summary of client information in one web page, eliminating the need to go to multiple sources for accurate and current client program eligibility information.

Letter Generation (Unique ID 1794)

We routinely provide data extracts for mailing purposes. The extract process addresses consistent formatting for things such as changing caps to sentence case, proper punctuation, correct salutations, and proper ZIP codes. Data extracts are easily imported into PC desktop mail merge applications such as Microsoft Word. Additionally, our proposed HP Exstream product makes it much simpler to design, develop, and produce letters. Advanced features allow letter development that is personalized with pertinent, custom information for delivery across many channels.

The designer functions in HP Exstream use the formatting and navigational techniques similar to the Microsoft Office suite of products, minimizing the learning curve. This point-and-click approach enables users to define the appropriate design, operational, and production requirements without programming. Additionally, the object-oriented design enables users to share and reuse objects to streamline the implementation of written correspondence.

Reusing a common mailing address template allows us to design a common routine to select the address out of the database and present it to the HP Exstream. This reuse of common processes

and components is the essence of a service-oriented architecture (SOA). This enables us to generate numerous letter types consistently and accurately with less time and effort, reducing letter development time by as much as 80 percent.

Coordination and Collaboration (Unique IDs 1795, 1804, 1805)

(1795) HP works with other contractors and other state agencies to routinely support interfaces to the MMIS across our 20 Medicaid contracts. HP will coordinate the interactions between the Department, other contractors, and HP will have the appropriate technical personnel available to answer questions and assist the other contractors through the process.

(1804) HP's provider relations staff will assist State staff members and the Department's contractors with research, resolution, and response to client and provider issues related to the MMIS or fiscal agent operations. Prompt resolution of issues minimizes potential negative effect on the provider and client community. Our approach is to place the appropriate focus on these types of activities so that we can quickly determine the possible effect and resolution.

(1805) The HP call center solution has warm transfer capability. We will configure our system to support an outgoing warm transfer to the Colorado Health Benefits Exchange (COHBE). Our call center solution can support incoming warm transfers from external entities approved by the Department.

Record Keeping (Unique ID 1802)

Documentation about charges included on the HP invoice will be retained for the entire term of the contract. HP will develop a cost allocation plan, before the Operations phase, to determine the appropriate Federal Financial Participation for each line item on the HP invoice. HP conforms to generally accepted accounting principles.

Payment Cycle (Unique ID 1803)

The interChange MMIS has multiple options for adjusting the timing of any payment cycle. Payments can be held in their entirety, reduced by a specific percentage, held only for certain provider types, or held for specific providers.

HP's Financial Payment Module is flexible to meet our customers changing needs. The payment cycles are initially set to run once per week. Should there be a change in requirements—on a onetime or an ongoing basis—it is as easy as changing a parameter in the system.

9.2 – Fiscal Agent Operations Business Requirements	**In Production? YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1293	**NO**

Electronic Document Management Solution (Unique ID 1293)

The components of IBM OnDemand, our enterprise document management solution (EDMS), are modular. Using interChange Connections and Business Services Framework will allow us to make changes to the EDMS, correspondence, and interChange without affecting the scanning, fax servers, or the OCR engine.

After a document has been scanned and fielded, the OCR engine will kick off a workflow instance within interChange Business Services. Workflow calls the Business Rules Engine to determine if specific rules apply to the document. Workflow triggers the process to store the document image in the EDMS. This process is carried across the Enterprise Service Bus (ESB) through the interChange Connections framework to maintain loose coupling between interChange and the EDMS. The workflow instance can generate and assign work items to humans or service-enabled applications.

The following figure depicts a workflow instance that manages the process of taking a scanned claim and uploading it into the EDMS.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Imaging a paper claim is a triggering event that will invoke a web services request and send inputs such as extracted client contact information to the interChange Business Services. The ESB manages the services that are illustrated by the green dots in the figure.

RESPONSE 40b

9.3 – Claim/Encounter Related Services	**In Production? YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1520, 1533, 1552, 1558, 1564, 1565, 1581, 1583, 1620, 1621, 1638, 1639, 1681, 1686, 1814-1829, 1852	**YES**

Comprehensive claims and encounter processing solutions are at the core of the Department's ability to manage multiple payer (multipayer) groups, provide timely processing for the provider community, and safeguard the State's funds.

The Department seeks a claim and encounter processing system that can execute these tasks according to the Department-defined policies. Maximizing online editing and error resolution drives accuracy, productivity, and timely payment for providers. Our claims and encounter processing solutions are customized, flexible, and backed with experience processing Medicaid transactions in 20 states, providing the Department and stakeholders with convenient, online, and secure access to their information.

The HP Colorado interChange transfer system fully complies with 42 U.S.C 1396a(a)(37) to provide for claims payment procedures. This system that 90 percent of clean claims for payments made for services covered under the plan and furnished by healthcare practitioners through individual or group practices or through shared health facilities are paid within 30 calendar days of the date of receipt of such claims and that 99 percent of such claims are paid within 90 calendar days of the date of receipt of such claims. Clean claims are defined as claims for which no further written information or substantiation is required to make payment.

HP also provides for procedures of prepayment and postpayment claims review, including the review of appropriate data regarding the client and provider of a service and the nature of the service for which payment is claimed to facilitate the proper and efficient payment of claims and management of the program.

Our table-driven system is fully compliant with the HIPAA transactions and code sets according to HIPAA and Department business rules and can easily be updated if changes are required. As shown in our proposed organizational chart in RESPONSE 32, HP has the requisite staff members with the appropriate skill sets to meet the requirements of the RFP throughout the term of the contract, including staff members to key paper claim forms within three days of receipt.

During the initial phase of the contract, HP will meet with the Department during the Design, Development, and Implementation (DDI) Phase to fully define the Department's business rules to incorporate into the following required processes:

- A recoupment process
- A recoveries process
- A coordination of benefits process
- An encounter process
- A 1099 process

After these processes are updated and approved, they are implemented and operated according to the business rules defined by the Department.

In these budget-conscious times, the Department faces increasing pressure to rigorously monitor policy, performance, and expenditures and to respond rapidly to diverse demands from the provider, legislative, and State and federal regulatory bodies. Because of that, the Department seeks an experienced MMIS fiscal intermediary that can provide an advanced, proven MMIS with the capacity to expand and grow with the Colorado Medicaid program—a fiscal intermediary with the requisite experience and knowledge to respond to the ever-changing needs of Colorado's healthcare landscape. HP readily accepts this challenge and is proposing the Colorado interChange Medicaid Enterprise system to meet the request for proposal (RFP) requirements. The following are some of the benefits our Colorado interChange brings to the Department:

- Proposed transfer solution from Wisconsin is our newest CMS-certified system and was certified in December 2010, back to the first day of operations, using the new CMS certification criteria.
- HP's platform moves customers up the MITA maturity continuum by providing real-time enabling technologies that support processes to improve program administration in a client-centered model.
- Colorado interChange rolls out policy changes faster, supporting rapid activation of healthcare reform initiatives, especially critical and time-sensitive initiatives relating to cost containment and coverage expansion.
- Colorado interChange includes a rules-driven claims engine that supports authorized users in configuring rule changes, reducing the reliance on technical staff members for process and policy change requests.
- The Colorado interChange enterprise care managed solution enables the Department to coordinate care across provider types and monitor compliance and outcomes to care plans—supporting true pay-for-performance models.
- The Colorado interChange provides real-time adjudication of claims, enabling accurate and faster settlement with providers to help improve satisfaction and increase participation.

- Using our distributed open architecture, advanced analytics, and new services modules, our customers have transformed from payers to purchasers of healthcare that is outcome-based, improving quality of care and helping states to become better stewards of scarce state healthcare dollars.
- Colorado interChange provides a high level of flexibility within security features to allow broader control of more components of the system, providing to the right people access to the right data to make more informed decisions.

Nothing replaces the innovations that result from implementing modern MMIS solutions. HP has more extensive MMIS implementation and operations experience than any other vendor. In 2008, HP became the only vendor to implement five MMIS solutions in a single calendar year.

In our national role as the number one Medicaid fiscal intermediary, we are responsible for claims processing for 46 percent of the nation's Medicaid population. This type of financial and service responsibility requires tremendous discipline and commitment to quality. We look forward to working with the Department and bringing our Colorado interChange Medicaid Enterprise system, processes, and people to work for you.

Production Reporting Capability (Unique IDs 1558, 1828)

The Colorado interChange solution includes a production reporting capability that provides standard operational reports available through our document management system and the ability to build ad hoc reports on key MMIS data attributes. The expected second claim report is something that HP understands the Department needs to properly monitor health outcomes and quality of care.

During the Discovery and Requirements Validation and Requirements Elicitation Phase, we will work with the Department to define parameters to put this report into monthly production as a scheduled batch report and an "on demand" online report for more flexibility for the user.

Additionally, the Colorado interChange provides the ability to flag, re-price, suspend or deny the first claim when a second claim is expected, which will spur the provider to complete the care. Our rules-driven claims engine supports authorized users in configuring rule changes, reducing the reliance on technical staff members for process and policy change requests. Edits and audits can be configured through the Business Policy Administration (BPA) rules engine without any coding. Rules can be configured to flag, suspend the original claim for a period of time or deny the claim. The pended claims would recycle each week looking for the expected second claim and then pay the two together. If the second claim is not received in the predefined number of weeks, the original claim will pay or deny as directed by the Department. A monthly production report can be generated to show the claims that receive this edit.

HIPAA Transactions Overview

Our Colorado interChange table-driven system is fully compliant with the HIPAA transactions and code sets according to current HIPAA and Department business rules and can easily be updated if changes are required.

The Colorado interChange allows providers to submit claims and transactions in multiple venues and supports the following HIPAA-compliant claim standards:

- ASC X12 837 Professional Claim
- ASC X12 837 Institutional Claim
- ASC X12 837 Dental Claim
- National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Claim

Additionally, interChange also provides access to claim information through the automated voice response system (AVRS) and HIPAA-mandated X12 276/277 Healthcare Claim Status Request/Response.

Providers who have implemented one of the many HIPAA-mandated claims-related transactions can use the Healthcare Portal and interChange to exchange one or more of the following transactions:

- HIPAA-compliant X12 276/277 healthcare claim status request or response transactions
- Unsolicited X12 277 healthcare claim status for pended claim status notifications
- HIPAA-compliant X12 835 healthcare claim payment or advice transactions

Using the X12 276/277 and unsolicited X12 277 transactions, providers can verify in real time the status of a single claim or several thousand claims. Colorado interChange also posts X12 835 transactions to the Healthcare Portal following each financial cycle.

We detail features and capabilities of electronic claims submission offered through the interChange solution in more detail in the “System Requirements” section and include additional details on electronic data interchange (EDI), interactive claim billings, electronic claims batch billings, and other electronic claim media:

- **HIPAA-compliant X12 275 Patient Information transaction—**This transaction is expected to be part of the HIPAA claim attachments standard and is not yet finalized by CMS. HP will fully comply with the X12 275 after CMS releases the final requirements for this transaction.
- **Health Level Seven—**HL7 is a standard for exchanging information between medical applications. This standard defines a format for the transmission of health-related information. Information sent using the HL7 standard is sent as a collection of one or more messages, each of which transmits one record or item of health-related information. Examples of HL7 messages include client records, laboratory records, and billing information. HP does not have requests to use the HL7.

Adjustment Processing (Unique IDs 1520, 1639, 1819)

The Colorado interChange claims adjustment process is easily accessible to the provider community and minimizes negative financial and administrative impacts to the Department and the providers. Colorado interChange provides an effective and efficient solution for claims adjustments. Through Internet access, providers have user-friendly access to initiate adjustment requests that are immediately processed and paid or denied. During adjustment processing, the system links related transactions so that the latest adjustment can easily be tracked back to the original claim.

The adjustments that Colorado interChange processes accurately reflect in the files that are accessed during the reversal and reprocessing of a claim, including the provider master, the client maintenance, the PA, and the financial tables. The system also clearly reflects adjustment transactions on the provider's remittance advice (RA), which helps the provider to reconcile records. The interChange reporting function is an important component of the adjustment processing function. It also is designed to meet Department and federal reporting requirements.

The Colorado interChange adjustment function offers the following:

- Online capability for adjustment processing for providers
- Cross-referencing of the original and adjusted claim for easy referencing
- Online web page for mass adjustment requests by different selection criteria, such as per diem rates, procedure codes, and dates of service
- Ability to review financial effect of mass adjustments before release in the system—when released, adjustments adjudicate instantaneously

Colorado interChange processes claims adjustments through the claims processing subsystem. Adjustments are allowed on claims that were approved for payment, regardless of whether there was actual reimbursement issued because of payment reductions for such factors as third-party liability (TPL) and spend-down. Adjustments are allowed on the most recent version of the claim and void the most current claim or adjustment and then reprocesses the adjustment as a replacement of the original claim or adjustment. The adjustment contains the internal control number (ICN) of the original claim as a link to the claim that is being adjusted.

The original and adjustment claims are then processed in the same cycle and displayed on the same RA. interChange displays the original and adjusted claims on the provider's RA as offsetting transactions. Additional payments due or receivable amounts resulting from the adjustment are applied to the current check-write. This approach of processing and reporting adjustments makes it easier for the provider to determine the net result of the adjustment and make the necessary account reconciliation.

Credit-only adjustments are performed in the financial function by establishing an accounts payable with the desired balance and the appropriate explanation in the entry. The account is then credited in the next processing cycle.

Colorado interChange accepts claim and nonclaim–specific adjustments, automated adjustments from accounts receivable (AR) and TPL case tracking, no-history adjustments, recoupments, mass adjustments, and cash transactions. Colorado interChange also accepts retroactive adjustments to account for retroactive changes to client spend-down, TPL retroactive changes, and retroactive changes to medical coverage codes (groups). The system also accepts program integrity automated adjustments and can accept and process claims or encounter adjustments from third parties if the request has the appropriate information.

interChange also allows the adjustment of claims history to reflect a partial recovery of payment because of TPL. During the claim adjustment process, the refund amount is applied to the claim and the original claim is systematically adjusted to zero. The system then creates an AR for the provider, where the TPL payment is applied. The net payment to the provider is zero. This action is accomplished similarly as internal adjustments and is logged in the claim history. The AR is reflected on the provider's RA, which can be received on paper or electronically depending on the provider's choice. If the Department desires, providers can receive additional weekly or monthly letters specifying the ARs that are created for them.

As with other claims, claim adjustments can be data-corrected in real time and processed through the MMIS multiple times in a given day. Online changes to adjustment claims are part of the interChange data correction function. During data correction, sometimes referred to as pend resolution, authorized users can make online corrections or changes to the adjustment claim record. The ability to process suspended adjustments online, coupled with multiple daily claim cycles, gives rapid turnaround on suspended adjustments, resulting in increased service to providers.

Adjustment Request (Unique IDs 1520, 1639)

In Colorado interChange, the user performs a claim-specific adjustment by entering the ICN of the claim to be adjusted. The following figure is a sample Adjustment Request page interChange uses to initiate adjustment requests.

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The Adjustment Request page comprises two sections. The top section contains fields related to the entire adjustment request. The bottom section contains fields related to an individual adjustment within the batch request.

As each adjustment is entered by pressing the Add button, the Corrections page appears and allows the user to change the claim. The system extracts the claim data from claims history and displays it. The user then changes the appropriate fields and resubmits the claim for processing. By requiring the user to enter only the ICN to pull the claim from history and the new data necessary to adjust the claim, the user is required to enter only a minimal amount of new data to accomplish the adjustment.

If the ICN of the claim to be adjusted is not readily available, the user also may initiate a search for the claim by entering the appropriate claims information—such as provider number, client number, or date of service—on the Claims Inquiry page. The system searches history for claims meeting the search criteria and displays them for review. As soon as the appropriate claim is displayed, the user accesses the system's point-and-click feature to display the entire claim. Users can make an adjustment by simply changing the information that needs to be corrected and resubmitting the claim for processing.

Mass Adjustments

Colorado interChange also provides for processing of user-initiated mass adjustments by authorized users. The adjustment processing function is flexible in supporting processing of individual or mass adjustments of claims. Mass adjustments include systematically selected claims for repricing because of retroactive pricing changes, including capitation rate changes, [redacted] spend-down changes, client or provider eligibility changes, and other changes that require reprocessing of multiple claims. The targeted claims are selected from paid claim history, voided, and then reprocessed using the new pricing rate or criteria. With the mass adjustment function, adjustments that used to take weeks to complete and needed to be done by a programmer can now be completed by select operational staff members in a matter of minutes.

The authorized user specifies the search criteria in an online mass adjustment screen. The following figure is an example of the screen that would display the adjustment selection criteria within interChange.

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The system displays claims meeting the specified criteria. Variables that can be selected include time period, age, sex, claim type, diagnosis-related groups (DRG), diagnosis, ESC (error code), NDC, program, provider ID, client ID, region code, revenue, procedure, modifier, and provider type or specialty. The user can select or deselect the claims, release the selected claims for continued adjustment processing, or cancel the adjustment. This capability gives added flexibility in performing mass adjustments.

If the selected claims are released for processing, the previous payments are taken back, and the adjusted claims are paid. Both claims are displayed in the provider's RA, which shows the original and adjusted claims as offsetting transactions. Each adjusted claim has an adjustment reason code and a description of the reason code. Mass adjustments also will create an AR transaction for each claim adjusted if appropriate.

The retroactive rate adjustment capability is part of the mass adjustment processing function. This function automatically identifies claims affected by the rate adjustment, creates claim adjustments, and reprocesses the claims. As with other adjustments, a link is maintained between the original and adjustment claims. This function also can be used to select claims affected by changes in client liabilities.

An adjustment clerk initiates these adjustments by updating information on the retroactive rate adjustment page. Additionally, this page also can be enhanced to include client liability changes. The following table lists a representative sample of the pages that support the claims adjustment function.

Colorado interChange MMIS Web Pages for Claims Adjustment

Page Name	Description
Adjustment Header	Lets an authorized user make corrections or adjustments to header claim information
Adjustment Detail	Lets authorized users make corrections or adjustments to detail claim information
Mass Adjust NDC Entry	Supports the entry of drug codes as search criteria for a mass adjustment
Mass Adjust DRG Entry	Lets users enter DRG as search criteria for a mass adjustment
Mass Adjust Diagnosis Entry	Supports the entry of a diagnosis as search criteria for a mass adjustment
Mass Adjust Program Section	Supports the entry of multiple medical assistance programs as search criteria for a mass adjustment
Mass Adjust Provider ID Entry	Supports the entry of a provider ID as search criteria for a mass adjustment
Mass Adjust Region Code Selection	Lets users enter region codes as search criteria for a mass adjustment
Mass Adjust Claim Type Selection	Used to enter claim types as search criteria for a mass adjustment

The following figure shows the Adjustment Request Search page, which provides users with the capability to view and search for active or finalized adjustment requests within interChange.

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Online web pages provide up-to-the minute updates about the status of adjustment requests.

Mass Recoupments

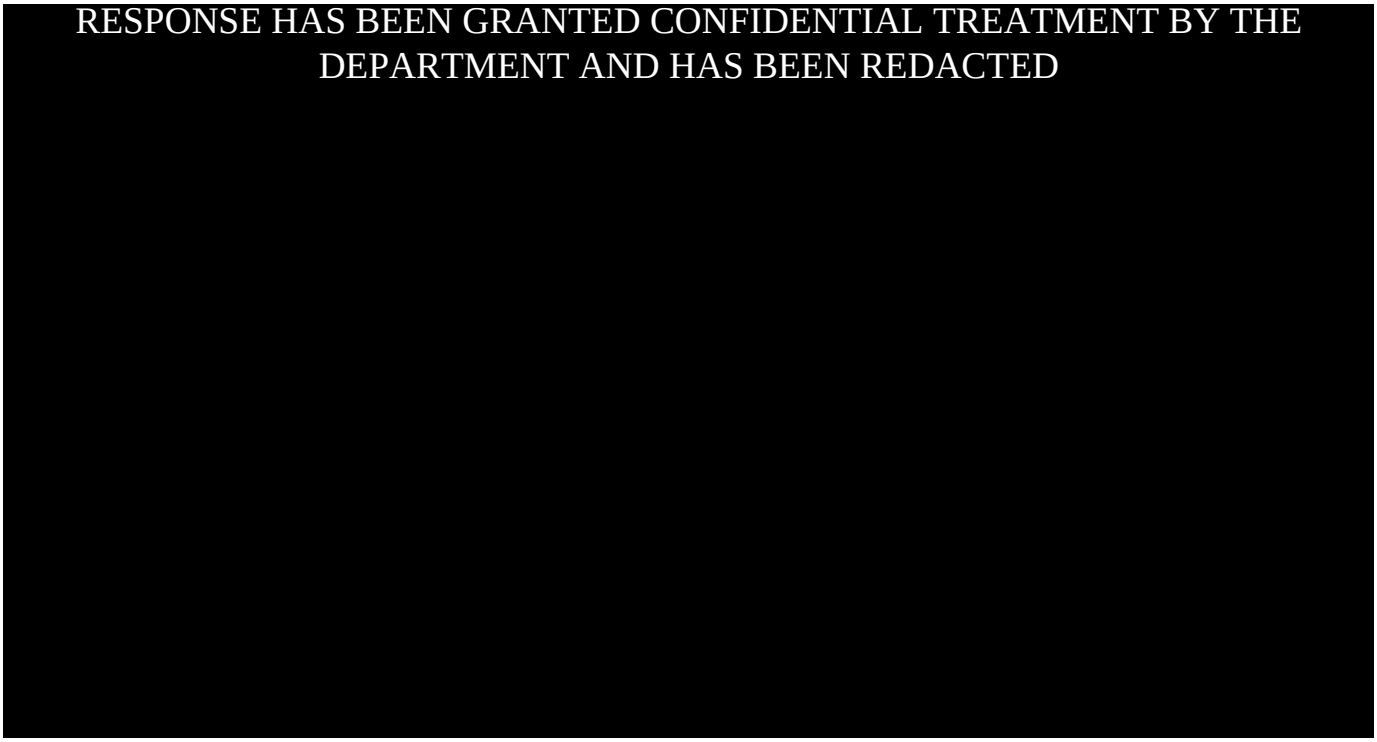
In the same manner that mass adjustments are processed, the Colorado interChange also provides for processing of user-initiated mass recoupments by authorized users. The targeted claims are selected from paid claim history and voided, deducting immediately from the provider's next payment. These claims can be selected based on user-defined criteria, including combinations of client, provider, service, date of service, benefit type, benefit class, diagnosis, or other user-defined criteria. These will be automatically reflected on the provider's RA and will indicate the original claim information so that the provider knows exactly what claim is being recouped. Mass recoupments also will create an AR transaction for each claim recouped. With the mass recoupment function, items that used to take weeks to complete and needed to be done by a programmer can now be completed by authorized operational staff members in a matter of minutes.

Payment Processing (Unique ID 1827)

The financial business area within the Colorado interChange provides the ability to reverse, void, reissue, split, or hold payments. Through the financial screens authorized users specify the payments to reverse or void and whether to reissue payments. For all reversed or voided payments, the related transactions are automatically reversed.

When payment is received it is entered through the cash control feature in the Colorado interChange MMIS. After the cash control is created, the amount can be dispositioned across one or multiple open accounts receivables.

The hold payment option allows authorized users to specify the criteria for holding payments as shown in the following graphic. The criteria include such factors as provider type and specialty, benefit plan, dates of service, type of payment (check or EFT), claim type, fund code and category of service.



Using this payment hold criteria, authorized users can specify the exact time period to hold the payments and for example, hold all payments for those enrolled in PACE.

Provider Notification (Unique ID 1620)

The robust Colorado interChange MMIS provides the ability to notify providers by paper, email or publishing to the web portal, whenever an accounts receivable is created. Additionally, a reminder letter can be generated 30 days after the original notification.

With a rich culture of innovation and a commitment to invest in our evolving products, HP provides a solution that meets the Department's current business objectives and has the flexibility to solve current and future challenges. The Department's interest in availing itself of the best-in-class COTS technology is clear in the RFP. COTS products are licensed and used by multiple industries, commercially available from a third-party, and provide a common solution throughout the application.

HP has invested significant time and effort in our review of the COTS products available in the marketplace today and is proposing superior COTS products that bring the best value to the

Department. We list our selections of COTS—and their use in the Colorado interChange—in the following table.

Claims and Encounter Adjudication Transaction COTS Products

Product	Use
IBM OnDemand	Document management system
Mavro MavBridge software	Software to allow the system to properly route incoming documents
OPEX DS2200	High-volume production scanner for converting paper documents to digital images
SunGard FormWorks	Optical character recognition (OCR) document scanning solution

These COTS products are integrated into the Colorado interChange solution and provide the value the Department desires. The base interChange MMIS has been successfully implemented in 13 states and is a proven, robust, and innovative Medicaid solution that has incorporated the use of COTS products to address requirements and enhance solutions. This track record of success significantly reduces the risk to the Department as you move to a new, flexible MMIS and Medicaid fiscal intermediary.

Our commitment to our customers is well documented through customer testimonials. We are known as the company that does what it takes to get the job done and can be relied on to work with you as you move forward with your goals to take your Medicaid program into the future.

Payment to Correct AR Record (Unique ID 1621)

The Colorado interChange enables authorized system users to apply payment to the correct accounts receivable (AR) record. The AR screen can display a list of the delinquent ARs for a provider. The system has reports that list AR data, and the user can run ad hoc reports for specific AR data. The payment cycle will systematically apply provider payments to ARs that are set up for automatic recoupments (to hit against uncollectible accounts). Dispositions that are applied to ARs carry specific reason codes that identify the type of recoupment. The AR carries the fund code for dispositions applied to the AR to distinguish federal and State funding. The AR screen and the ad hoc reporting system allow for multiple search criteria, including a full query history of open and uncollectible AR. The screens allow for updates and corrections depending on the user's authority. ARs can be claim-specific or nonclaim-specific. Claim-specific ARs will have a link to the claim that caused the AR to be created.

Publications (Unique IDs 1686, 1816)

As part of our certification process, the claims and encounters billing processes, policies, and procedures will be reviewed with the Department and made ready to be placed online. These

documents are made available to internal staff members for training purposes and provider assistance. The documents also are placed on the HP Healthcare Provider Portal so that providers can access them directly. As part of this documentation, HP will publish an electronic searchable crosswalk of the HIPAA adjustment reason codes and remark codes to edits that are used in the interChange system.

Reference File (Unique IDs 1581, 1681)

The Colorado interChange MMIS maintains all code sets used for the processing of claims and encounters including revenue, HCPCS, CPT, CDT, and diagnosis within the BPA functional area. These tables contain both active and inactive date spans and can only be updated by authorized users. Records are never deleted so a complete history of the file is available for auditing purposes.

For each code set, online inquiry and update access is available based on the security of the user. Authorized users maintain the base information, restrictions, effective and end dates. Through the BPA rules engine, authorized user configures the coverage information, service limitations, error codes, and pricing rules.

Receive Mail and Paper Claim Transactions and Attachments (Unique IDs 1552, 1814)

The Department has an enviable record of receiving most of its Medicaid claims electronically. However, even a small percentage of paper volume still equates to more than 20,000 paper claim documents a week. Paper volumes of this magnitude necessitate an innovative, cost-effective solution to capture the paper documents quickly and accurately for input into the HP Colorado interChange system.

With a demonstrated commitment to our Medicaid customers to invest in our evolving products, HP provides a solution that meets the Department's current business objectives and has the flexibility to solve future challenges. We have experience processing, receiving, logging, reviewing for completeness, imaging, and processing paper claims and claim attachments in our 20 current Medicaid states.

Each morning the incoming mail sent to our fiscal agent P.O. Box at the local U.S. Postal facility will be picked up by our courier and delivered it to the HP Denver facility. HP places mail delivered to or picked up from the post office in a locked mail transport container to provide proper control of the protected health information (PHI), personally identifiable information (PII), and checks en route. Mail delivered to the Denver office location would include proprietary forms, RAs, checks, correspondence, and office mail. Our HP staff members, including the mailroom and courier personnel, are trained in privacy and data protection and security awareness to protect the confidentiality of the Medicaid mail. The courier follows strict procedures to verify that the PHI and PII are not compromised from the paper claims and correspondence being picked up or delivered.

Log and Review for Completeness

After the mail is delivered to the mailroom, the scanning clerks using the COTS product OPEX DS2200 high-volume production scanners process it. The mailroom data preparation clerks would sort mail by claim type in a typical mail processing location, but using the OPEX scanner eliminates most of this time-consuming manual process. The scanning clerks simply load the mail onto the mail extraction desk, where the suction cups grab one envelope at a time and run the envelope across the razor to open. Next, more suction cups pull the sides open so the scanning clerk can reach in and take hold of the contents, pull the extracted documents from the envelopes, and lay the contents on the conveyor that runs the documents through the scanner.

The OPEX DS2200 eliminates the need to transport, batch, prep and sort between extraction and scanning. In just one pass, letters, checks, claims, forms, legal-sized documents, and file folders can be scanned intermixed with little or no preparation.

The documents are then fed through a unique feeder that is capable of handling the widest range of document sizes, shapes, and thicknesses. The OPEX scanner images paper claims, classifies them, and categorizes them into folders by claim type. A mailroom operator classifies unrecognized images using a one-stroke hot key while viewing the image—for example, classifying UB-04 forms into inpatient and outpatient or long-term care. They also can adjust the claim image to correct items too dark or too light, which affects the final image in the repository.

The OPEX DS2200 scanner, which we depict in the following figure, virtually eliminates the additional preparation and post-processing tasks associated with conventional document capture.

OPEX DS2200 Scanner

Incomplete claims or claims with missing key data fields are identified at the scanning desk. Before the claim is loaded into the system, the scanning clerk can automatically route the claim directly to individuals in the mailroom for further processing. For example, if a provider submits a claim form without an enrollee name, the claim can be rejected at the OPEX scanning station and routed to the mailroom, where the claim is returned to the provider with an appropriate instruction letter attached.

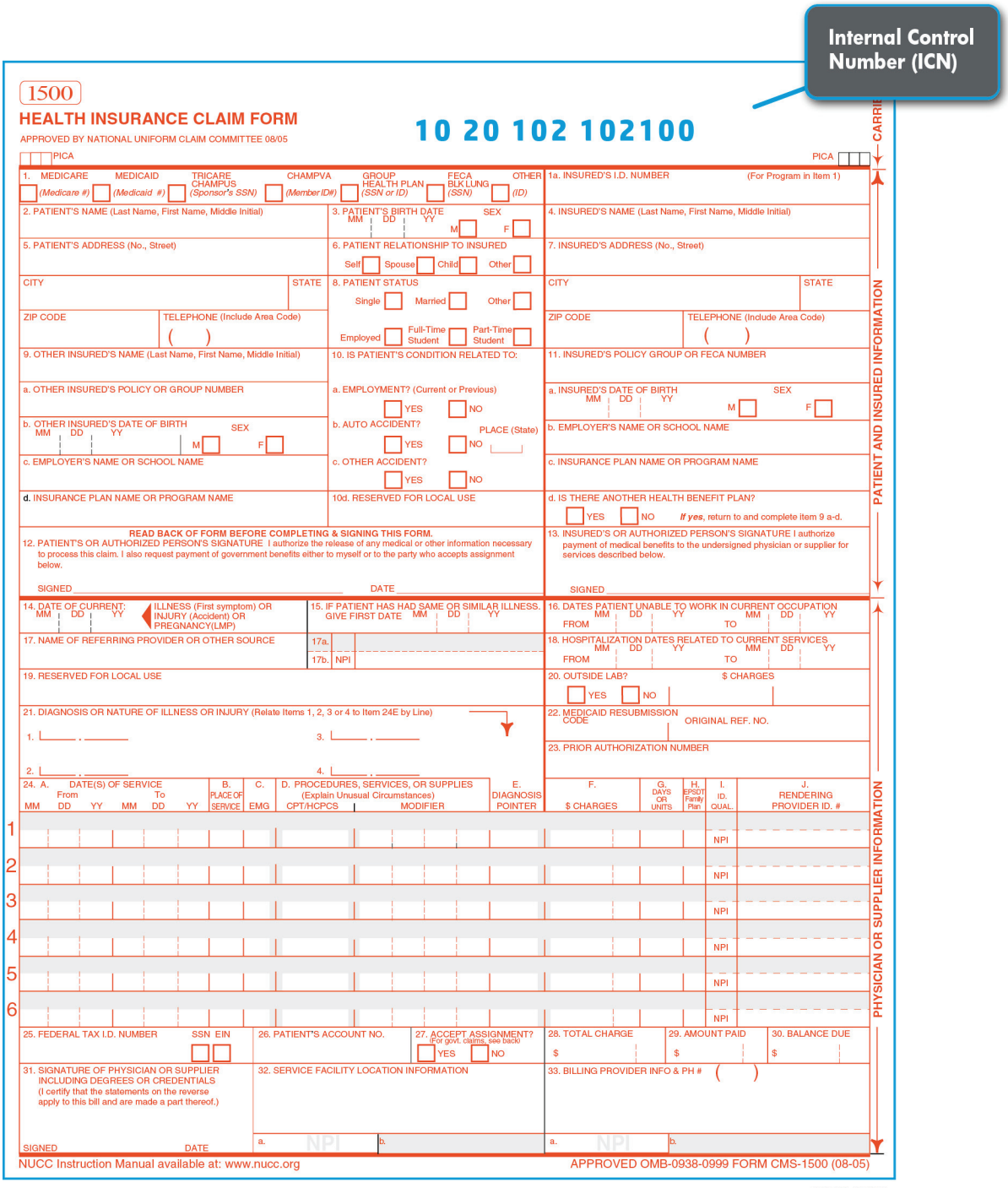
Eliminating preparation, paper handling, and other manual sorting tasks improves efficiency and results in superior transactional integrity. As documents are removed from envelopes and scanned, the scanning clerks view each image to verify it is properly captured and identified. This reduces time-consuming and costly rescanning later in the process. Our HP Oklahoma Medicaid account experienced an 85 percent reduction in the time it took to open and sort mail through the OPEX system going from a daily effort of 40 work hours to six work hours from the previous manual process to prepare the mail for scanning.

As valid (complete) claims are loaded into the online OPEX folders, the claims are prepared for the SunGard FormWorks OCR process. In the OCR process, claims are indexed to the IBM OnDemand document management system (EDMS) and assigned the unique ICN that identifies each claim in the system and is reported on the provider's remittance advice after the claim is adjudicated.

Our HP Oklahoma Medicaid account experienced an 85 percent reduction in the time it took to open and sort mail through the OPEX system—going from a daily effort of 40 work hours to six work hours from the previous manual process to prepare the mail for scanning.

The Colorado interChange system provides intelligent unique control number tracking for each claim, encounter, and adjustment through assignment of an ICN. The following figure provides an example of an ICN assignment for a claim.

Internal Control Number Assignment



The ICN assignment provides control number tracking for each claim that enters the Colorado interChange system. Regardless of the submission method the provider chooses, every claim received is automatically assigned a unique ICN. Each ICN is generated and encoded to indicate the method of submission by region and receipt date The ICN also is the key to tracking a claim throughout the adjudication process and validating processing timeliness requirements are met.

The following details the format of the ICN is RRYYJJJBBBSSS:

- **RR**—region
- **YY**—Year
- **JJJ**—Julian Date
- **BBB**—Batch
- **SSS**—Sequence

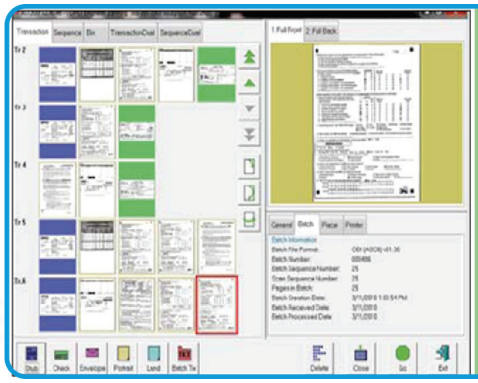
The Colorado interChange system ICN assignment process provides for intelligent tracking of claims from receipt to final disposition.

Image and Process Paper Claim Transaction and Claim Attachments

Mavro MavBridge software is used to interpret the information, sort the contents based on various custom parameters, output the optimized data to recognizable documents, place them in specific folders, and upload the folder contents to the COTS SunGard Formworks system for traditional indexing and OCR repair. The OPEX software verifies paper claims and claims attachments stay together when going through the OCR process and input into the Colorado interChange system. The scanning clerk can easily annotate on the screen that an attachment follows the claim, enabling the claim and attachment to remain together throughout the processing of the claim.

OPEX CertainScan, depicted in the following figure, allows the scanning clerk to visually classify documents during the scanning process. The OPEX scanner can dramatically sharpen the image as it is viewed or enlarge the image on the screen, allowing a higher percentage of scanned claims and attachments to process automatically through the system without the need for rejecting or having to reimage the document.

OPEX CertainScan Capture Software



348_157_06_043

The DS2200 comes equipped with CertainScan. Besides various exclusive features, CertainScan offers the most intuitive way to visually classify documents during the scanning process. The display shows each image as it is scanned and color-codes each document type for easy verification.

Each item in a transaction is grouped together for quick visual confirmation of transaction integrity.

Based on the claim volumes provided in the RFP and the information documented in the Procurement Library, HP provides dedicated OPEX scanners and verifies that our account is adequately staffed to process the anticipated daily volume of paper transactions received. This innovative solution for imaging paper claims and attachments provides the Department with a proven, successful solution for imaging and processing claims and attachments.

Informational Messages (Unique ID 1818)

Colorado interChange provides an integrated text component feature within the RA logic that provides the capability of broadcasting messages to specific provider groups. The design is scalable and flexible in that a provider is only sent pertinent messages. Providers are not frustrated by reading through volumes of information and are given only updates that are important to their particular practice or provider specialty.

The capability to print informational messages on the RAs includes selectable print parameters, such as provider ID number, provider type, claim type, and payment cycle dates. The flexibility in presenting the broadcast message format, type style, and use of symbols allows the Department and HP staff members to tailor the messages to the providers. The Colorado interChange system includes several online pages that allow users to flexibly define broadcast messaging and select the providers who will receive them for a particular payment cycle.

Robust EDI Capabilities

The interChange EDI engine provides electronic data exchange using secured socket layer protocols, a fully integrated translator, and direct VAN connectivity for each claim type.

The Colorado interChange system provides online access to authorized users to create these informational message criteria through its online Broadcast Message Maintenance browser pages. The Maintenance browser page allows users to create, change, or delete a broadcast message that is sent to providers on their RA.

Electronic Claims Submission (Unique IDs 1552, 1814)

Colorado interChange supports electronic claim submission by using the EDI solution. This approach supports the input and output of electronic transactions in HIPAA-compliant formats. Because of this, providers can submit claims and transactions in the method that they find most convenient. The following figure highlights the electronic claims processing flow.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Colorado interChange allows providers to submit claims and transactions in multiple ways and supports the following HIPAA-compliant claim standards:

- ASC X12 837 Professional Claim
- ASC X12 837 Institutional Claim
- ASC X12 837 Dental Claim
- NCPDP Retail Pharmacy Claim

We discuss features and capabilities of electronic claims submission offered through the interChange solution in the following subsections:

- Electronic Data Interchange
- Interactive Claim Billings
- Electronic Claims Batch Billings
- Other Electronic Claim Media

Electronic Data Interchange

The most innovative approach to electronic claims submission is Colorado interChange's EDI engine. Providers can access the EDI web through traditional Internet service provider (ISP) connections or direct dial-up connections through secured remote access servers. The EDI website is a single portal through which providers can bill claims or check status of claims.

Interactive Claim Billing (Unique IDs 1814, 1818)

Colorado interChange allows providers to accomplish the following:

- Access a secure website through ISP or direct dial-up
- Submit any claim type for processing
- Receive an immediate, full response, including adjudication and pricing

Traditionally, only pharmacy claims have been submitted in a truly interactive manner, with pharmacists submitting claims at the point of sale (POS) and receiving an instantaneous adjudication response. This adjudication included edits, audits, prospective drug utilization review (proDUR) alerts, copay deductions, and pricing. With the implementation of Colorado interChange, the Department can offer this capability to providers for each claim type. Colorado interChange enables providers to access a secure website, through ISP or direct dial-up, submit any claim type for processing, and receive an immediate, full response, including adjudication and pricing.

Providers access the Healthcare portal and complete an online claim form similar to the following figure.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

On submission, the claims are transmitted to the Colorado interChange claims processing engines and assigned a unique ICN. Claims submitted in this manner pay, deny or pend. With a denied claim, providers can make the necessary modifications—for example, adding missing units field and resubmit the claim. The system assigns a new and unique ICN to the claim. It is then fully adjudicated.

Colorado interChange edits each claim as completely as possible during an edit or audit cycle rather than ceasing the process when a failure is encountered. This capability prevents providers from having to resubmit claims after each edit or audit failure.

Electronic Claims Batch Billing (Unique IDs 1552, 1814)

Fast Claim Response Access

Within minutes of submitting a claim using the batch submission process of the EDI engine, providers can inquire to see if a claim was paid or denied, correct the denied claim, and immediately resubmit.

We recognize that interactive claim submission does not meet each provider's business needs. For those providers who prefer the traditional batch submission approach, the EDI engine also provides a secure, encrypted method for billing. The Provider Portal eliminates bulletin boards and asynchronous protocols, which do not meet the stringent security demands of private health information. However, we recognize that not every provider contracts with an ISP because of cost or business reasons. To support these providers and offer a method for batch claim submission, we establish a bank of remote access servers that providers can access directly without giving them access to other Internet sites. By using the ISP or remote access servers, providers have a secure mechanism by which they can upload batches of claims for billing.

Similar to the interactive billing described previously, providers submitting claims in batch mode receive immediate ICN assignment and claim adjudication. Within minutes, providers can inquire on submitted claims, determine if the claim was denied, suspended, or paid, and determine the amount of payment. Providers have the same option to correct denied claims from the Provider Portal and resubmit the claim.

Other Electronic Claim Media

If a provider is unable to use the HP Healthcare Provider Portal, we receive and process electronic claims on the following media:

- Diskettes
- Value-added networks (VANS)

Claims and Encounter Processing (Unique IDs 1552, 1814, 1823)

The Colorado interChange edit and audit process is optimized for automated first-pass processing. Our system logic suspends claims only as a last resort.

The claims business function performs the rigorous claims editing and auditing, based on the Department's policy and rules, to determine whether claims should be paid, suspended, or denied. The Colorado interChange system's edit and audit process is optimized for automated first-pass claims processing, including business intelligence for multiple same-day surgeries and duplicate checking, depending on the Department's specific criteria and requirements. Because of this, fewer claims suspend, reducing the manual review workload. This improved system logic suspends claims only as a last resort.

To support the objectives for the Department's claims and encounter processing function, HP uses interChange to provide the following functions:

- Receive claim types by providing interactive online Colorado interChange (edits and audits) through the web, POS, and direct entry through PC so that providers know whether claims are paid and the amount of the payments they receive
- Adjudicate batch-submitted claims within minutes of receipt in the interChange MMIS
- Track claims throughout processing by maintaining an audit trail of activity applied to each claim
- Maximize online editing and auditing of each claim type
- Support rapid changes to edit and audit criteria through a table-driven pricing data function that enables authorized users to make immediate changes rather than waiting for technical personnel to implement the changes
- Provide efficient online claims resolution by allowing claims resolution specialists to view imaged claims and keyed claims in a split window and providing them with easy-to-use browser pages that feature drop-down menus for online database updates
- Control online data updates and protect the confidentiality of data with user IDs and extensive audit trails that show data that has been changed
- Offer minimal downtime and continuous claims processing by having a system design that can forward claims to another claims engine node should one node fail
- Provide a scalable claims processing engine that can handle claims volumes
- Provide powerful data storage, online inquiry, and reporting capacity
- Offer flexible, on-demand desktop inquiry and reporting through easy-to-use, parameter-driven pages that present formatted inquiry results immediately
- Provide report output electronically on the IBM OnDemand document management platform for rapid report retrieval and the capability to perform electronic searches, print only a portion of a report, or export report information to spreadsheet software for analysis
- Provide secure web access for providers to obtain detailed claim information
- Supplement interChange reports with those available through the management and administrative reporting (MAR), ad hoc, and decision support system (DSS) functions to support the Department research, monitoring, and reporting requirements
- Bring a proven, decades-long track record of providing data to meet CMS reporting requirements for Medicaid customers

Effective support of the claims and encounter processing function results in outstanding customer service to providers, promoting provider participation, increasing enrollee access to care, and reducing the Department's administrative costs.

System Functions and Efficiencies (Unique ID 1826)

HP designed interChange based on an Oracle relational database. While other systems may be retrofitted to a table structure, the system proposed for Colorado was designed specifically to meet the program challenges faced by our Medicaid customers. This design approach allows for rapid processing of modifications and minimizes the level of effort and program dollars required to implement changes. With HP's innovative design that makes extensive use of shared-object libraries and parameter-driven edits, the Department can implement program changes quickly.

By using the Internet to process Medicaid claims, providers can submit claims in a truly interactive manner through a user-friendly and secure web submission method. Claims pay, suspend, or deny. With denied claims, providers can immediately make the necessary modifications—for example, adding missing units and resubmitting the claim. Besides claims submission, providers can use the Internet to verify eligibility, request prior authorization (PA), view claim payment information, and retrieve recent 835 transactions. Using the Internet in this user-friendly and secure manner further encourages electronic submissions, leading to cost savings in the reduction of paper and material requiring manual processing.

Colorado interChange also contains powerful features to manage workflow and enhance the quality of claims processing. One of these features is the work scheduler used to control the processing of suspended claims. This tool controls the number and type of claims to be processed by a claims resolution specialist. Because of this, based on each specialist's experience, knowledge, and expertise, the claims or operations supervisor can control the specialist's access to specific claim locations and claim types and control the specialist's authority to override or force a claim. This feature allows us to maximize staff resources and easily adjust to increases in suspended claim inventories.

The work scheduler also is used to monitor the quality of a specialist's work. The supervisor can randomly select claims processed by claims resolutions specialists for review, suspending the release of the selected claims into the claims processing system until the supervisor has reviewed and approved them. Additionally, by using the Online Resolution Manual tool, resolution specialists have immediate online access to the most current adjudication guidelines related to the suspended claims they are resolving. Because of this, the specialists have continual access to the most current resolution guidelines.

Colorado interChange is designed around ease of use and provides authorized users with point-and-click access to MMIS data through easy-to-learn, online browser pages. These pages provide the pull-down menu, pop-up window, and point-and-click functions users have come to know from their work with Windows-based PC applications. This familiar look and feel greatly reduces the learning curve required to master the new system and increases the comfort level of staff members as they use the system to monitor claims inventories or respond to provider billing inquiries. Additionally, the user-focused design of Colorado interChange helps reduce manual input and improve productivity and accuracy of data.

Colorado interChange also enables users to retrieve reports from their desktops in electronic formats, greatly reducing the time delay to receive updated ones. Additionally, the electronic format of the report lets users run searches for critical information, print only the portion of the report they need, or export data to spreadsheet applications for analysis.

Colorado interChange offers many features and benefits that effectively and efficiently support the present and future requirements of the Colorado healthcare programs. One of these features is the weekly financial cycle. Generally, other states using the interChange platform prefer to run a weekly financial cycle; however, the interChange system can run more frequent payment cycles. For example, one client runs three claim payment cycles weekly and has additional payment cycles for nonclaim payments. These cycles can be configured and initiated by authorized users only.

The following table highlights some of the key features and benefits obtained through the system.

Claims and Encounter Processing Features and Benefits

Feature	Benefit
Proven multipayer system	Allows migration of multiple state payers from manual processing to an automated system while maintaining individual benefit packages and restrictions
Online adjudication of claims and adjustments	Decreases time from receipt to adjudication and allows many provider types to submit point-of-sale transactions for their claim
Interactive adjudication with posting of denials results in reduced suspense, quicker payment, and fewer adjustments	Increases provider satisfaction
Multiple daily edit and audit cycles with suspended claims available after each cycle	Eliminates the two-week turnaround for adjustment processing seen on legacy systems
Enhanced mass adjustments processed on the same day they are entered	Eliminates massive delays in processing, providing quicker recovery of overpayments because of annual rate changes

Colorado interChange offers many features and benefits that effectively support the claims and encounter processing business function.

Claims Search and Navigation

Colorado interChange provides a user-friendly, flexible claims search or inquiry capability. The Department staff can search and sort by data elements, including ICN, date of payment, date of service, category of service, procedure code range, provider and client information, or other

criteria as defined by the Department. Additionally, the Colorado interChange system searches can be limited to fee-for-service (FFS) claims, managed care encounters, or other claim types. Colorado interChange provides easy and logical access for Department staff members to view lists and details of claims, encounters, service authorizations, reference files, and MMIS records by provider, date range, or category of service.

The Colorado interChange system incorporates friendly navigation that allows users to move freely throughout the system, using consistent menus, drop-down boxes, and navigational links. These features enhance the user experience and reduce the learning curve for new users, which is often a significant concern in the introduction of any new system.

The system takes advantage of advanced browser-based technologies to provide a user-friendly menu system that is easily understood by nontechnical users and provides access to functional areas of the system. The menu is customizable to provide flexibility in defining page or menu flows unique to a user's business responsibilities, which provides enhanced efficiency to the user's workday.

Claims Processing (Unique IDs 1522, 1814)

HP looks forward to providing the Department with a highly efficient claims processing system that accepts electronic and paper claims and transactions in HIPAA-mandated formats. Colorado interChange allows providers to submit claims and transactions in the method that they find most convenient. To allow for maximum flexibility, we accept electronically submitted claims through the Internet, directly from a PC through a modem, or diskette. Additionally, we electronically scan and image paper claims and claim-related documents.

Benefits to providers include the following:

- Ease of access
- Fast claim submission
- Rapid turnaround time on clean claims

Our Internet solution provides information access for the Department, providers, clients, and other authorized users. HP facilitates the access and exchange of information with a website that is easy to use, secure, and contains the capability for exchanging various information between multiple users. Providers can use the Internet to verify eligibility, submit claims, request PAs, and view claim payment information.

interChange claims processing performs more than 700 edits and audits. It performs edits on the current claim as it is being processed so that data is valid and present. The system checks claim data and adherence to Medicaid and program-specific rules and regulations, such as determining if a specific procedure code requires PA. The Colorado interChange also performs audits after completing editing and initial pricing. Additionally, the system performs auditing on details that are approved to pay against paid details that are found on the current claim, current cycle, or paid claims history.

During duplicate auditing, the system reads the history that overlaps the dates of service of the current detail. The system performs the exact duplicate and the suspect duplicate audit for each history detail obtained. While the system uses numerous tables in provider, reference, client, and PA for editing, users can customize audits online through a series of easily updateable audit criteria pages.

Using highly efficient pages, the claims resolution specialists perform online correction of claims that fail the edits and audits requiring manual review. The system processes data-corrected claims throughout the day. If a data-corrected claim fails another edit or an audit, it becomes available to be reworked following the next cycle—usually within 20 minutes—eliminating the typical waiting time for a weekly cycle.

The system also can apply global changes to suspended claims based on the Department-defined criteria and approval. Targeted claims may be selected and the changes applied. interChange can then release the claims to the editing and auditing cycles and process them as new-day claims subject to the edits and audits in the claims processing subsystem.

During the processing lifetime of the claim, an audit trail is established that shows where the claim has been, what error codes were failed and corrected, who made the corrections, and the dates the corrections were made. If data was changed, this audit trail also shows the data that was originally entered and the data that was changed. From the time a claim is entered into the claims processing system, it can be tracked as it moves from one location to another until it is finally adjudicated for payment or denial.

HP meets claims processing requirements identified in this section of the RFP. The flexibility of interChange allows the Department to respond to the changing needs of a dynamic medical assistance program. We can readily add edits and audits that do not reside in the system. When they are added, we can change them to accommodate new policies, procedural changes, or changes in the local medical practice.

The following figure is a sample of one of the several audit criteria pages that the Department and HP will use to view, update, or add criteria associated with an audit.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Because this structure allows for easy update capabilities, we include effective security measures to grant only authorized personnel the ability to change the tables. We work with the Department to define and implement security measures that positively control the various tables within Colorado interChange.

The system maintains online adjudicated claims history and claims for lifetime procedures on a current, active claims history file for use in the claim audit process, online inquiry, and claim reporting functions. Colorado interChange claims history is updated automatically at the end of each adjudication cycle so that the most current information is available for audit processing, online inquiry and update, and ad hoc reporting.

We work with the Department to identify the required edit and audit criteria to support Colorado Medicaid. During the DDI Phase, we will document required edits, audits, system suspense locations, disposition criteria, and other edit-related items. The resulting claims edit and audit

function provides the controls and processing mechanism necessary to pass claims to adjudication. As policies are changed, Colorado interChange also can maintain active and inactive spans for the edits, audits, and rules. If the Department determines a year after implementation that it wants to turn an edit off, it is easily done. That same edit can then be turned on later, maintaining the window in which it was inactive so that claims can be processed appropriately, based on the date of service.

Claims Editing (Unique IDs 1533, 1552, 1823, 1852)

Colorado interChange edits data elements on the claim for required presence, format, consistency, reasonability, and allowable values as part of and with editing according to the National Correct Coding Initiative (NCCI). Edits perform quality control checks in data fields for alphanumeric values, high- or low-range checks, data validity, and timely filing. Examples of edits that interChange performs include the following:

- Dates are edited so that they are valid dates and do not represent future dates.
- Service codes are edited for validity.
- The number of services performed is edited against the span of time being billed to confirm that they agree.
- Service codes are edited so that they are payable in accordance with the Department guidelines and policies—for example, second surgical opinion and PA.
- Service code combinations are reviewed to prevent improper payment.
- Claim is edited to verify that the provider is approved to render the service based on the provider's specialties, licenses, trainings, certifications, accreditations, taxonomy, or other Department-granted special permissions or characteristics.
- Covered services are edited in the context of the benefit plan being processed to verify that the service is covered and no coverage-based restrictions are present.

Claims are subjected to system edits to verify that they comply with Colorado Medicaid policies and medical criteria. Validity editing of claims is part of Colorado interChange. Claims are edited against the provider, client, and reference data files as part of the claims processing function. Colorado interChange edits each claim as completely as possible during an edit or audit cycle rather than ceasing the process when a failure is encountered so that multiple resubmissions of the claim are not required.

As mentioned previously, the Colorado interChange system also includes editing for NCCI edits that define when two HCPCS/CPT procedure codes may not be reported together except under special circumstances. CMS based the NCCI coding policies on current coding conventions, coding guidelines, national and local Medicare policies (NCDs and LCDs), and standard medical and surgical practice. Within the interChange system, individual NCCI edits can be turned on or off, based on a State's decision.

Additionally, interChange enables users to edit claims or encounters based on provider referral conflict of interest as defined by the Department. In working with the Department, HP will incorporate editing, so when a conflict of interest is identified, the claim will be adjudicated according to Department policy. Examples of provider referral conflict of interest includes: the Stark Act prohibitions, the federal anti-kickback statute, or any other situation in which a physician's interests conflict with those of the client.

Edits also can be placed on services to suspend payments for individuals who are inpatients of a hospital, nursing facility, or ICF/ID, or who are enrolled in PACE. These edits can be placed at the individual service level or the client level depending on the service involved. For example, if a client is in a global payment period of a transplant, an edit can be placed on the client file to catch each claim for extra review to verify the providers are not overpaid.

During editing, the claims processing system accesses various file tables to validate the claims data. As part of this, Colorado interChange can process the programs that a client is eligible for in a single pass and to pay individual details under different benefit plans. The system also allows for a configurable hierarchy of benefit plans to be established so that services are paid under the correct program. We demonstrate some of these checks in the following table.

interChange System Checks

Action	System Checks
To verify the client is eligible for the services billed	Client table
To verify the provider's eligibility to perform the service billed	Provider table
To confirm that the services billed are covered during the date of service and that they do not conflict with services previously billed	Reference table for diagnosis and edit and audit disposition
To verify that a PA exists when required	PA table
To verify that other payers have been accounted for	TPL table

Claims Auditing (Unique IDs 1564, 1565, 1817)

After claims pricing, the system performs audits to validate compliance with Colorado Medicaid

policies and medical criteria. Audits are performed based on configurable rules that can be easily user-modified to support Department policy. These audits include the following:

- **Duplicate audits—**Verify that claims have not been previously paid
- **Relationship audits—**Look for relationships between the service billed and services paid in history, as well as services in the same claim or cycle
- **Contraindicated audits—**Look for conflicts between the services being billed and services paid in history, as well as services in the same claim or cycle
- **Limitation audits—**Verify that the services billed do not exceed the Department limitations in dollars, units, or occurrences—for example, limitation audits that can be placed on a benefit plan to control overuse of services

Colorado interChange performs audits for exact and potential duplicate claims by using history claims, claims awaiting payment, and same-cycle claims. Duplicate claims auditing is based on client, billing provider, service dates, services rendered, modifiers, attending provider, billed amount, and other data elements specific to each claim type. Colorado interChange cross-references between group and rendering providers and multiple provider locations and across provider, claim types, and categories of service.

Duplicate auditing is an automated function performed by interChange's claims processing subsystem. The current exact duplicate audit function checks for duplicate claims based on client, billing provider, service dates, services rendered, modifiers, attending provider, billed amount, and other data elements specific to each claim type. The following criteria are used to determine whether a claim is an exact duplicate of a previously received claim:

- The potential duplicate audit function performs checks for potential duplicate claims based on client, billing provider, overlapping service dates, services rendered, and other data elements specific to each claim type.
- Duplicate claim auditing prevents the subsequent payment of a claim for which a provider may have already been paid.
- Claims also are audited against historical files to verify that they conform to established Colorado Medicaid policies, service, and dollar limitations.

Limitation audits can be placed on a benefit plan to control overuse of specific services. Services for individual clients also can be limited by the use of the PA screens. During the claim processing process, the claim system automatically looks at the Authorization module to determine if there is an authorization in place for the service billed. If there is an authorization, the system also will check the number of services authorized to determine if the claim exceeds the number of allowed units and the number of units previously billed.

Various combinations of individual, ranges of codes, and combinations of codes can be grouped together to form certain conditions or episodes of care. The Colorado interChange provides the capability to group codes for the following for a wide range of codes such as client benefit plan, diagnosis, DRG, modifier, occurrence code, provider contract, provider type, provider specialty, revenue code, and type of bill. This enables authorized users to define the criteria associated with a specific episode of care for auditing for the same provider or different providers.

Claims Resolution (Unique ID 1814)

Claims that fail the edits and audits that are not set to systematically deny are suspended and routed to the appropriate system claim locations for manual review and processing by the appropriate Resolution team member.

Suspended claims resolution involves the following functions:

- **Data correction—**For paper claims, incorrect data is changed if the error resulted from a keying or scanning error, as we detail in the following figure. When corrected, the claim continues through the adjudication process.
- **Manual pricing—**A price is assigned by the Resolutions team based on the complexity of the service and using the Department-defined and applicable pricing policy.
- **Forcing or overriding an error—**The claim is forced to pay based on documented exception criteria and based on Department-approved procedures.
- **Denying a claim—**The claim is denied because the error cannot be corrected without additional information from the provider, and the error cannot be overridden.
- **Referring a claim—**The claim is forwarded to another location for further review and adjudication determination.

Claims resolution in Colorado interChange is a paperless process performed online in real time. The claims resolution specialists work with a split window that displays the claims data that was entered into the claims processing system and an optical image of the claim that was submitted for processing. During the data correction and adjustment processes, they also have access to other data that may be necessary to verify the validity of the data on the claim. With point-and-click navigation, they can access the client eligibility file, provider file, and reference files.

The claims processing subsystem processes the claims again that have gone through claims resolution, except those that are denied. These claims are edited and audited again to verify that they conform to Colorado Medicaid policies and medical criteria. The denied claims are forwarded to the financial function for inclusion in the provider's RA.

Colorado interChange provides online, real-time, user-friendly claims resolution for claims through browser pages, pull-down menus, and point-and-click navigation. An authorized user can have multiple open windows on a desktop to move freely throughout the system. When appropriate, the system relays identifying data to new pages, eliminating the need to enter data multiple times. Claims resolution pages clearly display failed edits and audits.

Colorado interChange allows users to address claims issues by using multiple windows. The following figure is an example of how a pending claim appears in interChange.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Online resolution of claims in pending status provides added efficiency by making pended claim information available immediately following a processing cycle. This online, real-time capability results in a streamlined, efficient claims resolution process. Additionally, for claims that have been submitted on paper, the resolution clerk may retrieve the claim images from the online imaging system to verify information. The claim resolution pages also allow for claim editing to the greatest degree possible, and the system provides unlimited error code occurrences per claim header and detail.

The Online Resolution Manual provides resolution specialists with immediate online access to the most current adjudication guidelines related to the suspended claim they are addressing. Colorado interChange's overall user-focused design helps reduce manual input and improve productivity and accuracy of data.

Claims Disposition (Unique ID 1583)

Colorado interChange dispositions claims based on the result of claims editing, auditing, and suspended resolution. Claims may be paid, denied, or suspended for further review and processing. Paid and denied claims are forwarded to the financial function to await processing in

the next scheduled financial cycle. As detailed previously, the base system is not restricted to a single weekly financial cycle but can be configured for multiple cycles. Claims suspended for further review and processing go to claims resolution specialists.

Certain edits, when applied to a claim, can indicate to a provider that further information is needed for the claim to be processed appropriately. These edits can be configured to maintain the claim in suspended status for a certain number of days and recycle the claim waiting for the additional information (for example, if an attachment is expected but not received). If the additional information is not received before the specified number of days elapse, the claim would automatically deny.

The following table lists available dispositions for claims edits and audits and the description of each.

Disposition of Edits

Disposition	Description
Pend	Causes the analyst to review the header or detail in a specific processing location
Deny	Causes the header and the detail to automatically deny, with the related explanation of benefits (EOB) indicated from the Error Disposition Code Maintenance page
Pay	Allows the header or detail to adjudicate for processing and display an informational EOB to the provider
Test	Processes the claim, tracking the number of claims that would fail if the edit or audit were applied without suspending claims that fail; reports test results for review by designated personnel
Batch	Indicates that batch activation edits must be resolved before claims processing can continue
Inactive	Indicates the edit or audit is not active and is not applied to claims processing

Claim Resubmission (Unique ID 1821)

As documented by our processes throughout this section, HP is committed to enabling accurate and timely processing of claims. HP will identify, analyze and correct errors that have resulted in improper claims/encounter processing, trace to the source, reprocess as needed, and report to the Department.

If it is determined that some sort of incorrect configuration has taken place—for example, an incorrect edit disposition which caused claims to deny—the base system also has a resubmission process by which claims or encounters can be sent back through the processing cycle. This simple process can be run by authorized users and can resubmit any number of claims based on

user-specified criteria. These resubmitted claims will reprocess through the appropriate edits and audits and will appear in the next financial cycle.

While claims that paid improperly (for example, an incorrect loaded rate) can be sent through the mass adjustment process we described previously.

Claim Processing Data and Report Access (Unique IDs 1823, 1825)

Timely, flexible online inquiry and reporting dramatically improves access to data for program analysis and supports the Department in containing costs. Additionally, online reporting improves program managers' abilities to increase access to quality healthcare by providing information that enhances provider relationships and supports focused and meaningful communication with them.

User-Focused Solution

Colorado interChange provides users with easy-to-learn online browser pages, reducing the learning curve and increasing productivity of staff members using the system.

Colorado interChange allows authorized users to access MMIS data through easy-to-learn, online browser pages. These pages provide the pull-down menu, pop-up window, and point-and-click functions users have come to know from their work with Windows-based PC applications. This familiar look and feel greatly reduces the learning curve required to master the new system and increases the comfort level of staff members as they use Colorado interChange to monitor claims inventories or respond to provider billing inquiries.

Colorado interChange provides online summary pages to display MMIS data at the summary level. From these pages, users may tailor their searches or customize the page display by providing selection, sort, and optional display parameters. Records meeting the selection criteria are retrieved from the system and listed in the summary page. Double-clicking on a specific claim or transaction in the summary page immediately opens a second window containing details. Users may view data elements specific to the claim or transaction being displayed. Additionally, certain elements such as provider ID or procedure code may be selected to access supplemental pop-up windows containing detailed provider certification information, procedure code PA requirements, or other data.

Users can open multiple windows on a desktop and easily navigate between them by pointing and clicking. This user-focused design offers quick and easy data access, increasing staff responsiveness and improving productivity.

Besides the DSS capabilities, HP's solution offers flexible, on-demand, desktop inquiry through the easy-to-use, parameter-driven browser pages. Formatted inquiry results are presented immediately.

Colorado interChange offers several standard client ad hoc reports that quickly provide current claim information. The following figure is a sample of one of the many searches a user can produce within the system.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Claim reports are stored in OnDemand, which enables users to retrieve reports from their desktops in electronic formats, greatly reducing the time delay in receiving updated reports. Additionally, the electronic format of the report lets users run searches for critical information, print only the portion of the report they need, or export data to spreadsheet applications for analysis.

The following table lists a representative sample of the reports that support claims processing.

interChange MMIS Reports for Claims Processing

Report Name	Description
Claims by Claim Type Received for the Month	Lists claims by claim type that were received for the reporting month
Claims by Provider Type Received for the Month	List claims by provider type received for the reporting month
Aged Claims Listing	Reports aged clean claims, sorts in Julian date order, and displays the current system location of the claim and how long it has been in that location
Claims Processing Daily Summary	Lists summary information by claim type for a claim adjudication cycle
Claims by Individual Provider Received for the Month	Shows by individual provider number and media type the number of claims received for the month reported

Report Name	Description
Claims by Geographical Area Received for the Month	Shows by geographic area and media type the number of claims received for the month reported
Error Analysis by Error Code	Shows how many times the listed error status code (ESC) set during the reported period
Error Analysis by Provider Number	Lists the top 10 provider numbers and their top five error status codes
Error Analysis by Forced Error Code	Lists the error code, description, and number of errors per claim type forced through the system; gives totals for the number of forced claims
Error Analysis by Denied Error Code	Supports the monitoring of daily edit denials by paper, electronic, and POS claims
EOB Denial Analysis List	Lists, for each claim, the error code, description, and the EOB posted to the claim when it was denied; displays the total number of denials for each error code and the number of denials per claim type
Edit/Audit Override Analysis	Contains the clerk ID who overrode the error, the claim type on which the error occurred, the error code and the number of claims that had that error code overridden, and the frequency of the overrides
Specially Handled and Processed Claims	Lists claims that were specially handled based on the region code in the ICN
Clerk ID Recycle Claims Report	Determines the number of edits each specialist ID has in the suspense table
Age of Claims Processed to Final Status	Lists the ages of the claims when they were adjudicated to pay or deny
Estimated Savings by EOB/Audit Number	Lists the estimated amount of money that was saved because of the implementation of a particular audit or EOB message
Weekly Claim Payment Report for the Period Report	Shows the total dollar amount, per claim type, paid to the provider community for the previous week and is reported on the check-write date; reports month to date, fiscal year to date, and calendar year-to-date summaries
Daily Claim Activity	Provides information on claims, suspense, and adjustments regarding beginning inventory, new inventory, number processed, and ending inventory

Report Name	Description
Suspense File Analysis by Claim Type	Lists the number and dollar value totals of the various claim types that are in the suspense file; includes the same totals for claims that are 1 to 30 days old, 31 to 60 days old
Daily Claims Disposition Summary	Shows the number of claims processed daily and the disposition of the claims processed; shows claim disposition by the claim location assigned to the claim; includes new day claims and corrected suspended claims

Additionally, the Colorado interChange MMIS solution provides reconciliation reporting on all claims/encounters processes. For example, through the use of the EDI screens in interChange, a user can determine when an electronic claims file was received, the incoming size of the file, and the size of the file sent to interChange. Having this information readily available through the online browser pages enables users to determine is records were dropped.

Colorado interChange provides multiple reports as noted above based on the specific edit(s) posting on the claim. During DDI, HP will work with the Department to validate these reports meets the Departments requirements.

Medicare Crossovers (Unique ID 1638)

HP understands how prompt and appropriate processing and payment of Medicare crossover claims from Medicare intermediaries reduces Department and provider administrative costs. Providing prompt payment also supports excellent customer service. The key to achieving maximum efficiencies and cost savings in this area is developing and maintaining strong and positive relationships among critical parties.

[redacted] Maintaining these relationships and quickly developing new relationships with new carriers is integral to the success of Medicare crossover claim processing. HP has relationships with the largest Medicare Part A carriers, and they can interface with interChange. Additionally, we continue to build on our existing relationships with the Medicare carriers and establish new relationships in an effort to provide the Department with efficient Medicare crossover claims processing.

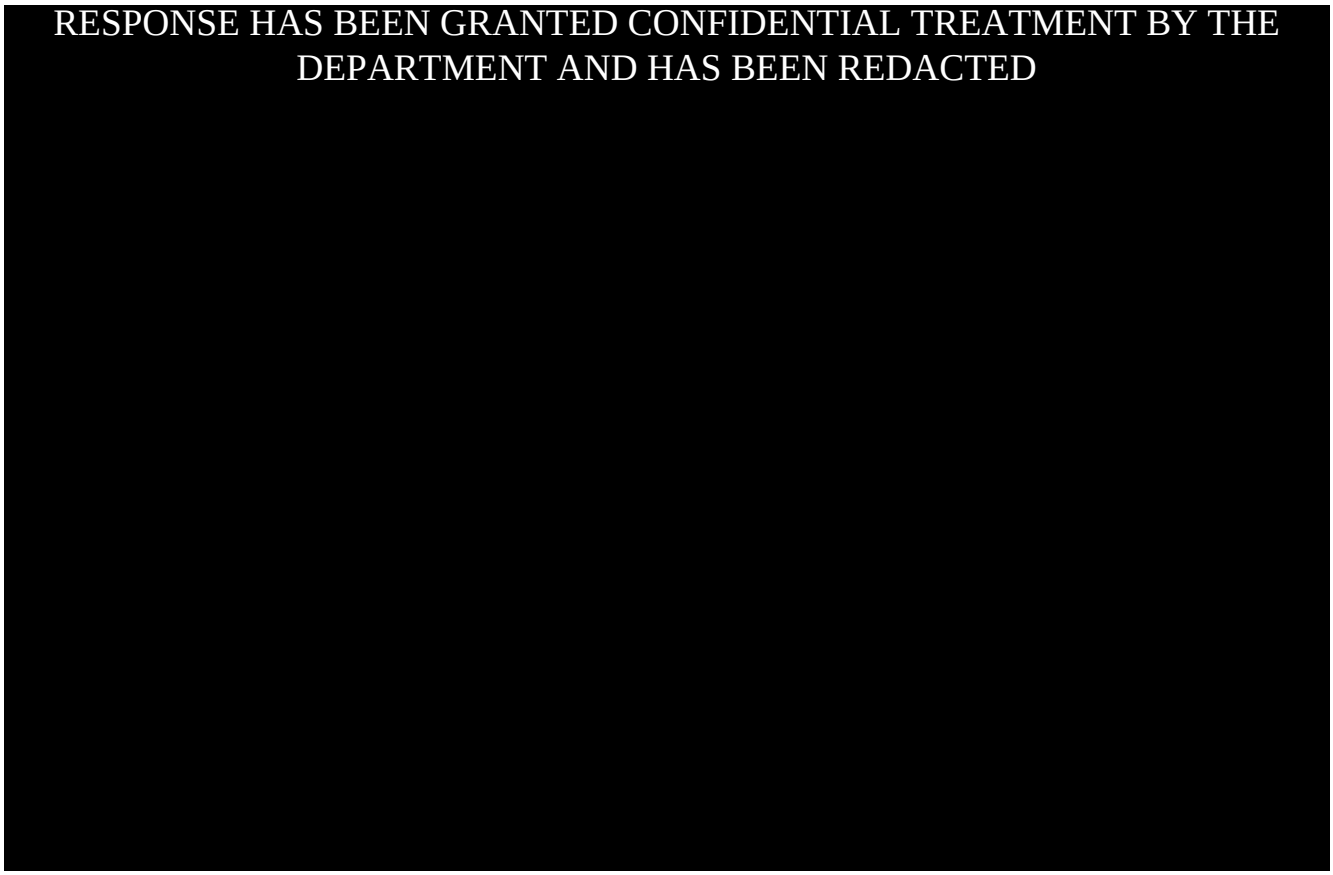
As documented previously, interChange supports the paper and electronic claims submission of the Department-required claim forms, including Medicare crossover claims. interChange also accommodates the Department's pricing methodologies related to Medicare crossover claims. Additionally, we apply the same exceptional adjudication, reporting, and online access to Medicare crossover claim processing. The Colorado interChange provides great flexibility in quickly integrating new Medicare carriers into the system for claims processing.

System-Generated Capitation Financial Transactions

Colorado interChange provides the capability to calculate and generate capitation payments to the Department managed care organizations (MCOs) that have pricing based on a capitation payment model. The system can prorate capitation payment to the days the client is enrolled with the managed care provider in the given payment period, or the system can pay a flat monthly rate based on the payment requirement for the particular managed care program.

interChange also provides the ability to make capitation payments at provider-specific rates based on client demographics, including eligibility program, place of residence, age, gender, and risk factors. The system bases the capitation rates on these factors and automatically calculates and pays the appropriate provider of the managed care benefit plan based on the client's choice of a provider. Colorado interChange stores the capitated rates for the respective managed care programs in an easily maintainable and user-friendly browser environment. Meaningful displays of MCO capitation rates provide quick, easy access to current and historical rate information.

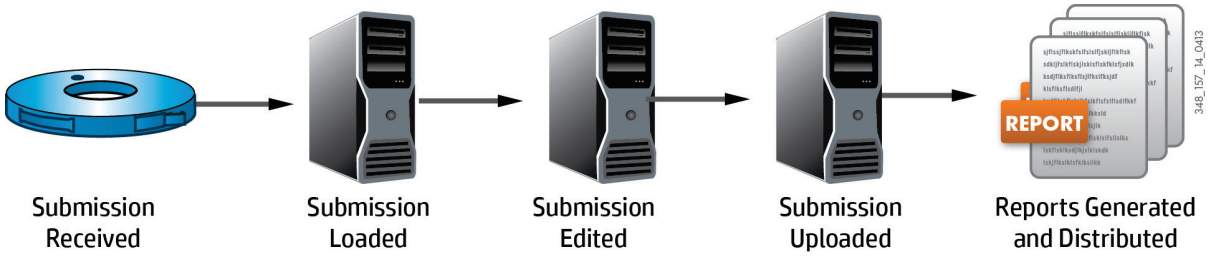
The following figure is a sample of the page that would be used to store Colorado Medicaid MCO rates.



Encounter Claims (Unique IDs 1683, 1815, 1822, 1824, 1829)

[redacted] The Colorado interChange system accepts, processes, and adjusts encounter claims using the same features as that of FFS claims described previously. Encounters go through the same edits and audits as claims. Tailored to the Department's desires, the edits and audits can be set to apply or not apply to encounters as needed. This allows the interChange system to accept encounters for clients who are not Medicaid-eligible. The only additional steps that encounters require are certain reporting requirements, as described in the following figure and subsections.

Encounter Data Processing



Submission

MCOs submit encounter data to the Department as needed. We receive and process encounter data and provide the MCOs with a status of their submission in an electronic report format called the Submission Status Report (SSR), which is sent to the MCOs after processing of their submission is complete. We detail the SSR contents in the "Reporting" subsection that follows.

Each encounter record identifies the specific encounter types, such as the following:

- Dental
- Inpatient
- Outpatient
- Medical
- Pharmacy

The encounter type distinguishes which fields are required on the detail record within the file. The encounter data file contains Medicaid client encounter records. The file comprises two types of records. Every file must contain one header record, which contains summary information about the submission—for example, date of submission, number of records transmitted, technical contact names, and email addresses. The balance of the submission contains detail records that provide details about each encounter—for example, billing provider, client, diagnosis, procedure, and encounter type.

Editing

Editing is a critical piece of the encounter information processing system. Editing occurs at different stages throughout the processing system to evaluate the integrity of the data. Header loading edit checks occur at the time the file is being loaded into the encounter system for

processing. When a single header loading edit failure occurs, the entire submission fails. The MCO receives an automated email response explaining the submission failure. Detail loading edit checks also occur at the time the file is being loaded. Detail loading edits cause the transmission to fail only if 40 percent or greater of the detail records contain loading detail failures.

Detail field edits are used to check detail encounter record data. Each data element on the encounter record must pass certain edit criteria, such as the following:

- Required and required if applicable versus optional and never required fields for a particular encounter type
- Valid values—for example, procedure and diagnosis codes
- Appropriate relationships between fields on the record—for example, billing provider is required if performing provider is blank

Reconciliation

Reconciliation, also known as recycling, is a process that allows previously submitted encounter records to be reprocessed. Recycling involves the following categories:

- Edit number
- Record ID
- Encounter type
- Submission date
- MCO ID

In each situation, records that meet the definition are reprocessed after the category is defined. The reprocessing cycle may include one or more recycling categories. The results are grouped so that at the end of the recycling period, a single report is distributed to each affected MCO. The recycling process enables the Department and HP to work with the MCOs in an effort to provide the most accurate data to the users.

Reporting

Maintaining accurate encounter data is critical in evaluating the overall health of the Colorado Medicaid program. HP produces multiple encounter reports to assist in monitoring encounter processing to establish accuracy. We generate and distribute the following encounter data system reports based on the Department-defined reporting schedule:

- SSR
- Reconciliation Status Report (RSR)

The SSR is an electronic report that comprises six record types. Following are descriptions of the six types:

- **Summary—**Includes a snapshot of the number and type of records processed for the submission, including year-to-date totals
- **Aging—**Identifies the record and age (one to more than 120 days) of encounter records pending correction
- **Accepted—**Displays records that have been edited, accepted, and placed in the data warehouse for utilization and data quality analysis
- **Erred—**Identifies records that have failed at least one critical field edit
- **Bad—**Identifies records that have failed a detail-loading requirement
- **Duplicate—**Identifies records that have been determined to be a duplicate of another record

The RSR is an electronic report distributed to MCOs that have reprocessed records. If an organization requests that a specific record be reprocessed, only that organization would receive the results of the recycling. The RSR contains the same record types as the SSR, excluding the Bad and Duplicate record types.

Third-Party Resources

HP is sensitive to the need for accurate cost-avoidance to support the Department's cost containment efforts. Diligence in tracking third-party coverage and systematically denying claims when the client is covered by other health plans can save the Department millions of dollars that can be diverted back into enrollee programs. For Colorado benefit packages, interChange includes an automatic cost-avoidance process that maximizes payments from other health plans.

Cost avoidance is a key component of the Colorado interChange subsystem. The system contains detailed edits that check the client eligibility file to determine the plans and benefit packages for which the client is eligible, and if any applicable third-party coverage exists. The system may suspend, pay, or deny the claim based on the disposition of these edits and the payer/benefit plan-specific cost avoidance parameters established through web-based pages. These edits verify that Medicaid or other plans in the multipayer environment exhaust the other insurance coverage before issuing payment. Other important benefits of the Colorado interChange include the following:

- Online user updateable exceptions
- Reports
- Questionnaires

Online User Updateable Exceptions

At times, the Department may choose not to subject certain claims to cost-avoidance editing. For example, the Department may decide not to subject crisis intervention services to cost avoidance because this is typically not a covered service under private insurance plans. By exempting crisis

intervention services from cost avoidance, we provide prompt payment of the claim and eliminate improper denials. This capability ultimately leads to streamlined operations for providers. The user controls exemptions from cost avoidance through updateable web pages. After the update is made, claims immediately are processed using the new exception list. The use of updateable web pages allows for full and immediate access to cost-avoidance exemption criteria. Additionally, changes to edit exemption criteria that used to take weeks to complete can now be completed in a matter of minutes.

Reports

The Colorado interChange will generate several reports related to third-party payments, claim denials, and savings related to cost avoidance because of established TPL. With the relational database design and the advanced DSS, the options for reporting cost-avoidance statistics are flexible.

Questionnaires

Colorado interChange can produce a regular report identifying claims with a TPL amount indicated, but for which no TPL resource exists in the system for the indicated client. In these instances, the system can automatically generate a questionnaire to the carrier requesting third-party information concerning the client.

Claims or Encounter Pricing (Unique ID 1820)

To reimburse providers appropriately, the Department must have a system that can apply multiple pricing methodologies based on various criteria, such as client plan or program eligibility, claim type, and other rules established by the Department. Colorado interChange meets this need as the system's claims pricing function includes the following:

- Provides timely online updates to the pricing files for inpatient, long-term care, home health, outpatient, medical, dental, pharmacy, and Medicare crossover claims
- Maintains current and unlimited historical pricing data to use in claims processing
- Maintains the flexibility to accommodate multiple reimbursement methodologies for different client populations
- Maintains the reimbursement rule applied at the service detail line which indicates the pricing methodology used
- Allows varied pricing methodologies between benefit plans
- Provides the ability to apply benefit adjustment factors which can increase or decrease the allowed amount by a set dollar amount or percentage.
- Adheres to the Department's medical policies and reimbursement methodologies
- Complies with federal regulations and State statutes as they apply to provider reimbursement

Colorado interChange is a versatile, dynamic system that meets pricing requirements outlined in the RFP. Claims in the interChange environment are priced 24 x 7. This feature, along with our web-based claims submission option, allows provider organizations to know exactly what they are paid immediately after submitting their claim, provided the claim does not suspend for policy-related reasons. On payment or denial of a claim, necessary payment data—such as the pricing method, calculated allowed amount, manually priced amount, client cost-sharing amounts, and actual payment amount—is stored on the claim history record within the relational database.

Besides supporting a multitude of pricing methodologies, interChange also provides dozens of reports for monitoring and reporting claims pricing results. Whatever data is not represented in a report can easily be derived and reported on through our advanced DSS.

The multipayer and benefit plan functions also provide great flexibility in the development and maintenance of pricing methodologies. Because of the system's table-driven design, pricing methodologies can be rapidly added or modified within a benefit plan without significant time delays or effect on other plans. On the Colorado interChange system, the pricing method applied for a given service is entirely rules-based and user-configurable. Pricing reductions can be tied to an EOB that provides a clear explanation of the pricing action and supports the balancing requirements of the 835 transaction.

Claims Pricing

Colorado interChange has a robust claims pricing system that is driven by user-updateable tables, such as fee schedules and provider-specific rate tables, as well as client cost-sharing tables—for example, client liability, client spend-down, and copayment—and TPL tables. These tables provide the Colorado interChange system with the data necessary for calculating the appropriate claim or detail payment for each service according to the rules and limitations applicable to each claim type, category of service, and type of provider. For example, pricing of inpatient hospital claims uses revenue code and DRG tables, whereas pricing drug claims uses a series of drug and dispensing fee tables.

Colorado interChange uses the claim or detail services performed with service date information to access the appropriate information from the rate tables. By having this capability in the system, we reimburse for a particular service at the price in effect on the date the service was rendered. Based on the specific pricing methodology for the service, a price is determined by the system. After the price is determined, the claim or detail automatically interfaces with the client cost-sharing tables to determine the payment amount to the provider. This is calculated using the cost-share hierarchy that the user has configured.

The Colorado interChange prices claims according to a various methodologies to accommodate Colorado's unique client populations and pricing policies. Additionally, the system easily

supports the Department's current pricing methodologies and the implementation of future pricing methodologies with minimal system changes and impacts.

Authorized users have point-and-click access to a web-based browser page to review and update fee schedules, provider-specific rate tables, client TPL information, and claim information. These authorized users can reduce payment for a specific claim line or an entire claim, in any manner that is needed, be it by overall percentage, or noncontracted special agreement. With interChange's rules-based reimbursement methodology, the pricing reductions are tracked with a specific EOB so that providers have a clear understanding of why their claim paid as it did.

The following figure is an example of the page used to display and update the table of DRG pricing information. User-friendly online pages provide current and historical DRG pricing information.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

A unique feature of the system is its capability to maintain unlimited pricing segments and corresponding effective dates within its tables. Reimbursements rates—whether FFS or managed care—are maintained in online tables with unlimited date-specific price segments. This feature becomes valuable in pricing claims exceeding the filing limit and in accurately processing retroactive adjustments. By having these capabilities, we know that we reimbursed fairly and accurately based on the date the service was rendered and in accordance with the payment policies established by the Department.

Managed Care Capitation Pricing

Colorado interChange provides the Department with a managed care function that was designed for diverse managed care programs. Managed care payments are made based on program-specific negotiated capitation payment rates. As with claims pricing, online, real-time user updateable tables drive the managed care capitation payment process. The capitation payments are based on criteria that may include the county or ZIP code of the client or provider, client age or gender, aid category, rate region, TPL resource code, program status code, Medicare status, or other risk factors. Meaningful displays of capitation rates provide quick and easy access to current and historical rate information for managed care programs.

When the system determines the rate for the specific client and managed care program, the system applies any deductions because of client cost sharing before issuing final payment. Additionally, interChange contains robust editing, preventing duplicate managed care capitation payments for the same client.

The Colorado interChange subsystem also contains edits to prevent FFS reimbursement when the client is enrolled in an MCO, unless the service is a carve-out, which is a service not covered by the specific MCO but covered under an FFS arrangement. In carve-out situations, the system bypasses managed care editing so that providers receive timely reimbursement for these services.

Encounter Data Pricing

The Department requires MCOs—including HMOs, care maintenance organizations, and waiver programs—to report encounter data that is used to analyze and monitor medical utilization. These organizations provide quality of care based on the same cost-conscious approach the Department employs for the Medicaid program. HP has played a part in developing and implementing the existing encounter cost system used by MCOs.

The purpose of the encounter cost system is to assign a cost (or price) to each encounter that reflects an approximation of what would have been paid to the provider by Colorado Medicaid under an FFS arrangement. The encounter cost system is similar to that of the FFS system. However, the encounter cost assignment process is streamlined and does not include several key elements of the FFS process, such as spend-down and copayment. These items are configurable, allowing the Department the flexibility to apply cost share to encounters if it chooses. Furthermore, the encounter cost system invokes the same editing and auditing of records as the FFS environment.

The encounter cost system has access to the pricing methods that the FFS cost system uses, including the following:

- Max fee pricing, including provider specialty, Health Professional Shortage Area (HPSA) incentive, and pediatric incentive
- Drug pricing

- Inpatient hospital pricing—DRG pricing and per diem
- Outpatient hospital pricing—per diem and percent of charges

Data Selection

After a month, encounter records with a From Date of Service (or Fill Date for pharmacy encounters) on or after October 1 of two years prior are processed through the encounter cost system. Each record meeting the minimum requirements is assigned a cost type and cost dollar amount. The records that do not meet the minimum criteria are not included in the process or are assigned a zero cost amount and a cost reason code explaining why.

To be included in the cost process, the encounter record must meet the following criteria:

- Meet the date criteria at the time of the run
- Be accepted by the encounter data system
- Contain no ANSI/NCPDP reject codes or at least one code with DHCF Financial Use=Y

Editing

During cost processing, records may be disqualified from cost assignment for several reasons. Cost reason codes are used to explain the reason for this disqualification. The MCO may wish to review these records to determine whether they have inaccurately or inadequately reported the encounter data. Corrections must be submitted through the encounter data system by reversing the accepted encounter and submitting a new, corrected version with a new record number. The new record is then considered for costing during the subsequent month's processing.

Reporting

On completion of the encounter cost system monthly process, records are selected for reporting to the MCO. Encounter records submitted during the prior month that qualified for cost processing are reported.

Client Cost Sharing

Client cost sharing is another significant component of controlling state health plan benefit costs. To maximize this cost control mechanism, it is critical that client cost sharing information in the MMIS is current. Colorado interChange provides the technology and flexibility to maximize the cost control element of client cost sharing accurately and allows the Department to use a cost-share hierarchy to determine the cost-share priority for each benefit plan.

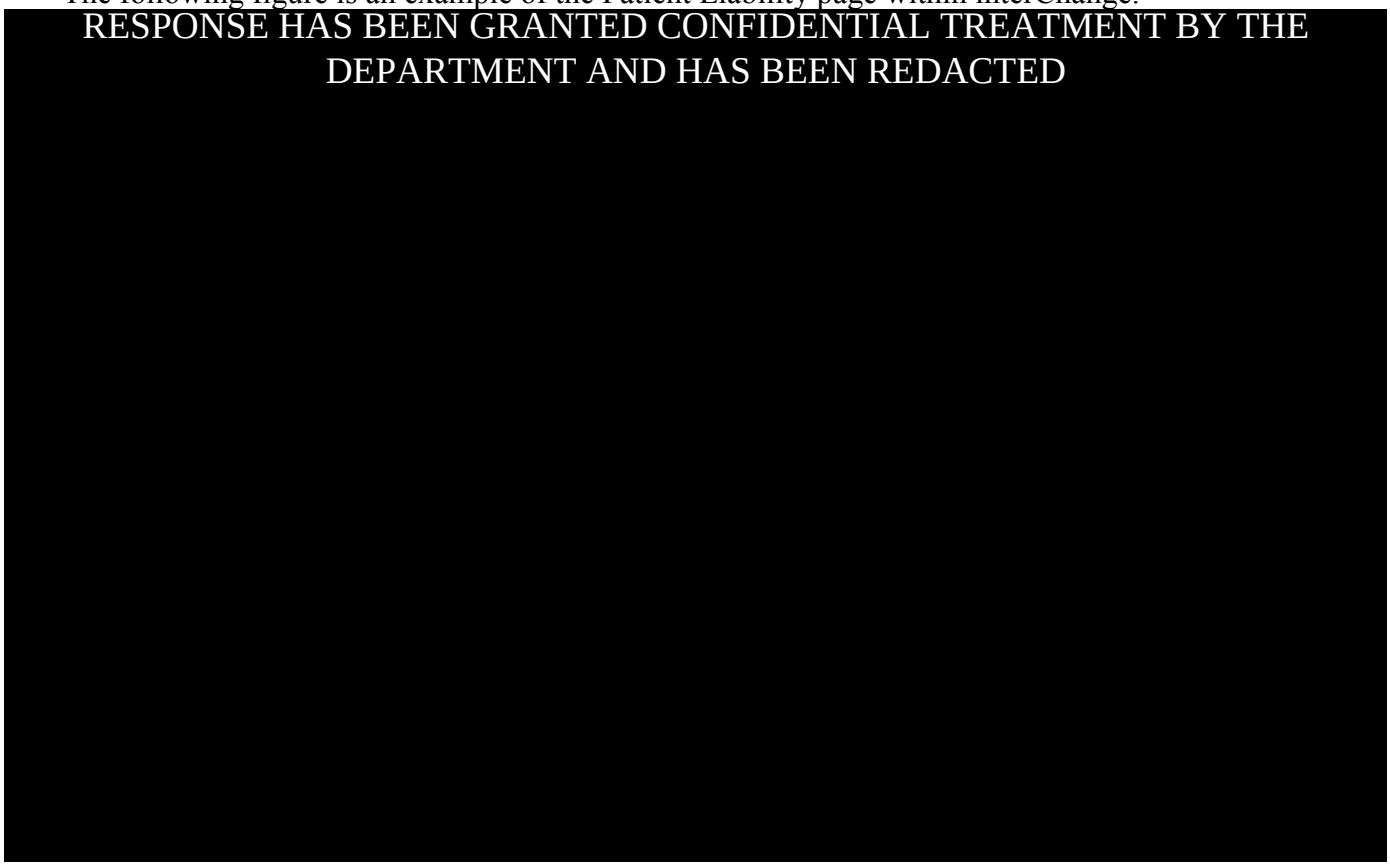
Colorado interChange offers many enhanced functions in the area of client cost sharing. The system contains numerous web-based pages that give users more information than ever before to effectively oversee the various cost-sharing programs supported by Colorado healthcare programs.

One significant area of client cost sharing is client liability. Colorado interChange provides a client liability feature that deducts client liability from applicable institutional claims. Client liability amounts are maintained in user-friendly, web-based pages. The system easily accepts

and processes liability updates through the Medicaid Encounter Data System (MEDS) interface and allows authorized users update capability through the online pages.

The following figure is an example of the Patient Liability page within interChange.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED



The client liability information is accessed during claims processing to determine the correct client liability amount to be used on the claim. Colorado interChange also enables the Department to easily and accurately deduct client liability on multiple claims received within a month and report remaining liability balances. Claims with liability deducted are immediately associated with the liability amount for that month and posted for subsequent claims processing. The system keeps an online record of the liability amounts, claims applied to the amounts, and remaining balances.

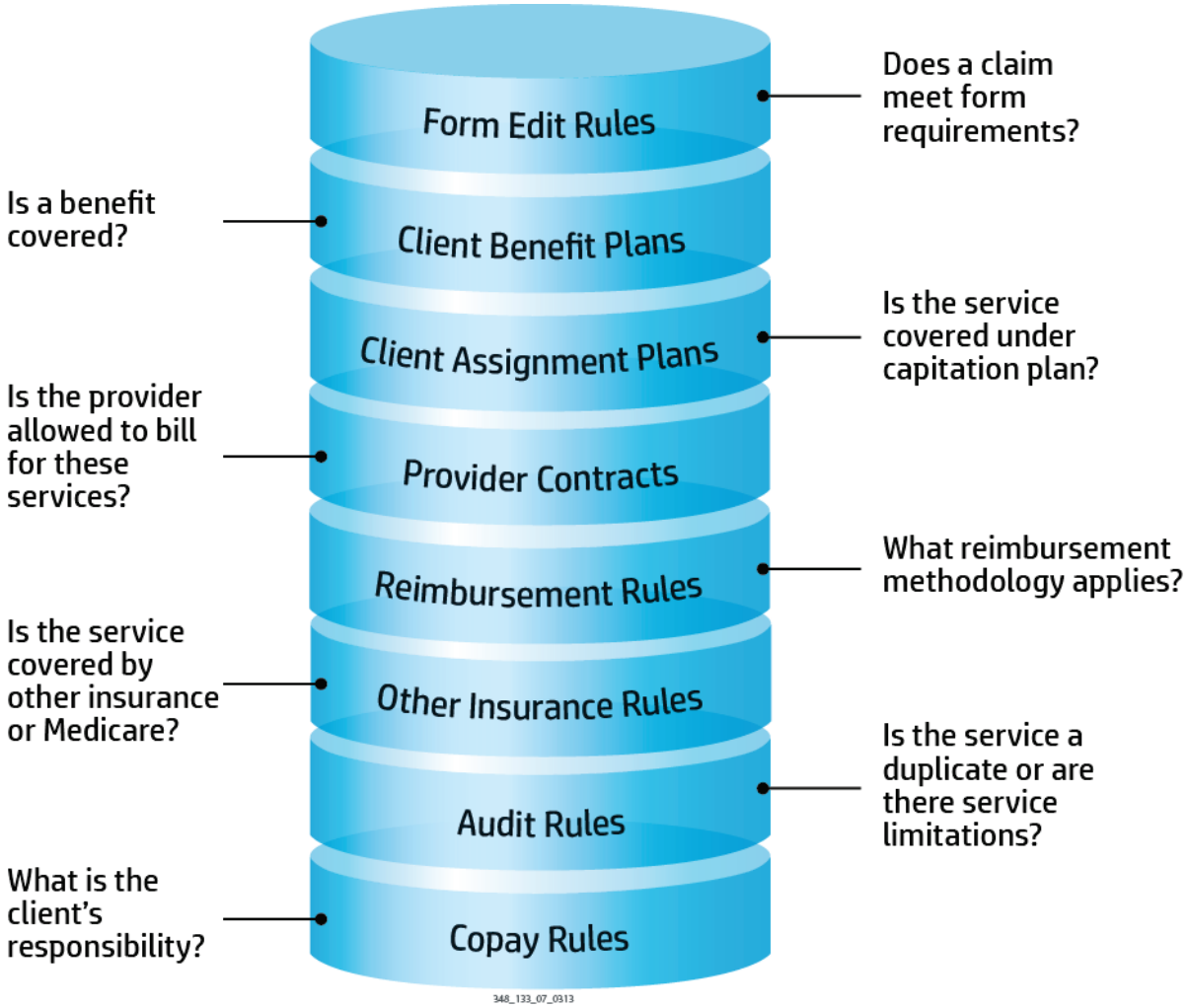
The following figure is a sample page that is used to track this information. The Patient Liability Claims page provides users with easy-to-read current information about the claims applied to client liability and the amounts deducted and remaining.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Another significant area of client cost sharing is spend-down. Again, Colorado interChange maintains client spend-down amounts in a user-friendly, web-based page. The system easily accepts and processes spend-down updates through the MEDS interface and gives authorized users update capability through the online pages. Spend-down amounts can be applied and tracked to a specific provider. Additionally, Colorado interChange provides the capability to track and appropriately apply spend-down amounts during a client's entire spend-down period to multiple providers. Colorado interChange also has the capability to apply spend-down using the claim detail billed amount besides applying spend-down to select denied claims. Through online spend-down tracking, the system maintains every claim that applies to a segment and maintains a continual tally of claims on which spend-down was applied. It also includes the spend-down amount remaining for the specific client.

The following figure is an example of the page that displays the spend-down applied to date. The Spend-Down Claim page provides meaningful, current information to users about claims applied in whole or in part to a spend-down period.

Spend-Down Claims Tracking



Because Colorado interChange processes claims 24 x 7 and adjudicates each claim immediately, the client cost-sharing pages provide updated cost-sharing information. Updates to cost-sharing data supplied through these pages immediately are applied in claims processing.

Besides client liability and spend-down, Colorado interChange also effectively applies other client cost-sharing amounts, such as copayment. The benefit plan design allows for easy application of client cost-sharing policies and restrictions specific to each healthcare program and has rules-based copay methods and limits. This design enables the Department to alter the particulars of how cost sharing is used within interChange, from exclusions to defining the specific criteria used to deduct client cost-sharing amounts from claims payment.

Remittance Advices

Accurate and timely posting of claim and financial information reduces calls to the provider help desk and allows for timely resubmission of claims, if necessary. Colorado interChange provides the capability to improve communication of RA information through enhanced messaging features that are provider-specific, easy to maintain, and simple to change.

Colorado interChange produces HIPAA-compliant electronic and paper RAs. The provider RAs supply details on paid, adjusted, and denied claims and claims in process. The RA also contains error code and TPL information, where appropriate, and gives a summary of the provider's year-to-date earnings information.

The RA process generates a comprehensive document that provides weekly and year-to-date provider earnings information, detailed Colorado interChange information, and recoupment reason codes. Provider payments are generated with a provider RA in paper and HIPAA-compliant formats as requested by the provider. Colorado interChange creates RAs for providers with claim or financial activity during the week. The financial function produces paper RAs, electronic RAs in the HIPAA-compliant ASC X12N format, and pended claims in the ASC X12 277 format. The RAs display paid, denied, and pended claims for the week with the appropriate explanation for claim denials and suspensions.

Colorado interChange provides the flexibility to suppress the generation of zero-pay checks but still generate the associated RA. The system generates an RA to every provider who has had claims activity during the week, regardless of the payment amount. The RA displays the status of the claims submitted that may have been pended or denied. It also includes EOB codes and their full translations to inform the provider of the reason for the claim denial or suspension.

Interactive RAs

interChange transforms how providers reconcile and resolve billing issues. Through the interactive web-based RA capability, the reconciliation process that historically took at least one week can be accomplished in less than one day.

The system also can generate an RA if a provider has an outstanding AR or account payable, until such account is fully satisfied by claim activity or the issuance of a check. Colorado interChange reports error codes for each claim header and detail on the RA. For HIPAA-compliant electronic 835 transactions, we use national adjustment reason codes and healthcare remark codes to convey this information. The codes that apply to the claim, adjustment, denial, or financial transaction are reported in the corresponding area of the RA. On paper RAs, as allowed by HIPAA standards, the detailed message text of each applicable error code, including suggested corrective action, can be printed for the provider's convenience. This detailed, thorough error reporting helps providers understand and correct billing errors in one resubmission of the claim.

Colorado interChange accommodates wording lengths and formats on the remittance so that it provides the appropriate information for the claims presented—for example, dental information versus pharmacy. Messages that accompany the RA are presented in nontechnical language that is easily understandable to providers. The text for these messages is contained in online, user-maintained tables. Messages are reviewed for accuracy and readability by operations staff members and can be approved by the Department before processing. We will provide clear, concise communication to billers to reduce questions, frustration, and the need for resubmissions. Additionally, interChange transforms how providers reconcile and resolve billing issues.

Through the interactive, web-based RA capability, the reconciliation process, which historically took at least one week, can be accomplished in less than one day.

Through Colorado interChange, the Department also has access to an RA Summary Inquiry page, which is used to search for RA information for a given provider number and location code, RA number, tax ID, and other optional search criteria.

Claim Status Inquiries or Notifications (Unique ID 1818)

Colorado interChange provides flexible and convenient access to claim status information for the Department and provider community. The system takes full advantage of the Internet and provides instant access to claim adjudication results. Providers know immediately if their claim paid or denied. interChange provides access to claim information through the AVRS and several HIPAA-compliant transactions.

The Department has convenient, online, secured access to claims status and historical information. The Department has the option of accessing one of many standard claim status reports. It also can use the system's ad hoc claim status inquiry capability that includes multiple criteria for selecting and reviewing claims.

Users can retrieve reports from their desktops in electronic formats, greatly reducing the time delay in receiving updated reports. Additionally, the electronic format of the report lets users run searches for critical information, print only the portion of the report they need, or export data to spreadsheet applications for analysis.

The following table shows the key Colorado interChange features and benefits for the claims status inquiries and notifications business function.

Claims Status Inquiries and Notifications Features and Benefits

Feature	Benefit
Multiple electronic methods for checking claim status	Provides flexible and convenient access to claims status information
Unsolicited 277 transaction for pended claims	Improves provider satisfaction and reduces calls to the call management center
Immediate claim status through the Internet on electronically submitted claims	Encourages electronic billing and reduces providers' administrative costs

Colorado interChange offers many features and benefits that effectively support the Department claims status inquiries and notifications business function. We discuss our approach to meeting the requirements for claims status inquiries and notifications in the following subsection.

Claim Status Checks Through the Healthcare Provider Portal

Colorado interChange and the Healthcare Provider Portal support the exchange of claim status information based on the needs of the individual user, using flexible, convenient, and secure technology. As mentioned previously, providers can verify the status of claims from the instant they are submitted by using the interactive claim submission and status verification capabilities.

Providers that have implemented one of the many HIPAA-mandated claims-related transactions can use the Healthcare Provider Portal and Colorado interChange to exchange one or more of the following transactions.

- HIPAA-compliant X12 276/277 healthcare claim status request or response transactions
- Unsolicited X12 277 healthcare claim status for pended claim status notifications
- HIPAA-compliant X12 835 healthcare claim payment or advice transactions

Using the X12 276/277 and unsolicited X12 277 transactions, providers can verify in real time the status of a single claim or several thousand claims. Colorado interChange also posts X12 835 transactions to the Healthcare Provider Portal following each financial cycle.

Claim Status Checks by AVR

Providers who do not have convenient access to a PC or the Internet appreciate the user-friendly AVRS. The proposed AVRS offers providers access to pertinent healthcare information. Using a touch-tone telephone, providers can use the system to verify eligibility information, receive weekly check-write and suspended claim status, submit claim status inquiries, and determine the status of PA. This system provides prompt information to standard inquiries for providers.

The AVRS has a menu-driven design so that callers can easily navigate through the prompts to obtain information. Shortcut key sequences allow the caller to repeat prompts or messages, reuse information previously entered, and enter the current date. The AVRS has barge-in capability, which allows the caller to interrupt an AVRS prompt or message, enter information, or request to speak with a friendly provider representative during business hours.

Our AVRS solution offers expanded capabilities to the provider community, including the ability to obtain the status of a specific claim. When calling the AVRS, the provider receives an option to verify claims status information. The provider accesses the claim status by entering either an ICN or the client ID number, from date of service through date of service, and the exact amount billed. On completion of the AVRS claim review, the provider receives the following information:

- Claim status—paid, denied, or suspended
- Status date
- ICN, when applicable
- Amount paid for claims in a paid status

Claim status is accessible regardless of whether the provider submitted the claim on paper or filed electronically. If necessary, the AVRS can transfer providers to the Call Management

Center (CMC). At any time during the call, the provider can select the Colorado interChange CMC transfer option. CMC maintains call statistics and provides an online call summary report.

Claim Status Checks by Help Desk

Providers can obtain the information regarding the specific reason that describes the status of the claim or encounter through the help desk. As we detail in RESPOSE 40a in our response to Unique ID 1801:

- We will provide cross-training to help desk and call center agents where applicable.
- The systems supporting the call center and the help desk will be tightly integrated with each other.

This way, we can fully comply with this requirement and fully support the providers who call the help desk regarding the status of a claim by directly transferring them to the call center or providing the information that they need directly from the help desk.

9.3 – Claim/Encounter Related Services	**In Production?** **YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1362	**NO**

Alerts and Reporting on Claims/Encounters Without Expected Second Claim (Unique ID 1362)

The Colorado interChange solution includes a production reporting capability that provides standard operational reports available through our document management system and the ability to build ad hoc reports on key MMIS data attributes. The expected second claim report is something that HP understands the Department needs to properly monitor health outcomes and quality of care.

During the Discovery and Requirements Validation and Requirements Elicitation Phase, we will work with the Department to define parameters to put this report into monthly production as a scheduled batch report and an “on demand” online report for more flexibility for the user.

Additionally, the Colorado interChange provides the ability to flag, re-price, suspend or deny the first claim when a second claim is expected, which will spur the provider to complete the care. Our rules-driven claims engine supports authorized users in configuring rule changes, reducing the reliance on technical staff members for process and policy change requests. Edits and audits can be configured through the Business Policy Administration (BPA) rules engine without any coding. Rules can be configured to flag, suspend the original claim for a period of time or

deny the claim. The pended claims would recycle each week looking for the expected second claim and then pay the two together. If the second claim is not received in the predefined number of weeks, the original claim will pay or deny as directed by the Department. A monthly production report can be generated to show the claims that receive this edit.

RESPONSE 40c

9.4 – Prior Authorization Services	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1473-1475, 1545-1547, 1558, 1659, 1830	**YES**

Key Benefits

- Easy entry and update of prior authorization information
- Appropriate editing to support program policy
- Fast access to status and approvals and reduced response time to providers

The Colorado interChange prior authorization (PA) solution will provide the designed functions detailed above. Additionally, the solution supports the delivery of medically necessary, appropriate, and cost-effective care through PA procedures and medical review of services by the Department's authorizing agents. The solution provides the flexibility for authorized users to change the scope of services to be prior authorized at any time or to provide online, real-time corrections to suspended PAs. Fast access to PA status is available through the Colorado interChange, the Healthcare Portal, or the voice response system. Through the letter generator and HP Exstream, we can generate provider and client decision notice letters that document the finalized status of the PA request, including the appropriate right of appeal language.

Provider Access to Client Data through Web Portal (Unique IDs 1473, 1474, 1475, 1659)

(1474) HP makes Department-specified provider content, provider information updates, and other information for Department-specified stakeholders available through the portal. Sample types of provider documentation that we can make available through the Healthcare Portal include coverage information (including limitations or PA requirements), provider bulletins, provider notices, provider billing guides, alerts, fee schedules, formulary information, forms, client notices, training materials, and online training options. We manage changes to content on the Healthcare Portal through the publications process.

(1473, 1659) When inquiring on authorization requests, providers can access a "dashboard" view. The dashboard immediately presents providers with a list of their most recent authorization requests and the at-a-glance status. The Healthcare Portal also provides a search feature that allows a provider to request authorization information based on authorization ID or tracking number, authorization type, client information, servicing or referring provider, or date range. Providers can view a list of authorizations matching the request criteria and drill down and view details about the authorization including the number of authorized units, the number of units used, and the number that remain.

Providers who need to retrieve a copy of the PA determination can select the PDF copy of the decision notice letter associated with that PA request. The following figure provides a view of a provider's PA search results through the Healthcare Portal.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

(1474) The Provider Portal allows secure access for providers to easily request client eligibility to verify the client's eligibility status, scope of coverage and coverage type. The Provider Portal provides a user-friendly display of information returned within the HIPAA 271 transaction data content. Information—including covered services; coverage limitations; service usage; spend-down information; primary care physician; managed care assignment; long-term-care (LTC) information; early and periodic screening, diagnosis, and treatment (EPSDT) information; service periods; and other insurance information—may be displayed using configurable options.

(1475) HP, working with healthcare professionals, assembled requirements for the Provider, Client, and Trading Partner portals. We consulted physicians, nurses, pharmacists, and other portal users for information and input into the creation of these systems. With a focus on usability and multiple navigational paths, the Healthcare Portal has several features that assist in workflow navigation. This includes a navigation bar, breadcrumb trail, comprehensive searches, results display, client focus, and contextual help. The following figure of the Provider's Client-Centric Focus page illustrates

some of these features to support the Departments requirements to search for and retrieve service specific information that have limitations including Prior Authorizations.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Standard Processing and Tracking (Unique ID 1545)

The Colorado interChange coordinates and standardizes processing and tracking of PAR data. The system does this by updating the PA records based on claims and claim adjustments. The system decrements the number of units and dollars used during the claims processing cycle, and the PA History web page reflects the number of units and dollars remaining. The PA History

web page also includes a claims history button that the user can click to view claims related to the selected PA.

The Claims List web page displays the internal claim number of each claim applied to the PA, the number of units, and amount used by the claim. The Colorado interChange also will automatically update the PA record with the correct information processed during the adjustment cycle. This process eliminates the possibility of manual error, providing the State and providers with accurate and current information in the PA History web page and in the claims processing cycle.

As shown in the following figure, PA Search panel, users can further streamline the search process by using additional criteria. Users access this window to view, add, or update a PA request as well as access other PA windows. Only authorized users can add new information or change existing data.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

The Colorado interChange PA panels are simple and straightforward to use with tool tips providing context-sensitive help for valid field values and code definitions using point-and-click access. The user-friendly navigation and the graphical user interface (GUI) capabilities allow the authorized user to move effortlessly through the PA system using pull-down menus and point-and-click technology. The system allows for quick searching of the PA database for specific PAs based on characteristics including service type, provider number, client ID, PA number, category of service, and procedure.

PA Editing (Unique IDs 1546, 1547, 1830)

(1546) The HP PA solution will identify, search and report on PARs as described below. Data entered into the edited fields are verified for presence, format validity, and data consistency with other data in the related database tables. Online editing also validates procedure, diagnosis, and revenue codes. Approved PA line items that have not had payments applied can be updated or adjusted. PA line items that have had payments applied also can be adjusted; however, the Colorado interChange does not allow for the lowering of authorized units below the amount already consumed by paid claims. The Colorado interChange supports online editing, such as verification of provider and client ID numbers, so that only valid data is entered on the PA file. Edits are based on the state program policy and include the following:

- Valid client ID and eligibility
- Valid provider ID and eligibility
- Valid procedure, diagnosis code, and covered service
- Valid national drug codes (NDCs), revenue codes, and Current Procedural Terminology or Health Care Financing Administration(HCFA) Common Procedure Coding System (CPT/HCPCS) procedure codes
- Presence, format validity, and consistency editing
- Start and stop dates
- Duplicate authorization check for previously authorized or previously adjudicated services, including the same services during the same time frame by different providers

The Colorado interChange notifies the user when an entered data field fails an edit as shown in the following figure. An edit web page appears, alerting the user to the online edit set and any override capability on the edit. The edit web page also contains the edit number and description. HP will work with the Department to determine the edits appropriate and inappropriate for override by PA type.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

(1547) The PA system also checks for duplication of service authorized by client ID, service dates and overlapping dates of service, and previously authorized or previously adjudicated services, including the same services during the same time frame by different providers. Duplicate editing capabilities prevent situations involving misuse of services or funds.

(1830) The PA data is accessed during claims processing to verify that services billed that require PAs have a valid PA record available. If a PA record exists for the service, the claim information is compared to the information on the PA database. Claims with discrepancies in information—for example, the dates on the claim fall outside the dates on the PA record—are denied, modified, or paid based on disposition criteria set forth by the Department. Likewise, claims submitted for a service that requires authorization but has no PA record on file are denied or suspended for manual review depending on Department criteria. Claims billed with a valid PA

number and record are processed, and the number of approved units and dollars used is decremented.

Supports HIPAA transactions (Unique ID 1558)

The Colorado interChange will support the transactions required above. Specifically, the solution supports authorization requests through standard X12N 277/278 transactions or through the Healthcare Portal. The Colorado interChange will be enhanced to support the submission of attachments through the Healthcare Portal and the X12N 275 transaction, which supports the exchange of HL7 claim attachment information.

CMS 7 STANDARDS

The Healthcare Portal gives providers access to the web PA. Providers will start a PA request by selecting a billing provider number from their profile and service area or process type that is specific to the service area. Based on the process type, the appropriate PA process type web page and the appropriate attachment for that service area will be presented. The PA request web page is divided into provider, client, and treatment sections. As each section of data is completed, it is edited for length, format, and basic validity. If an error occurs, an error message is promptly displayed and must be corrected to continue. In the event the provider cannot complete the request, Colorado interChange allows the provider to save the request and come back to complete it later.

After the request has passed the validity edits, it is edited against the Colorado interChange files for a more detailed review. For example, edits will verify provider and client eligibility to dates of service, procedure code to modifier validity, procedure code to provider type, procedure code to age, and many more. This editing will confirm that the request is ready to be approved, except for any clinical data review required. If a system edit error occurs, a message associated with the edit will be displayed. The provider can fix the error and resubmit the request. This process can continue until the PA passes the editing.

After the request passes editing, the provider is required to fill in the attachment information. When possible, fields will be auto-populated based on information already entered on the PA request. Some editing of the attachment information occurs, but this process is primarily focused on completeness. When the attachment is complete, the provider submits the final PA by clicking on a message box to verify completion, and the request is submitted for processing. If the PA does not contain errors, the system generates a PA number.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

PA requests received through the Healthcare Portal will be automatically routed to the appropriate PA work queue in the Colorado interChange based on the PA process type. PAs that require clinical review will be ready to be reviewed by the Department's authorized agents as soon as the PA request is submitted.

RESPONSE 40d

9.5 – Provider Management Services	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1070, 1151, 1175, 1186, 1189, 1447, 1448, 1450-1452, 1454-1459, 1462-1464, 1466, 1468-1469, 1476, 1477, 1481, 1487, 1491, 1493, 1495, 1497-1500, 1503, 1506, 1509-1511, 1513, 1619, 1698, 1700, 1770, 1794, 1818, 1825, 1831-1839, 1841-1844, 1874	**YES**

Provider Management Services

As with any customer service organization, the ability to connect with the people you serve is what makes Colorado Medical Assistance a success. HP works well with the provider community because the providers know, trust, and rely on us daily.

We stand by as an ally and collaborator, ready to assist in increasing the number of quality healthcare providers enrolled in Colorado Medicaid. HP knows that the needs of Medicaid clients, providers, and stakeholders are constantly evolving. Among the challenges facing Colorado Medicaid are the changes in federal healthcare introduced by the Affordable Care Act, as well as the pressure to keep costs down while still providing high-quality care to clients.

Provider Support Highlights

- Robust, rules-based, multi-parameter, configurable system that effectively controls and manages provider data
- New healthcare portal that enables higher degrees of self-service, including additional transaction types, health information exchange, and user profile maintenance
- Customizable reports that easily track provider participation
- Multi-program/payer capability to accommodate Department-administered programs in one system
- MITA-aligned business processes and interoperations

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We understand that the Department is firmly committed to making sure its Medical Assistance clients are receiving the best care possible. A key piece of the healthcare equation is the provider community. Providers who are satisfied with the services, information, and assistance they receive from the Department and fiscal agent are more apt to actively participate in Medical Assistance, and promote participation among their peers.

Providers are busier than ever before. The pressures on providers are significant. They are dealing with more regulation from insurers and must keep current with a tremendous amount of information. HP sees its role with providers as that of a business associate—we are here to minimize the hurdles providers face through self-service portal features, easy-to-use communications, extensive training opportunities, and ongoing support.

HP manages provider services for 16 other Medicaid clients supporting a provider base of nearly 700,000 providers. We are an innovator in the Provider services arena, bringing new services that include creating a vast online library of Medicaid Provider publications, delivering flexible customer oriented training, offering specialized call center options, and providing web-based provider enrollment.

HP supports the Department desire to improve and enhance services to the provider community. To this end, our approach includes a standard suite of services and increased emphasis on self-service, education, and access to information. These services are delivered through a well-organized operational structure supported by best in class technology, proven best practices and a strong foundation of continuous improvement. The services include:

- Provider Management
- Provider Enrollment
- Provider Publications
- Provider Self-Service
- Call Center Support
- Research and Resolution
- Outreach and Training

Across the provider management operation, we focus on continual process improvement. To this end, we regularly review and monitor performance against SLAs and operational metrics. We also institute several best practices throughout the organization to support consistently high quality and timeliness in our service delivery. HP will use dashboard reporting to give the Department a quick view of our KPI performance and provide insight to growth or seasonal trends to be considered. We will address areas of concern immediately and offer source analysis and implementation of corrective actions to prevent recurrence.

We look forward to the implementation of interChange and workflow solutions, bringing the Colorado MMIS the Service Oriented Architecture (SOA) platform it needs for flexibility and evolution. Our solution creates alignment with the goals of MITA maturity. This platform allows Commercial-Off-The-Shelf (COTS) products to be added and upgraded through scheduled releases. HP will use MITA checklists and the Medicaid Enterprise Certification Toolkit (MECT) as a framework for a Core MMIS that fully complies with the Seven Conditions and Standards.

Key features of the Colorado interChange Medicaid Enterprise system include:

- A robust provider portal that offers a one-stop access point for information gathering
- An enhanced provider enrollment process, combining workflow processing and automated screenings and background investigations to streamline the enrollment process

- MMIS screens built and organized by MITA business processes, allowing DMS to easily adapt to the evolving MITA maturity path
- @neTouch Help, which indicates the definition of every field on the screen, their related data type and format, and any screen edits and validations that are performed
- Innovative workflow tools that allow users to see each step in a business process and a historical view of specific steps that were performed within a workflow, providing information in any dispute resolution

Technical Components

Besides the interChange MMIS, our solution includes key technical components, including COTS, which advance and improve the business processes of Provider Enrollment, Provider Inquiry and Provider Relations business functions. These components include the following:

- **Contact Tracking Management System—**A comprehensive service desk system that tracks interactions with providers including telephone calls, on-site visits, and correspondence. As part of the CTMS, we offer a quality assurance and work force management tool that confirms the workload is effectively managed and monitored.
- **Voice Response System (VRS)—**Besides the self-service features of the Healthcare Provider portal, providers can obtain eligibility information and check claims status through the automated VRS feature of the call center. This service is available 24 hours a day, 365 days a year.
- **Electronic Document Management System (EDMS)—**EDMS will be used to store claim and correspondence images for electronic or hardcopy claims. This tool also stores provider correspondence. Its online query tools give users immediate access to letters generated to any given provider.
- **HP Exstream—**Our letter generator tool will be used to auto-generate letters in response to provider inquiries and send them to the mailroom for prompt mailing. HP Exstream uses standard templates for routine correspondence such as acknowledgment letters but allows for customized letter creation such as Erroneous Processing Corrections (EPCs) or other special provider communications.
- **Web-Based Knowledge Base Forum—**We have selected “LiveHelpNow!” as the platform to provide online knowledge base solution for Colorado interChange providers. This platform will provide strong yet appropriate Internet presence for Colorado interChange. This tool provides extended search functions that can be used by our (HP) call center and help desk agents as well as the providers of Colorado interChange. The system supports various file formats including text, picture, and even video. Because the security levels can be set by function, HP Help Desk Agents and Colorado interChange providers can have different levels of access. This tool also enables the HP agent to see the same information on the

provider's screen, which will result in efficient and prompt handling of calls when a provider needs support from the Help Desk.

We are excited to offer our provider management experience and the technical capabilities of the interChange MMIS to help the Department achieve its goals of offering high value services to the provider community. This unbeatable combination of technical and business processes will increase the efficiency of Colorado Medicaid to support providers enrolled to serve Colorado Medicaid healthcare clients.

In the following section, we present an overview of the provider enrollment and data management solution. We present our detailed response to each Provider Management requirement following this section.

The Colorado interChange MMIS will integrate and interface with COTS products, streamlining the provider enrollment process and supporting almost 700,000 clients' access to healthcare.

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Provider Enrollment

The provider enrollment process uses a blend of COTS products and proven Medicaid-specific components used successfully with our other state customers. The COTS products and transferred components are choreographed to automate and integrate business processes that historically are manually intensive and disjointed. The following figure highlights the inputs, process steps, and outputs for enrollments.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

A key feature of the HP solution is enabling providers to complete Colorado interChange enrollments using the Provider Portal. HP has found in other states that online provider enrollment, followed by the ability for certified providers to perform many self-service tasks using a secure portal, reduces provider errors, makes providers more self-reliant, and allows providers to perform tasks at their convenience.

Provider Enrollment Process Completion (Unique ID 1832)

Enrollment Function

The HP Provider Enrollment solution incorporates significant automation and workflow processes from the start of the provider's enrollment and continuing through certification and revalidations. This automation greatly reduces errors in the process such as missing or invalid data submitted by the provider, while enabling providers to be enrolled quickly and within the five business day enrollment/response requirement. In the following section, we describe the end-to-end provider enrollment solution, which includes:

- Portal Enrollment
- Paper enrollment
- Processing Enrollments
- Provider Revalidation
- Re-Enrollment of Terminated Providers

Online Enrollment Success

Providers in other HP states have readily adapted and embraced web-based provider enrollment and recertification. For example, in Wisconsin, 86 percent of new Medicaid provider enrollments and recertifications are completed through the HP Provider Portal. As with Wisconsin, we will work with the Department to increase web-based provider enrollment and recertifications.

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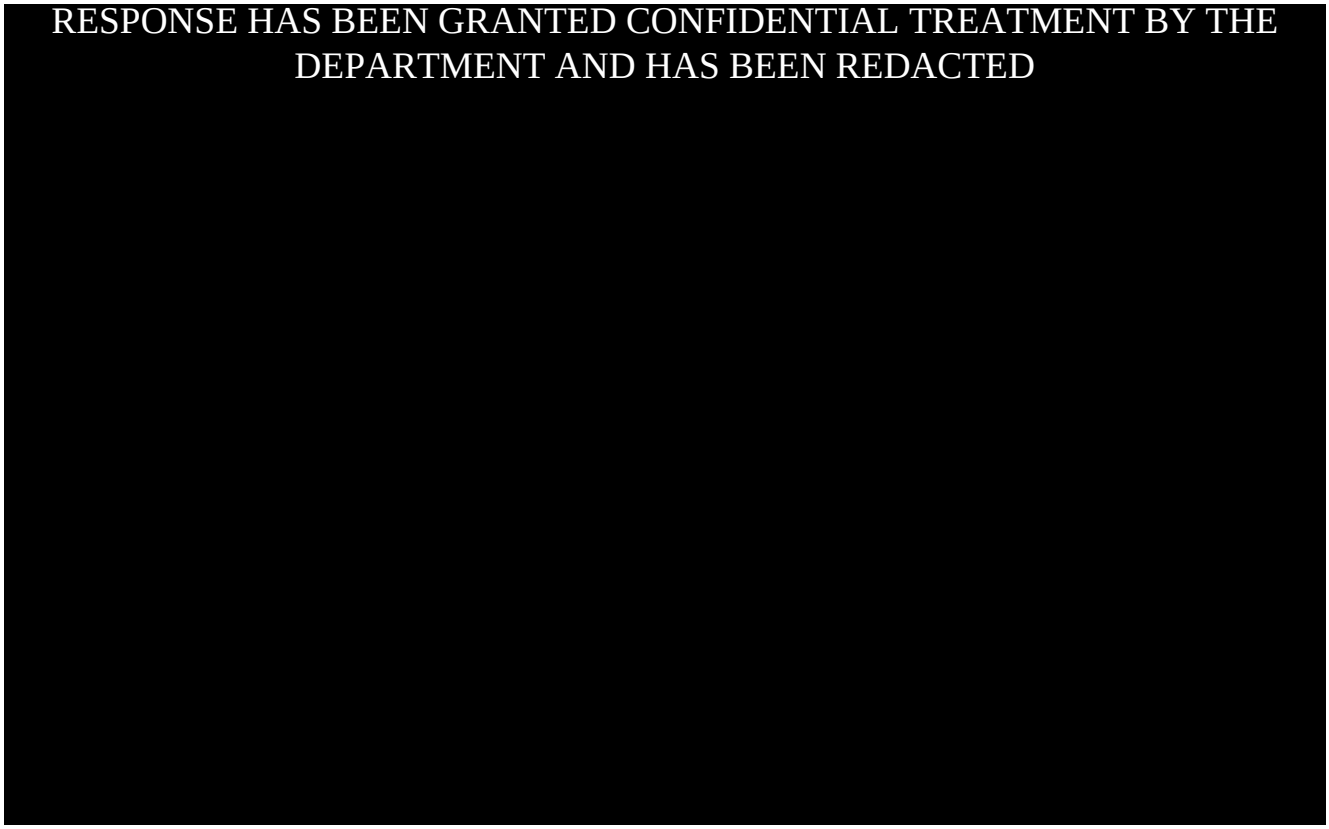
Provider Enrollment through the Provider Portal

An important facet to a provider wanting to take part in Colorado Medicaid is validating that their first contact with Medicaid is smooth and efficient. The HP provider enrollment solution offers providers the opportunity to submit enrollment information using the Provider Portal. As HP has seen in other states, offering a quick and efficient online enrollment experience sets a positive tone for the provider's ongoing participation. Additionally, HP offers online revalidation/recertification and provider file demographic maintenance through the secure portal—reducing the physical paperwork a provider experiences.

Providers initially access the portal application tool from the public area of the portal. However, the data is captured in a secure environment to facilitate safety of Personal Identifiable Information. We have used this method in other states with great success. It is a streamlined method of enrollment that does not require that a provider establish a portal account before application—as shown in the following figure.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

The Provider Portal Enrollment tool will walk providers through the enrollment process, targeting questions and information related to the provider's specific type and specialty as shown in the following figure. Providers will only view questions and supply information needed for them to be certified as a specific type of provider. The Portal Enrollment tool also allows for uploading of documents if attachments are required for processing the provider's enrollment.

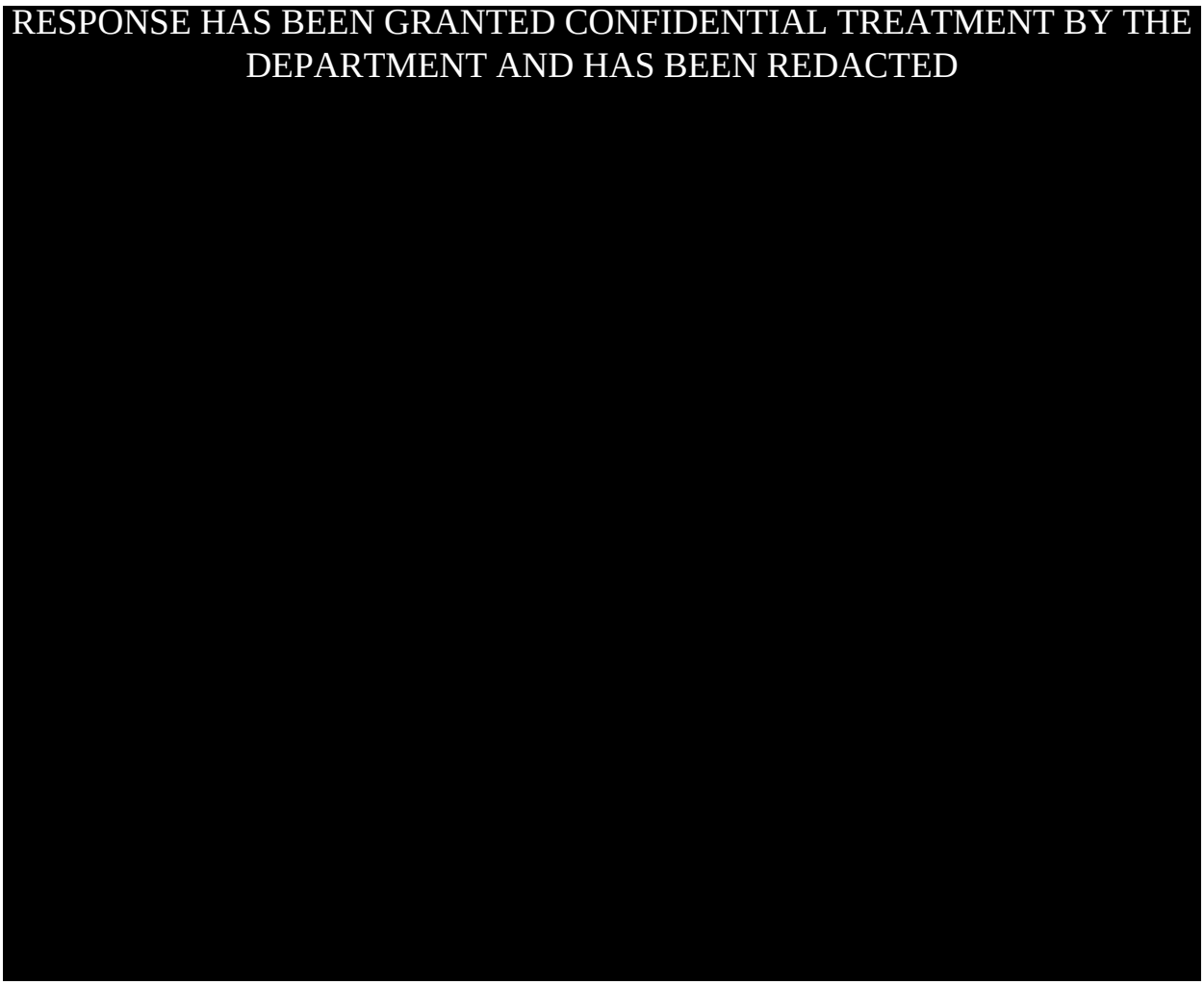


The enrollment tool also greatly reduces the number of provider application returns through pre-editing and validation of information the provider enters. If a data field is required for enrollment processing, the provider will not be able to bypass that field. Other editing also will occur for fields, such as verifying a correct number of digits in a license are entered.

The HP Portal enrollment solution is customizable based on the Department's requirements. Each provider type within the enrollment tool can be tailored to meet the Department's enrollment requirements. Providers can limit their participation to a specific health plan or to a specific population during initial enrollment and throughout their term as a Colorado provider.

After the provider has completed the enrollment information, they will digitally "sign" the state-approved provider agreement, making the process completely paperless, and submit their enrollment information using the portal as shown in the following figure

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED



RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

After the provider submits the enrollment file, they will be presented with a PDF version of their application, which they can save or print for their records, and an Application Tracking Number (ATN). During the enrollment process, the provider can access enrollment status by accessing the portal and entering the assigned ATN in the application status tool.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Paper Enrollment

HP acknowledges that some providers may opt to use a paper application submission process. A provider who wants to submit a paper enrollment application accesses the enrollment forms on the public area of the portal. The provider can download a copy of the applicable forms for completion and mailing to HP for processing.

HP implements tools such as high-end scanners and rules based data capture that make the process efficient and traceable. Our automated tools make certain that business processes are consistently executed, well managed, and made auditable. Consistent application of business rules and processes also improves the quality of provider data.

During the scanning, imaging and data capture process, the system converts the paper applications into electronic format. We create an XML output file that triggers the same enrollment or re-certification workflow service used by the HP Healthcare Portal. By using the same service, fewer components are available to manage.

An image of the paper application also is stored in the OnDemand Document Management System. If provider services needs to access the original application, it is available and virtually attached to the electronic version of the application. Integration to OnDemand is performed through interChange Connections providing the same benefits of re-usability and loose coupling.

Enrollment Processing

Regardless of the method of submission, the Colorado interChange MMIS accepts a new record and passes it to the Business Service Framework workflow, simultaneously adding the enrollment to the work list for the Provider Enrollment team. Workflow processes are managed by interChange Service Framework Workflow, which is the blending of interChange UI, K2 blackpearl workflow COTS product, and Corticon business rules engine COTS product. Workflow services will be designed for provider enrollment, recertification/revalidation, updates, as well as disenrollment.

The workflow user interface guides the provider enrollment clerk through the business process as defined by the workflow and business rules. These flow-managed process steps inform users when a manual step is required, placing the application and related data in their work queue. Predefined rules determine the path the application takes. As the application and related data moves through each step, the information is recorded and managers can view statistics of the business processes to identify and remedy bottlenecks. They also have immediate view into a specific enrollment application for visibility of its current step, steps completed, and next steps.

The workflow tool is completely configurable and scalable to Department requirements. Work queues may be broken out by provider types, application types, or other definable parameters. Work queues can be quickly modified and reassigned, based on work need. For example, if a provider enrollment clerk is out of the office for a period, their work queue can be shifted to other staff.

Provider enrollment clerks access their work queues in the interChange UI. The clerks follow Department-approved adjudication guidelines to process the application, credential and background checks, and enter or validate data in interChange. Supervisory staff can monitor work queues in real time including the ability to assess which items are approaching deadlines easily so they can be processed within Department required timeframes.

A vital step in the enrollment and re-certification processes is to verify credentials and conduct screening for various provider data. HP will use LexisNexis to provide this service. LexisNexis maintains vast public and proprietary records to give a detailed view of individuals or businesses and their history. This service aids in the investigation process by quickly identifying fraud and other incidents within the last five years that involve the owners, indirect owners, and managing employees. Systematic interfaces between LexisNexis and the Core MMIS reuses the interChange Connections framework providing consistency of the integration processes. These interfaces remove the need for manual query of data by enrollment staff, thereby significantly improving the efficiency and accuracy of this critical step in the enrollment process.

LexisNexis compiles reports on companies and individuals associated with a Tax ID or Social Security number. These reports can include such information as civil judgments and liens,

bankruptcies, court and regulatory rulings, negative news and felony charges. LexisNexis also is can validate and authenticate the identification credentials of potential providers. Medical licensure as well as State and federal sanctions or exclusions are also part of the data maintained by LexisNexis.

Files regularly submitted to LexisNexis contain provider information and the names of individuals and entities listed on the disclosure forms, including managing allies and individuals with more than a State-defined percentage interest in the business. We work with the Department to define processes for providers with negative information identified during screening and determine the frequency of file submissions to LexisNexis.

Promoting Program Integrity

LexisNexis is the largest single provider of public record data to federal, state, and local agencies and law enforcement. More than 7,500 agencies including DOD, DHS, DOJ and their components trust LexisNexis for investigative, analytical, data hygiene, and background investigations. Commercially, more than 90% of Fortune 500 companies use LexisNexis services, as do the nation's largest non-profits.

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We will use interChange to interface with CMS to capture Clinical Laboratory Improvement Amendments (CLIAs) certification information and the specific procedures each laboratory is authorized to cover. Providers will supply their CLIA information at time of enrollment. When appropriate, it is validated against the master CLIA table before being added to the provider's file. The system includes an interface with CMS to receive master CLIA file updates three times a week. Additionally, the BPA/Reference area includes a table that is used to maintain procedure codes and modifiers associated with lab codes for use in claims adjudication.

If the provider meets the enrollment criteria, they are added to the interChange provider file, assigned an effective date, and sent welcome materials, which are auto-generated through the workflow process. The welcome packet gives providers key information they need to begin work with Colorado Medicaid such as:

- Effective date of certification
- NPI, Taxonomy on file for the provider
- Information about new-provider educational opportunities
- Information about accessing provider communications
- Information on creating a secure provider Portal account

If the application requires additional information, provider enrollment generates a Notification of Missing Information letter from HP Exstream detailing the missing information. After the provider has submitted the additional information, workflow triggers will immediately prompt HP enrollment staff to take action on the application, enabling it to continue processing. This automation enables HP to meet the five business day turn-around for provider enrollment when a provider has furnished the required enrollment information and passes Department-defined requirements.

Provider Revalidation

HP understands that new regulations and guidance under the Affordable Care Act will require that providers re-enroll (referred to as revalidation by CMS) within specified periods. Furthermore, CMS is issuing continued clarification regarding background checks and collection of application fees. We know the challenges these mandates have on the enrollment process and therefore we have designed an overall solution framework that is flexible to respond to these changes. Additionally, HP has multiple Medicaid accounts that have begun re-enrollment/revalidation for providers and we have experience in conducting background checks and handling application fees for Medicaid providers. We will apply these lessons learned to develop these processes within the Colorado operations.

[redacted] We will take advantage of the capabilities described for enrollments. However, we will design online submission, workflow, business rules, and procedures specific to revalidation. Our intent is to make this process controlled, yet as streamlined as possible for providers so there is no disruption in service to Colorado clients.

HP will establish a review schedule with the Department for revalidation of providers. interChange will populate the date for each provider to revalidate with Colorado Medicaid. We will issue notifications to the provider, which allow adequate time to submit information to HP. Additionally we will publish information on the portal regarding due dates and revalidation processes. Further outreach activities, such as additional communications, either provider-specific or general, may be warranted depending on provider participation. We will monitor the overall provider base and take necessary corrective actions to make sure that providers respond within required timeframes.

Re-Enrollment of Terminated Providers

[redacted] HP will provide the capability to document provider disenrollment information. For example, when a provider is terminated, interChange captures the reason for the termination of the Provider's participation. Disenrollment may be at the Provider's request, the result of notification from appropriate and specified sanctioning entity, from a licensing authority or at the Department’s request. The interChange system contains configurable related data tables that allow the HP Provider Enrollment Unit to define various enrollment end reasons. This information is easily maintained and reported and is stored in the specific provider's record, viewable on the Provider Contract panel as shown in the following figure. When a provider is terminated within the Colorado interChange, an end-date and End Date Reason Code is placed on their enrollment file. The provider cannot submit any claims for dates of service on and after that end-date without being re-enrolled. If a provider submits a claim outside their certification dates, the claim will be denied.

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Re-enrolling a terminated provider will involve a careful determination whether that provider should be enrolled so there is no chance of them posing a risk to the program. HP understands this complexity and we will work with the Department to define procedures and processes a terminated provider must follow to re-enroll in Colorado Medicaid.

Screening, Enrollment, Disenrollment and Management of Pharmacy Providers (Unique ID 1874)

HP acknowledges responsibilities for managing enrollment and disenrollment of pharmacy providers including the required screening under ACA Provider Screening Rule and ongoing maintenance of the provider information within the Colorado interChange. We will develop business rules and procedures specific to the pharmacy provider type to make sure we manage this business function consistent with Department policy. We describe our overall solution to provider enrollment and data management in this response section as well as in RESPONSE 39B which includes web-based enrollment, configurable workflows, systematic interfaces to federal and state databases, and automated communications that helps promote efficiency and cost-effectiveness within the HP operations and for the provider community.

HP will develop an interface to transfer pharmacy related provider data to the PBMS contractor. This data will include new enrollments, updates, terminations, and disenrollments. We will work with the Department to define and develop this interface during the DDI phase.

Provider Screening Functions (Unique ID 1455)

As discussed in Unique ID 1832, HP will work with LexisNexis to conduct screening functions on providers as well as managed care entities and their networks if the Department mandates managed care entities and networks enroll in the Colorado Medical Assistance program. Automatic interfaces to LexisNexis to conduct these types of screenings uses provider information and the names of individuals and entities listed on the disclosure forms, including managing employees and individuals with more than a State-defined percentage interest in the

business. We work with the State to define processes for providers with negative information identified during screening to determine whether the provider should be denied enrollment.

The provider enrollment solution and framework uses rule based workflow to establish consistency and control in the enrollment process. This flexibility allows the State to change workflow easily such as adding new requirements like on-site visits or additional interfaces that may not be in place today. During DDI, we will work with the State to define these workflows so they align to State and Federal guidelines and clearly define the roles that HP and the State play in the workflow cycle.

Links to Federal and State Regulations (Unique IDs 1451, 1452)

It is essential that providers understand the federal and state regulations they must meet and adhere to when enrolling in Colorado Medicaid. (1451) The HP provider enrollment tool helps verify that providers have access to the applicable rules and requirements during the enrollment process.

As a provider begins the enrollment process, a page will display with the specific state and federal requirements the provider must meet for enrollment. These requirements will be customized based on which provider type the provider has selected.

As enrollment requirements change, HP will revise the posted rules and requirements based on Department direction.

(1452) HP provider enrollment staff understands the need to be well versed in state and federal enrollment and certification/licensure regulations. Procedure manuals will document Department approved procedures for adjudicating enrollments, disenrollments, revalidations, appeals and making provider data file changes. Provider Enrollment clerks will be trained on the rules and requirements for their provider types using these Department-approved procedure manuals for adjudicating enrollments and making provider data file changes. The enrollment supervisor will work with their designated Department contact to make sure future changes are incorporated into the procedure manuals and conduct any necessary training. This approach helps establish consistency in processing eliminating rework or delays. The most-current operational documentation will reside on the Enterprise SharePoint site.

Besides extensive staff training and documented procedures, the HP solution has automated workflows and rules that support the enforcement of state and federal regulations. This automation supports the business process and helps minimize the risk of human errors.

Sanctioned Databases (Unique ID 1466)

Our solution supports the upload of sanction, termination, and exclusion information to federal databases. For example, in Wisconsin, we upload information to the Medicaid and Children's Health Insurance Program, CHIP, State Information Sharing System (MCSIS). During DDI, we

will work with the Department to define and develop the specific upload processes for this requirement.

Provider Fingerprinting (Unique ID 1698)

The CMS 6028-FC rule states that fingerprints must be collected and criminal background checks must be conducted on the high-risk providers including those who maintain a five percent or greater direct or indirect ownership interest in the provider or supplier.

HP has worked with LexisNexis for much of the provider background screening services. LexisNexis has a robust fingerprinting offering that we will employ in Colorado.

LexisNexis is one of the few FBI-approved fingerprint channelers and a trusted resource for completing fingerprint-based criminal background checks. As an approved channeler for the FBI, LexisNexis complies with the policies and requirements established by the FBI for channeling and outsourcing of fingerprint based criminal background checks.

The LexisNexis national fingerprint program has been in production since 2003 and has been an FBI-approved fingerprint channeler since 2007, offering banking customers a streamlined and efficient program for fingerprint-based background checks with a direct connection to the FBI's Integrated Automated Fingerprint Identification System (IAFIS). LexisNexis employs a dedicated fingerprint management, customer service, and operations team, working with the service for almost 10 years. Representatives from LexisNexis attend the FBI Compact Council meetings every six months to ascertain any relevant changes to the Outsourcing Standard, CJIS Security Policy, regulations/statutes, or process in general. LexisNexis directly manages a call center for fingerprint collection scheduling and an operations center for rap sheet submission and processing.

The following are key features and benefits:

- The system can capture and submit prints using secure web-based print management software
- Added capability to adjudicate results according to Department guidelines and reconcile final dispositions of relevant arrest records (requires FBI outsourcing approval). Fingerprint-based checks with the FBI rely on biometric data, not candidate-supplied information, and include a search of more than 48 million unique criminal arrest records.
- The system meets requirements or guidelines set forth by the Financial Industry Regulatory Authority (FINRA), the Transportation Security Authority (TSA), the Federal Deposit Insurance Corp. (FDIC) and others

LexisNexis can adjudicate reports, which list any charges against an applicant, of provider applicants. Adjudication means LexisNexis will designate a rap sheet as eligible, ineligible, or decisional based on the information available from the disposition, or the outcome of the charges.

- If the fingerprint submission returns a report with no derogatory information, the applicant and HP will be notified that the applicant is eligible
- If the fingerprint submission returns a report with derogatory information and the report contains the final dispositions, the applicant will be determined eligible or ineligible (based on a scoring matrix defined by Colorado Medicaid). If the report is scored ineligible based on the charges, the applicant will receive an FBI dispute process letter, per FBI protocols.
- If the fingerprint submission returns a disposition with missing information (unresolved charges against an applicant), the applicant will be designated as decisional. The Department and HP may then investigate those charges and make the final adjudication determination.

Conflict of Interest on Enrollment (Unique ID 1450)

As part of the enrollment and revalidation process, providers will be required to disclose any potential conflicts of interest with their business associations. Based on Department criteria, HP will take the appropriate action on disclosure of this information.

Detailed Documentation (Unique IDs 1458, 1513)

HP wants to verify that providers are not only certified quickly, but are also certified correctly, according to State and federal requirements. The HP provider enrollment team will work closely with the Department to define, document and gain approval for enrollment procedures. Our objective is to verify the enrollments occur according to Department-approved processes.

The HP provider enrollment team will develop and maintain operational documentation for the processes based on provider type. This operational documentation will reside in the Enterprise SharePoint site. (1458) HP will revise documentation as needed and revisions will gain approval from the Department before being implemented and posted in the Enterprise SharePoint site.

(1513) The HP provider enrollment team will revise approved documentation based on Department requests and input. The provider enrollment team will follow the prescribed submission, review, and approval process within the Department's Communication Management Plan.

Communications to Providers (Unique ID 1457)

Communicating enrollment status to providers is accomplished by leveraging features of the Provider Portal and automation within interChange. While an enrollment is in process, providers can use the portal to view the status. After a provider successfully completes an enrollment

request using the Provider Portal, the provider receives an Application Tracking Number (ATN). The provider can follow the progress of their enrollment request using the ATN.

The provider can see various customizable messages as defined by the Department. For example, the provider can see that the application is being processed, needing more information, or has been approved.

If a provider reviews the status of their application and has additional questions, the provider can contact the call center and provide the ATN. The call center staff can review the status of the enrollment request and answer any additional questions.

After an enrollment is approved, the provider is sent a welcome packet with specific enrollment information, including the provider's effective date with Colorado Medical Assistance. The provider welcome packet will include details for the provider regarding establishing a secure Provider Portal account, information regarding online tutorials, and information on essential provider communications.

If additional or corrected information is needed to complete the enrollment, HP provider enrollment will send the provider a letter detailing the application issues and how to resolve them. The letter is generated as a step in the K2 blackpearl workflow process and generated using HP Exstream. The enrollment is put into a pending status awaiting the information from the provider.

If a provider enrollment request is denied, HP will generate a notice of denial letter to the provider, which will include any Department-defined follow-up appeal actions the provider may take.

Transactions or User Entries (Unique ID 1469)

Internal users will have access to specific provider data management screens to process enrollments or other needed changes to the provider's record. Online rules and prompts help establish the accuracy of updates and changes. @neTouch, the user interface feature of interChange, allows users to navigate easily to what they need when they need it. The intuitive, fast, and context-sensitive features simplify their tasks in interChange. If a user frequently accesses the same screen to do their job, they can simply add the screens they use most to their own Favorites list. Fast access and accurate information result in enhanced productivity.

interChange will capture an audit trail of changes and updates made to provider data for a period specified by the Department. interChange has an audit trail of revisions that shows the historical information before the change, when the change was made, and the clerk ID (which could be an HP staff person ID or the ID of a provider making a change using the portal). Authorized users can easily view the audit trail information using interChange screens.

The following figure demonstrates the comprehensive provider data available through interChange provider screens. Users can customize the view of their screens to commonly used pages, making research and maintenance much more streamlined and efficient.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Update Provider Directory Information (Unique ID 1509)

The Provider Portal also allows providers once enrolled, to view and update their respective information, such as address, email, telephone and fax numbers, pay to and other contact and demographic characteristics. Information enabled for update is part of the configurable options within the Provider Portal allowing the Department to authorize only specific types of data to be updated in this manner.

This functional capability saves providers significant time compared to completing paper change request forms or calling the contact center – it creates a self-service atmosphere for the provider community. HP will work with the Department to define any limitations or restrictions the Department may wish to establish relative to data elements that can be updated directly by providers.

To make changes, the provider logs into their secure Portal account and chooses Demographic Maintenance. The demographic interface connects to the interChange provider file. Because interChange makes real-time changes to the provider file, the provider's demographic revisions are immediately applied and available for use.

The changes are logged in the field's audit trail in interChange, so there is a record of the activity on the provider's file.

Provider Enrollment Roles and Processes (Unique ID 1454)

The Colorado interChange will maintain and support the provider enrollment roles requested for this procurement. This includes multiple Provider types, specialties, and taxonomies in one Provider profile. HP understands that it is necessary to collect unique, specific information dependent on the provider enrolling. As the provider completes the Portal enrollment, they will be prompted to answer specific questions and provide specific information based on the type of provider they are.

For each certified provider type assigned to a provider, interChange will create a separate service location and internal ID. Then, at the time of enrollment, these provider types and service locations are linked together. The information will link to the one base Provider ID even if the provider has multiple service locations in the system. The provider enrollment team can retrieve a provider profile and view this information.

Colorado interChange includes the functional capability and flexibility to create Provider IDs for identification purposes for those Providers who may be exempt from payment but who still perform services or for providers who have Department-defined limitations on them. This also can be used to identify in-home caregivers or clients as payees.

The system will identify providers as billing, performing, or both billing and performing. Providers identified as performing only can perform services, but they will not be allowed to bill. We will create and use provider billing indicators for other unique providers, such as primary care providers as shown in the following figure.

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ID for providers Without NPI (Unique ID 1493)

HP will use the interChange system and its relational database design to assign each provider enrolled in Colorado Medicaid a unique internal base provider number. This number is assigned regardless of whether a provider has an NPI or is a nontraditional provider that cannot obtain an

NPI. The Colorado interChange has the capability to identify which providers require an NPI using an indicator on the Provider Type and Specialty Code panel.

Flag if Multiple IDs Are Assigned (Unique ID 1500)

The Colorado interChange includes warnings designed to prevent providers from being enrolled with duplicated information including notifications for duplicate provider numbers, license numbers, name or name type, and tax ID numbers. We will develop procedures to notify the provider of the duplication and how to respond appropriately to these system warnings to correct the error. We will communicate any issues to the Department as necessary.

Data Merge Function (Common Acronyms) (Unique ID 1794)

Numbers and IDs are only a part of a complete and accurate Provider profile. It also is essential that consistent naming conventions be used to differentiate between first names, last names and business or corporate names and to allow flexible searches based on Provider names. HP will support this by using interChange's capability to store either a personal or a business name in association with each address type that the provider chooses at enrollment.

HP will work with the Department to develop a set of approved naming conventions to better assist with queries on the provider file. This includes common abbreviations for medical degrees, as well as defined naming conventions for addresses and abbreviations. Establishing these conventions upfront results in consistent data being available for data merge purposes using standard PC desktop applications, such as Microsoft Office.

As part of our provider enrollment process, the HP provider enrollment solution will validate provider addresses against the United States Postal Service National Change of Address Database. This database contains the most-exact address and ZIP combination for a location possible. After a user enters their address information, interChange will access the NCA Database, compare it with what the user entered and either recommend a correction to the user or automatically correct what the user entered (depending on the Department’s preference).

Additionally, interChange provides a flexible search engine that allows users the ability to search by both partial and exact names.

EFT Identifier (Unique ID 1495)

interChange can indicate Providers who can receive payments electronically through Electronic Funds Transfer (EFT). The interChange Provider file can hold additional information such as EFT contacts and other account holder information, including the start and end-date of any segments. Details for the provider’s EFT account (bank routing and account numbers, for example) are stored in the financial area of interChange.

Provider Enrollment Fees (Unique ID 1447)

ACA requires states to collect an application fee at initial and re-enrollment. HP will collect the applicable application fee before completing enrollment. The application fee is applied to the

organizations that are not participating in Title XVII of the Act, another state's title XIX or XXI plan, or have not paid the application fee to a Medicare contractor or another state. If the provider is unable to pay the full enrollment application fee, they are allowed to submit a hardship request. This request will require an explanation of why the fee cannot be paid.

HP will set up an application collection step as part of the provider enrollment process, which will allow providers to pay the application fee using check or credit card. HP will work with the Department to determine final processes for handling hardship requests or nonpayment of fees, and for transfer of monies to state accounts. HP will use the HP Convenience Pay system to process application fees.

If it is determined during the enrollment process that the provider does need to submit an application fee, the provider will be directed to the HP Convenience Pay website. The provider submits their payment transaction to HP Convenience Pay and receives a confirmation number. The provider is directed back to their enrollment screen and puts the confirmation number on the application. HP will verify during the enrollment workflow process that the payment occurred. HP Convenience Pay can accept EFT payments, and direct debits from either checking or savings accounts.

HP Convenience Pay Services provides a highly flexible outsourced payment service. This service enables providers to initiate payments using credit/debit cards or electronic check (ACH and EFT) through multiple channels including the Internet and through Interactive Voice Response (IVR).

Current and Historical Address Records (Unique ID 1462)

interChange allows the maintenance of multiple license information as well as up to five different types of addresses, including practice location, mail to, pay to, prior authorization, and home office addresses as shown in the following figure. interChange can be configured to handle more than five addresses, for example, in Oregon HP maintains six addresses.

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Besides maintenance of active address records, the HP solution maintains details on any record changes. The audit trail includes what updates were made to the record, when the updates occurred, and who made the change—including whether the revision was made by HP staff or by the provider using the portal.

Multiple Provider Email Addresses (Unique ID 1463)

The Colorado interChange will store multiple email addresses on a provider's file. Providers can change these email addresses using their demographics page on the secure Provider Portal.

interChange allows for complete audit trails for each email address. If an email address is added or deleted, the action date is recorded. Additionally, if a change is made to an existing email address, the date of that change, what was changed, and who made the change are recorded in the address's audit trail.

Automated Verification of Email Addresses (Unique ID 1464)

HP understands the importance of having valid email addresses on file for providers for ongoing outreach and communications. As part of the provider enrollment process, HP will have an automated verification of email addresses supplied in the provider's enrollment information.

As part of the provider enrollment workflow process, interChange will send out an automated email to the addresses within the provider enrollment file and then hold the enrollment in the work queue waiting for a response from the provider. The enrollment will wait in queue for the provider to click on a link in the email that creates a related form that will match up with the held enrollment document (based on the ATN). When completed, the enrollment would move out of the hold queue and continue processing.

If, after a Department-defined period, no validation occurred, HP will generate a physical letter to the provider indicating that the email information has not been verified and outline the next steps to remedy the issue.

Provider Agreements (Unique ID 1491)

The HP provider enrollment team will keep copies of provider agreements in the image library. When a provider completes an online enrollment application, a PDF version of the provider application packet and provider agreement is created. The agreement is used during the final review of the provider's enrollment request. The agreement also is indexed and stored in the OnDemand image library. Imaged provider agreements are indexed and can be searched in the OnDemand library using a variety of search criteria, such as NPI, tax ID, and name. HP will work with the Department to determine retention periods for historical provider agreements.

Notification for Applicants of Enrollment Status (Unique ID 1459)

When a provider completes their enrollment application using the portal, an Application Tracking Number (ATN) is created. The provider can perform a query with the ATN to check on the status of the enrollment request at any time using the portal. HP will develop a set of status codes and descriptions the provider can receive when doing a status inquiry.

Additionally, when a provider is approved, HP will automatically generate a welcome letter to the provider letting the provider know their approval effective date as well as any other pertinent data.

If more information is required to process the enrollment, HP will generate a follow-up letter using HP Exstream requesting the additional or corrected information.

If a provider is denied enrollment, HP will generate a rejection letter along with any state-approved instructions for appeal.

Undeliverable Communications (Unique ID 1151)

If the HP mailroom receives an undeliverable piece of provider mail, it is imaged routed to Provider Enrollment using the appropriate work queue. Based on Department-defined criteria for the given type of mail, HP will take action. Based on Department direction, this may include calling or emailing the provider or inactivating the provider.

If an email is returned as undeliverable, the HP team will generate a letter to the provider's office indicating that we received an email bounce-back. If a corrected response is not received from the provider, the invalid email address will be end-dated in interChange.

Authorized Users Can Check Enrollment Status (Unique ID 1510)

Department and HP interChange users who have been given the appropriate security clearance can see the status of a provider's enrollment request. For example, a call center representative can check on the status by using the provider's Application Tracking Number. The status will show in a human-readable format, with Department-approved status messages. Providers may also use the portal to view the status of their application as it processes through the adjudication cycle.

OOS Provider Enrollment Process (Unique ID 1456)

HP understands that non-Colorado providers will supply services to Colorado Medical Assistance clients and those providers need to be certified before receiving reimbursement. HP will work with the Department to develop an Out-of-State enrollment process for these providers.

We believe the most efficient method of enrolling out-of-state providers is through a simplified enrollment tool in the provider Portal.

When an out-of-state provider contacts HP and Colorado Medical assistance for enrollment information, the provider will be directed to the online provider enrollment tool on the Portal. When the out-of-state provider begins completing the enrollment information on the Portal tool, they will have an option to choose "Out-of-State Provider."

The out-of-state provider will then be directed through a simplified enrollment process, gathering only the Department-required data needed for claims processing.

The out-of-state provider's application will route through the K2 blackpearl workflow for provider enrollment and be processed by HP provider enrollment clerks according to Department-approved processes.

If the out-of-state provider application is approved, the provider will be added to the interChange provider file with an effective and end-date based on the provider-submitted data and Department requirements. The provider will be sent out-of-state provider specific materials with billing and coverage information.

If additional information is required to process the out-of-state application, a follow-up letter will be generated through workflow and HP Exstream with additional information for the provider.

Our solution leverages the existing capabilities of interChange and the provider portal to create a controlled, efficient process for enrolling this unique subset of providers.

Claims Submissions for Inactive Provider (Unique ID 1468)

The interChange solution captures the effective and end-dates for a provider's Colorado Medicaid enrollment. Using editing within the interChange claims and rules engine, any claims submitted for dates of service before their listed effective date and on or after any listed end-dates are denied.

Effective and end-date changes take place real-time in interChange. This means that if the Department determines that immediate termination of a provider is required, the HP Provider Enrollment team can apply the end-date and no claims will be paid after the requested end-date.

Regardless of the method used – portal, voice response system, or calling the contact center – the provider must supply their provider number to obtain eligibility information. If the provider was not actively enrolled in interChange for the date of service on which they are requesting eligibility verification, the request will not be processed. The electronic eligibility verification options will display an error message notifying the provider they have supplied an invalid provider number. Our contact center staff will not provide eligibility verification information to a provider not enrolled for the date of service requested.

Entities not enrolled as billing providers who will to need retrieve reports will be set-up with a user ID and password to access the secure section of the Healthcare portal where they can retrieve their reports. User IDs and passwords granted to these types of entities have limited access to other data. For example, "report only" entities will not be able to check client eligibility or submit claims.

interChange's audit capability details any changes to a provider's effective date, including the date of the change, reason for the change, and who made the change.

Electronic Provider Files (Unique ID 1503)

HP will house provider files, electronic claims/encounters, submitter files, and subsequent updates. Base provider and EDI submitter files are stored in the provider database within interChange. Any add-on documentation, such as provider-submitted documents or PDF documents created as part of the provider enrollment process, are stored in the OnDemand image library. The files can be indexed in various ways such as by NPI or tax ID.

As part of the HP portal solution, EDI submitters, vendors, clearinghouses and providers can enroll in their appropriate functions through the portal enrollment tool.

Review or Survey Schedule Tracking (Unique ID 1448)

The HP Provider Enrollment team will work with the Department to establish a provider review schedule and incorporate this within the interChange system and workflows as needed. The K2 blackpearl workflow solution allows for robust reporting of the enrollment review process. K2 blackpearl allows for real-time monitoring of enrollment activities, including allowing the Department and HP team to see how many providers have completed review activities or how

many providers have pending reviews. HP will work with the Department to define schedules and reporting.

Reevaluation of Provider Enrollment (Unique ID 1833)

We have described the enrollment solution in detail throughout this response section. One of the advantages of the Colorado interChange is its ability to keep providers informed regarding the status of their enrollment application and recertifications and any follow up actions the provider must take. After a provider has begun the enrollment or recertification process, they can return to the web portal at any time to retrieve the status of their submission using the application's assigned ATN. The provider can view short messages on the status of their application. This allows providers the ability to see if their application is still pending or if additional information is required. If additional information is required, HP will send a follow-up letter to the provider requesting the information, within five business days of identifying the missing or incomplete information.

The HP provider enrollment portal is designed to prevent many of the errors that cause provider applications to be returned for more information. Many times, applications are returned for basic information that is missing or written on a paper application incorrectly, such as a missing address or incorrectly written license. A provider enrolling through the Portal must complete the required fields – they will not be able to proceed through the application without completing those fields.

The Provider Portal has built-in editing which will not allow a provider to proceed if defined required fields are not completed. Additionally, editing can be put in place to verify certain fields, such as licensure information, are entered in the correct format (number of digits, alphanumeric). This editing validates that at the field and form level, base information is supplied and in an acceptable format.

Automated workflow steps apply business rules to verify presence of required or duplicate data, as well as systematic screening of provider information. Manual workflow steps may also need to occur, such as reviewing for presence and validity of required attachments. After required workflow tasks are completed, the application will be either approved or denied. If additional information is needed, a notice will be sent to the provider requesting this information within five business days. These system-generated letters are maintained in flexible, online templates in HP Exstream and can be customized. This allows the provider enrollment team members to edit the letters using individualized information.

Inactivate Providers Who Do Not Recertify (Unique ID 1834)

Providers who do not comply with a scheduled provider recertification effort can be suspended on a given end-date, based on Department direction. The HP Provider Enrollment team will work with the Department to define the cut-off date for any recertification effort. HP will produce

ongoing reporting during a recertification effort, so the Department has timely data on recertification compliance.

On a Department-defined date, HP will end-date providers who have not complied with the recertification. HP will send messaging to the noncompliant providers regarding any follow-up actions the provider may take to reinstate their certification.

Submitter Contracts (Unique ID 1499)

The interChange provider enrollment screens contain vendor information associated with the provider, such as whether they use a trading partner or clearinghouse to submit claims or eligibility verification requests. Providers can manage these relationships through the demographic function within the secure provider Portal. Providers can access their contract information, make revisions to their contracts (based on Department-defined and approved processes) and view the applied changes to their contracts.

Confirmation of Provider Address Every Six Months (Unique ID 1844)

Provider information must be valid on a provider's interChange file to make sure communications and payments are reaching the correct location.

The HP provider Portal solution allows for regular, scheduled validation of provider information, such as physical addresses and email addresses every six months. When a provider reaches an address confirmation time, they will be prompted to review their data from the demographic portion of their portal account. The provider will be prompted to either check and confirm the information is correct or determine if changes are needed. If the provider indicates changes are needed, they will be prompted to edit information within the demographic page of their portal account.

Broad Range of Training for Department and Contractor Staff (Unique IDs 1070, 1186)

(1070) Training management encompasses the entire Medicaid enterprise. It includes the process of systematic planning, implementing, and monitoring the channel of education and the dissemination of information to stakeholders, including federal, State, vendors, providers, clients, and others who work with the system. The need for the training may arise from new policy and procedures, changes and updates in existing policy and procedures, status and operations reporting updates, and the collaboration and sharing of information.

In its work throughout various state Medicaid programs, HP has learned valuable techniques and processes that allow providers to have a solid educational background and are a successful ally in the Medicaid arena. The same applies to other key stakeholders, such as Department staff, partners, HP staff, and other allies and contractors.

We will take advantage of our experience in other states to bring Colorado Medicaid a best-in-class training program.

Training Plan

HP will work with the Department to develop an annual training plan for Department approval. We will begin work on the training plan in collaboration with Department staff in the third quarter of a year for the following year. We will solicit training ideas and initiatives from Department team members as well as from subject-matter experts (SMEs) within HP.

The HP training plan will be broken out in to two parts: a narrative that will outline key training initiatives for the coming year and a detailed month-by-month calendar of planned training sessions (such as provider association conventions).

HP understands that this training plan can only be a starting point and that the training plan needs to remain dynamic during the year as new initiatives and needs can arise. Our training team will continually review and evaluate the training calendar, working in collaboration with the Department, to make enhancements to the schedule as needed. Each month, the HP training team will collaborate with the Department and key HP staff to determine if any new training needs have arisen, and to let the Department know of any new needs the training team has identified. HP will add the additional training sessions to the annual training plan as the Department approves them.

Training Development

Providers, Department staff, and internal staff members need a solid knowledge foundation to be successful in their respective roles. A training program must meet the needs of its audience in order for the training, and attendees, to be truly successful. The HP training development process works to verify that each facet of the educational experience is positive and effective.

As the HP Training team begins educational development, they will first look at the best medium for the training. Some training sessions may require live, face-to-face interaction, while others may lend themselves better to web-based experiences. HP will offer the following methods of training:

- **Live—**As appropriate, HP will conduct live—that is, face-to-face—training sessions with providers, Department staff, and internal staff members. HP will work with the Department to define which training topics are best suited for face-to-face. We also will work with the Department to define optimal sites around Colorado for the face-to-face sessions.
- **Webcasts—**HP will video certain training sessions and have them available for viewing 24 x 7 on the portal. These may be sessions which are “core” training sessions offered to providers (such as Portal Fundamentals classes), which allow the providers to learn at their own pace at a time of their choosing.
- **HP Virtual Room—**There are times where live, face-to-face training may not be needed, however, more interaction with the audience is needed than a taped webcast provides. In these instances, the HP training team will use HP Virtual Room. This tool allows the training

team to have live, web-based training sessions with providers and other entities. HP has found Virtual Room to be a valuable tool in its training arsenal for other states. In some states, such as Wisconsin, about 50 percent of the training sessions are conducted using Virtual Room.

The benefits of Virtual Room are many, including the following:

- Less time away from the office for providers and the ability for trainers to conduct more training sessions in a given period
- Everyone in the meeting room sees the same content at the same time for discussion and real-time collaboration
- No special software is needed. Providers can connect from any PC with Internet access.
- Document sharing through the Virtual Room. Providers have access to hand-outs directly from Virtual Room.

(1186) The HP training team will work with the Department to create a training curriculum development and approval process. We know that the Department needs to be comfortable with the material and message being used in training sessions. At the start of any training project, a trainer will be assigned as lead. The lead will identify key Department and HP SMEs to involve in the training development.

The lead will meet with the SMEs to develop the key training messages, medium, audience, and other key elements. The lead also will develop a project plan that will include key benchmark draft development and review dates.

SMEs will have the opportunity to review training slide decks, notes, and handouts as part of the development process. After the review team is satisfied with the training product, it will be routed for final review to a list of Department-defined approvers.

Training Announcement and Registration

Verifying that Department staff members, internal staff members, and providers know about training opportunities is essential to a strong turnout at sessions. HP will notify trainees of open events in the following ways:

- The HP training team will generate monthly emails to Department staff and internal staff announcing upcoming training activities
- Providers can access a training home page on the provider Portal that will give them many valuable resources. Providers can see a listing of upcoming training sessions in a continually updated training calendar, access a catalog of taped webcasts for training at their convenience, access handouts and other resources from previous training sessions, and register for upcoming training sessions.

- Every month, HP will generate a provider email detailing upcoming training sessions for the next month, with links to the provider training registration site

Potential trainees can register for sessions online. Our online training registration system, shown in the following figure, allows the following:

- For providers, internal staff, and Department staff to register for specific sessions using the provider Portal or emailed link (depending on the trainee and subject)
- Providers can choose a physical location or Virtual Room session to attend
- The registration tool has an attendee limiter available, which allows training sessions to be capped at a defined number, automatically closing registration when the cap is hit. The system also allows that number to be increased or decreased, if desired, during the registration process. The system will alert training staff when a course registration has reached a set percentage of capacity.
- For automatic confirmation emails to be sent to registrants. This email also can contain directions to the facility and links to training documents
- For automatic closing of a session after the training date has passed
- For production of a class roster that the trainer can use at check-in

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Each training session will include an evaluation form so attendees can provide feedback on the session. This feedback will be used to continually improve training sessions to better support the needs of the users.

Provider HIPAA Training (Unique ID 1175)

The HP training team understands the importance of verifying providers are well aware and following the HIPAA regulations, particularly surrounding PHI. As part of our ongoing training

effort, HP will create an initial training session for implementation that will discuss the types of information providers will have access to using the Provider Portal and its various transactions. The training will cover set up of security roles within the portal and provider responsibilities regarding PHI. HP also will conduct ongoing sessions regarding provider HIPAA responsibilities. Refer to Unique ID 1070 in this response section for detail on our training plan and process.

Training on Any New Initiatives (Unique ID 1189)

HP knows that Colorado Medical Assistance is constantly evolving from changes in state and federal regulations. We are committed to responding with detailed, targeted provider training sessions as the program implements changes. We will have training staff involved in discussions with key Department and HP staff as new initiatives arise and make provider training part of the overall implementation plan for a new project.

Please refer to Unique ID 1070 for additional details on our training plan.

Training on the Portal (Unique ID 1842)

The Colorado Provider Portal will be an extremely powerful tool for the provider community. HP has found amongst our state clients that the portal and its functional capability have literally changed the way providers conduct business with Medicaid.

It is essential that providers' initial experiences with the portal are positive to verify early and successful adaptation of the tool. That starts with training.

HP recommends taking an approach in Colorado similar to how we approach other MMIS portal implementations in which HP developed a robust training program for provider Portal users. Our training sessions started before implementation to give providers information on Portal registration and overall Portal functional capability, and continued after implementation with more-detailed sessions on features—such as client eligibility verification, claims submission and follow-up, prior authorization, and resources. HP will offer ongoing Portal Fundamentals classes for new users, as well as training sessions on new functional capabilities as needed.

HP recommends a combination of live in-person training sessions and Virtual Room sessions to train portal users.

HP will follow the training development process detailed in Unique ID 1070.

Finally, HP will develop a set of Portal User Guides, as the following figure details. These guides supply portal users with step-by-step instructions on different portal functional capabilities. The guides provide information portal users to troubleshoot issues and will be readily available in the portal.

RESPONSE HAS BEEN GRANTED CONFIDENTIAL TREATMENT BY THE DEPARTMENT AND HAS BEEN REDACTED

Training is updated as new features added or changes are made to the portal. Updated training modules will be developed at least one month before the portal changes go live to verify that providers have sufficient time to familiarize themselves with the changes before implementation.

Communications function (Unique ID 1836)

As with training and education, provider communications are essential to a provider's success within the Colorado Medical Assistance Program. The HP communications solution verifies that providers have quick access to the Colorado Medical Assistance communications, guides, forms, and other support materials.

As important as the availability of these communications, is validating the accuracy of everything published. The HP publications team is dedicated to creating a review and approval process helping verify the publications meet Department requirements.

HP will provide communications development, publication, and support for:

- Colorado Medical Assistance Program newsletters
- Provider billing manuals
- Provider bulletins and announcements
- Enrollment forms
- Transaction companion guides

- CPT, HCPCS, ICD-9 and ICD-10, CDT and other reference lists
- Frequently Asked Questions

HP will work with the Department during implementation to develop a set of communications styles and standards to be used in development of communication products.

Development and Management of Communications

The HP training team will work with the Department to create a communications development and approval process. For each communication, HP will assign a lead staff person. The lead will identify key Department and HP SMEs to involve in the development of the communication product.

The lead will meet with the SMEs to develop the key communication points and then develop a draft for review.

SMEs will have the opportunity to review the draft as part of the development process. After the review team is satisfied with the draft communication, it will be routed for final review to a list of Department-defined approvers.

Publication and Indexing of Communications

HP will work with the Department to develop a one-stop Communications page on the Portal for the provider community. This page will house the current newsletters, manuals, and other materials. Providers can sort through communications by provider type, program, or date of issue.

After a communication is approved, HP will publish it to a specific Communications page on the Colorado Portal. As a communication is being finalized, we will work with Department staff to determine the appropriate indexing parameters for the communication. For example, the communication may need to be indexed so that it is available for physician, pharmacy, and therapy providers.

Communications and Relations Function (Unique ID 1476)

HP understands the importance of a holistic provider communications and relations function. Through our communications, training and call center options, HP enables that providers have the information, training, and resources they need to be successful in Colorado Medical Assistance and to effectively serve Colorado residents.

Call Center

The HP team has a dedicated team within the organization that focuses on healthcare call center needs in client and provider services. We have extensive healthcare and eligibility experience and have operated Medicaid-specific contact

Industry Leadership

Internationally, HP manages more than 450 contact center outsourcing customers, with 42,000 call center representatives in 26 countries supporting 47 languages. HP understands that no matter the country, time zone, or industry, our call center representative is often the voice of our customer, and it is our responsibility to help each caller respectfully and courteously.

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centers for more than 40 years. Each contact center model is tailored to our customer's program and requirements, so while each is different, we share our knowledge base to assist across the organization.

The goal of our customer service support call center approach and solution is to offer a professional and responsive experience. HP provide the staff, technology and facilities, needed to support providers so they can deliver safe, appropriate, and quality health service to Colorado residents. Our HP Call Center Management team will work with the Department to create the most efficient program possible while providing the best customer service experience. Our HP team is highly effective at blending lessons learned, innovative technology, comprehensive training and extensive industry knowledge to provide outstanding customer service

HP has extensive experience in call center support in many environments, including commercial and state healthcare programs. We have thus learned the critical role the call center plays in delivering excellent service and support to clients and providers. We continually invest in technology that provides a stable yet flexible platform to meet the fluctuating demands of the environment. The telephony technology includes customer friendly voice response services to promote self-service or to route callers to the appropriate customer service desk. Supplementing the technology aspects of our solution, HP invests significant time and effort in educating our call center agents so that we deliver comprehensive responses to providers. Our agents will respond to the following kinds of contacts:

General program inquiries

- Client benefit questions
- Client eligibility information
- Provider enrollment and re-enrollment
- Prior approval, prior authorizations, or service authorizations
- Claims billing, correction, and payment issues
- Use of various access channels such as the provider web portal and IVR

HP will develop, implement, and operate a provider call center with toll-free access for voice and fax communication, to assist providers as they interact with the Colorado Medicaid Program. A provider assistance email box will be established and monitored by designated customer service staff.

Our provider call center staff will be knowledgeable with Colorado Medicaid-covered services. The team will receive initial and ongoing training to be aware of changes to program policy and enhancements to the interChange transfer system. Besides receiving training on the system and Colorado services and policies, the staff is well versed in each aspect of providing high-quality, compassionate customer service.

We promote quality customer service by monitoring calls. Our experience and commitment to provide outstanding customer service form the basis for devising the appropriate configuration

that prevents callers from receiving busy signals. Our system is flexible in its design, which allows us to add additional lines or contact center representatives should the long-term need exist. Our staff members are well-trained professionals who understand the importance of treating providers with care and understanding.

HP uses commercial off-the-shelf (COTS) products to provide call center technology solutions, including the following:

- **Computer Telephony Integration (CTI)—**Otherwise known as screen-pop technology, CTI takes the NPI entered by the provider in the automated voice response system (AVRS) and integrates it with the Colorado interChange. With this integration, the call center agent receives a "screen pop" with the provider's information before the provider and the call center agent are connected on the telephone. The CTI technology eliminates the time the provider has to wait on the telephone for the call center agent to re-enter the provider's NPI.
- **Avaya Call Management System—**A call center statistics tool built into Avaya's telephony product allows for reporting of hundreds of call center statistics. Reports are available in real time, daily, weekly monthly, annually, or in 30-minute intervals. Avaya's Call Management System also has more than 100 historical reports on call center and call center agent performance. We will create reports as needed by the Department and the Call Center Management team. Avaya's Call Management System exports reports to standard spreadsheets or database programs such as Microsoft Excel or Microsoft Access. The Avaya Call Management System also enables users to develop call center agent and operational dashboards. Additional features include administration of call center agent skill assignments, queues, and resource usage.
- **NICE Quality Management—**This quality assurance and call-recording tool provides voice recording and real-time monitoring. HP leaders often use real-time or recorded monitoring to perform quality assurance checks on call center agents and as a training tool for new call center agents. This tool enables HP to develop helpful and focused communications and training for providers.
- **Verint Systems (formerly Blue Pumpkin)—**This work force management tool provides scheduling and real-time adherence reporting for call center agents. Scheduler features provide scheduling of breaks and lunches based on historical call volumes and handle times. We collect the data from the Avaya Call Management System to forecast call volumes and optimize call center agent productivity.

- **Genesys IVR—**The Colorado MMIS AVRS automatically answers client and provider inquiry calls 24 x 7, except for Department-approved and scheduled maintenance downtime. When clients need additional information, they can speak with a call center agent during regular business hours. Providers can make unlimited calls into the AVRS or to the call center for assistance.
- **NICE Real-Time Integration (RTI)—**This desktop consolidation tool provides integration at the desktop level between separate systems, windows, or programs. The tool is programmed to pull data needed to answer the most commonly asked caller questions from separate windows into one consolidated view. This tool helps reduce training time of call center agents and can reduce the need for copying and pasting or the need for duplicate work or data entry.

The HP Call Center Management team also will have access to the innovative our Resource Optimization Center (ROC). The ROC is a central HP team designed to assist call center management with custom reporting, call center analytics, call center agent scheduling, and general call center consulting expertise. We staff the ROC with personnel experienced in multistate Medicaid call center service, enabling the implementation of best practices and call center solutions to keep the Department call center operating as efficiently as possible while engaging in continuous process improvement. A contact center leader whose customer service programs have been recognized as one of the top three in the country by Consumer Reports manages the ROC team. This staff member has won awards from industry trade journals such as CIO magazine and other professional organizations and has presented in several customer service conferences.

HP will staff accordingly to meet the hours of operation and answer rates the Department outlines. This includes strategic scheduling using an industry-leading work force management and scheduling software to support proper staffing during breaks and lunch times. HP also will provide IVR features to collect caller information and provide self-service capabilities.

We detail our call center solution in RESPONSE 40j.

Provider Education

HP is committed to making sure that providers are receiving the education and training support they need to be successful, as successful providers mean more providers to serve Colorado Medical Assistance clients.

We recognize that providers are busier than they ever have been before and that they work with a variety of payers beyond Medical Assistance. It's essential that Colorado Medical Assistance educational offerings are relevant, timely, and effective to make the valuable to providers.

Our primary offerings recognize the limitations and pressures on providers, and their staffs, time. We will offer extensive online learning opportunities through recorded webcasts available 24 x 7

on the Portal and through Virtual Room training sessions, which bring live, interactive training to the user's desktop.

We understand however, that there are times when PC-based training may not be the optimal way to educate. We will work with the Department through the annual Training Plan to identify those instances where alternative training sessions are needed.

Please refer to Unique ID 1070 for information on our training program.

Provider Communications

The first resource for provider answers must be through communications. Effective communications reduce calls to Provider Services, give providers solid reference materials, and help support the provider's overall success in Colorado Medical Assistance. The HP communications solution uses a variety of formats to disseminate policy and billing information. Please refer to 1836 in this response section for information on our communications plan.

Communication Formats Maintenance (Unique ID 1477)

HP knows that solid communications are the first, and primary, method for disseminating information to the provider community. Well-crafted communications reduce billing errors, fraud, calls to provider services, and overall provider frustration. Through our work as fiscal agent for other states, HP has extensive experience creating provider publication formats which help create a thorough provider understanding of state policies and billing. HP provider communications can take on a variety of formats which, while different, serve to deliver a consistent message to the Colorado provider community. With an eye on producing easy-to-understand provider publications that are also legally sound and risk averse, from newsletters and billing manuals to policies and procedures, we will follow industry best practices and look for cost-effective opportunities to distribute publications. We also will work with the Department to develop a stylebook for common acronyms and grammatical usage. HP will have revisions to the stylebook and themes approved by the Department before they are implemented.

HP has employed the following communication tools in other states and is ready to implement them in Colorado as well:

- **Provider Bulletins—**As new policies or billing requirements are implemented, the Provider Bulletin acts as a primary notice for providers of the change. Creating well-written, concise Bulletins is essential so providers may immediate implement changes needed to be successful and receive payment for services.

  Provider bulletins will be developed with Department and HP content experts. We will work with the Department to define review and approval routing processes to make sure that outgoing Bulletins meet state expectations.

  On approval to publish, Bulletins will be loaded to the provider Portal. Bulletins will be available for viewing and download as PDF files.

Previously published Bulletins will be available for download and will be searchable through an online index. Users may search for Bulletins by issue date, program, or providers affected by the Bulletin.

- **Provider Manuals—**While Provider Bulletins are the resource for announcing changes to policy and billing. Provider Manuals are the "encyclopedia" and permanent repository for policy and billing information.

HP will apply best practices for publication production by writing provider manuals and updates using templates and boilerplate text approved by the Department. By using standard templates, we can make sure that we develop and write policy manuals and manual updates better and faster, with a consistent look and feel. Additionally, the templates help us increase consistency across similar provider publications for the benefit of the state and the provider community. When HP writes policy, including billing and claims processing instructions, we will use easy-to-follow steps written in clear and accurate language that is standard practice for professional policy writing.

As revisions occur to policy and billing information, the HP communications team will quickly make the appropriate changes to the Provider Manuals so that providers have the most-accurate information possible at their disposal.

As with Provider Bulletins, Provider Manuals will be published electronically to the provider Portal. Users may search for Manuals by issue date, program, or provider type.

- **Email messaging—**Through the email subscription function on the provider Portal, providers and other interested parties may register to receive email notifications of new provider publications.

HP knows that consistency in terms and styles across communications is essential not only for a professional communications appearance, but also to validate that important messaging is well understood by its intended audiences.

The HP communications team will work closely with the Department to define a clear, consistent style for communications, with common themes that can be used across the communications vehicles.

Publications Archival (Unique ID 1481)

Department users must be able to view previously published documents for historical research and audit purposes. As a publication is posted to the Communications page on the Portal, HP also will archive a copy on a Microsoft SharePoint site developed for communications. This site will be available to Department and HP staff and will have an interface which allows for searches within the archived communications.

Social Media Function Maintenance (Unique ID 1487)

HP supports the Departments desire to use the newest technologies, such as social medial, to obtain and deliver communications from the Medicaid community. Social media provides a channel specifically purposed to reach large audiences of providers and clients. To optimize its value for the Department, HP offers the following services which complement the existing social media presence. We will work closely with the Department to develop various social media activities for the Department:

- **Social media—**HP will provide a social media analyst who will be responsible for maintenance of Department-defined social media accounts, such as Facebook and Twitter. The analyst will review and respond to Facebook and Twitter comments as well as create proactive Twitter and Facebook messages for outreach to providers and/or clients. They also will be responsible for measuring and analyzing statistics related to social media usage and for monitoring and quantifying public opinion.
- **Communications forum—**HP is contracting with Salesforce.com to assist with chat forums. Salesforce is one of the world's top social technologies companies and provides forum services to organizations such as NBCUniversal, Bayer, GE, and Wells Fargo. Salesforce's Chatter application allows for instant collaboration and discussion among users. Chatter allows for mobile usage, file sharing, group creation, and more.
- **User Knowledge Base—**HP is teaming with LiveHelpNow.Net, an industry-leading live-chat and Knowledge Base provider. Through its LiveChat application:
  - HP can do live monitoring of users, keyword searches, referrals, locations, and more
  - Department-approved canned scripts are readily available to quickly respond to inquiries
  - Inquiry histories (who asked, what was asked) are available for reporting and follow-up

  The LiveHelpNow Knowledge Base system is a multifunctional knowledge base. It allows the questions to come together in one location that is easily accessible both internally and externally. These questions can easily be published as Frequently Asked Questions within the knowledge base.
- **Web-based video training—**Through Camtasia capture software, HP can create a wide variety of web-based video products for publication as Windows Media and QuickTime files. Web-based videos can be as basic as capturing a PowerPoint presentation with audio, to recording full video. These videos can be published to the provider Portal account or to other sites, such as YouTube.

Collecting and Sharing Useful Information with Providers (Unique ID 1506)

HP understands that traditional communications such as bulletins and manuals serve as the foundation for provider understanding of billing and policy requirements. However, often additional, supplemental information is needed to give providers context and to expand on issues

which may not be explicitly covered in bulletins and manuals. We will work with the Department to completely define additional resources for the provider community. Some additional resources will include the following:

- A Frequently Asked Question area on the provider portal using Live Help Now
- A "What's New" area on the provider portal to share the latest updates
- A provider-type specific resource page for each provider type containing additional provider-type focused information

Besides the additional resources available for providers, HP wants to be an ally with providers in verifying that Colorado clients have access to care and services. HP will work with the Department to develop a resources area of the Provider Portal. This area can have links to important information for clients, such as the following:

- Access to Medicaid application information
- Available specialists participating in Medicaid
- Access to Food Stamp information and applications
- Other healthcare programs
- Elderly care information

Web-Based Survey Tool (Unique ID 1831)

Feedback from program stakeholders is important to making sure that services are delivered appropriately and continue to meet their needs. As a standard practice, we survey provider satisfaction during training events as well as post training. These results go toward refining future training offerings such as new courses and delivery methods. For training related surveys, HP will develop evaluation questions with SMEs during the training development process. The team also will determine the most appropriate time to send the evaluation to attendees. Frequently, having an attendee complete an evaluation immediately following training may not be the most effective use of the tool. Often, attendees need to have some time pass to really use the skills learned. A more effective evaluation may occur days or even weeks after the training.

Attendees will receive an email with a link to the survey. Questions may be multiple choice, ranking, open ended, or in other formats as determined by the training development group.

On a broader scale for surveys to providers and clients on more general program topics, HP will use Survey Monkey to develop and disseminate these surveys.

Survey Monkey is one of the world's most-used survey design, dissemination, collection, and analysis services. HP uses Survey Monkey to serve many other Medicaid accounts with great results.

Surveys are completely configurable with more than 15 different types of question formats (such as radio button, scales, multiple choice, open-ended narratives). Surveys can be custom branded with State of Colorado colors and logos.

Survey participants are sent a customizable link. Survey parameters can be set to allow only one response or multiple responses from a single workstation, as well as with other parameters.

Survey Monkey offers robust reporting and analytic services. The reporting and analytics are database driven, meaning results can be sorted and parsed in countless ways. Results are available in a variety of formats, such as Excel files or PDF and can be published to providers or supplied to agencies and Department staff at Department direction.

Medicaid Website (Unique ID 1835)

Our vision for the Colorado Medicaid website is to be a primary source of information for the program as well as a tool that enables stakeholders to conduct business as efficiently as possible. Effective website management includes enabling a broad suite of transactional services. It also considers readability, navigation, branding, HIPAA and ADA compliancy as well publishing information in a controlled yet timely and flexible manner. We know from our experience in managing other state Medicaid programs, that an effective website, particular one that promotes self-service, is invaluable to program stakeholders. The proposed HP portal provides the technology platform to meet these demands while our Medicaid operational expertise provides strong and reliable program management. We offer highly skilled staff who will apply their expertise and best practices from our other Medicaid programs, in developing and managing a comprehensive Colorado Medicaid website.

The Colorado healthcare client and provider portals that will allow providers, trading partners, and other Department authorized stakeholders access to secure features, includes a non-secure public-facing site. We will work with the Department to define the content details of this site, however, it may generally include the following:

- Overview of program information for providers and clients
- Links to Department statutes and code
- General communications (current and archived)
- Other links defined by the Department

Help Desk for SLR Implementation (Unique IDs 1838, 1839)

(1838, 1839) HP will implement and manage a provider relationship management help desk for Colorado Registration and Attestation as part of our overall call center plan. Upfront menus in the IVR will allow providers to indicate what their inquiry is related to. For example, a provider selecting the Registration and Attestation option will be routed to the queue for staff trained in that solution. Our call center stall also will be trained to assist with provider enrollment issues and electronic data interchange issues.

Provider Inquiries (Unique ID 1841)

HP will respond to provider inquiries through a variety of methods. As detailed in Unique ID 1487, HP will provide Knowledge Base and live chat services to providers. As detailed in

Unique IDs 1855 through 1866 in RESPONSE 40j, HP will handle telephone, written, and email inquiries from providers.

1099 Information Maintenance and Reporting (Unique IDs 1497, 1498)

As the Medicaid fiscal intermediary in 16 states, HP is responsible for federal Form 1099 processing, including issuance to providers. We process millions of dollars in payments to the providers we serve and we fully understand the intricacies involved in establishing accurate financial reporting. Our solution provides a highly accurate and controlled means for tracking and reporting these payments including the ability to make adjustments or corrections to 1099's as necessary. We initially enter providers' financial information into interChange during the provider enrollment process. Data elements such as the EIN, W9 indicator, Social Security number, and IRS indicator display on user interface screens in the Provider Maintenance component of interChange. Other data elements such as EFT and 1099 information display on user interface screens in the financial component.

interChange tracks payment and 1099 data by provider service location. Service locations with the same tax ID are accumulated together to produce a 1099.

Internal authorized users can make changes online, within interChange to correct errors in earnings amounts or tax IDs. We also will make changes through our financial processes to adjust earnings amounts on 1099s resulting from payouts, recoupments or other financial transactions. Should changes be required after the 1099s have been issued, we will generate corrected 1099s.

On a predetermined schedule, we will submit the 1099 file to the IRS and provide a copy to the Department based on their requirements. The annual earnings that we report to the IRS reflect receivable and payable financial processing throughout the year, excluding any adjustments that should not be included as taxable income.

(1497, 1498) We report payments as medical and healthcare on the Form 1099 MISC. We update and maintain financial data, including 1099 reported amounts, based on the Department's required retention periods. Should questions arise during audits, HP will provide staff to support the Department.

interChange screens allow authorized users to view 1099 information, including prior year, for a provider as shown in the following figure. Additionally providers can access their 1099s through the Provider portal.

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RTP Claims Processing (Unique ID 1619)

There are times when providers need to have documents returned to them. Provider enrollments and other provider file maintenance requests need follow-up with the provider if not completed fully and correctly. Claims may also need to be returned to providers if they are missing critical information. The criteria for returning a claim or other documentation will be outlined in our procedure manuals and incorporated within workflows. All communications to providers will indicate the reason for the return of the materials and we will keep a record of this correspondence on file.

EPSDT Information Maintenance (Unique ID 1700)

HP knows that healthy outcomes for children rely on regularly scheduled check-ups and screenings, like those offered through EPSDT. The HP Provider Portal will allow providers to determine where a client is on their screenings and check-ups. interChange will track EPSDT visits that will be associated with the client's enrollment file. The screening information, including current and historical, will be available to the provider when they are doing an eligibility inquiry on the portal.

The EPSDT Screening History Screen displays EPSDT screening information for a client as shown in the following figure.

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The information displayed includes claim ICN, provider ID, dates of service, procedure code, screening description and claim status. The ICN, Provider ID, and procedure code are hot links to their respective information screens. If an analyst is unfamiliar with the procedure code, they simply click on the hot link and the procedure base information screen opens in a new browser window. Additionally, the EPSDT Notices screen within interChange provides a history of the EPSDT notices sent to the client.

The client subsystem maintains database tables that store information about a specific client, specific Medicaid cases as well as cross-references between the clients and the case(s). Besides online access, standard reports detail EPSDT activity, and the interChange reporting solution can be used for ad hoc reporting.

Notifications are generated using the HP Exstream software. HP Exstream uses standard templates for routine correspondence but allows for customized letter creation by authorized system users.

TPL information Submission (Unique ID 1770)

Providers often find third-party liability (TPL) discrepancies as they verify enrollment and work with Colorado clients. The HP solution allows providers to access an online submission form using the Provider Portal to submit information on TPL discrepancies for research and, as needed, correction. Once submitted, this will trigger a workflow task and an alert to the appropriate recipient for follow up.

Claim Status (Unique ID 1818)

TECHNOLOGY HIGHLIGHT

Our solution enables providers to get detailed claim status information through their secure Provider Portal account. Claims information is secure and only accessible by portal users who have been granted permission by their portal administrators to view claims. Additionally, claims are only viewable

for a given NPI, taxonomy, ZIP combination. Users cannot see claims for providers outside their NPI, taxonomy, ZIP combination. Although we anticipate that most providers will use the portal to inquire on claims, HP also will provide this information electronically through the help desk voice response system (VRS). The VRS will authenticate the provider before allowing the disclosure of claim related data.

Providers can view claims in various ways as shown in the following figures:

- Users will see a listing of the most recent claims—received, paid, denied or suspended—through the secure home page of their provider Portal account. This list can be configured to show a certain number of claims, or to not appear at all.
- Within the claims functional capability section of the secure Provider Portal, users can conduct searches for submitted claims. The search feature is robust and has search parameters including:
  - Claim number
  - Client ID
  - Dates of service
  - Claim status
  - Type of claim
  - Payment date

These search parameters may be combined to give providers the ability to conduct detailed claims analysis.

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Through this MMIS online window the user fills out the specific fields and then clicks on 'View' to receive the reporting results. This user driven, variable reporting is available as part of the Contact Management, Prior Authorization, Provider and TPL business areas. During DDI we will work with the Department to determine the preferred reporting method to fulfill this requirement.

Voice Response (Unique ID 1837)

The Colorado MMIS AVRS automatically answers client and provider inquiry calls 24 x 7, except for Department-approved and scheduled maintenance downtime. AVRS features include eligibility verification and access to HIPAA transaction information. Providers can make unlimited calls into the AVRS or to the call center for assistance using our toll-free numbers. Additionally, using their Value Added Networks (VAN), software vendors or clearinghouses, provides can obtain eligibility information using HIPAA compliant 270/271 transactions.

Providers with secure portal access can access information including:

- Client eligibility
- Access to 837 transactions
- Access to PAR information
- Access to 835 information

Please refer to Unique IDs 1855 through 1866 in RESPONSE 40j for details on HP's AVR solution.

Appeal Claim Denials/Appeal Enrollment (Unique IDs 1843, 1511)

(1511) The appeals process can often be manually intensive for providers. Our solution offers an online method for providers to claim related or non-related appeals and to be able to track the status of those appeals online. Our solution takes advantage of the easy to use capability of the Provider Portal, and configurable business rules and workflow that supports a controlled and streamlined process for providers to manage their appeals.

The provider Portal will allow users to file and track appeals. This includes the following:

- **(1843) Appeal of claim denials—**HP will work with the Department to define parameters for claim denial appeals. Providers will have the ability, based on these parameters, to select a claim on the portal and submit an appeal using the portal.
- **Challenge claim payment amount—**Providers can select a claim in a paid status and challenge the payment amount. As with appeals of denials, the user can select the claim from the secure portal and, based on Department parameters, submit a challenge to the payment amount.
- **Enrollment Appeals—**If a provider receives an enrollment rejection or denial, is terminated from Colorado Medical Assistance, or wants to appeal an enrollment effective date, they will be given instructions on how to file an appeal, if desired. The appeal process is defined below.

Pre-Appeal Assessment

The Provider Portal allows providers to create a new appeal and resubmit an appeal when the provider disagrees with the outcome. The first step of the appeal process is known as pre-appeal assessment as shown in the following figure.

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The portal Assessment engine is used to configure questions and responses. Users are asked a series of client configurable questions that help direct the user to the next appropriate step (workflow tool). Branching logic is associated with the user responses and tells the system which question to display next. Based on user responses, users are given dynamic instructional messages and links that will enable them to follow the appropriate workflow. At the end of the assessment process, the user will continue to the next step and create an appeal.

Submit Appeal

The two types of appeals are nonclaim-related—such as enrollment appeal—and claims-related—such as dental, institutional, or professional claim.

Nonclaim-Related

Nonclaim-related appeals are initiated from the portal menu using the pre-appeal assessment capabilities. The user enters required information which is validated by the payer system. The provider information is prepopulated based on the logged on user and is not editable. The user can add contact information for the appeal, reason for appeal, and provider notes. Attachments can be uploaded during the appeals submission process.

Claim-Related

Claim related appeals can initiate from the portal menu using the pre-appeal assessment (if the user answers that they want to appeal a claim), from claims related pages or they can link from the appeals page to claims to find the claim they wish to appeal. After the user selects the claim to be appealed, the claims data is prepopulated on the appeal. Users can appeal the following claim types: professional, institutional, and dental. There are multiple steps in the appeals process. Users can view the client information (from the claim) but cannot edit it. The user can add contact information for the appeal, reason for appeal, and provider notes. However, the user cannot change the provider information. Attachments can be uploaded during the appeals submission process as shown in the following figure. The appeal must be associated with at least one service line on the claim.

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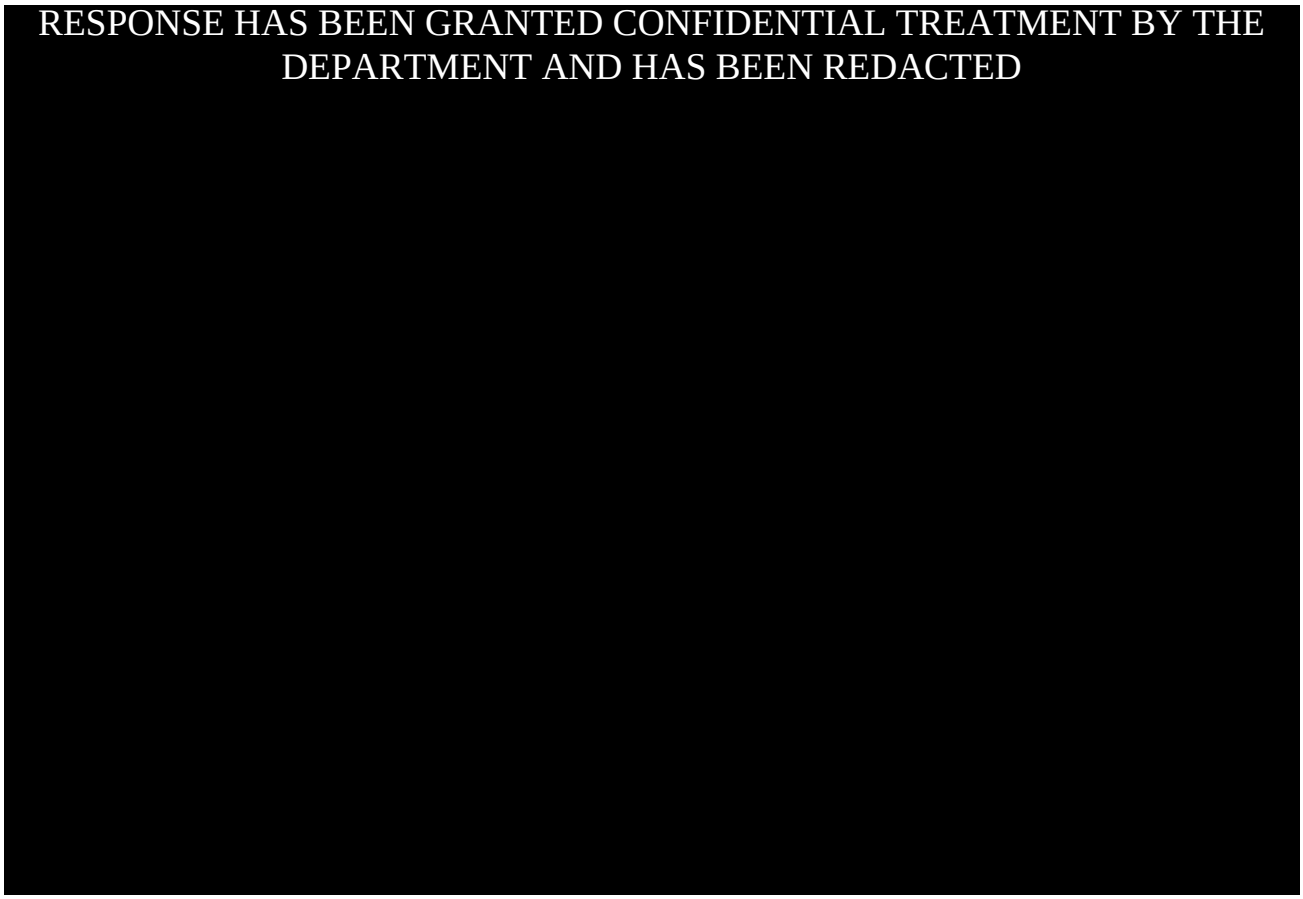
Search Appeals

The Provider Portal allows providers to search for appeals. There are two tabs on the Search Appeals page as shown in the following figure.



- **Search by ID tab—**The user must enter at least one ID (Appeal Service Request #, Appeal ID, Claim ID, Authorization #, or Client ID). The IDs match on exact values (partial searches are not supported on this tab). The identity of the provider is added to the search criteria and the search results are limited to a single provider.
- **Search by Appeal Details tab—**The user can search on the following fields: Appeal Status, Appeal Decision, Reason for Appeal, Procedure/Service Code, Date of Service Range, Appeal Submitted Date Range, Client ID, Last Name, First Name, and Birth Date. Reason for Appeal, Appeal Status, and Appeal Decision are specific to medical or dental users as determined by the backend system. The identity of the provider is added to the search criteria and the search results are limited to a single provider.

Search Results

The default sort for the appeal results is by Date Appeal Submitted in descending order. The Claim ID link displays claim detail from the claims system. The pagination is defaulted to 10 rows. When the provider clicks on the Appeal ID link, the Appeal Detail is displayed (see View Appeals below).

View Appeals

As we detail in the following figure, the HP Provider Portal allows providers to view at a glance the status of their appeal on a real-time basis, as requests are being processed in interChange. The user can view status, decision, and notes from interChange

Some appeals can be resubmitted—such as Level I, Level II, or External Review—when the provider disagrees with the outcome. The interChange indicates if another appeal is allowed and the portal will display a message that indicates a subsequent appeal is allowed. If the user clicks the "Appeal Again" button, they can resubmit the appeal.

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Workflow

After an appeal is submitted to the Core MMIS, it triggers an automatic workflow task within interChange to guide the HP representatives through the process. InterChange Workflow is the blending of interChange UI, K2 blackpearl workflow COTS product, and Corticon business rules engine COTS product. Workflow services have been designed for provider appeals processing. The workflow moves the process through the steps informing the users when a manual step is required and putting the information in their work queue. The predefined rules

determine the path the appeal takes such as routing to the appropriate Claims or Provider unit for processing. As the process moves along through each step, additional information is recorded and managers can view statistics of the business processes to identify and remedy bottlenecks. They also have immediate view into a specific grievance for visibility of its current step, steps completed, and next steps.

An image of scanned documents also is stored in the OnDemand Document Management System. If users need to access the original appeal, it is available and virtually attached to the electronic version of the appeal.

After the appeal request processed, HP will generate a decision to the provider in a formal correspondence. As noted earlier, providers also will have access to appeal status online.

9.5 – Provider Management Services	**In Production? YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1840	**NO**

Background Checks (Unique ID 1840)

As discussed in Unique ID 1832, LexisNexis is used to meet the requirements of Rule 6028 of the Affordable Care Act (ACA) for provider credentialing and background checks. HP uses information from a large database provided by LexisNexis of public and proprietary records to give a detailed view of individuals or businesses and their history. This service aids in the investigation process by quickly identifying fraud and other incidents within the last five years that involve the owners, indirect owners, and managing employees.

The LexisNexis database already includes information from federal databases such as NPPES, LEIE, EPLS, Medicare terminations, and the SSA Death Master File and is capable of supporting additional interfaces if available. During DDI, we will work with the Department to determine all applicable sanction databases that require and support systematic interface process. In the case where a systematic transfer of data is not available, HP will work with licensing and sanctioning agencies to verify that providers meet the federal and state enrollment requirements.

These verification functions will occur at initial enrollment and following provider revalidation or re-enrollment.