Approach to Core MMIS Statement of Work

Approach to Core MMIS Statement of Work

RESPONSE 39

RESPONSE 39: 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 Core MMIS technical and business services requirements provided in Section 8 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.

The Core MMIS Statement of Work is the heart of the project. The technical solution drives each function and operation. The Department has read enough by now to know that our solution aligns to your goals and objectives. As the Executive Summary underscores, HP understands the Department's key goals for the success of this project:

- Adaptability
- Business intelligence and data analytics
- Service-focused
- Performance-based contract
- Information sharing
- Realistic project schedule
- Maximize federal funding
- Federal standards compliance
- Federal certification
- Integration with other State systems

The Department's ultimate goal is to build out the necessary information technology to support a business model that can quickly adapt and support the next decade of healthcare transformation. HP can deliver on every bullet point. HP describes our approach to the Department's Core MMIS statement of work using the following responses:

- 8.3 – Client Management (RESPONSE 39a)
- 8.4 – Provider Management (RESPONSE 39b)
- 8.5 – Operations Management (RESPONSE 39c)
- 8.6 – Program Management (RESPONSE 39d)
- 8.7 – Business Relationship Management (RESPONSE 39e)

- 8.8 – Program Integrity (RESPONSE 39f)
- 8.9 – Care Management (RESPONSE 39g)
- 8.10 – Managed Care (RESPONSE 39h)
- 8.11 – EDI (RESPONSE 39i)
- 8.12 – EDMS (RESPONSE 39j)
- 8.13 – Case Management Tool (RESPONSE 39k)
- 8.14 – Web Portal (RESPONSE 39l)
- 8.15 – Colorado Registration and Attestation (RESPONSE 39m)

As you read these responses, we hope you see that with HP, the Department gets a solution that aligns with Medicaid Information Technology Architecture (MITA) and CMS' Seven Standards and Conditions (7SC) and the people who helped shape them. As your trusted adviser, we will put you on the clearest, most sensible path toward full MITA maturity.

RESPONSE 39a

8.3 – Client Management	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1211, 1254, 1260, 1399-1413, 1415 – 1433, 1435, 1437, 1439, 1440, 1442, 1443, 1445, 1649, 1716-1718, 1750	**YES**

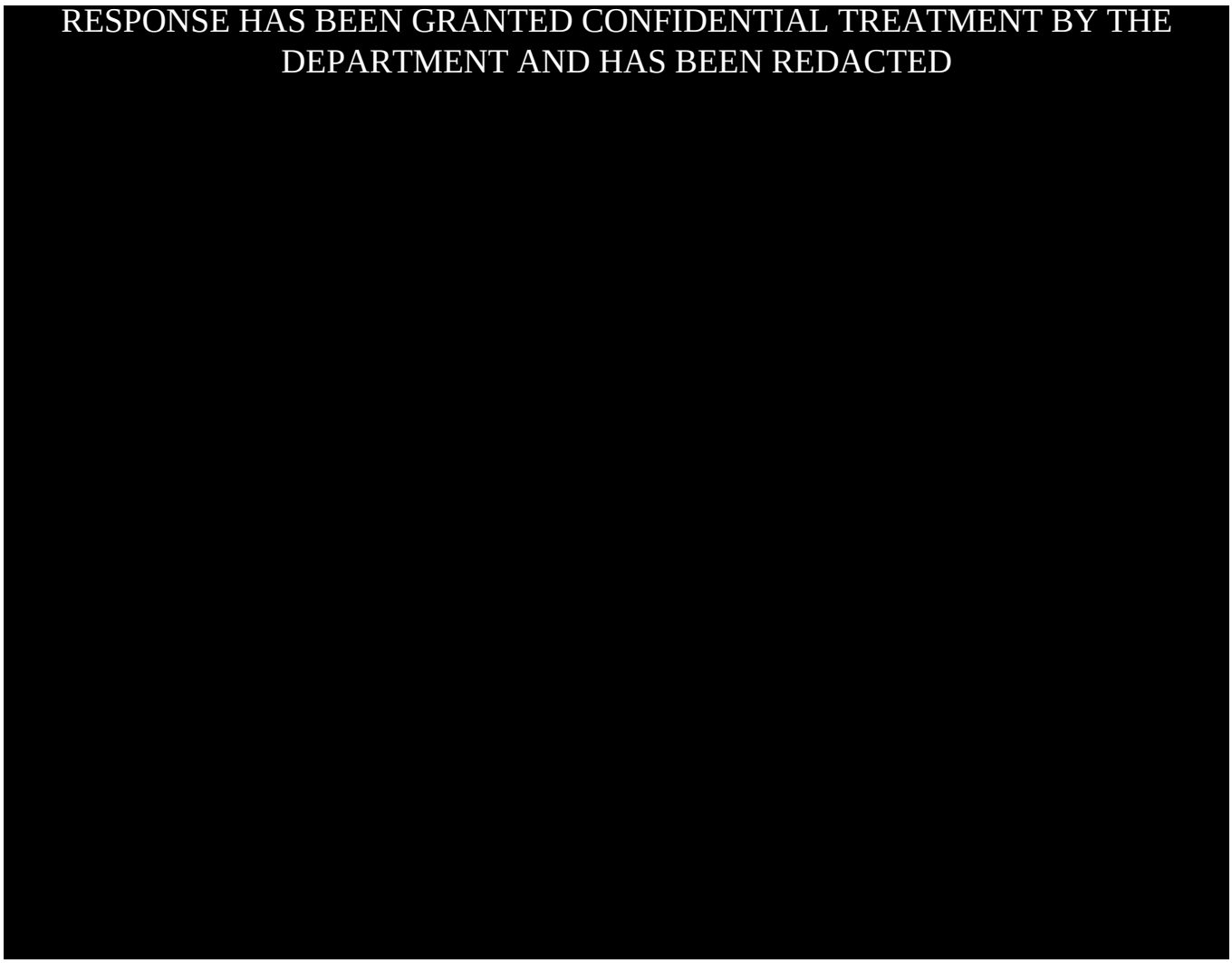
HP understands the complexity of managing client data in a constantly changing healthcare environment, and we are uniquely qualified to meet the Department's needs. Your Colorado interChange Medicaid Enterprise system offers a robust solution for maintaining accurate client demographics and enrollment information and is highly customizable for the Department's array of healthcare programs.

An innovative web-based HP Client Portal will enable Colorado's residents to access important information about their healthcare benefits, options for doctors and treatment facilities, and much more. The Client Portal also facilitates communication with clients and keeps them updated on program changes, appeals process, and other outreach and educational needs the Department defines.

Integrity of Client Data (Unique IDs 1211, 1410, 1411, 1412, 1420, 1649)

(1211) The Colorado interChange maintains an extensive audit trail for every client record. Within the Colorado interChange, authorized users can view client data and the associated audit history. Through user-friendly web-based panels, users can generate a complete history of actions taken on the data—such as when it was added, changed, or deleted and by which user. This functional capability enables a user to see—as the following figure details—at a glance when data changed, how it changed, and determine the source of the change.

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



(1412) The Colorado interChange stores each client's benefit plan assignments, and program enrollment for a client—current and historical—is available at a glance when an authorized user looks up the client's record in the Colorado interChange, as the following figure shows. (1420) Historical assignments are never removed from a client's record and are always available for review and reference. Storing effective and end dates for coverage allows the Colorado interChange to retain historical eligibility segments that are no longer active. If eligibility was entered in error and should no longer be part of a client's record, a status of "History" is applied to the benefit assignment, meaning that it is only maintained for historical purposes.

The storage of client data relating to benefit assignments is not limited by time. After a client is enrolled in a benefit plan, that enrollment data is available in the client's record throughout the Colorado interChange and by interactive eligibility inquiries, regardless of when an authorized user looks up or inquires after the information.

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

The Colorado interChange gathers eligibility and client data from many sources (such as CMS, CBMS, state agencies, and eligibility vendors) and input methods (such as electronic transactions, data exchanges, and web-based interfaces). The system tracks the source of eligibility information, and the Colorado interChange audit panels can be used to display eligibility source for any given segment.

(1649) Client data integrity requires a comprehensive solution for maintaining the most current client identification number. The Colorado interChange verifies that client IDs are kept current using processing logic which includes a cross-reference table to associate the current ID number with former client IDs. This allows the system, for example, to process a claim for the correct client even if a provider uses an old ID number. System logic identifies possible "duplicate" clients—two client records that may represent a single client—and notifies appropriate staff members for reconciliation. A batch process performs a client "link" process that automatically updates the applicable system tables and references when a client's ID is updated. The link process also updates client data used in other parts of the system so that other functions such as claims, prior authorization, and financials are not adversely affected by an update to a client ID.

These processes verify that client ID discrepancies do not interfere with system functions. If a state agency identifies a client using a prior ID number, the Colorado interChange will promptly

identify the correct client record. Where the Colorado interChange passes client information downstream to other systems, the updated client ID information will be sent in the next interface file.

(1411) The Colorado interChange has the flexibility to apply certain updates to client data based on a source hierarchy or by limiting how updates are applied. For example, if many eligibility files are received from different agencies, the files can be processed in ascending order during a nightly cycle so that eligibility from the lowest source is applied first and overridden by eligibility from later sources that are at the top of the hierarchy, while retaining a comprehensive audit trail of changes. (1410) As part of the update process, maintenance and discrepancy reports are auto generated. The ability to set the eligibility update hierarchy applies the Department identified rules when performing the data updates.

For sensitive data such as client address or household data for children in foster care, updates can be restricted to only the appropriate agency while updates from other sources are not applied. Certain data elements, such as date of death, may be applied exclusively from the most trusted and reliable source (such as SSA), as defined by the Department.

The system automatically addresses retroactive enrollment and end dating due to circumstances such as receiving a client's date of death. Retroactive enrollments in presumptive eligibility also may be updated by the system. The system provides daily reports on batch and real-time eligibility transactions failing edits or validity checks for rapid online analysis and resolution. The system allows authorized staff members to resolve eligibility errors by manually updating client data, if needed.

Client Management Interfaces (Unique IDs 1254, 1260, 1419, 1427, 1445)

(1260) Managing client data requires a system that can communicate with the multiple entities that provide client eligibility data. (1427) The Colorado interChange will exchange client eligibility files with the entities specified by the Department. Updates are applied in real time when authorized staff members enter data into a client record through the web-based user interface. Updates received in batch transactions are processed on a defined schedule which can be configured to run regularly enough to be considered 'near real-time'.

(1419, 1254) When accepting external data feeds the eligibility processing logic edits and validates incoming records for quality and accuracy before applying to the Colorado interChange database. Edits serve several functions. They verify the accuracy of data—for example, the Social Security number value is nine digits and numeric. Edits also check data elements against established system codes—for instance, verifying that an agency code exists in the system and does not contain an unknown agency value. Edits prevent inappropriate updates—such as closing an eligibility record when a matching record is not found for that client. Edits are set up to reject a single element of the incoming record or the entire record.

(1445) Besides receiving eligibility records from an outside system, interChange enables authorized users to manually enroll clients directly through our user interface. After a client is

enrolled through the interChange Client Management business area, the client can be assigned the appropriate benefit plan in order to receive benefits.

HP has many years of extensive experience in 20 States coordinating client eligibility data from many sources: eligibility determination vendors, state agencies and workers, federal programs, and other business allies.

Client Enrollment: Health Benefit Plans and MCOs (Unique IDs 1399-1409, 1716-1718)

Enrolling clients in the correct benefit category is one of the most important features of a functioning MMIS, and HP has more than 40 years of experience managing complex, multifaceted state healthcare programs. (1402) The Colorado interChange will use data from eligibility sources including CBMS and enroll clients in the appropriate health benefit plans and MCOs. (1400) If a client does not make a specific MCO selection, the system applies automatic business rules to perform timely assignment of clients.

The Colorado interChange enrollment functions are highly configurable, and HP will work the Department to determine the criteria for a client's enrollment in a health benefit plan or MCO during the requirements validation phase.

(1400, 1716) System logic establishes criteria that a client must meet—such as county of residence, category of coverage, or dates of coverage—before automatic enrollment in a particular MCO or HMO is allowed. The automatic enrollment will be based on the Department specific business rules for enrollment. This up-front editing prevents clients from becoming enrolled in the wrong MCO or HMO and eliminates the need for additional error reporting and reconciliation. (1404) Criteria specific to the Department's policies can be configured in the system to prevent client enrollment in an inappropriate type of MCO, or to exempt clients from managed care enrollment for a specified period of time. These exemptions can be entered and updated using online panels and will apply to both online and batch enrollment, as shown in the following figure.

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

(1401) Batch processes support enrollment, disenrollment, and transfer of clients to health benefit plans and MCOs. Based on records received from CBMS or other entities as defined by the Department, the system updates client eligibility in a health benefit plan. (1717) Additional system logic runs nightly and identifies clients who are eligible for managed care enrollment. The system then automatically enrolls clients in the correct MCO. (1718) The managed care logic includes a series of checks and balances to validate that clients are enrolled in the correct MCO based on the eligibility data that the system received from an outside source.

(1405) Mass enrollment, disenrollment, and transfer of clients is a similar process. In special scenarios, when an entire population of clients must be reassigned to a different health benefit plan or MCO, special processing may be needed to accommodate the change. The system supports continuous updates to client eligibility, so mass changes should be rare. For managed care enrollment, the system can determine future eligibility and store the client's information to auto-enroll the client at the correct time. (1408, 1409) The system also retroactively enrolls clients when a correction is made to the client's eligibility record that qualifies the client for managed care. Retroactive enrollment also applies to circumstances such as a birth that is newly reported to the system. Retroactive dis-enrollment is performed in situations such as a death. The Colorado interChange can be configured to set limits to retroactive enrollment. The interChange solution supports the ability to retroactively enroll and disenroll a client or client group into

managed care. Through this process interChange supports the ability to automatically retroactively make claims adjustments based on such program enrollment changes.

(1407) An automatic process also is used to reassign clients to an MCO after a period of lost eligibility. The standard time frame for automatic reassignment is one calendar year after the client first lost eligibility. The client is then treated like any other new client in the system and assigned to an MCO. Users with appropriate security access can update client enrollment in real time for immediate changes.

(1403) Flexible rule configuration in the benefit plan administration section of the Colorado interChange enables the creation of health benefit plans and MCOs in the Colorado interChange that best capture the Department's unique healthcare policy. The following interChange features will support the Department's enrollment policies:

- Ability to configure hybrid fee-for-service and managed care benefit plans—for example, in Wisconsin, some clients are covered by an MCO for most physician services but mental health services are covered under fee-for-service
- Ability to define different benefit plan groups according to funding source—such as TXIX or special waiver program

(1399, 1406) Besides receiving eligibility records from an outside system, interChange enables authorized users to manually enroll/disenroll clients directly through our user interface. After a

client is enrolled through the interChange Client Management business area, the client can be assigned the appropriate benefit plan to receive benefits. Within 48 hours the enrollment team will resolve enrollment issues that are within their control.

Client Enrollment Verification System (Unique IDs 1413, 1422, 1426)

HP is highly experienced in operating Enrollment Verification Systems (EVS) that give healthcare providers and trading partners many options for retrieving accurate and timely client enrollment data. A well-built EVS helps clients receive services, assists providers in identifying client coverage and billing for services, and greatly improves the Department's healthcare outcomes. The HP EVS solution includes the following features:

- **Web-based—**Providers can send inquiries and receive responses about client enrollment through a secure, user-friendly provider portal.
- **Telephone—**Providers can call in to an interactive voice response system, enter client data according to prompts, and receive a spoken response about the client's enrollment.

- **Electronic HIPAA transactions—**Providers and trading partners (including MCOs) can send and receive the 270/271 Healthcare Eligibility/Benefit Inquiry and Information Response HIPAA-compliant transactions. The Colorado interChange generates a compliant response transaction with client enrollment data, including MCO enrollment.
- **Swipe card identity –** A swipe card action will initiate a 270/271 inquiry transaction supported by the solution

The interChange Connections solution includes an enterprise service bus (ESB) which acts as a conduit for three flavor of eligibility request by providing interoperability with the same underlying web service.

(1426) The aforementioned mechanisms provide information about the client's enrollment in a state healthcare program, state-contracted MCO enrollment (including contact information for the MCO), Medicare enrollment, commercial health insurance coverage, and copayment.

(1422) The Colorado interChange stores records of eligibility inquiries, whether submitted by web portal, voice response, or EDI. Results can be queried by the user and filtered by provider ID, client ID, or transaction date. Additionally, a monthly report is generated that displays the provider ID, client ID, dates of service, and transaction date and time.

Client Communication (Unique IDs 1415-1418)

Clear communication with clients is vitally important to the success of state Medicaid administration. (1415, 1417) HP manages several different methods of client communication. The client call center manages telephone communications regarding coverage and billing issues. (1416, 1418) The interChange Client Management business area will generate multiple types of communications including appropriate approval, pending, and denial notices to providers or clients including denial reason, grievance and appeal rights, and procedures as part of the automatic update processes. These notices are generated from our correspondence management component HP Exstream. Interaction with the clients or providers by using the call center is tracked using the interChange CTMS module. If hard copy documents are sent in such as medical questionnaires, the mailroom logs the entry and the document is stored in the EDMS and indexed to the appropriate client or provider.

The Publications team produces notifications for large changes, such as the addition of a new healthcare program or a major change in coverage or policy for an existing program. The Client Management section of the Colorado interChange enables users to generate and customize letters for clients, as the following figure details. Client data relevant to communications is easily accessible in the system. Authorized staff members can use the Colorado interChange screens to search for claims and encounters associated with the specific client and find details of the client's billing and coverage history.

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

Client Data Storage and Reporting (Unique IDs 1421, 1423-1425, 1429, 1430)

HP understands that state healthcare requires access to a large body of information about clients, which is why the Colorado interChange manages so much data beyond client ID numbers and enrollment history.

(1423) Clients are entered into a "case" in the Colorado interChange system; the case groups clients into a household. Cases have a unique ID number and searches can be conducted on the case number, as we detail in the following figure. One client is designated as the head of household. Reporting can be done on a per case basis instead of per client, depending on business need. The case grouping also allows a case head to inquire about benefits for other case clients. The system includes safeguards to protect clients in sensitive eligibility categories such as foster kids or children who were adopted. They are immediately enrolled in their own case and the case head of their former case cannot access the child's personal information.

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

(1424) Client records in the Colorado interChange are designed to store multiple addresses and other contact information, as we detail in the following figure. This design allows the Department to store contact information for different programs and for use in different business processes. For example, if a client is enrolled in a sensitive benefit category and correspondence related to that coverage must be sent to a specific address, it can be stored in a special address category and kept separate from other contact information. Besides an address, this feature stores telephone numbers, an email address, and the relationship of the contact named in the address to the client—such as mother, case worker, or spouse.

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

HP manages prior authorization for many large Medicaid systems, and the Colorado interChange will maintain thorough prior authorization records as we detail in the following figure. (1421) As part of the Colorado Medicaid Management Innovation and Transformation (COMMIT) solution, the Colorado interChange will capture and store the PAR data attributes passed to the Colorado interChange from the prior authorization vendor. The authorization data is retained within the Colorado interChange database for permanent record keeping. (1425) We also maintain client wait lists for state healthcare benefits.

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

(1429) Additionally, copayments are tracked in the system for cases or households. The Colorado interChange can cap cost share for a case so that after a certain percentage of a case's income is applied to cost share, copayments are no longer applied to claims for the clients in the case. (1430) The Colorado interChange stores encounters as if they were another claim type. This means the transaction history has a complete record of the fee-for-service and encounter services for a client. On each encounter record, the unique identifier for the Managed Care Organization is stamped as a permanent record.

Client Portal (Unique IDs 1428, 1431 – 1445)

(1431) The overall Colorado interChange facilitates the ease of access of information for the clients and providers. For example, through the interactive voice response system, a client can access real-time information, including enrollment status, eligibility information, and PAR status. The Colorado interChange is designed to give each access channel such as the IVR, or Healthcare Portal the same response because we hold 'one source of truth' that each of those user access channel checks in real time.

The HP Healthcare Portal gives clients access to information about their state health benefits and allows for two-way communication between the health plan and the client. (1428, 1432) The client-specific section of the HP Healthcare Portal allows state healthcare clients to register and

access their protected health information through HTTPS connection. Clients may view the following information for themselves and for dependents in the same eligibility case:

- Applications status
- Demographic information
- Eligibility information
- Prior authorization information
- Claims information
- View and search provider information

Additionally, clients may update the following information:

- Address
- Marital status—if newly married, also may add spouse name and address
- Income change—new or lost income
- Expense changes—new or expired
- Number of people in household
- Indicate that the client is expecting a child

(1439) The portal provides clients with the following additional capabilities:

- Withdraw State assistance application—for example, because a move or death
- Change the client's or the client's dependent's Preferred Medical Provider (PMP)
- Make a request for a new or replacement ID card
- Print proof of eligibility for the last 12 months
- View eligibility information—including benefit limits, spend-downs, and benefits used
- Check and update managed care enrollment
- View status of client prior authorizations
- View list of claims for the client during a specified time period
- View EOMBs (PDF)
- Review TPL coverage on file

(1433) Successful access to the client portal requires the Medicaid ID, date of birth, or Social Security number or date of birth. During registration on the website, each client is required to set up a unique user ID and password and provide an email address. Clients also are required to select and answer security questions. When a client logs in from a public computer, the security questions are used to verify the client's identity. If users forget their password, they can reset it after answering a security question. The new password is emailed to the address provided at registration.

The Secure Correspondence feature of the Client Portal facilitates two-way communication between the health plan and the client. For example, clients can inquire about the progress of an appeal using the Secure Correspondence feature. Different types of correspondence are assigned to different categories—in this case, "Appeals." Using the correct category routes the message to

the correct HP staff member. Additional relevant information about the appeal—such as the claim number—also can be included in the Secure Correspondence setup for appeals.

After the client sends a Secure Correspondence message, HP returns a response, and the client can continue by adding a second message to the original. The resulting "conversation" enables the client to share additional information and remain updated on the status of the appeal. (1435) The Secure Correspondence feature also will allow clients to inquire after premium reimbursement status and track the status of grievances.

(1437) Details about health benefit plans is readily available to clients on the Client Portal, which enables clients to view a list of covered benefits for their particular health benefit plan. The name of the health benefit plan displays with a brief description of the coverage, and additional detail can be added as desired. Benefit details also include the following:

- Coverage limits (services and dollar amounts)
- Spend-down (including non-claim charges eligible for spend-down)
- Copayments
- Coinsurance

The Client Portal displays information for the current month. Clients can help manage their own provider elections through the Client Portal. The portal includes provider search functions. Search criteria include covered health benefit plan, distance, location, provider type, and provider specialty. Additional advanced criteria can be included according to the Department's needs. The search results for a provider include the following details:

- Is the provider accepting new clients?
- Is the provider an individual or group practice association?
- Provider's hospital affiliations
- Provider's specialties
- Providers board certifications

Clients also can view a list of providers in order of closest distance to the client's home. The list includes the provider's address and telephone number. Clients can access a map that displays the provider's office location.

(1440) Besides finding a provider, clients can select a primary care physician or an MCO using the Client Portal. Clients may select a provider from the search results to designate as the primary care physician—for the client or for a dependent of the client. (1442) Additional portal features enables clients to enroll in a managed care program and select a primary care provider during managed care enrollment.

(1443) The Client Healthcare Portal enables the gathering of data that subsequently initiates a workflow for validating and processing the information. The first example is the ability for a client to report alleged provider fraud and the follow on workflow to resolve the referral.

Additionally, the ability to allow a client to submit TPL information via the portal, and forward that information via workflow to the appropriate authorized System users.

(1445) The Colorado interChange enables authorized System users to manually enroll Colorado Medical Assistance program clients whose eligibility is not submitted or received through CBMS. This work is performed through the on-line windows of the Colorado interChange.

Client Communication (Unique ID 1750)

HP proposes new and innovative ways to use current communication technology in client interactions. HP Exstream will generate and send mass system-generated messages to clients. These messages could convey important information about changes to benefits, upcoming deadlines in client certification, or other healthcare news. Conversational SMS will be handled through LiveHelpNow so that clients can send questions by text message and receive responses.

In today's fast-paced environment, mobile access is an important tool. HP is developing a client eligibility mobile application that will enable clients to log on securely and identify coverage and coverage dates.

8.3 – Client Management	**In Production?** **YES**
Description Addresses Requirements (Provide the range as applicable): 1414, 1434, 1436, 1438, 1441, 1444, 1483	**NO**

Data Load Staging of Ongoing Eligibility (1414)

The eligibility processing system performs extensive editing and verification of data before updating client data in the system. Specific edits can be created for different interfaces—for example, some types of edits may only apply to files submitted through the HP Healthcare Portal, while others may apply to files submitted through the eligibility vendor. This depth of flexibility and editing within PS2 removes the need for a separate data staging environment and reports generated from PS2 edits provide additional detail for manual reconciliation of client data.

Client Portal (Unique IDs 1434, 1441, 1444)

The HP Healthcare Portal gives clients access to information about their state health benefits and allows for two-way communication between the health plan and the client. (1434, 1444) Clients can make updates to personal information that is relevant to their health benefit plan coverage, obtain details about their covered benefits and coverage limitations, search for providers, and track hearing requests for appeals in a secure web-based environment.

(1441) The Client Healthcare Portal enables the gathering of data that subsequently initiates a workflow for validating and processing the information. The first example is the ability for a client to report alleged provider fraud and the follow on workflow to resolve the referral.

Additionally, the ability to allow a client to submit TPL information via the portal, and forward that information via workflow to the appropriate authorized System users.

Client Portal Scheduling and Referrals (1436, 1438)

Please see RESPONSE 49 for detail regarding these optional requirements.

Desktop Mail Merge (Unique ID 1483)

HP will make modifications to the Colorado interChange to implement the desktop mail merge capability referenced in this requirement. Requirements validation will be conducted to fully understand the Department's needs and standardize the data structure for the files to be exported. The Colorado interChange user interface will be modified to implement capability that will allow an authorized user to export client and provider data in comma separated (CSV) format for mail merge. HP acknowledges there is some risk to private information inherent in this capability (since users can potentially mass export client and provider data) and will work with the Department to implement system security and business process steps required to mitigate this risk in the operations phase.

RESPONSE 39b

8.4 – Provider Management	**In Production? YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1222, 1399, 1346, 1416, 1421, 1446-1513, 1656, 1657, 1699, 1874	**YES**

A feature-rich provider management system is critical to successful provider operations. The HP proposed Colorado interChange solution offers the Department a more streamlined enrollment process. It offers innovative tools that give providers more information at their fingertips and allows operational staff to manage provider data and assist providers more effectively through intuitive web-based screens.

The principles on which interChange is founded will move the Department forward in its pursuit to use innovative and proven business solutions to meet ongoing program demands while continuing to deliver high value services. This easily configurable system is based on a Service-Oriented Architecture (SOA) platform and allows commercial off-the-shelf (COTS) products to easily be installed, integrated and updated as deemed necessary by the Department. Our continued commitment to the Department and support of Colorado Medicaid providers also includes more efficient and streamlined automated processes that have the flexibility to adapt and change to fit the needs of Colorado. Our solution provides:

- A robust provider portal that offers a one-stop access point for information gathering
- An enhanced provider enrollment process, combining workflow processing and automated background investigations to streamline the enrollment process
- Colorado interChange Web pages built and organized by MITA business processes, allowing the Department to easily adapt to the evolving MITA maturity path
- @neTouch Help, which indicates the definition of every field on the Web page their related data type and format, and 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

During the Wisconsin interChange Certification process, CMS recognized HP as a leader in the industry. The CMS Certification Approval Letter called out Provider Management as exceeding CMS' defined Industry Best Practices.

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These proven solutions and others detailed in this section, combined with excellent support, will make Colorado Medicaid one of the most accessible programs in the country.

Our provider management solution complies with state and federal requirements while anticipating future business process improvements, including those outlined in the MITA Model. MITA structures have been used as a road map for our flexible solution, incorporating automation from beginning to end with our enrollment process. We will work with the Department, recommending improvements to provider management business areas. Using the MITA checklists and the Medicaid Enterprise Certification Toolkit (MECT) as a framework for development, we will verify the enhanced provider management functions meet the standards and conditions.

Additionally, using the MITA checklists and MECT as a framework for development, HP will verify the enhanced Colorado interChange meets the standards and conditions to deliver a Medicaid system with true service-oriented-architecture (SOA). The enhanced Colorado interChange will meet the CMS Seven Standards and Conditions (7SC) and support HIPAA-compliant transactions, including standardized interfaces for providers. Its flexibility will enable it to keep pace with changes in budgetary, regulatory, and CMS requirements. The Department can take full advantage of current Health Information Technology and the Health Information Exchange to better serve clients, stakeholders, and providers.

Another standard practice within our provider management operation is continual process improvement. Our success is only as good as the success of our customers and we fully acknowledge that we must grow and adjust with their needs and the needs of the Medicaid program itself. To this end, we regularly review and assess our performance and take corrective steps to continually improve our operations.

Regular and standard reporting of KPIs and operational metrics is a key tenant of monitoring the health of an operation. We will measure key metrics and KPIs for business areas routinely. 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.

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.

Provider Enrollment and Data Management

The provider enrollment function is often the first contact that potential providers have with Colorado Medical Assistance. HP knows this experience can set the tone for a new provider's impression of the program and how well it functions. Furthermore, HP understands the

responsibilities involved in successfully operating provider enrollment to protect the integrity of the program. This includes authorizing only legitimate providers into the program, updating the provider file maintained in the Colorado interChange, and continually validating that providers are authorized to perform services rendered. Provider enrollment and data management includes the receipt and processing of provider enrollments, disenrollments, changes and grievance and appeals in accordance with State and federal requirements.

MITA structures have been used as a road map for our flexible solution, incorporating automation from beginning to end with our enrollment process. The Colorado interChange robust data management features supports enrollment and maintenance for every Colorado provider type including unique providers for instance, out-of-state hospitals, as well as enrollment of nonbilling and nonpayable entities such as referring or rendering providers.

Overview Solution for this Business Process

Enrollment business logic is extremely configurable and scalable. Beginning with data capture, and continuing through workflow and business rules within the Colorado interChange, the Department can apply provider type based policy, enabling appropriate control yet greater degrees of efficiency for providers as well as for the various stakeholders that interact with the Colorado interChange. We will work with the Department to create State-specific enrollment edits and rules for the Colorado Medicaid provider types.

Providers will have three options to submit enrollment materials: through web submission, web download, and hard copies of paper forms.

- **Web Submission—**A provider may complete an application online and transmit the information to the provider enrollment team electronically. This portal solution gives providers the fastest and most accurate method of applying for enrollment. HP will strongly advocate for web-based enrollment in the provider community.
- **Web Download—**A provider may download an application from the system, complete the application, and mail it to the provider enrollment team.
- **Paper Forms—**A provider may call and request a paper application be mailed to him or her. The provider completes the application and returns it to the provider enrollment team.

Regardless of how the provider elects to submit the enrollment information, interChange provides the necessary infrastructure to track and route applications, suspend applications for additional information, and automatically generate notifications to providers. We will use an automated workflow to facilitate routing, whether the provider submits enrollment materials online or on paper. We will establish specific work queues and workflows that facilitate the processing of enrollments, such as routing applications based on application type.

The workflow solution is part of the interChange application. It is not a stand-alone tool but is integrated into each of the layers in the SOA. This includes data, presentation, services, and the

processing engine. This connectivity transforms the business activity, simplifies the analyst's job, and standardizes the processing.

Users do not need to navigate to a separate workflow application. Rather, they perform workflow tasks as part of their daily interaction with the Colorado interChange. The portal based enrollment system allows for electronic attachment of add-on documents, which speeds up the enrollment process. If a paper form is required for enrollment to continue, the application submitted online is pended in workflow until the provider submits the necessary paper forms. When the mailroom receives the needed paperwork, the team scans the attachments and indexes them to the provider enrollment work queue. Workflow recognizes that attachments have been received and then automatically updates the provider enrollment team's queue for processing.

Paper applications will be imaged and then routed into a workflow similar to a portal-submitted application. Paper forms and attachments are imaged and become part of the provider's electronic folder. These folders are indexed by an Attachment Tracking Number (ATN). The file contents are organized into types of document subfolders, including enrollment folders; signed provider agreements; change requests; provider notice information forms; and miscellaneous processing change, add, and update modifications.

Workflow automatically assigns tasks and delivers them to individual or group task lists. Notifications are automatically distributed to inform users that they have work to perform. The tasks remain in the work list until they are completed—they cannot be lost, ignored, or deleted. The leadership team can use the workflow tools to determine if tasks are outstanding for a lengthy time and need to be reassigned to another analyst.

The Work List web page presents the user with a list of assigned tasks. The following figure shows an example provider enrollment work list. In this instance work list items are sorted by the provider ID, enabling the analyst to quickly determine work in queue by provider, and through one call, takes care of the set of follow-up items specifically for that provider. By being able to dynamically change the organization of the work list data, users can configure the list to optimize their work efforts. Each list item represents the next workflow step to be completed. Tasks are assigned according to a user's group memberships, which can be tailored to reflect departments, business areas, or even individual task specialization.

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ViewFlow

A key feature of the Colorado interChange workflow solution is the process flow view of workflows in progress. The following figure shows that users can view workflows that are in progress, see what steps have been completed, and determine what steps remain. This interface is available within the workflow window through the ViewFlow action button on the menu bar. This is helpful to allow an analyst with a task in the middle of the flow to see what has happened in previous steps.

The Colorado interChange workflow solution transforms workflow from an abstract concept to a user-centric, high-business–value capability. ViewFlow mode provides the "big picture," showing what has been completed and what will occur next.

The ViewFlow is available for in-process and historical workflows, allowing reviewers to determine exactly what path a given instance of a workflow followed, even months later. Processing data is archived and retained for every work instance and maintain based on the data retention requirements. This archived record supports research or dispute resolution if the need arises.

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As described, HP uses a sophisticated workflow solution through the interChange Business Service Framework powered by K2 blackpearl. Employing the workflow capabilities of the Business Service Framework and the Department-defined business rules, provider enrollment becomes a more standardized, metrics-driven process. Department and HP staff members have

desktop, real-time access to enrollment work queues and work volumes. This leads to faster, more accurate processing of provider enrollment applications.

[redacted] Along with initial provider enrollment, this solution offers streamlined, configurable processes for provider revalidation and recertification as well as ongoing maintenance.

We understand the importance of credential verification for new provider applicants. We use LexisNexis to verify provider data against its national database of public and proprietary records. We anticipate embedding systematic queries using LexisNexis within workflow, lessening manual intervention by HP staff members and increasing efficiency and accuracy in the enrollment process.

[redacted] These features demonstrates a significantly enhanced end-to-end enrollment process enabling greater MITA compliance for the Department and adherence to federal and State enrollment guidelines and regulations. It supports a consistent and standard method for enrollment, making the process simpler for providers, yet still maintaining the necessary controls to prevent enrollment of potentially fraudulent providers. We will use our experience and knowledge of provider enrollment operations to implement the technological features so the Department can quickly capitalize on the investment and begin gaining expected efficiencies and increased customer satisfaction.

Portal Enrollment

A key feature of the HP Colorado interChange Medicaid Enterprise system solution is the ability for providers to complete Colorado Medicaid enrollments using the HP 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 through a secure portal, reduces errors and makes providers more self-reliant.

Provider enrollment through the portal will be a simple, secure, and highly efficient process. Portal usage greatly reduces basic “clerical” errors providers often make when completing paper applications, and sends the data directly into workflow eliminating manual data entry. Portal applications eliminate a main reason for returned provider applications.

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. The initial acknowledgment is delivered to the email address supplied by the provider. Additional communications and updates are accessed through the application tracking number (ATN).

The applicant is presented with general information regarding enrollment in Colorado Medicaid and is prompted to begin the application process. As the provider works through the enrollment Web pages, the information is customized for the particular provider type. The data needed for each provider type is configurable, based on Department direction. Providers also can upload any required attachments along with the application.

When the application is complete, the provider electronically signs the application and submits it for processing. Applicants can print a PDF copy of the application for their records. The provider also receives an ATN. The applicant can then check the status of the application at any time in the portal using the ATN.

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 are committed to working with the Department to increase web-based provider enrollment and recertifications.

Enrollment Status Checks (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 ATN. 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.

Enrollment Denial Decision (Unique IDs 1511, 1512)

(1511) If a provider wishes to appeal an enrollment denial decision, HP will support the appeals process in compliance with the federal guidelines in 42 CFR 431.105. (1512) A provider can submit a grievance through the secure correspondence feature available on the HP Provider Portal. When a provider submits an appeal, the request will go into a workflow process and be routed to designated enrollment staff members for handling.

Providers will be issued an appeal tracking number at the time of submission allowing them to use the portal to check the status. Providers will be notified of the outcome of an appeal through a notification in their portal messaging box.

Provider Enrollment, Disenrollment, Recertification, Account Maintenance, and Enrollment Status (Unique ID 1446)

The HP web portal solution provides significant provider enrollment and maintenance functional capability for Colorado-certified providers. HP has successfully implemented Provider Portal solutions in many other states. We have found providers readily accept the change in business practice the portal affords.

With the portal, providers can conduct self-service operations on many functions that may have required completion of paper forms or contact with Medical Assistance. This greatly reduces the

amount of time providers spend filling out forms and sending them in, or waiting on hold in a contact center. Instead, the provider can access the portal and complete the transaction directly from their office. This means less time doing "paperwork" and more time seeing Colorado Medical Assistance clients.

Provider Enrollment

The HP Provider Portal offers a secure and easy-to-use enrollment wizard that provides options to support enrollment, re-enrollment, disenrollment, and updates to enrollment information. The portal captures enrollment information—shown in the following figure—from initiation through to disclosures and online submission, replacing paper-intensive, manually driven processes. While entering enrollment information, the provider can save and resume an enrollment application later and check on the status of a submitted enrollment application. The online enrollment process is simple, secure, and highly efficient.

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Provider Documentation and Information

The HP Provider Portal makes Colorado Medicaid-specified provider content, provider information updates, and other information for Colorado Medicaid stakeholders available. Provider documentation available online may include policy information, program information, Department information, provider bulletins, banners, provider manuals, forms, fee schedules, formulary information, and training materials. We will follow a structured web content management process to manage changes to content on the Provider Portal.

The Provider Portal also allows providers, with Department approval, to view and update their respective information, such as service location addresses, telephone and fax numbers, enrollment data, and other contact and demographic characteristics. Information enabled for update is part of the configurable options within the Provider Portal.

Role-Based Security

The role-based security feature allows providers to create delegates and give those delegates access to specific functions based on that user's role in the provider's practice or organization. For example, if the provider has a role in their organization for validating client eligibility, the provider can create a delegate for that user, granting access to client eligibility inquiry but restrict access to other areas such as financial information.

Digital Signatures (Unique ID 1346)

After providers have completed the applicable enrollment information through the portal enrollment tool, they will digitally "sign" their provider agreement as the following figure details. HP will work with the Department to define the appropriate disclaimers and requirements a provider must agree to and digitally acknowledge as part of their signature. The provider's acknowledgment of these disclaimers and requirements will be recorded as part of the provider's enrollment file.

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[redacted]

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 is unable to be paid.

HP will set up an application collection step as part of the provider enrollment process that 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. Providers submit their payment transaction to HP Convenience Pay and will receive a confirmation number. The provider is directed back to the enrollment Web page and puts the confirmation number on the application. HP will verify during the enrollment workflow process that the payment has occurred. HP Convenience Pay can accept EFT payments and direct debits to checking or savings accounts besides processing credit or debit card payments.

Appropriate Approval, Pending, and Denial Notices (Unique ID 1416)

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 the enrollment request through the public area of the portal 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 work with provider enrollment to answer 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 and other Department-defined key welcome information. 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. If a provider enrollment request is denied, HP will generate a notice of denial letter to the provider that will include Department-defined follow-up appeal actions the provider may take.

ACA Provider Screening Rule Implementation (Unique ID 1222)

As part of the provider enrollment process, HP will check sanctions, licensure, and conduct screening of potential Colorado Medical Assistance providers. LexisNexis is used to meet the requirements of Rule 6028 of the ACA for provider credentialing and background checks. HP staff members will pull 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.

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

Ensuring 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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liens, bankruptcies, court and regulatory rulings, negative news, and felony charges. LexisNexis also is can validate and authenticate the identification credentials of potential providers.

Files regularly submitted to LexisNexis contain 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 will work with the Department to define processes and protocols for conducting additional screening activities such as on-site visits and actions to be taken for providers with negative information identified during screening.

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 40D 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, but is not limited to: new enrollments, updates, terminations and disenrollments. We will work with the Department to define and develop this interface during the DDI phase.

Conflicts of Interest (Unique ID 1450)

Files regularly submitted to LexisNexis contain provider information and the names of individuals and entities listed on the disclosure forms, including managing employees and individuals with more than a Department-defined percentage interest in the business. We will work with the Department to define processes for providers with negative information identified during screening to determine whether the provider should be denied enrollment.

Federal and State Requirements Links (Unique ID 1451, 1452)

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

(1451) 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 the provider type the provider has selected to enroll as. As enrollment requirements change, HP will revise the posted rules and requirements based on the Department's direction.

HP provider enrollment staff will be well versed in the State and federal enrollment regulations. Procedure manuals will document Department approved procedures for adjudicating enrollments and making provider data file changes. Provider enrollment clerks will be trained on the rules and requirements for each provider type and will use 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 also conduct any necessary training. This approach helps establish consistency in processing eliminating rework or delays

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 aligns to the business process and helps minimize the risk of human errors. (1452) HP will work with the Department to develop interfaces with regulatory agencies to automate certification and regulatory checks when possible. For example, HP has automated interfaces with federal agencies, as well as state licensing boards, OSCAR/CLIA, and DEA.

Provider Enrollment "Roles" and Process Provider Enrollment and Contracting (Unique ID 1454)

The Colorado interChange system will maintain and support the provider data requested for this procurement. This includes multiple provider types, specialties, and taxonomies in one provider profile. For each certified provider type assigned to a provider, the Colorado 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 information is stored in multiple service locations in the system. Authorized users can pull up a provider profile and see this information.

Colorado interChange includes the functional capability and flexibility to create provider IDs for identification purposes of those providers who may be exempt from payment but who still perform services or for providers who have State-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 billing and performing. This will allow these providers to perform services, but they will not be allowed to bill. We will create and use a provider billing indicators for other unique providers, such as primary care providers, as the following figure details.

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Program Integrity Provider Screening Functions (Unique ID 1455)

We understand the importance of screening applications according to State and Federal rules. These rules are in place so only legitimate providers are allowed to participate in Medicaid. Screening of providers includes the following:

- State and federal sanctions
- NPI validation
- License/certification validation
- Specialty board certification
- Civil and criminal background checks
- On-site visits
- Deceased status
- Medicare verification
- Address verification
- Tax Number Information (IRS TIN or Social Security number)

HP will work with LexisNexis to conduct screening functions on providers and managed care entities and their networks if the State 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 easily

change workflow such as adding new requirements like on-site visits or additional interfaces which 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 also clearly define the roles that HP and the State play in the workflow cycle.

Verification of Provider 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. The enrollment will wait in queue for the provider to click on a link in the email that creates a related form, which 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 State-defined time 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.

Data Capture from Relevant Federal and State Databases (Unique ID 1465)

The HP Colorado interChange solution will be compatible and compliant with ACA Provider Screening Rule G474 and has interfaces with necessary federal and State databases. Please refer to Unique ID 1455 earlier in RESPONSE 39Bfor more information. During DDI we will work with the Department to determine which specific databases require development of an interface.

Sanctioned Databases (Unique ID 1466)

As we detail in Unique IDs 1451 and 1455 in RESPONSE 39b and 1840 in RESPONSE 40d, the HP Provider Enrollment team will use data from various resources supplied through LexisNexis to screen and validate provider credentials. The LexisNexis interface and upload already includes information from federal sanction databases such as LEIE and EPLS. During DDI we will work with the Department to determine applicable sanction databases that require an interface and upload process.

Enrollment Pending Status (Unique ID 1459)

When a provider completes their enrollment application through the portal, an ATN is created. The provider can use the ATN to check on the status of the enrollment request at any time using the portal. As the following figure details, HP will develop a set of status codes the provider can receive when doing a status inquiry.

Additionally, when a provider is certified, HP will generate a welcome letter to the provider letting the provider know their effective date of certification and other pertinent data. If more

information is required to process the enrollment, HP will generate a letter using HP Exstream requesting the additional or corrected information. The provider enrollment is put in to a pending status in the K2 blackpearl workflow queue waiting for the additional or corrected information. If a provider is denied enrollment, HP will generate a rejection letter along with Department-approved instructions for appeal.

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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.

Provider Enrollment Status (Unique ID 1449)

interChange can capture changes made to a provider's file, including changes in enrollment status. When a change is made to the provider's file, an audit trail is created that details the change made, who made the change, and what was changed. Users also can see what the data looked like before the change.

Provider Termination or Denial Reason or Explanation (Unique ID 1453)

The Colorado interChange can track and record provider terminations. The Colorado interChange provider file creates a record of the provider's termination and reason codes or open text field explanations for the termination. When a change is made to the provider's file, an audit trail is created that details the change made, who made the change, and what was changed.

Provider Terminations (Unique ID 1460)

HP will work with the Department to develop a process to notify outside parties of specific provider terminations. For example, if the provider is associated with a managed care organization (MCO), HP will notify the MCO of the termination.

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 on a standardized transaction, including practice location, mail to, pay to, prior authorization, and home office addresses. As changes are made to either license or address information, the historical information is retained with the provider record.

The HP solution maintains details on 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 members or by the provider through the portal.

Multiple Provider Email Addresses (Unique ID 1463)

The Colorado interChange system will store multiple email addresses on a provider's file, including on each provider location—such as physical address or payee address. 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.

Identifiers for Designating Providers (Unique ID 1472)

The Colorado interChange provider subsystem contains an EDI indicator that is flagged for providers who are approved to submit electronic claims or encounters. If a provider is flagged, they can submit paper or EDI claims. If a provider does not have the EDI indicator flagged, they can only submit paper claims.

System Maintenance for Provider Data (Unique ID 1488)

The Colorado interChange will be the primary repository of the provider data. HP's robust provider system houses the necessary data to allow the provider to submit claims or conduct transactions they are authorized for, plus additional supplementary or background information. interChange maintains provider contact information. This includes mailing information such as

physical, email, and EFT information within interChange. Provider records will be indexed by provider identifier and searchable by the identifier (such as NPI) or provider name.

We will use real-time electronic interfaces to validate provider information against licensing boards and regulatory or certification agencies including CMS-mandated verification against the OIG List of Excluded Individuals and Entities (LEIE) and the GSA Excluded Parties Lists System (EPLS, which has transitioned to SAM). LexisNexis will provide source data. We will build online, real-time interfaces to LexisNexis' vast database of public records to automate this piece of the enrollment process. People such as managing and owning employees who are associated with the provider and disclosed on the application also will be checked in this process. Interfaces with LexisNexis facilitate greater automation yet stringent program integrity controls in the enrollment process, promoting speedy yet appropriate enrollment of providers. The sanction and licensure data will be captured and held in the Colorado interChange.

Hard-copy applications submitted by newly enrolling providers also will be stored in OnDemand and can be retrieved using provider-specific identifiers such as NPI, provider name, tax ID, or license. We will maintain information in these repositories according the defined record retention schedules of the RFP. Colorado interChange will maintain the provider master data, including the elements we list in the following table.

Provider Master Data

Master Data Elements				
Provider name	Provider title	Addresses, type of address (physical, billing, mailing), locations, ZIP codes	Provider country	Email and web addresses
Telephone numbers, fax number	Contacts and their roles	Service locations	Payee TIN, Federal EIN, or Social Security number	Application and enrollment dates and status
Qualifications such as licenses and certifications	Services offered by service location	Affiliations with multiple groups, clinics, hospitals, district medical officers (DMOs), chief medical officers (CMOs), or other organizations	Provider-specific rates	NPI

Master Data Elements				
Taxonomy or provider type	Begin and end dates for specialties	Information on contracts or agreements specific to the provider	Enrollment status code	Languages
Teletype writing device for the deaf/teletypewriter (TTD/TTY) and handicap capabilities for hearing-impaired people	Name of billing agent	Name and address of owners of enrolled entities	Social Security number of provider or owners	Date of birth of provider or owners of entity
Provider status code	Suspense flag	Tax-exempt status	Review and sanction data	

Manual Enrollment or Disenrollment Functions (Unique ID 1399)

Department staff members will be granted access to perform manual enrollments or disenrollments. The actions taken within the provider subsystem are in real time, so are reflected immediately within interChange.

Information on Professional Relationships (Unique ID 1478)

Colorado interChange can track relationships between entities within the provider subsystem to verify the relationships are fully defined as shown in the following figure. The Group Web page in interChange allows users to set up relationships between individual providers and practices, locations, and billing organizations they are associated with. These associations may have effective and end dates placed on them as provider relationships change.

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The Owner and Owner Relationship panels allow for interChange to establish the owners and partners within an organization and their relationship with the organization. These associations may have effective and end dates placed on them as ownerships change. Colorado interChange also will have a panel to identify relationships within MCOs.

MCO Provider Network Information (Unique ID 1656)

The Colorado interChange will allow providers to be linked to MCO and listed as a fee-for-service provider within the provider file. Additionally, the MCO's network will show providers affiliated with the MCO. As relationships change, interChange can track changes, such as a provider leaving an MCO's network or an MCO leaving Colorado Medical Assistance.

MCO's Specific Providers (Unique ID 1657)

The Colorado interChange captures provider-related information as an encounter is processed. This includes rendering, attending, or supervising provider information. The provider-related information is stored in the claims subsystem of interChange.

Sanction, Termination, or Exclusion View (Unique ID 1699)

Provider files are flagged when a sanction, termination, or other exclusion is made to the provider's file. The flag includes information on the date the flag was placed, who placed it, and why the action occurred.

interChange's search and reporting features allow users to find specific providers who have had such actions occur. Searches can occur by multiple provider identifiers, such as provider name, location, NPI, or tax ID. The searches can be sorted by the search criteria, such as sanction codes.

Department-Approved Provider Agreements (Unique ID 1491)

HP will work with the Department to gain approval of provider agreements to be used as part of the provider enrollment and re-enrollment process. When a provider submits an enrollment or re-enrollment through the portal enrollment tool, a copy of the provider agreement, populated with the provider's applicable data, will be displayed. The provider is directed to print out a copy of the agreement and keep it for their records.

The provider agreement is an imaged file that is included as part of the data routed using K2 blackpearl workflow to the HP Provider Enrollment team. As part of the workflow process, provider enrollment indexes the provider agreement with the provider NPI. The agreement is stored in the image warehouse. We will work with the Department to define provider agreement retention periods for providers who are no longer certified.

Reconciliation of Errors Process (Unique ID 1492)

HP will develop procedures that address reconciliation of transaction errors. Online Web pages prompt users to enter information according to defined business rules as well as prompting for missing or required data. For example, if a provider is activated in interChange with invalid effective dates, this transaction prompts the user to make the correction. This approach promotes completeness and accuracy in updating provider information within interChange.

The Colorado interChange solution will capture an audit trail of changes and updates made to provider data for a time period specified by the Department. interChange has an audit trail of the revisions made to provider information. This audit trail 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 through the portal. Users can easily view the audit trail information in interChange panels.

Relational Database Design (Unique IDs 1490, 1461, 1493, 1494)

(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 provider who cannot obtain an NPI. The Colorado interChange system has the capability to identify which providers require an NPI using an indicator on the Provider Type and Specialty Code panel. If an NPI is required, HP will verify the validity of the NPI against the National Plan and Provider Enumerator System (NPPES) as part of the enrollment process.

(1494) The base provider number can be used instead of the NPI and can be used for multiple programs. Additionally, interChange has the capability to map, store, and maintain the provider's individual number along with the NPI, taxonomy or other ID associated with the provider.

(1461) HP also will provide the ability to link and delink to other provider IDs for the same provider, such as numbers used before the NPI was established, erroneously issued prior number, multiple NPIs for different subparts, and similar situations. Subpart NPIs can be stored on the Provider IDs panel in interChange. The system includes the capability to link multiple locations to a single base provider ID at the time of enrollment.

(1490) The provider file will handle unique data for each group practice or organizational role for a provider's NPI. For example, if a provider NPI has a physician group practice and a therapy group practice, interChange can store unique information—such as address, telephone number, type, and specialty—for each group role.

EFT Identifier (Unique ID 1495)

Colorado 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. Details for the provider's EFT account, such as bank routing and account numbers, are stored in the financial area of interChange.

Supervising Physicians and Non-Physician Practitioners Affiliations (Unique ID 1496)

Refer to Unique ID 1478 for information on maintaining relationships between providers.

1099 Information and Reporting (Unique IDs 1497, 1498)

As the Medicaid fiscal intermediary in 17 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 verifying 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. (1498) 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 Web pages in the Provider Maintenance component of interChange. Other data elements such as EFT and 1099 information display on user interface Web pages 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.

(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 Web pages allow authorized users to view 1099 information for a provider as shown in the following figure. Additionally providers can access their 1099s through the Provider portal.

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

Submitter Contracts (Unique ID 1499)

The interChange Provider Enrollment panels contain vendor information associated with the provider, such as whether they have a trading partner or clearinghouse they submit through. 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.

Multiple ID Flag (Unique ID 1500)

The Colorado interChange solution 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 issues to the Department as necessary.

MCO Provider Identification (Unique ID 1501)

Each provider file in interChange can indicate if a provider is associated with an MCO. This is updatable as relationships and MCOs change. An audit trail will show previous relationships for the provider with MCOs.

Provider Data Audit Trail (Unique ID 1502)

The Colorado interChange captures updates made to the provider's file, including date-specific information regarding the provider's initial enrollment, subsequent re-enrollments, changes to demographic information, and enrollment terminations.

Each data field in interChange has an associated audit trail for changes that have occurred. The audit trail shows what changes were made, when they were made, who made the change, and provides a snapshot of the field before the change.

Electronic Provider Files (Unique ID 1503)

As described in our response to Unique Identifier 1488, interChange stores comprehensive data for each provider. Besides the provider data stored, the HP Colorado interChange solution includes storage and maintenance of provider documentation within the image library. The enrollment and supplemental provider files are stored for viewing within the image library. Electronic submitter files also are available using the image library. Subsequent documents may be added to the image files. The files can be indexed in various ways—such as NPI or tax ID.

Provider Profile (Unique IDs 1489, 1504)

(1489) The secure Provider Portal contains a Demographic Maintenance page. This allows providers to view and change their information directly, versus having to contact the fiscal agent. (1504) Providers can, for example, change practice data (such as services provided), location, and whether they are accepting new clients. Because this is accessing information stored within interChange, changes a provider makes will take effect in real time. HP will work with the Department to define which data providers will be allowed to change using the portal.

When a change is made to demographic information, an email will be automatically generated to the portal administrator for the provider account, informing them of the changes made to verify the changes are appropriate.

PAR Notifications (Unique ID 1421)

HP will work with the prior authorization contractor to maintain PAR notifications. HP will store associated PAR information needed to populate the notification within interChange and keep archives of PAR notifications in the image library. interChange allows for a separate prior authorization address in the provider's file. Based on the information in the provider file, interChange can generate PAR notifications through the letter generator software, HP Exstream enabling providers to receive timely responses to PARs.

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 (OOS) enrollment process for these providers. The most efficient method of enrolling OOS providers is through a simplified enrollment tool in the HP Provider Portal.

When an OOS provider contacts the Department and HP for enrollment information, the provider will be directed to the online provider enrollment tool on the portal. When the OOS provider begins completing the enrollment information on the portal tool, they will have an option to choose "Out-of-State Provider."

The OOS provider will then be directed through a simplified enrollment process, gathering only the Department-required data needed for claims processing. The OOS 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 OOS 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 OOS provider-specific materials with billing and coverage information.

If additional information is required to process the OOS application, a follow-up letter will be generated using workflow and HP Exstream with additional information for the provider. Our solution uses the existing capabilities of interChange and the provider portal to create a controlled, efficient process for enrolling this unique subset of providers.

Provider Communication (Unique ID 1457)

Communicating enrollment status to providers is accomplished by using features of the Provider Portal and automation within interChange. 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. If a provider enrollment request is denied, HP will generate a notice of denial letter to the provider that will include any Department-defined follow-up appeal actions the provider may take.

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.

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 ATN. The provider can follow the progress of the enrollment request through the portal using the ATN. The provider can see various customizable messages the Department defines. 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 additional questions.

Documentation Update (Unique ID 1458)

The HP Provider Enrollment team will make revisions to 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.

Detailed Documents and Procedures (Unique ID 1513)

HP wants to verify that providers are certified quickly and correctly, according to State and federal requirements. (1513) The HP Provider Enrollment team will work with the Department to define, document and gain approval for the enrollment procedures. Our objective is to verify the enrollments occur according to Department-approved processes.

The HP Provider Enrollment team will develop and maintain documentation for the processes based on provider type. The documentation will reside in the SharePoint site. HP will revise documentation as needed and revisions will gain approval from the Department before being implemented and posted in the SharePoint site.

Providers and Associated Encounter Data (Unique ID 1467)

The interChange provider file is used by the interChange claims engine to process claims and encounters. The provider data associated with those claims and encounters is captured during processing by interChange.

Claims or Encounters Submission (Unique ID 1468)

The interChange provider file is used by the interChange claims engine to process claims and encounters. If a provider is not eligible for a date of service, the claims engine will deny the claim. Additionally, if the provider is not enrolled, they will not be allowed access to process verifications or other secure transactions. HP acknowledges the need for exception criteria for report retrieval by entities not enrolled as billing providers. HP will work with the Department to define and develop this exception process during the DDI phase.

Transactions or User Entries (Unique ID 1469)

Internal users will have access to specific provider data management Web pages 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 easily navigate 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 Web page to do their job, they can simply add the Web pages 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 time 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 Web pages.

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

From the provider perspective, the HP Provider Portal solution allows for providers with secure portal access to revise and maintain their provider file information. Providers can maintain information based on Department-approved criteria. Providers will log on to their Provider Portal account and access demographic maintenance. The provider can then choose to update information such as the following:

- Addresses
- Telephone numbers
- Email addresses
- Payee information

Providers will be prompted to verify that they wanted to make the indicated change. Changes are logged in the field's audit trail in interChange, so there is a record of the activity on the provider's file.

Electronic Options for Claims and Encounters (Unique ID 1470)

Electronic Claim Submission

Providers will have multiple methods of submitting claims to Colorado Medical Assistance with the HP solution. Providers may submit 837-compliant transactions through billing vendors or their own approved transactions. Additionally, providers may submit, adjust, and inquire about claims or encounter statuses through the provider's secure portal account.

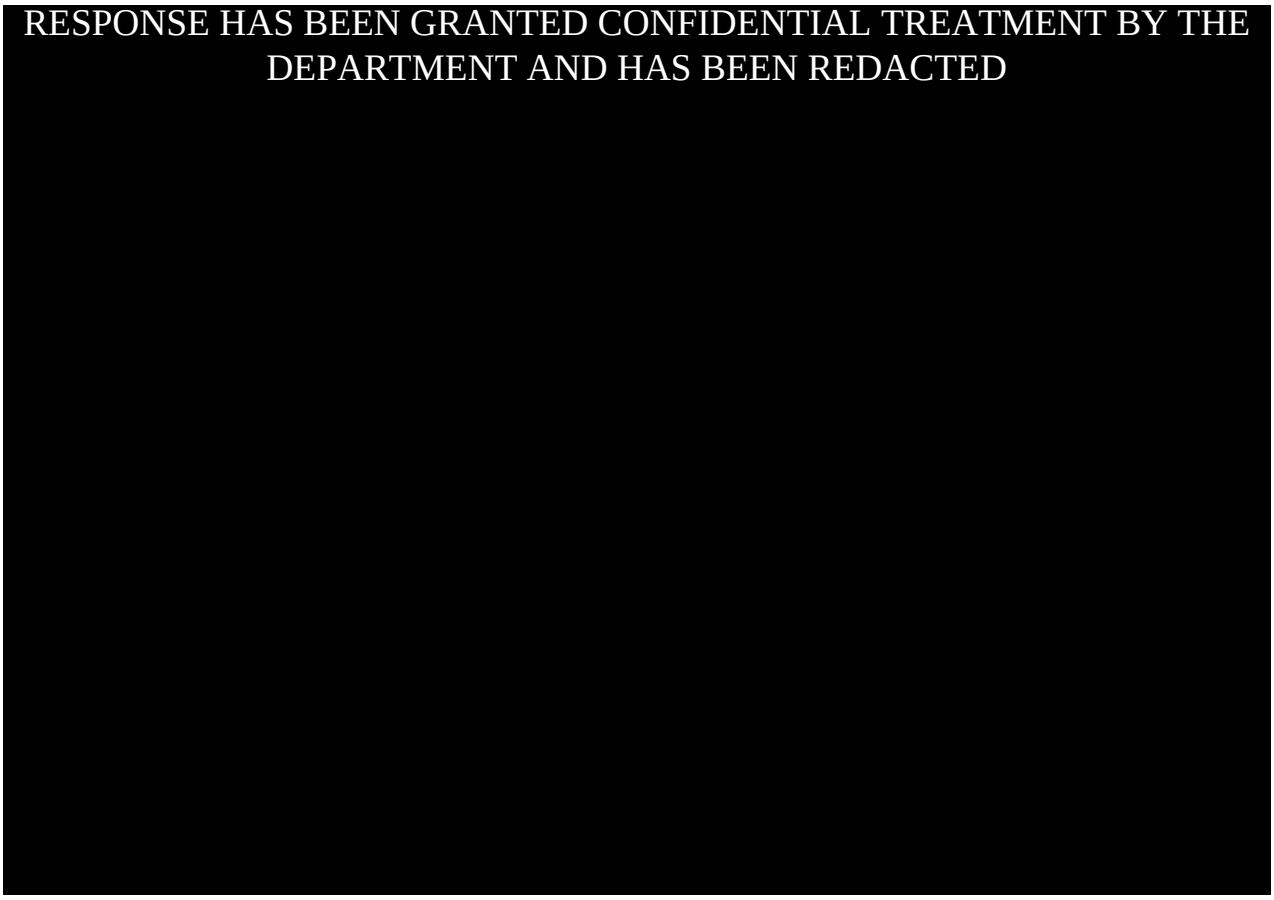
Providers can choose to submit the claim through direct data entry on the portal. Direct data entry allows a provider to quickly submit a claim to Colorado Medicaid without intermediary or additional software.

Users who have been granted claims access on their secure portal account can access the claims section of the portal and click the appropriate link for their desired claim format. The user will be presented with a blank input format, as shown in the following figure that meets HIPAA 837 requirements in a user-friendly interface. The user enters the claim data and clicks "submit."

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

If the claim has errors such as missing required data or fields without the correct number of characters, the user receives a prompt to correct the data. After the claim is submitted without errors, the provider will receive a message acknowledging receipt of the claim.

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



The HP provider Portal solution gives incredible data mining power to users who have been granted claims access for the provider's portal account. The following figure shows the robust search capability that allows providers to look up claim status using multiple search criteria including:

- Claim number
- Client ID
- Dates of service
- Payment dates
- Claim type
- Claim status

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Users can combine search criteria to further narrow search results. After the results are populated, as shown in the following figure, users can click on a claim that will then display the claim detail. At that point, a user can resubmit or adjust the claim online if necessary.

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

Claim Adjustment

If a provider needs to adjust a claim, they can do so using the claims function on the Provider Portal. The user searches for the claim on the portal. After the user finds and selects the claim, they have the option to adjust it. The user can make the needed changes to the claim they have selected. When the revisions are made, the user clicks the submit button at the bottom of the claims page. The claim immediately is entered in to interChange for processing according to Department guidelines.

Human-Readable View of 835 Transaction Information (Unique ID 1471)

HP understands that many provider offices need additional accounting and posting information than the HIPAA 835 transaction. We will supply a remittance advice (RA) in an electronic format for providers to access on their secure portal account. An RA provides important information about the processing of claims and adjustment requests and additional financial transactions such as refunds or recoupment amounts withheld.

HEALTHCARE SIMPLIFIED

The portal will provide electronic RAs to providers through their secure portal accounts when at least one claim, adjustment request, or financial transaction is processed. An RA is generated regardless of how a claim or adjustment is submitted—electronically or on paper.

RAs are accessible to providers in a text (.txt) or Comma-Separated Values (CSV) format using their secure portal accounts. This gives providers multiple options for working with their RAs, including import of CSV files into popular spreadsheet programs such as Microsoft Excel.

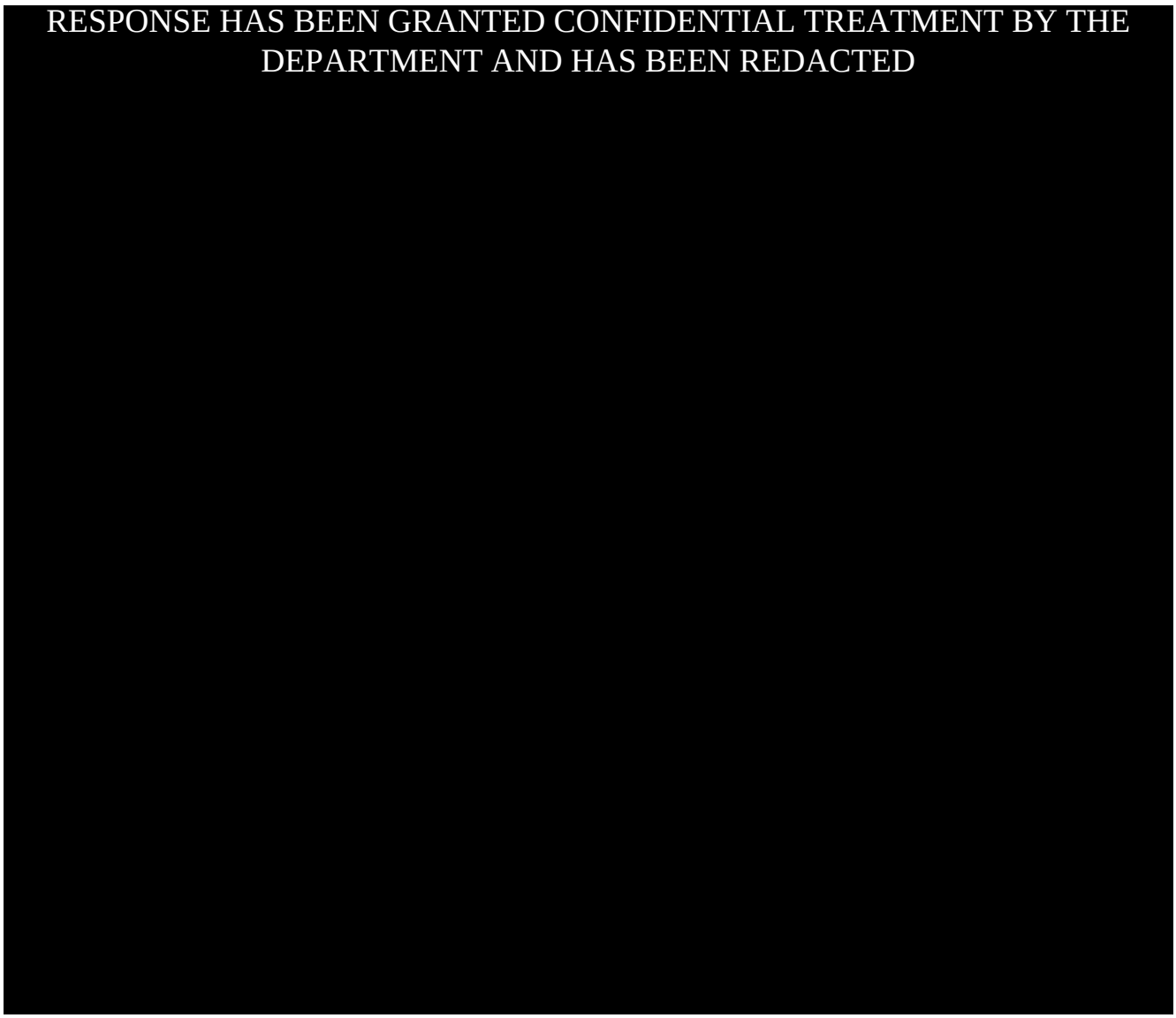
Human-Readable View of PA Status and Service Detail Information (Unique ID 1473)

Portal users who have been granted access to prior authorization information have a wealth of data available to them through advanced search capabilities. Users can see the detail of an individual prior authorization and listings of submitted prior authorizations based on the search criteria entered as shown in the following figure.

The View Authorization Status page of the Healthcare portal allows providers to view at a glance the status of their authorizations on a real-time basis, as requests are being processed. Information shown in the summary page includes client ID, tracking number, authorization type, authorization service dates, status, requesting provider, and servicing provider. Portal users may select a specific authorization in the summary list to view details, including diagnosis information, remarks/notes, and the number of remaining units for a given approved service line based on claims activity.

Users can create and view a PDF of submitted prior authorizations. The PDF may be printed or saved for future reference. Users also can see a PDF version of a prior authorization as soon as it is submitted.

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



HIPAA Privacy Regulations Adherence (Unique ID 1474)

Portal users can be granted access to client information. Initially, providers need to apply to create a secure Provider Portal account. When established, the provider creates a portal administrator who is responsible for creating users within the organization. Users may be granted access to portal functions. Access is role-based, meaning that the Provider Portal administrator may limit a user to one portal function, multiple functions, or all functions.

If users have been granted access, they can retrieve various information, including the following:

- Current-day eligibility
- Future-date eligibility (as defined by the Department)
- Historical eligibility
- Prior authorizations including usage and availability of service units
- Claims information including service history information

- Medicare information
- TPL information
- Managed care information
- Benefits and restrictions
- Copay, program information

Service-Specific Information with Limitations (Unique ID 1475)

It is essential that providers have access to key coverage information to verify they are providing appropriate services to Colorado clients within program guidelines and validate they are following the requirements to be reimbursed.

Although publications do contain details about coverage, providers also need a quick solution and index to covered services and related limitations. As the following figure details, HP will implement a coverage index tool on the Provider Portal to assist providers with coverage and limitations.

This tool will show coverage information including the following:

- Covered procedure codes
- Service limitations, such as frequency
- Service location limitations
- Any copayments
- Prior authorization requirements
- Other Department-defined limitations

Providers can search the index in multiple ways, including the following:

- Healthcare program
- Service area
- Benefit group—such as CPT or HCPCs codes
- By specific procedure code
- Description

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

Provider Communications or 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 providers access to information, training, and resources they need to be successful in Colorado Medical Assistance and effectively serving Colorado residents.

Call Center

HP has a dedicated team within our 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 centers for more than 40 years. Each contact center model is tailored to our customer's program and requirements, so while they are all 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 will provide staff, technology and facilities needed to 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. Internationally, we manage 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.

We have thus learned the critical role the call center plays in delivering excellent service and support to clients and providers. Consequently, 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

HP will develop, implement, and operate a provider call center with toll-free access to assist providers as they interact with the Colorado Medicaid Program. 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 Colorado interChange system to facilitate program or process changes. 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 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. The Department may find it helpful to listen in on calls to gain more in-depth insight on the types of questions providers are asking about the program. This tool enables the Department and 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 interChange 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 Call Center Management team also will have access to the innovative HP's 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. The ROC team is managed by a contact center leader whose customer service programs have been recognized as one of the top three in the country by *Consumer Reports*. 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. HP will work with the Department to identify the overall operational needs to determine which hours of operation are appropriate.

We detail our call center solution in RESPONSE 40j.

Provider Education

HP believes a strong education and outreach program is vital to retaining providers by helping them to operate as effectively as possible within the Medicaid program. HP manages these services for numerous Medicaid clients and we offer our expertise, best practices and solutions using this experience. We recognize that providers are busier than they ever have been before and that they work with various payers beyond Medical Assistance. Colorado Medical Assistance educational offerings must be relevant, timely, and effective to make them valuable to providers.

Our primary offerings recognize the limitations and pressures on provider's and their staff's time. We will offer extensive online learning opportunities through recorded webcasts available 24 x 7 on the portal and through HP Virtual Room trainings, which bring live, interactive training to the user's desk.

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 live, face-to-face provider training sessions are needed.

We detail our training program in our response to Unique ID 1070 in RESPONSE 29g.

Provider Communications

The first resource for provider answers must be through communications. Effective communication reduces calls to provider services, gives providers solid reference materials, and helps verify the provider's overall success in Colorado Medical Assistance. The HP communications solution uses various formats to disseminate policy and billing information.

We detail our communications plan in the responses to Unique IDs 1477 later in this section as well as Unique ID 1836 in RESPONSE 40d.

Communication Formats (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 that help verify a thorough provider understanding of state policies and billing. HP provider communications can take on various formats that, while different, serve to deliver a consistent message to the Colorado provider community. With an eye on producing easy-to-understand provider publications—from newsletters and billing manuals to policies and procedures—that also are legally sound and risk-averse, 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.

Provider Bulletins

As new policies or billing requirements are implemented, the provider bulletin acts as the, primary notice for providers of the change. Creating well-written, concise bulletins is essential so providers may immediately 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 verify that the outgoing bulletins meet Department expectations.

Following approval to publish, bulletins will be loaded to the HP Provider Portal. Bulletins will be available for viewing and download as PDF files. Previously published bulletins will be available for download and 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 verify 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 Department 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 to verify 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 may register to receive email notifications of new provider publications. Please refer to Unique ID 1480 later in this response section for additional information.

HP knows that consistency in terms and styles across communications is essential for a professional communications appearance and to validate that important messaging is well understood by its intended audiences. The HP Communications team will work with the Department to define a clear, consistent style for communications, with common themes that can be used across the communications vehicles.

Online Access for Authorized System Users (Unique ID 1479)

HP will maintain the communications area of the portal and provide publication rights to Department-approved users. Approved users can publish provider communications, such as bulletins, billing instructions, and other notices. HP will work with the Department to define publication and editing styles and standards and publication time frames and windows.

Subscription Options for Provider Communication Delivery (Unique ID 1480)

Subscription capability on the HP Provider Portal allows providers to receive email notifications of new provider publications. Users have multiple options to select the types of program materials they want to receive.

Users can at any time update their preferences, change their email address, or cancel their subscription.

Publications Archival (Unique ID 1481)

It is important that Department users can 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 members and will have an interface that allows for searches within the archived communications.

Automated Provider Communications (Unique ID 1482)

As part of the provider subsystem workflow process for provider terminations, interChange will automatically generate a letter to the provider when a termination occurs. The system uses an online letter generation template that allows notification letters to be updated as business needs dictate. The notification letter also includes free-form text comments, allowing analysts to include additional information if necessary. HP will work with the Department to define the contents of letters for voluntary and involuntary terminations. The letter also will contain appropriate follow-up the provider may take.

Targeted Communications for Specific Provider Groups (Unique ID 1484)

During development of a given communication, HP will work with the Department to define the audience and timing for the publication. The HP Communications team will target the communication only to the identified audiences. For example, email notifications sent out on the communication will be targeted only to those email subscribers who identified as wanting to receive the communication.

For any paper mailings, HP will extract only addresses for the Department-approved provider types and specialties for a given mailing. The extract will be shared with the Department for final approval before production and mailing.

Secure Provider Forum (Unique ID 1485)

Department staff members will have access to forum and live chat participation as the Department directs. Please refer to Unique ID 1487 later in this response section for HP's social media solution.

Client Feedback (Unique ID 1486)

We understand how important collection of feedback on provider performance is to verifying that Colorado Medical Assistance clients are receiving high-quality, effective care and that the Department is maximizing its healthcare dollar. HP will contract with Survey Monkey to host and disseminate client and provider 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 across 15 different types of question formats—such

as radio button, scales, multiple choice, and 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 and 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. The results are available in various formats—such as Excel files or PDF—and can be supplied to agencies and Department staff members as directed.

Social Media Functions (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 with the Department to define the parameters for developing these various social media activities for Colorado Medicaid.

- **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, to accomplish the following:
  - HP can do live monitoring of users, keyword searches, referrals, locations, and more.
  - State-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 internally and externally. These questions can easily be published as Frequently Asked Questions within Knowledge Base.

- **Web-based video training—**Through Camtasia capture software, HP can create a various 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.

Provider Directory Updates (Unique ID 1509)

After enrolling and establishing a secure Provider Portal account, providers can manage their key demographic data within the Provider Portal. This functional capability saves providers significant time compared to completing paper change request forms or calling the contact center because it creates a self-service atmosphere for the provider community. HP will work with the Department to define limitations or restrictions the Department requires.

The providers log on to their secure portal account and choose Demographic Maintenance. The providers then have access to the provider file. Providers can make changes to their data. This can include the addresses, telephone numbers, email addresses, and payment information, based on Department definitions. The demographic interface connects to the Colorado 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.

Selected Client Information for Third Parties (Unique ID 1505)

HP will work with the Department to define the types of client information and the procedures for disseminating this information to Department-approved third parties.

Useful Information for Providers (Unique ID 1506)

HP wants to be seen as an ally with providers in verifying 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
- Access to food stamp information and applications
- Other healthcare programs
- Elderly care information

Opt-Out Option in Provider Enrollment Tool (Unique ID 1507)

As part of the enrollment process, providers can opt out of being included in the web-based provider directory. Additionally, providers may opt out of the directory later by changing their demographic information in the secure portion of the HP Provider Portal.

Public Search for Providers (Unique ID 1508)

The Provider Portal supports user-friendly search features to find providers. The primary source of data is the Medicaid provider data that HP maintains for the Department. The following figure

demonstrates the easy-to-use search feature, which includes the ability to search by distance and location using an address and also by provider type and specialty.

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

Note that providers will have the option—at the Department's direction—to not be included in the Find a Provider listing. Users will access the public area of the portal and click on the Search Provider link. The user can search for providers as follows:

- Specific healthcare program
- Provider type
- Provider specialty
- City, State, and ZIP code

The results will show a list of available providers meeting the criteria. The list will include the provider's name, physical address, provider type and specialty, and contact telephone number. Additionally, a link is shown to map the location of each provider.

8.4 – Provider Management	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1313, 1483	**NO**

Electronic Picture and Other Biometric Identifiers (Unique ID 1313)

HP interprets this requirement to mean that the authentication of the biometric is occurring at the point of biometric capture. HP will enhance the interChange solution to accept a picture or other biometric identified for providers and clients. The provider and client tables will be updated to store this information. interChange Connections will be used to accept and process the interface file and store this information on the database.

Within the interChange provider subsystem, the user interface will be updated to display the biometric information on the basic tab of the provider information screen, as shown in the following figure.

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

The provider portal will also be updated to support the display of the client biometric identifier. The biometric identifier will be displayed in the upper left corner within the member details portion of the Member Focused Viewing capability, as shown in the following figure.

Desktop Mail-Merge Functions (Unique ID 1483)

Colorado interChange users can export data collected from online reports in various formats. This includes exporting the data as an Excel or CSV file. These file formats can then be merged in to word processing templates for customized communications with providers, clients, and other entities.

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8.5 – Operations Management	**In Production? YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1182, 1213, 1308, 1383, 1470, 1472, 1505, 1514-1582, 1584-1592, 1594-1607, 1609-1621, 1623-1625, 1627-1662, 1698,1714, 1715, 1843	**YES**

Claims processing is where we started in the healthcare industry and is still the core of our offering. While HP has watched the Medicaid industry change and expand over the years, claims processing has stayed the central purpose for states outsourcing to fiscal agents. HP has more claims processing experience and is the fiscal agent for more states than any other vendor.

Perform Batch Control and Reporting (Unique ID 1383)

Timely, flexible online inquiry and reporting dramatically improves access to data for program analysis and will support the Department in containing costs. The interChange system is federally certified and supports batch control processing along with daily, weekly, and monthly reporting regarding all claims processing activities.

The interChange system provides intelligent, unique control number tracking for each claim and adjustment through the assignment of an Internal Control Number (ICN). Regardless of the submission method the provider chooses, interChange systematically assigns every claim received a unique ICN, which provides for intelligent tracking of claims from receipt to final disposition.

interChange individually monitors claims through the processing cycle and reports them in various daily reporting functions, from the initial assignment to its final disposition and display on control reports. The system produces balancing and control reports for claim reconciliation functions, including batch processing cycle input and output figures. We provide examples of these reports in the following table.

Claim Control Report Examples

Report Name	Description
Input and Output Control	Provides accounting of the number of new days and aging claims input to the system and tracks their disposition through the system

Report Name	Description
Daily Claim Activity	Provides information on claims, suspense, and adjustments regarding beginning inventory, new inventory, number processed, and ending inventory
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 totals for claims that are 1- to 30-days old, 31- to 60-days old and so on
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
Aged Claims Listing	Reports aged clean claims, sorted in Julian date order, 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

These reports are stored electronically in OnDemand, allowing users to print in hard copy or retrieve reports from their desktops in electronic format. OnDemand enables the long-term secure storage and retrieval of reports so that users can easily navigate to the current and historic versions of a report. The electronic format of the report allows users to run searches for critical information, print only the portion of the report they need, or export data to spreadsheet applications for analysis. Users can create, store, and recall interChange predefined MMIS reports. The Colorado interChange will provide claims-entry batch control and statistical reports.

Assign Unique Claim/Encounter Identifiers and Track Life Cycle (Unique IDs 1213, 1516)

(1516) The interChange system will provide intelligent, unique, control number tracking for each claim/encounter and adjustment through assignment of an ICN. The ICN remains consistent throughout the system. Regardless of the submission method the provider chooses, interChange automatically assigns every claim/encounter received a unique ICN. Each ICN is generated and encoded to indicate the method of submission by region, receipt date, and claim type so that users can easily identify key information as they view the claim. The ICN also is the key to tracking a claim throughout the adjudication process and verifying that we meet processing timeliness requirements. The following defines the RRYYJJJBBBSSS format of the ICN:

- RR—Region
- YY—Year of receipt
- JJJ—Julian date of receipt

- BBB—Batch number
- SSS—Sequence number

The interChange system ICN assignment process provides for intelligent tracking of claims/encounters from receipt to final disposition of the claim/encounter. Additionally, adjustment claims are assigned an ICN that is cross-referenced to the original claim for tracking and audit purposes. The cross-reference allows all prior and subsequent versions of a claim to be viewable through a single Claim Inquiry panel.

The Colorado interChange includes audit trail functions within the system tables. Claim status is tracked at the header and detail level by date, location, and status for all claims. Error codes encountered by the claim and the business rule numbers that were used to adjudicate and price the claim are captured. The resolution for each error code identifies if the error code was forced or denied systematically, or by a specific user.

The base system includes the Medical Policy History Table that contains prior and subsequent versions of a claim. (1213) The table tracks a claim through each location from receipt through final payment. User-applied changes—such as data corrections, manual denials, and error overrides—are captured in audit trails along with the ID of the user performing the update. When the interface feed updates an interChange database table, an audit record is created for those tables.

interChange provides screens that are used to display the information as seen in the following figures.

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

This screen shows the relationship between one ICN and another.

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

This screen, seen in the following figure, shows the locations associated with the claim, which tells the user what has transpired during processing, the status of the claim, the error code, and description of the status.

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

Maintain PBMS Identifier (Unique ID 1517)

The Colorado interChange system will allow for customization to receive pharmacy claims from the PBMS through an interface based on Department requirements. This approach is similar to how converted claims from a state's legacy system are handled. We set up a cross-reference table to store the identifier from the source system and cross-reference it to the ICN assigned in the target system. Either identifier can be looked up in the system when performing a search. This process has been implemented successfully in multiple state implementations, including Oregon and Pennsylvania.

As claims are transmitted from the PBMS, the interface brings the pharmacy claim data into the interChange database for storage and reporting. The interChange system will maintain the PBMS identifier assigned by the PBMS, and also cross-reference this identifier to a compatible interChange ICN and allow lookup by either identifier.

Retrieve Claim/Capitation/Encounter Adjustments (Unique ID 1518)

interChange links all adjustment claim/encounter transactions to the original claim being adjusted using a cross-reference. Claims/encounters and their associated adjustments can be viewed through the Claim Inquiry panel using the claim/encounter's unique ICN. This feature allows the user the ability to view all claims/encounters associated with the same service and to know which one is the most recent version.

Capitation adjustments are currently independent transactions from the original capitation payment. HP is developing an enhancement to interChange to enable the capitation adjustment to be linked to the original capitation payment. This enhancement will be in place in the Colorado interChange system with the implementation of Phase II.

Reconcile Claims/Encounter Payments to COFRS (Unique ID 1520)

HP recognizes that the Colorado Financial Reporting System (COFRS) is the statewide accounting system used as the official book of entry for accounting activity. Interoperability of the Colorado interChange will be powered by our interChange Connections component that orchestrates interaction of the MMIS with the broader healthcare ecosystem. The interChange Connections module of the Colorado interChange will accommodate the exchange of data with internal and external entities using the appropriate media for each exchange. This connectivity will be used to interface between interChange and COFRS to transfer payment and vendor information which allows COFRS to issue payments to providers. See RESPONSE 38k for more detail on interfaces. See RESPONSE 40b for more detail on mass recoupments and adjustments.

The Colorado interChange will exchange data with COFRS based on the following functions in interChange:

- The Financial Payment Status panel within interChange allows the user to void/reissue/stale date MMIS generated payments. After a payment is voided or stale-dated, related transactions are reversed. If a payment is reissued, the related transactions are assigned to the new payment number.
- Cash receipts can be split between multiple providers/carriers/drug rebate manufacturers.
- Claims can be held from payment using the Financial Fiscal Pend panel. This panel provides the user many criteria options to hold claims from the final payment. If a claim adjustment is held, the related claims are also held. The claims will continue to hold until the hold has been removed. After the hold is removed, the claim will be allowed to process through to final payment.

- During the financial payment cycle, positive payments for a provider are compared to open account receivables (ARs). If there is an open balance, the provider's payment will be systematically applied to the AR.
- All financial transactions and adjustments will be reported on the Provider's Remittance Advice (RA) or electronic 835. If the transactions are linked to a claim in the system, those transactions will be seen linked to the claim on the RA.

Claims Data (Unique IDs 1521, 1528, 1530, 1533)

(1521, 1530) HP's interChange is designed to support claims/encounters adjudication including header and detail level pricing, edits, audits, and history search capabilities. Users can assign suspended claims to other users based on the types of edit and audit settings on the claims. After assigned, these users can work these claims including data corrections when necessary. The Colorado interChange captures the required data elements required to price, edit and audit a claim/encounter. This information is maintained from the time of receipt and continues through to the claims engine until the claim is finalized to support adjustment and post pay billing. Subsequently, all claims history is available for reporting and for search by authorized users. HP will work with the Department during the implementation to customize State-specific edit/audit rules and pricing through configuring the interChange rules engine. The following sections describe these functions in further detail.

Managing Claim/Encounter Adjudication through Balancing and Reporting Processes

The proposed Colorado interChange will contain built-in controls that provide claims balancing within each processing cycle to promote correct adjudication of claims/encounters. Whether providers submit a claim electronically through batch, on the web, or on paper, interChange tracks the claim by assigning it an ICN which is carried throughout the claims processing cycle. interChange individually monitors claims through the processing cycle and reports them in various daily reporting functions, from the initial assignment through to its final disposition and display on balancing and control reports. HP's interChange produces balancing and control reports for claim reconciliation functions, including batch processing cycle input and output figures. Reporting monitors claim inventory to meet required timelines for claim adjudication. Examples of these reports are provided in the following table.

Claim Inventory Report Examples

Report Name	Description
Daily Claim Activity	Provides information on claims, suspense, and adjustments regarding beginning inventory, new inventory, numbers 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, and so on
Aged Claims Listing	Reports aged clean claims, sorted in Julian date order, and display the current system location of the claim and how long it has been in that location

OnDemand enables the long-term secure storage and retrieval of reports so that users can easily navigate to the same copy of the report. Users can recall historical versions of reports because each is date time-stamped. 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. Users can create, store, and recall predefined reports electronically. HP's interChange system provides many claims entry and adjudication statistical reports.

Editing of Claims Data

The Colorado interChange will edit data elements on the claim for required presence, format, consistency, reasonability, and allowable values. The Colorado interChange will subject claims to automated system edits and audits to verify that they comply with Colorado Medicaid policies, industry guidelines, such as the National Correct Coding Initiative (NCCI), and medical criteria. The Colorado interChange will 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:

- Verifies provider enrollment and member eligibility
- Checks dates to confirm they are valid and do not represent future dates
- Uses reference data to validate claims data
- Determines the number of services performed against the span of time being billed to confirm that they agree
- Identifies service codes to verify they are payable in accordance with the Department guidelines and policies—for example, second surgical opinion and PAR

The Colorado interChange will subject claims to automated system edits and audits to verify that they comply with Colorado Medicaid policies and medical criteria. Validity editing of claims is a part of interChange and will edit against the provider, member, and reference data tables as part of the claims processing function. The system will edit each claim as completely as possible during an edit and audit process, rather than ceasing the process when a failure is encountered so that multiple resubmissions of the claim will not be required. During editing, the claims

processing system accesses various files to validate the claims data as demonstrated in the following table.

interChange System Checks

Action	System Checks
Verify the member is eligible for the services billed	Member file
Verify the provider's eligibility to perform the service billed	Provider file
Confirm that the services billed are covered during the date of service and that they do not conflict with services previously billed	Reference file for procedure/diagnosis and edit and audit disposition, and member for claims history
Verify that a PAR exists when required	PA file
Verify that other payers have been accounted for in the claim payment	TPL file

Claims will process in real time, in a single pass, and typically pass through the claim engine in seconds, not minutes. The edit/audit sequence occurring during processing includes the following:

- Client editing
- Pricing
- Provider
- Auditing
- Benefits
- Dispositioning

Our user documentation will detail these processes. Business analysts will use the proper browser pages and the rules engines to configure the appropriate parameters—such as client-related pages, provider-related pages, Benefit Plan Administration (BPA) coverage, contract and reimbursement rules, audit rules, and disposition criteria. Each will be available, searchable, and reviewable within the appropriate configuration windows.

Claims Resolution

Claims suspense resolution is a key component of the interChange Claims Business function. The Claims Business function performs rigorous claims editing and auditing, based on defined policy and rules, to determine whether claims should be paid, suspended, or denied. We will optimize the edit and audit process for automated first-pass claims processing. This will include business intelligence for multiple same-day surgeries, duplicate, and suspect duplicate checking, depending on the Department's specific criteria and requirements. 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, member, and PA for editing, users can customize audits online through a series of easily updateable audit criteria pages.

The base interChange product contains the edits typically used by our Medicaid customers. HP will work with Department staff to propose and define required new editing or auditing criteria to include Department-specific duplicate or suspect duplicate and criteria for adjudication of claims. Having worked with more than 20 state Medicaid programs, we frequently learn of new and innovative editing criteria being used by one of our state clients and will then bring this to the Department for possible inclusion in Colorado's interChange. We will work with the Department to verify the system is set up to incorporate the Department's existing edits and audits to include special adjudication rules or policies. This edit criterion will consider the current process to allow authorized users—with Department approval—to set criteria allowing claims to bypass the enhanced claims editing component based on various factors including the following:

- Dollar thresholds
- Member or provider-specific criteria
- Medical coding
- Other criteria as defined by the Department during DDI

interChange will have the capability to allow for processing of special claims through manual entry to include items such as late billing, member retro-eligibility, adjustments, mass adjustments, and edit overrides in accordance with the Department's instructions and for situations the Department defines.

Systematic and Manual Review of Suspended Claims

interChange offers many features and benefits that effectively support the claims processing business function. Claims will be systematically and, when appropriate, manually reviewed during claims adjudication per the Department's specifications. Suspended claims resolution involves the following activities:

- **Data correction—**For paper claims, incorrect data will be corrected if the error occurred during the data capture process. When corrected, the claim will continue through the adjudication process.
- **Manual pricing—**Price will be assigned by the Resolutions team based on the complexity of the service and using Department-defined applicable pricing policy.
- **Forcing or overriding an error—**Claim edit will be overridden or forced to pay based on documented exception criteria and in accordance with the Department-approved procedures and guidelines.

- **Denying a claim—**Claim will be denied when the error cannot be corrected without additional information from the provider, or the error cannot be overridden per the Department's rules.
- **Referring a claim—**Claim will be forwarded to another location for further review and adjudication determination in accordance with Department-approved procedures and guidelines.

Claims that fail edits and audits, not set to systematically deny, will be suspended and routed to the appropriate system claim locations for manual review and further processing. The location codes will be set up during DDI and implemented according to Department-approved criteria. These location codes will allow the edits to go directly to HP staff members for review and processing. Location codes enable the resolutions clerk to forward claims to an HP staff member should the need for further review be required. Claims resolution will be primarily a paperless process performed online in real time. The claims resolution specialists will work with a split screen that displays the claims data entered into the claims processing system and an optical image of the claim submitted for processing. The Resolutions team will have access with point-and-click navigation to various data needed to verify information on the claim.

interChange is a rules-based system that allows claims to be suspended and systematically or manually reviewed based on criteria the Department provides. interChange will adjudicate claims reviewed by HP staff members in the next available daily cycle. After the system adjudicates a claim and it is in a final status, the information will remain static and be displayed in its entirety in the system.

Claims Pricing

Payment rates are at the core of MMIS claims processing. The HP interChange BPA function [redacted] will accommodate the complexities and size of the Colorado Medicaid Program. It will be a true multipayer benefit plan solution, featuring internal coordination of benefits between payers and benefit plans administered under the fiscal intermediary contract.

The process of adding new programs and rates is table-driven, allowing the Department to expedite implementation of new programs or rates without experiencing the costs and time delays typically involved with a system development and installation project. The benefit plan functions of interChange have proven successful for Medicaid programs, including Pennsylvania, Oklahoma, Kansas, Florida, Georgia, and Wisconsin.

(1533) interChange rules management will allow trained, authorized users to identify, create, refine, and maintain business rules that effectively capture and enforce medical policy. Within interChange, various business rules will govern each claim processed—billing rules from policy and contracts, coverage rules from benefit plans, and reimbursement rules that will determine how to price and pay the claim. The disposition of edits associated with business rules will

determine whether to pay, suspend, or deny claims according to the Department's policy on how to adjudicate each service.

interChange has a robust claims pricing system driven by user-updateable tables, such as fee schedules, provider-specific rate tables, and member cost-sharing tables—for example, member liability, member spend-down, copayment, and TPL tables. These tables provide the system with the data necessary for calculating the appropriate claim or detail payment for each service according to the Department's 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.

interChange supports claims pricing using many different reimbursement methodologies, including the following:

- Inpatient DRG
- Crossover pricing
- FFS payment schedules
- Level-of-care per diem
- Federally Qualified Health Center (FQHC) and Rural Health Center (RHC)

Additional information that affects pricing may include modifiers, provider type and specialty, claim type, and member age. The Department will benefit from the flexibility interChange offers in applying these differing payment methodologies. Medicaid reimbursement systems continue to evolve and are becoming increasingly complex. This complexity is driven by continued pursuit of Medicaid payment systems that better match program rates (payments) to member care needs and services delivered. Complexity also is driven by increased federal requirements placed on Medicaid programs. The interChange system is flexible and configurable to allow pricing modifications to stay current with the ever-evolving industry changes.

Manual Pricing

interChange allows for online entry of manual pricing for claims as appropriate. We will enable this feature at the direction of, and with approval from, the Department. Based on the complexity of the service and using Department-defined applicable pricing policy, the Resolutions team will manually enter a price on the claim. HP's interChange retains user-entered manual prices and will have a pricing indicator of "MANUAL" when it is assigned a manual price.

Exception Pricing

interChange will price claims according to various methodologies to accommodate the Department's unique member populations and pricing policies. Additionally, the system will easily support the Department's current pricing methodologies and the implementation of future pricing

methodologies with minimal system changes and impacts. HP's interChange will process claims as directed by the Department on an exception basis. The proposed system will maintain a link to the coverage, billing, and reimbursement rules under which the claim was processed. The application also captures the pricing indicator, rate type used to price the claim or detail, and the user ID of the person who adjudicated the claim. This information will be stored as a full audit trail for the methodology and resulting claims payment. To preserve data integrity, interChange prevents users from deleting segments on the reference files. Rather than delete segments, users must end-date them. This feature allows historical data to remain in the database indefinitely for use by claims processing and presenting the data for users to view online for research purposes.

Overriding Claim Edits

The base interChange will contain many of the typically used MMIS claims processing reports. HP will work with the Department to create and provide reports to monitor the use of overriding edits during the claims correction process in accordance with Department-defined guidelines. Our online report repository, OnDemand, will store claim reports, enabling users to retrieve reports from their desktops in electronic format. The electronic format of the report will let 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, supporting the use of override or denial codes during claims correction processing that we will provide to the Department.

Representative Sample of Override Reports

Report	Description
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 pharmacy claims, and includes the clerk ID if manually processed
EOB Denial Analysis List	Lists for each claim, the error code, description, and the EOB posted to the claim when it 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

Recipient EOMB

Within interChange, the existing quarterly claims Recipient Explanation of Member Benefit (EOMB) process produces EOMBs using targeted filters or no filters. The filters allow the definition of a random sample of the population or claims that meet configured criteria. We can define those filters to identify a target percentage—for example, 3 percent—or a target number—for example, 1,000 clients. This process is set up during DDI according to Department guidelines. The output of the process is routed through our correspondence package, HP Exstream, and generates electronic or physical letters for mailing to the members. We retain the information generated through this process for reporting purposes and store it in our electronic document repository.

Online Access to Claims History

interChange will provide role-based security access for authorized users to help verify confidential access to MMIS data at the individual and group security levels. The role-based security access enables various levels of security, as defined by the Department, to the MMIS. HP grants access on a defined need basis. Business groups have profiles established within the security solution. As we add MMIS users, we authenticate and authorize them according to their assigned profile. This role-based approach limits the access to the specific business areas, the specific online user panels, and the specific features (add, update, or inquire) of the user panels, as needed, to maintain proper security.

The portal supports the HIPAA-compliant search parameters to enable providers to search for their claims. Portal security verifies that a provider or their designated representative only gains access to claims related to that provider. HP's 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 also provides access to claim information through the AVRS and several HIPAA-compliant transactions. The following table shows the key interChange features supporting the claims status inquiries or notifications business function.

Claims Status Inquiries or 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 for electronically submitted claims	Encourages electronic billing and reduces providers' administrative costs

Adjustments

The interChange claims adjustment process is easily accessible to the provider community and minimizes negative financial and administrative impacts to the Department and the providers. The MMIS provides an effective and efficient solution for claims adjustments. Through the web portal access, providers have user-friendly access to initiate adjustment requests that are immediately processed and paid or denied. We accurately reflect adjustments in the files that are accessed during the reversal and reprocessing of a claim, including the provider master, the member maintenance, the PA, and the financial tables. The MMIS clearly reflects adjustment transactions on the provider's remittance advice, which helps the provider to reconcile records. The interChange reporting function is an important component of the adjustment processing function. We design the reporting function to meet the Department and federal reporting requirements**.**

The 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 gross adjustments before release in the system so that when released, adjustments adjudicate instantaneously

interChange processes claim adjustments through the claims processing function. We allow adjustments on claims approved for payment, regardless of whether there was actual reimbursement issued because of payment reductions for such factors as TPL and spend-down. Partial adjustments are also addressed for scenarios such as adjusting a single line on a CMS 1500 claim. The provider modifies the detail that needs to be changed and resubmits the claim. HP's interChange then reprocesses and re-adjudicates the entire claim including the new information provided for the modified detail line.

The original and adjustment claims process in the same cycle and display on the same remittance advice as offsetting transactions. The original claim appears as a debit (negative) transaction and the adjustment appears as a credit (positive) transaction. 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. interChange maintains an audit trail of the previous processing along with the adjustment processing for future reference.

As with other claims, claim adjustments are data-corrected in real time. Online changes to adjustment claims are part of the interChange data correction function. During data correction—

or 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, provides rapid turnaround on suspended adjustments, resulting in increased service to providers.

System-Generated Capitation Payments

The Colorado interChange provides the capability to calculate and generate capitation payments to the Department MCOs that have pricing based on a capitation payment model. The system can prorate capitation payment to the days the member 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 member demographics, including eligibility program, place of residence, age, gender, and risk factors. The system bases the capitation rates on these factors and systematically calculates and pays the appropriate provider of the managed care benefit plan based on the member's choice of a provider. 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.

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Manual Capitation Adjustments

(1528) The Managed Care panels allow authorized users to create manual capitation adjustments at any time during the month before the monthly capitation cycle. Capitation adjustments also can be after a payment has already been made. An example of this situation is when we receive a beneficiary date of death notification and the capitation payment needs to be adjusted to recoup a partial month capitation.

Provide Data for Fraud and Abuse Cases (Unique ID 1522)

All claims history is available for reporting and for search by authorized users. interChange stores submitted values as well as system assigned information from claims processing. X12 claim submissions are maintained in the format received within the EDI subsystem. Claim images for paper claims can be retrieved through the OnDemand reporting solution user interface. The electronic document management system, OnDemand, can produce a facsimile report of electronic claims data in an easy-to-read format conducive to a legal setting. Templates are created within the system for the electronic claims so that when they are retrieved they can be viewed similar to a paper claim. These facsimiles can be used for proving fraud and abuse cases in a legal setting.

Retain Client Enrollment and Eligibility Data (Unique ID 1523)

interChange maintains a link between claims/encounters to the client and the client's benefit plan under which the claim/encounter detail was processed. Claims and encounters are processed based on the effective start and end dates for the client's eligibility segment and an audit trail is maintained to track any changes in the client's eligibility.

interChange stores claim/encounter history data such as the client benefit plan enrollment, provider contract and pricing information that was in effect for the claim detail's dates of service when the claim was processed.

Electronic and Paper Document Processing (Unique IDs 1524 – 1527)

HP uses an end-to-end solution for scanning, storage and retrieval of images to provide a full electronic document management solution to support the Department's needs. This includes comprehensive document storage and easy access to all documents from the user's desktop. A full discussion of our EDMS solution is found in RESPONSE 40h.

(1524) While the goal is 100 percent electronic claim submission, no Medicaid program has yet to achieve this goal. The Department is at the forefront with only 3 percent of claims received on paper. HP will accept the national standard claim forms, CMS-1500, UB-04, and the current ADA dental form. (1525) The claim form and accompanying attachments will be scanned and passed through the OCR process to capture the data for formatting to X12 and passed to the claims engine. The scanned image of the claim and attachments is sent to the document repository in OnDemand.

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(1527) The same process for claims is applied to Prior Authorization Requests (PAR) scanned by HP as well. As claim, attachments and PAR documents are scanned, the scan operator can adjust the claim image to correct items too dark or too light which affect the final image in the repository. Daily random sampling of images makes certain that the images are properly indexed and pages are viewable.

(1526) Users have ease of access to retrieve images associated with claims. Scanned images are linked to the claim in the interChange Navigation bar. They are also retrievable directly in OnDemand. While viewing documents, they are searchable for keywords to allow the user to jump to the information they are reviewing.

Provide Ability for Providers to Generate Reports (Unique ID 1531)

Nearly a decade ago, HP transformed the market with the first Medicaid real-time claim adjudication for claim types through a web portal. We have continued to expand the business functions providers can use to make their interaction with the Medicaid programs easy to navigate and use.

Providers will have convenient, online, secured access to claims status and historical information. Providers can access the Payment History web panels in the Web Portal to receive information about their submitted claims. There is an option on the Portal to allow download of the provider's RA image file in PDF format. Each level of the Payment History window has an "RA Copy (PDF)" button. The following figure is an example of the Provider Portal Claims Search Payment History panel and the RA button.

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The user can click this to open the PDF file. The Portal supplies the "hook" to access this file, while the back-end system in interChange generates the report. Providers can retrieve the RA information from their desktops, greatly reducing the time delay in receiving printed reports. The access to the data electronically lets providers run searches for critical information and print only the portion they need. We are currently enhancing interChange to allow providers to export data to spreadsheet applications for further analysis.

Report Non-Payable Claims/Encounters (Unique ID 1532)

Nonpayable, or denied claims, are communicated to providers in a variety of ways. An explanation of benefits (EOB) is included on the provider's Remittance Advice (RA) report or on the electronic RA transaction (835). Each EOB is mapped to an appropriate reason code for reporting on the RA. Denial information also is communicated in provider searches performed through the Web Portal. Denied claim information also is available in interChange through claim history data that is viewable on the Claims History panel.

Provide HIPAA-Compliant Transmission Responses (Unique ID 1534)

The Colorado interChange accepts the entry of electronic media claims in the appropriate HIPAA-compliant formats and responds to the provider accordingly. The Colorado interChange supports the following HIPAA-compliant claim standards:

- ASC X12 837-P Professional Claim
- ASC X12 837-I Institutional Claim

- ASC X12 837-D Dental Claim
- NCPDP Retail Pharmacy Claim
- HIPAA v5010
- 270 Eligibility Inquiry/271 Eligibility Response
- 276 Claim Status Inquiry/277 Claim Status Response
- 277 Claim Pending Status Information (Unsolicited 277)
- 278 Authorization Request/Response
- 834 Benefit Enrollment and Maintenance
- 820 Health Plan Premium Payment

For each file submitted, the system returns a 999 Health Care Acknowledgement. The acknowledgment provides a HIPAA-compliant transmission response to the submitting provider, including managed care entities, on the success or failure of the submission of files.

HP has a long history of processing prior authorization requests (PARs). We currently provide complete PAR services in seven states using HP staff or subcontractors. The interChange solution provides a robust PAR workflow and rules engine that can be configured for state-specific processes and rules.

Accept, Store, and Edit PARs (Unique ID 1535)

The interChange solution provides the ability for providers to submit PARs by using multiple media types including: paper, fax, interactive voice response, web portal, and standard HIPAA transactions.

PA transactions, regardless of entry, will go through data validation and verification editing to facilitate data integrity of the PA data structures and only data which have passed editing will update the database tables. PA transactions that do not pass validation editing will be rejected to the submitting entity for correction and resubmission.

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's 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

- Valid 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 MMIS notifies the user when an entered data field fails an edit. An edit web page alerts the user to the online edit that was set and any override capabilities 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.

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The system 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.

interChange processes PA requests through the claims engine using various "rules engine" edits, which check such data elements as provider billing rules, customer eligibility and coverage. This additional process verifies that only clean PA data is added to database.

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, interChange editing prevents lowering of authorized units below the amount already consumed by paid claims. Working with the Department, we will develop a data exchange batch process to apply revisions submitted by the UM contractors. Data exchanges between the fiscal agent and other State contractors are common within our existing MMIS contracts. In cases where HIPAA standard transactions are not used, a proprietary file can be developed that meets the Department's and the UM contractor's needs.

Produce PAR Notices (Unique ID 1536)

After a final decision has been made on the PA or amendment request, the system generates the appropriate approval, denial, or modification notices. interChange automatically generates decision notices with the following information:

- Authorization number
- Member name
- Address, telephone number
- Member Identification number
- Provider number
- Provider name
- Dates of service
- Quantity
- Procedures
- Modifiers

Through HP Exstream, we generate provider and client decision notice letters that document the finalized status of the PA request, including the appropriate right of appeal language. We send these letters to the client and the system automatically downloads the letters to the Healthcare Portal for retrieval by providers.

The system uses an online letter generation template that allows notification letters to be updated as business needs warrant. The notification letter also includes free-form text comments, allowing analysts to include additional information such as, "Please submit additional lab reports to support requested services."

Create PAR Types (Unique ID 1537)

During the Requirements Validation activities, the Department will define services requiring prior authorization. The transfer MMIS currently supports prior authorization for pharmacy, durable medical equipment (DME), dental, vision, professional and institutional services.

Adaptability and flexibility are integral to our prior authorization solution. For Medicaid groups with special needs, such as waivers or self-directed care, the flexibility of our user configuration at the benefit plan level will empower the Department to effectively manage services across a broader spectrum of the community. Our solution provides the Department the capability to change, at any time, the scope of services prior authorized and to extend or limit the effective dates of authorizations.

PA requests submitted by using paper and fax will be data entered using the interChange PA panels. interChange will accept PA requests using standard X12N 278 transactions or through the Healthcare Portal. Using the portal, providers will start a PA request by selecting a billing provider number from their profile and service area or process type, which 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, customer, 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, 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 MMIS files for a more detailed review. For example, system edits will verify provider and customer eligibility for the dates of service requested, 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.

After the request passes all editing, the provider completes 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 as seen in the following figure.

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PA requests received through the Healthcare Portal will be systematically routed to the appropriate interChange PA work queue 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.

Assign Unique PAR Control Numbers (Unique ID 1538)

The interChange MMIS assigns a unique PA number to all PA and PA adjustment transactions regardless of the input source, providing positive control and accurate reporting.

Regardless of how the PA request or adjustment is received, interChange will initiate a record in the PA system that contains the following fields:

- Single client or clients
- Status of the request
- Services authorized
- Number of units approved
- Service date range approved
- Cost approved
- Provider approved (unless approved as non-Provider specific)

The prior authorization record will be immediately viewable by registered providers through the secure Web Portal after a review decision has been entered into the system.

Working with the Department, we will develop a report or data exchange for use by the UM contractors. This data can be posted on the Healthcare Portal or transmitted using secure FTP and will include the unique PA numbers assigned to the PARs submitted by that entity. Data exchanges between the fiscal agent and other State contractors are a common process in our existing MMIS contracts. In cases where HIPAA standard transactions are not used, a proprietary file can be developed that meets the Department's and the UM contractor's needs.

Assign Unique PAR Number (Unique ID 1539)

The interChange MMIS auto assigns a unique PAR number to all PA requests regardless of the input source, providing positive control and accurate reporting. This unique identifier will be associated with that PA transaction for life. PAR numbers are considered "key" fields by interChange, as such, the database will not allow a record to be saved if it has the same PAR number as a record already existing in the system.

PA data is accessed during claims processing to verify services billed, that require prior authorization, have a valid PA record available. If a PA record exists for the service, the claim information is compared to the information in the PA database. Claims with discrepancies in information—for example, the dates on the claim fall outside the dates on the PA record—are paid, modified, or denied 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 filed with a valid PA number associated with a PA record covering the services billed, are paid, and the number of approved units and dollars used is decremented from the PA record.

Reconcile PA IDs With External Vendors ID 1540)

The PA data model will be updated with a cross-reference to the UM contractor's assigned PA identifiers. This identifier will be used in the production of the report or file for the UM contractors and can be posted on the Healthcare Portal or transmitted using secure FTP. Data exchange between the fiscal agent and other State contractors is common in our existing MMIS contracts. In cases where HIPAA standard transactions are not used for PA responses, a proprietary file can be developed that meets the Department's and UM contractor's needs.

PAR Adjustments (Unique ID 1541)

The interChange MMIS provides the Department with the ability to update or adjust approved PA lines, including changes to services authorized. The user can enter data or tab through the fields that are to remain unchanged and update the requested fields. The update capability allows the user to change only the applicable data and eliminating re-entry of the initial request information not requiring change. Authorized services and dates can be changed at any time until a claim has paid. The user cannot change the services or lower the units or dollars available if paid claims have resulted in units or dollars being used.

The interChange MMIS provides the user the ability to change or extend the PA request end date or change the unit field by entering the updated information into the applicable field on the PA line item.

Date-sensitive updates made through either online web pages or through the automated update processes will retain provider number, dollar amounts, and unit limits with associated begin and end date information, and additional line items. This feature enables older claims to process according to the rules in effect for the dates of service on the claim.

PA transactions, regardless of entry, will go through data validation and verification editing to facilitate data integrity of the PA data structures and only data which have passed editing will update the database tables. PA transactions that do not pass validation editing will be rejected to the submitting entity for correction and resubmission.

Working with the Department, we will develop a data exchange batch process to apply revisions submitted by the UM contractors. Data exchanges between the fiscal agent and other State contractors are a common process in our existing MMIS contracts. In cases where HIPAA standard transactions are not used for PA transactions, a proprietary file can be developed that meets the Department's and the UM contractor's needs.

Track PAR Revision History (Unique ID 1542)

The interChange MMIS tracks updates to PA data through batch, real-time external interfaces, or web panels, allowing a complete audit and reporting process. The audit trail records the action performed (insert, update or delete), date of the change, the source of the change (electronic file or staff ID making the change), and the information changed because of the update.

Update PAR Language (Unique ID 1543)

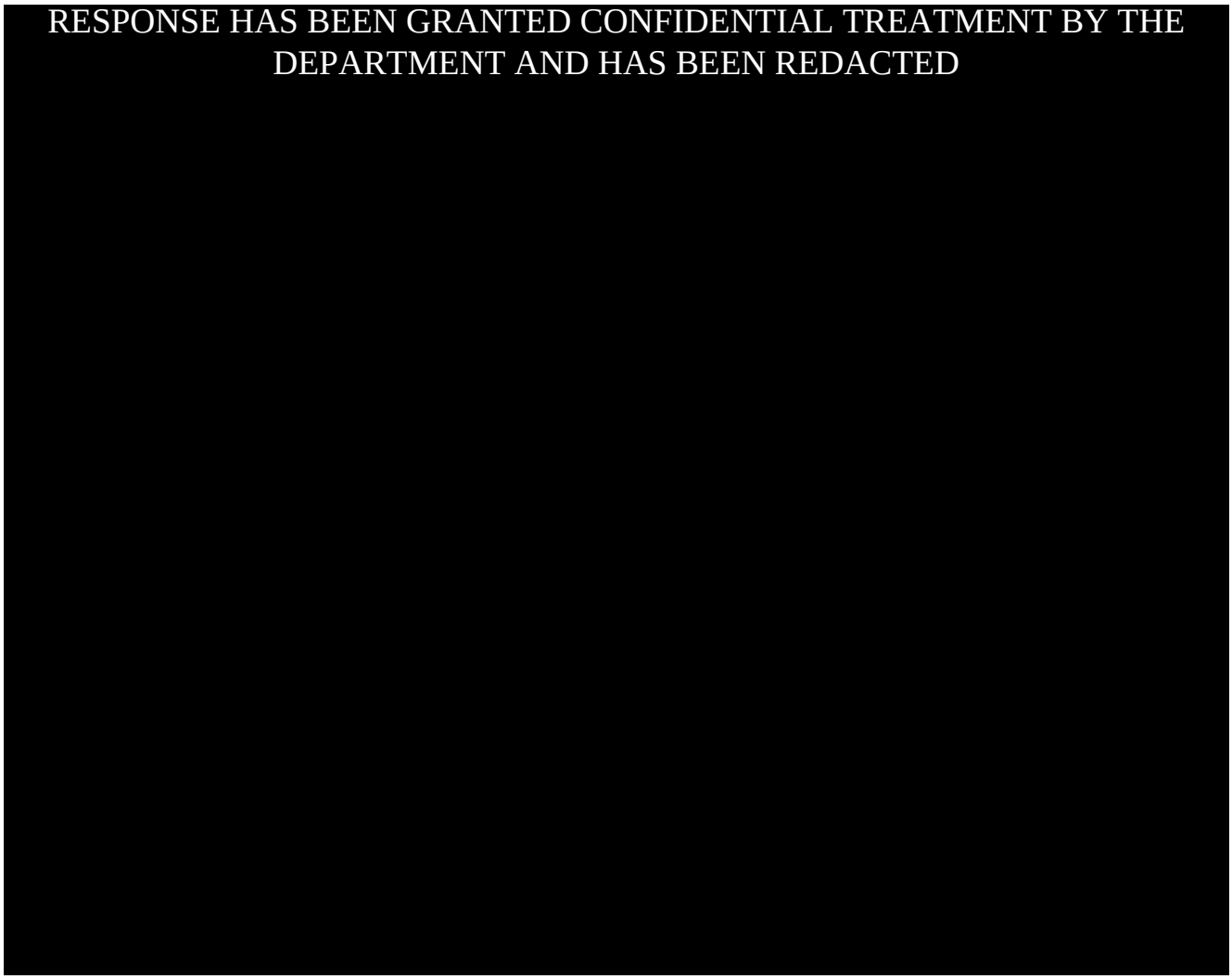
The flexibility and responsiveness of the HP solution equips the Department with the tools necessary for the timely management of benefit services and program features.

The reference data business area provides a reliable, configurable, flexible means to maintain information required by the Department for claims administration and transaction processing. The primary function of the reference tables are to serve as the repository of data and business rules required for prior authorization determination, claims adjudication and pricing, edits and audits. Codes sets within reference support various management, ad hoc, and utilization reporting functions. The reference tables provide an integrated method of storing MMIS reference data and allow for centralized control and an audit trail for table value changes.

Reference data provides authorized users the flexibility to update the data tables through the interChange panels and administer policies governing the Colorado Medicaid program. The reference business area contains tables of information needed to process prior authorization requests, approve claim types, support associated assistance programs, and enable various reimbursement methodologies.

Additionally, reference data is the repository for the text message information needed to support the ability to update PAR language when business rules are updated. The text component of reference allows a flexible means through which to change descriptions such as denial reasons.

interChange presents EOB and denial reason descriptions in language that is easy to read. The following figure is an example of the EOB maintenance screen, which allows authorized users to update these types of messages.



Perform PAR Mass Adjustments (Unique ID 1544)

A mass update of PA records can be performed if needed. Examples include procedure codes no longer requiring PA, changes in the rate paid for specific procedures, or when a cost of living adjustment is applied. Every edit action on the PA is tracked by an audit log that is available from the main PA line item page. By reviewing the audit log, the Department can view which staff member edited a PA, what was edited, and when it occurred.

Standardize and Track PAR Data for Utilization Review (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.

The Colorado interChange PA panels are simple and straightforward for 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.

Handle PAR Duplicative Data (Unique IDs 1546, 1547)

(1546) 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's program policy and will 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

- Valid start and stop dates
- (1547) 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. An edit web page appears, alerting the user to the online edit set and any override capabilities 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.

Search and View PARs (Unique ID 1548)

The interChange Prior Authorization Search panel provides the capability to search for PAs by many different criteria, including provider, client, PAR type, received date, procedure code.

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

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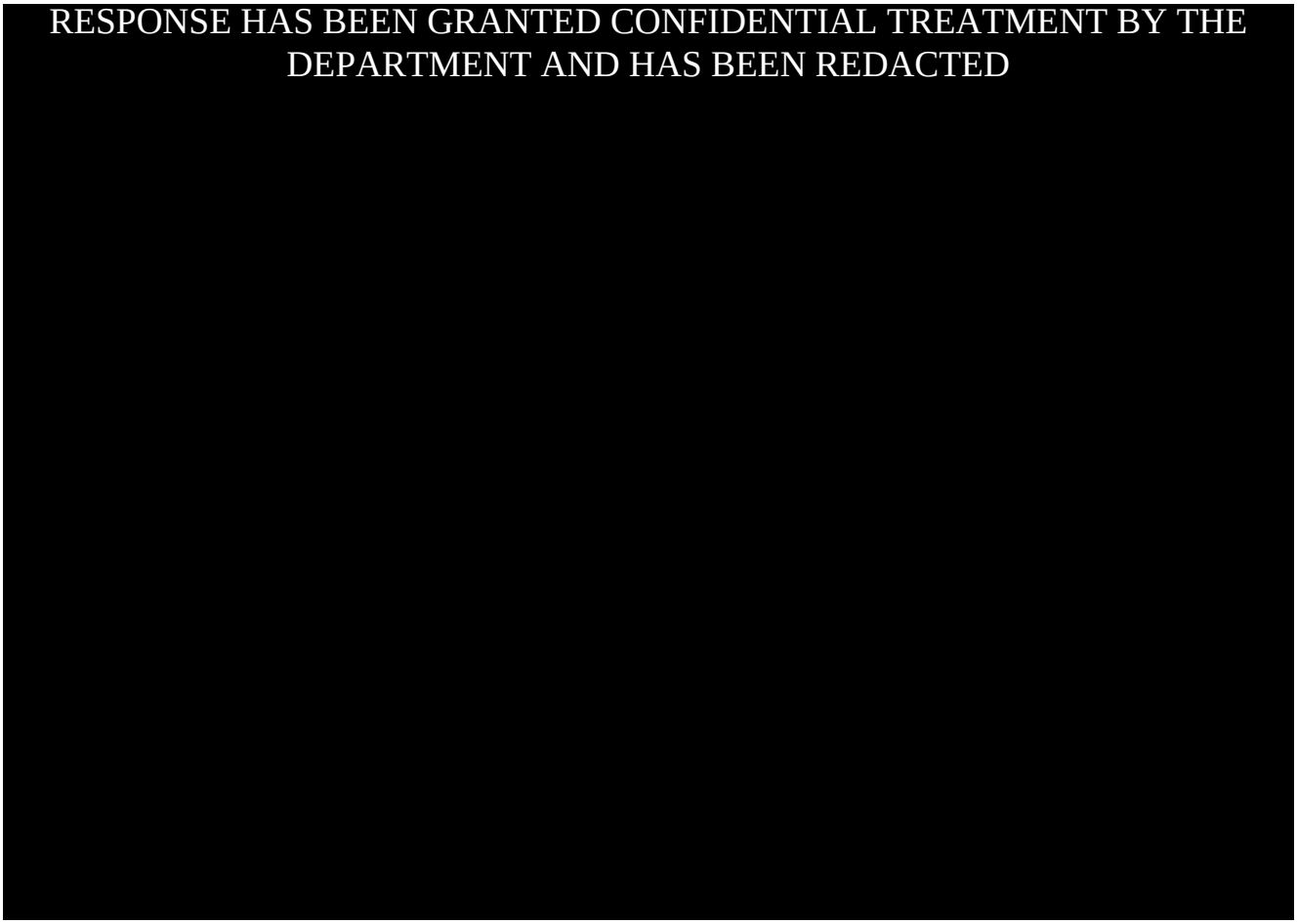
The interChange PA panels are simple and straightforward to use with tool tips providing context-sensitive help for valid field values and code definitions using point-and-click access. The user-friendly graphical user interface (GUI) capabilities allow the authorized user to move effortlessly through 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.

Link and View Multiple PARs (Unique ID 1549)

The PA Search panel shown above allows the user to search by client ID. The PA inquiry panel containing the client ID links back to the client data panel.

When inquiring about authorization requests through the Healthcare Portal, providers can access a "dashboard" view, which immediately presents them 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 client ID, authorization ID or tracking number, authorization type, 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.

The following figure provides a view of a provider's PA search results through the Healthcare Portal.



The interChange MMIS enables the designation of approved services through the purpose-built Benefit Policy Administration (BPA) rules engine. This feature aligns with CMS' Seven Standard and Conditions (7SC) desire for rules that are both human and machine-readable. We also can export rules to other processing environments without rekeying and publish to a designated repository. This rules engine sits at the heart of adjudication and policy decisions allowing users to configure the proper rules through the user interface with absolutely no technical assistance. A single UI allows for the configuration of these decisions across many parameters and elements and directly associates the services, members and providers to define

the proper benefits. We organize the rules by purpose and linked directly or inherited to the billed services such as procedures, revenue codes or diagnosis codes.

BPA rules are responsible for the vast majority of claims adjudication, pricing, editing, and auditing decisions. The configurability built into the BPA rules gives the Department the flexibility and scalability to use the interChange MMIS for pre-adjudication transaction processing for multiple programs across the MMIS enterprise. A single UI allows for the configuration of these decisions across many parameters and elements and directly associates the services, members and providers to define the proper benefits. The BPA rules engine defines and processes these rule types.

- **Provider Contract Rules—**What services a provider is allowed to perform
- **Client Plans Rules—**What services a client is eligible to receive
- **Reimbursement Rules—**What decisions to apply on appropriate pricing methodology
  Assignment Plan Rules—What services to carve out of a capitated managed care plan
- **Edit Rules—**Edits are rule-driven through configuration
- **Audit Rules—**Audits are rule-driven through configuration
- **Copay Rules—**Member responsibility amount
- **TPL Rules—**What services are covered by carrier-specific rules allowing cost avoidance and recovery

Each benefit plan or provider contract can have entirely different rules, allowing the definition and management of medical policy including covered services, benefit packages and rates from the available data elements at a granular level without any additional coding.

Rules Engine (Unique IDs 1572, 1573, 1574, 1599, 1614, 1628, 1631, 1650, 1661, 1662)

(1572) The MMIS supports a configurable rules engine where authorized users can define and update coverage and payment criteria as policy changes. Additionally, the system supports DRG pricing using DRG grouper software, and hospital acquired conditions as defined by CMS can be flagged and excluded from payment decisions.

(1573) The base system incorporates DRG pricing for inpatient claims and APC/EAPG pricing for outpatient claims. The MMIS supports various pricing methods, and outlier payments such as cost outlier and day outlier are supported based on an individual state's policy. Additionally, provider peer group pricing is an option that is supported based on an individual state's policy.

(1574) The base interChange system allows both provider contract billing rules and member coverage rules to allow coverage for services based on primary diagnosis or other diagnoses.

(1599) Authorized users configure edits and audits through the Rules Engine as part of the base interChange transfer system.

(1614) The base interChange system edits for enrolled member, eligibility based on service dates, and for covered services.

(1628) The configuration of coverage data in the benefit plan rules engine allows for various coverage criteria and restrictions. Rules can be configured to validate service and diagnosis combinations.

(1631) The federally certified base transfer system supports user configurable audits. These audits support enforcing service limits within defined timeframes. Audits are customizable and can be defined to support federal and state specific policy. Limitations can be client or provider based. The system supports unit limits, day limits and dollar limits and limits are configurable by time frame (calendar year, per day, lifetime, and so on).

(1650) The base interChange system assigns fund codes to track funding sources from which services will be paid. During implementation, HP will work with the Department to configure the Colorado-specific fund codes. During processing, the managed care system will assign the funding and financial will manage the funding in the same manner they use for all other transactions.

(1661) The base interChange system supports State Accounting Code Assignment capabilities that will be set up according to Colorado-specific requirements during implementation.

(1662) The interChange base MMIS includes support for all of the standard medical billing code sets as described in this requirement. The MMIS contains numerous edits that verify proper billing of these codes and the coverage rules associated with them. The rules engine allows new edits to be configured as policy is developed

For more details regarding our response to these requirements, please refer to RESPONSE 38l.

Maintain Client Eligibility and Plan Enrollment Information (Unique ID 1308)

HP understands the importance of accurate maintenance of claim payment data and the necessity of having the data available to determine how a claim was previously paid. To that end, the interChange system claims database stores information with the claim such as the rules the claim processed under and the benefit plan that covered the service billed. The specific client eligibility information is date segmented and is stored in the client file for review of current and historical eligibility information related to a client. Additionally, an audit trail capability exists in the database where changes to eligibility or other system data can be traced back to a specific user who made the change, and displays what the data looked like before the change that was made.

Process EDI Transactions (Unique IDs 1470, 1514, 1515, 1558)

(1470) Colorado interChange supports electronic transaction exchange by using our electronic data interchange (EDI) solution, Connections. This approach supports the input and output of electronic transactions in HIPAA-compliant formats. As a result, providers can submit claims and transactions in the method that they find most convenient.

The Web Portal supports submission of the electronic transactions covered under HIPAA in the approved HIPAA transaction formats and code sets. HP solution offers the ability to handle individual claim submission or batch files from any HIPAA submission method, through the web portal or direct Internet exchange. The claim submission includes both new claims as well as replacements/voids.

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 all claim types.

(1514) The Web Portal supports online entry of dental, professional, institutional, and pharmacy claims. Based on configuration settings and backend processing, these claims can be adjudicated in real-time by the payer system, returning claim status and any associated error messages. At that point, capability is available to edit and resubmit the claim after again to the back-end system.

The portal also allows users to view a claim and its associated detail from the search results of the Search Claims page. All pages and fields of the claim are protected, display-only fields. The summary claim page includes information such as the claim number assigned by the backend system, the status of the claim and date associated with that status, and claim total dollar amounts. The service line pages provide additional detail information, including any Remark codes associated with the service line.

interChange supports the following ASC X12N HIPAA Version 5010 electronic transactions through batch transaction processing:

- 270 Eligibility Inquiry/271 Eligibility Response
- 276 Claim Status Inquiry/277 Claim Status Response
- 277 Claim Pending Status Information (Unsolicited 277)
- 278 Authorization Request/Response
- 834 Benefit Enrollment and Maintenance
- 820 Health Plan Premium Payment
- 837P Professional claim
- 837I Institutional claim
- 837D Dental claim
- 835 Healthcare Payment and Remittance Advice

(1515) interChange Connections validates X12 transactions for HIPAA compliance as they are received and before they are sent to our trading partners. The batch submission mechanism validates and accepts or rejects X12 transactions at the claim level, allowing providers to get more of their claims/encounters and COB claims processed after each submission. 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. After received by the EDI system, electronic claim and encounter transactions are mapped to XML for processing in the claims engine.

interChange Connections currently has the 5010 278 acceptance and translation implemented for PA. HP will add the ability to process the 278 Referral as part of the Colorado interChange implementation.

(1558) The ANSI X12N 275 Patient Information transaction is expected to be part of the HIPAA claim attachments standard and is not yet finalized by CMS. HP's interChange currently supports the ability to process Health Level Seven (HL7) Continuity of Care Document (CCD) standards that will assist in the processing of 275/277 claim attachment transactions by the federally mandated date. HP will fully comply with the X12 275 after CMS releases the final requirements for this transaction.

For HIPAA-compliant electronic 835 transactions, HP' EDI interChange Connections uses national adjustment reason codes and healthcare remark codes to convey the claim finalization, as well as the provider's financial activities. HP's interChange posts X12 835 transactions to the Medicaid portal following each financial cycle.

For a full discussion of EDI capabilities, please see RESPONSE 40c.

Online End-to-End Claim Processing (Unique ID 1519)

A full discussion of online end-to-end processing of a claim through the system, and communication back to the submitter is located in RESPONSE 39l. Screen shots and process flows will guide you through the processes.

The Provider Portal allows users to submit professional, dental, and institutional claims, including details that apply to individual services. These details include Diagnosis Codes, Service Details, Other Insurance Carrier Details, and Attachments. Users also may perform limited searches on specific fields within the Claim pages and navigate to and from the other sections within the Claim page as seen in the following figure.

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After a claim is submitted to the payer system, a confirmation is returned to the user. After confirmation, a provider may use the View Claim Status Inquiry to view claim status and—if applicable—individual error messages.

Although not required in this RFP and not included in our solution, the Provider Portal also allows users to submit pharmacy claims using the following transaction types: billing transactions, reversal transactions, and rebilling transactions. The payer system receiving the transactions processes them in real-time and immediately returns a response to the Portal.

The billing transaction is used to report and request payment for prescriptions dispensed. The Portal submits each prescription as one transaction. The Portal allows the entry of compound drug claims with up to 35 ingredients. Drug Utilization Review (DUR) override code, diagnosis

codes and other insurance data can be included by the pharmacy if they wish to alert the payer of added service provided.

Payer systems process billing transactions immediately and send back a response to the Portal that includes the transaction response status, reject codes (if applicable), amount paid, and amount of copy or coinsurance.

The reversal transaction is used to back out a previously submitted claim. One common usage of the reversal transaction is when a client does not pick up a prescribed drug and the provider returns it to stock. Client configuration determines which claims are eligible for reversal.

The rebilling transaction is used to reverse a previously submitted claim and then submit a new claim in the same transaction. Client configuration determines which claims are eligible for rebilling.

Claims process real-time when submitted using the Provider Web Portal and return a real-time status response to the provider.

Provider Claim Corrections Through the Web Portal (Unique ID 1529)

The Provider Portal adjudicates claims in real time; when submitted, no further changes or corrections can be made while the claim is passing through the claims engine. After the claim result of Paid or Denied is returned to the submitter, claims can be adjusted or voided using the Provider Portal.

Suspended claims are not available to providers for data correction as the claim is immediately routed to the proper resolution location on submission. During the Requirements Validation sessions, HP will work with the Department to further define this requirement and provide a solution to meet the Department's request for this capability.

Claim Editing and Auditing (Unique ID 1550)

interChange fully edits and audits each claim on its entry into the claims engine, making it possible for a claim to be fully adjudicated within seconds. This feature will provide the Department with a faster turnaround time, allowing rapid payment of claims and increasing provider satisfaction.

The editing and auditing function is the heart of the claims processing system. Through the edits and audits, the system ascertains whether a claim is payable. The edits validate the data submitted within the claim, and the audits make sure that the claim complies with the Department's dollar and service limitations.

The flexibility of interChange will allow the Department to respond to the changing needs of a dynamic medical assistance program. We can readily add edits and audits that do not currently reside in the system. After added, we can change them to accommodate new policies, procedural changes, or changes in the local medical practices. Often, we can change edits and audits without the intervention of technical personnel. The following figure is a sample of one of the several

audit criteria windows that the Department and HP will use to view, update, or add criteria associated with an audit.

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Online access and update capabilities provide users immediate access to valuable data.

interChange's edit and audit hierarchy is set logically so that the system identifies and posts as many error conditions as possible before the claim is released for correction or returned electronically to the provider. The editing and auditing process continues unless an error is encountered, which will prevent further editing or auditing. For example, a missing or invalid provider number will preclude the editing for provider eligibility because there is no valid number with which to verify eligibility.

The system maintains 72 months of online adjudicated claims history and all claims for lifetime procedures on a current, active claims history file for use in the claim audit process, online inquiry, and claim reporting functions. HP's 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.

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

The resulting claims edit and audit function will provide the controls and processing mechanism necessary to pass claims to adjudication.

We describe the functions performed in the following subsections:

- Claims Editing
- Claims Auditing
- Claims Resolution
- Claims Disposition

Claims Editing

interChange edits data elements on the claim for required presence, format, consistency, reasonability, and allowable values. Edits perform quality control checks in data fields for alphanumeric values, high/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 Department guidelines and policies (for example, second surgical opinion and PA).

Claims are subjected to system edits to make sure they comply with Colorado Medicaid policies and medical policy criteria. Validity editing of all claims is part of interChange. All claims are edited against the provider, member, and reference data files as part of the claims processing function. HP's interChange edits each claim as completely as possible during an edit or audit cycle rather than ceasing the process when a failure is encountered to not require multiple resubmission of the claim.

During editing, the claims processing system accesses the various files to validate the claims data as demonstrated in the following table.

interChange System Checks

Action	System Checks
To verify the enrollee is eligible for the services billed	Enrollee file
To verify the provider's eligibility to perform the service billed	Provider file
To confirm that the services billed are covered during the date of service and that they do not conflict with any services previously billed	Reference file for diagnosis and edit and audit disposition

Action	System Checks
To verify that a PA exists when required	PA file
To verify that other payers have been accounted for	Third-party liability (TPL) file

Claims Auditing

After claims pricing, the system performs audits to validate compliance with Medicaid policies and medical criteria. These audits include:

- **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 DHFS limitations in dollars, units, or occurrences

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 member, billing provider, service dates, services rendered, modifiers, attending provider, billed amount, and other data elements specific to each claim type. HP's interChange cross-references between group and rendering providers and multiple provider locations and across provider and 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 member, 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 member, 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 are also audited against historical files to make sure they conform to established Department Medicaid policies, service, and dollar limitations.

After initial processing, interChange will enable us to identify claims and encounters so they can be adjusted and reprocessed. Data stored in the interChange Reference system for use in claim

adjudication is date segmented so that claims/encounters can be adjusted and reprocessed using information that was in effect for the claim dates of service. Edits and audits will be customized during the implementation time frame to conform to Department policies.

Claims/Encounters Reporting (Unique ID 1551)

Timely, flexible online inquiry and reporting dramatically improves access to data for program analysis and supports the Department in program management and cost containment. The base interChange system provides several reports that detail claim volume, error resolution, errors encountered, suspense volume and claim aging that can be provided at agreed-on intervals. For example, interChange reporting will assist the Department with identifying edits with high volumes of denied or suspended claims.

The advanced interChange MMIS—enhanced with OnDemand—provides significant new efficiencies that facilitate secure report distribution. Reports are available electronically in PDF and Microsoft Excel formats from the repository where users can access them when and how they need them. 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. During the DDI phase, we will work with the Department to design, implement, and test the reports and obtain approval of the report specifications and report distribution schedule.

The following table lists a representative sample of the reports in the base system 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	The Aged Claims Listing reports aged clean claims. The report is sorted 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 point-of-service claims
EOB Denial Analysis List	Lists, for each claim, the error code, description, and the EOB posted to the claim when it 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 of claims 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 as well as corrected suspended claims

Adjudicate Claims Within Policy (Unique ID 1552)

The base interChange solution has been CMS-certified 12 times, four with the new MECT checklists. As outlined in RESPONSE 38g, the system meets all federal requirements. The Colorado interChange that HP will deliver is fully configurable for Colorado-specific rules, edits, and audits as needed to comply with the Colorado Medicaid Program.

Adjudication of Managed Care Carve-Outs (Unique ID 1553)

The Colorado interChange provides the Department with a managed care function that was designed for diverse managed care programs. The Managed Care subsystem contains edits to prevent fee-for-service reimbursement when the recipient is enrolled in an MCO, unless the service is defined as a carve-out that is not covered by the specific MCO but covered under a fee-for-service arrangement. In carve-out situations, the system bypasses managed care editing so that providers receive timely reimbursement for these services.

interChange Business Policy Administration (BPA) rules are responsible for the vast majority of claims adjudication, pricing, editing, and auditing decisions. The configurability built into the BPA rules gives the Department the flexibility and scalability to use the interChange MMIS for pre-adjudication transaction processing for multiple programs across the MMIS enterprise. The BPA rules engine specifically defines and processes Assignment Plan Rules which contain the services to carve-out of a capitated managed care plan. For more details regarding the BPA rules engine, refer to RESPONSE 38l.

DRG and Manual Pricing (Unique ID 1554)

interChange has a robust claims pricing system which can interface between other payment systems and maintain accurate dates and times for records of claim payments. User-updateable tables, such as fee schedules, provider-specific rate tables, or client cost-sharing tables—for example, client liability, client spend-down, copayment, and TPL tables drive the claims pricing system.

These tables provide the system with the data necessary for calculating the appropriate claim or detail payment for each service according to rules and limitations applicable to each claim type, category of service, and type of provider to maintain an accurate record of claim payment.

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. These tables are updatable using various resources such as input directly from the user-interface or from other payment systems.

The Colorado interChange MMIS will supports the pricing of claims by many different reimbursement methodologies, including the following:

- Inpatient DRG
- Level-of-care per diem
- Price by PA
- FFS payment schedules
- Crossover pricing
- FQHC
- Rural Health Center (RHC)

Additional information that affects pricing may include modifiers, provider type and specialty, claim type, and client age.

interChange allows for online entry of manual pricing for claims at the detail service line and header level, as appropriate. interChange retains user-entered manual prices and will have a pricing indicator of "MANUAL" when a manual price has been assigned. Using Department-defined pricing policy, the claims team will manually enter an override code, as applicable.

interChange will use Department-configurable criteria within the reimbursement rules to determine the pricing policy for a specific service. The reimbursement rules main purpose is to assign the pricing method for the service. PA requests can be set up with a "price by PA" pricing method which will override the "max fee" on file for that service and pay the amount authorized on the PA request, when paying claims for that client.

Rent-to-Own Pricing (Unique ID 1555)

HP recognizes the need for pricing flexibility to contain costs as much as possible in the current budget conscious environment. HP will work with the Department to set up the specific edit rules in the rules engine that would encompass the following: the client's eligibility (Medicaid versus Medicare for example), the specific services (for example, apnea monitor, CPAP), and the duration. The rate that would be applied would be set up in the pricing rules. For example, for one of our state customers, the MMIS is configured to support the following policy:

- DME is eligible for purchase only in the following circumstances when the client has Medicare and Medicaid:
  - 1) DME is covered for purchase by Medicare.
  - 2) DME is covered by Medicaid but not covered for rental or purchase by Medicare.

- DME is covered for rental, or capped rental by Medicare, will be covered for rental only by Medicaid and only for the duration of the capped rental period. No repair or maintenance will be covered for items procured under Medicare rental or capped rental.
- Outside of Medicare related claims, rental is more specific to the type of DME:
  - Apnea Monitor rental is limited to 6 months then reviewed for medical necessity.
  - CPAP machine rental is covered for 6 months; after 6 months requires PA and considered purchased after 10 months of rental
- The overall guideline is rentable items require PA and are limited to six months rental. Many low cost items may only be purchased. The following information is requested for rental items:
  - Length of need
  - Why rental versus purchase
  - The actual rental amount is established by the program manager

Lower-of Price Methodology (Unique ID 1556)

The Colorado interChange solution has a robust claims pricing system that is driven by user configurable tables, such as fee schedules, provider specific rate tables, or member cost sharing tables—for example, patient liability, member spend down, copayment, and TPL tables. These tables provide the Colorado interChange solution with the data necessary for calculating the appropriate claim or detail payment for each service according to Department rules and limitations applicable to each claim type, category of service, and type of provider.

The process of adding new programs and rates is table driven, allowing the Department to expedite implementation of new programs or rates without experiencing the costs and time delays typically involved with a system development and installation project. The benefit plan functions of the Colorado interChange solution have proven successful for other Medicaid programs, such as Pennsylvania, Oklahoma, Kansas, Florida, Georgia, and Wisconsin.

The Colorado interChange solution's rules management allows trained authorized users to identify, create, refine, and maintain business rules that effectively capture and enforce medical policy. Within the Colorado interChange solution, various business rules govern each claim processed—billing rules from policy and contracts, coverage rules from benefit plans, and reimbursement rules that determine how to price and pay the claim. The disposition of edits associated with business rules determine whether to pay, suspend, or deny claims according to Department policy on how to adjudicate each service.

Some customization will be needed to create the appropriate rules to support this requirement. HP will work with the Department's staff during the DDI to create the appropriate rules to support the lower-of price methodology and to accurately price and adjudicate claims against submitted MSRP or invoice data. Claims can be set to suspend to review against real-time benchmark data to validate the MSRP and invoice submissions.

Health Benefit Plan Edits, Rates and Payment (Unique ID 1557)

The interChange MMIS provides the ability to establish, maintain, and administer multiple benefit plans by defining benefit plan covered services, member populations, reimbursement models, and capitation criteria. The BPA rules support the interChange MMIS' advanced claims processing engine. They offer flexible parameters used to validate and edit claims for service limitations. The interChange MMIS processes claims within the guidelines established in the benefit plan and out-of-scope service criteria maintained in the BPA functional area.

Benefit plan data identifies a group of covered services (benefits) granted to a member deemed eligible for the services the benefit plan represents. Benefit plan configuration includes the following:

- Coverage rules detailing restrictions for services within a benefit plan
- Reimbursement rules for selecting a payment method to reimburse a provider for services provided to an eligible enrollee
- Billing rules classifying services a provider can bill within a contract

For example, we can configure copay and several other variables managed today as a rules-based feature through the online web pages.

Health Benefit Plan Processing (Unique ID 1559)

The interChange MMIS applies system edits and audits to claims and encounters to verify they comply with the Department's Medicaid policies and medical criteria. The edit process validates data elements on the claim or encounter for required presence, format, consistency, reasonability, and allowable values. Examples of edits the interChange MMIS performs include the following:

- Dates edited so that they are valid dates and do not represent future dates
- Service codes edited for validity
- The number of services performed edited against the span of time being billed to confirm that they agree
- Service codes are edited so they are payable in accordance with the Department guidelines and policies (for example, second surgical opinion and PA) as defined in the BPA rules

The system edits claims and encounters against the provider, member, and reference data files as part of the claims processing function. The MMIS edits each claim or encounter as completely as possible during an edit cycle rather than ceasing the process when it encounters a failure so that multiple resubmissions of the claim are not required.

The MMIS performs audits after completing editing and initial pricing. Additionally, the system performs auditing on approved-to-pay details against paid details found on the current claim or encounter, current cycle, or paid claims or encounter history. 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's limitations in dollars, units, or occurrences

Individual and Batch Claim Adjudication (Unique ID 1560)

HP will provide the Department with a highly efficient claims processing system that accepts both electronic claims and encounter transactions in HIPAA mandated formats as well as paper claims. The Colorado interChange will enable providers to submit claims and transactions using the method they find most convenient. To maintain positive relationships with the provider community, detailed, accurate, and timely communication about the outcomes of processed claims is necessary. The Colorado interChange provides immediate, real-time adjudication of every claim type, from interactive responses to claims submitted through the Internet to batch responses provided within minutes of the claim submission.

Providers can submit claims through the Web Portal and receive a real-time response for each individually submitted claim. Claims that are submitted in batch mode are processed throughout the day as they are received.

Pilot Business Rules in a Test Environment (Unique ID 1561)

The base MMIS supports a configurable rules engine where authorized users can define and update criteria as policy changes. HP defines testing environments where users can pilot policy changes and run transactions to see the impact of the change.

The interChange Workflow for code sets provides orchestration of business activities standardizing best practice business rules for defining the covered services and administration under various benefit plans maintained in the Colorado interChange. We will use batch processes to load recommended coverage criteria and benefit package criteria to the test environment for Department review and approval. Department staff members can review the recommended changes, make modifications to the recommended changes, and approve or disapprove the recommendations through the user interface. When approved by the Department, HP will migrate the modifications to the production environment.

Capitation Suppression (Unique ID 1562)

interChange provides the Department with a managed care function that was designed for diverse managed care programs. It is an intuitive system that is separate and distinct from the claims adjudication system, streamlining research and flattening the learning curve. Managed care payments are made based on program-specific negotiated capitation payment rates. As is the case in 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 recipient or provider, recipient age or gender, aid category, rate region, TPL resource code, program status code, Medicare status, or other risk factors.

Retroactive Capitation (Unique ID 1563)

interChange provides rules based processing of capitation. As members are added to the eligibility file retroactively, or eligibility dates are changed to encompass retroactive dates, capitation can be adjusted back to the retroactive date according to the Department's rules and policy. The next monthly capitation payment will include the new dates and amounts for the client. With the configurability of interChange rules, this requirement can be defined and configured into the rules engine during the initial implementation for the Department.

Duplicate Claims (Unique IDs 1564, 1565)

interChange performs audits after completing all editing and initial pricing. Additionally, the system performs audits on details that are approved to pay against paid details that are found on the current claim, current cycle, or paid claims history. The system performs duplicate audits first. (1564) During duplicate auditing, the system reads all of the history that overlaps the dates of service of the current detail. The system performs both the exact duplicate and the suspect duplicate audit for each history detail obtained. While the system uses numerous tables in provider, reference, recipient, and PA for editing, users can customize audits online through a series of easily updateable audit criteria windows. The audit for duplicate can be set to deny or flag, by way of suspension to a certain claim location, for re-pricing.

interChange offers automated duplicate records checking. Authorized users will configure benefit plans using various criteria such as age, place of service, and provider type. The interChange screens present complex sets of rules as a straightforward, easy-to-understand

interface. After establishing the benefit plan and associated coverage rules, authorized users apply additional configuration to change the edits and audits associated with the different rules. (1565) Duplicate audits can be configured to match provider ID or provider type, or any other combination of variables defined as audit variables. This allows for suspension or denial of claims from different providers or different provider types billing separately for a service or defined episode of care.

We will change edits associated with rules for items such as resulting claim status (paid, denied, or suspended), and Explanation of Benefit (EOB) data correction information. Audits cause the

systems to access a member's claim history to determine if a member has reached benefit limitations, received duplicate services, or met other program limitations. After the configuration is accomplished, the edits and audits function systematically unless intervention is required as part of the claim resolution. For example, if the claim is an exact duplicate according to criteria determined by the Department and the stated disposition for that audit is "Deny", interChange automatically denies the claim.

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 member, 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 suspect duplicate audit function performs checks for potential duplicate claims based on member, 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 are also audited against historical files to verify that they conform to established Colorado Medicaid policies, service, and dollar limitations.

Suspend, Deny or Reduce Payment (Unique ID 1566)

The flexibility of interChange enables us to configure edits and audits to suspend or deny claims during adjudication according to the requirements as defined in federal and State rule and law. Additionally, interChange supports payment reductions through the configuration of rules to determine final claim payment based on services billed and the defined rules. As the ACA defines serious reportable events, the Colorado interChange can be configured to apply edits and audits to suspend, deny or reduce payment based on those events being identifiable on a claim.

Mass Adjustments (Unique IDs 1567, 1568, 1569)

Adjustment Processing

The Colorado interChange provides an effective and efficient solution for claims adjustments. During adjustment processing, the system links related transactions so that the latest adjustment can easily be tracked back to the original claim.

Adjustments that interChange processes are accurately reflected in the files that are accessed during the reversal and reprocessing of a claim, including the provider master, the member maintenance, the PA, and the financial tables. The system also clearly reflects adjustment transactions on the provider's 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 adjustment function offers the following:

- 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

interChange processes claim adjustments through the claims processing subsystem. Adjustments may be performed on claims approved for payment or with a paid status even if the paid dollar amount is zero. Paid claims may result in a zero dollar amount being paid because of payment reductions for such factors as TPL and spend-down. Adjustments are performed on the most recent version of the claim voiding the claim and treating the adjustment as a replacement of the original claim/adjustment. The adjustment contains the ICN of the original claim as a link to the claim that is being adjusted.

Both the original (void) and adjustment (replacement) claims are processed in the same cycle and displayed on the same RA. HP's interChange displays the original and adjusted claims on the provider's RA as offsetting transactions. The original claim appears as a debit (negative) transaction and the adjustment appears as a credit (positive) transaction. Any additional payment due or receivable amount resulting from the adjustment is 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.

(1567) interChange 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 accounts receivable for the provider, where the TPL payment is applied. The net payment to the provider is zero. This action is accomplished in a similar manner as internal adjustments and is logged in the claim history.

Mass Adjustment Processing

The Colorado interChange 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. (1567) Mass adjustments include systematically selected claims for re-pricing because of retroactive pricing changes, including capitation rate changes, 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 in the past had taken weeks to complete with the help of a systems engineer can now be completed by select operational staff in a matter of minutes.

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

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(1568) The system displays claims meeting the specified criteria. Variables that can be selected include time period, age, sex, claim type, DRG, diagnosis, ESC (error code), NDC, program, provider ID, client ID, region code, revenue, procedure, modifier, and provider type/specialty. The user has the flexibility to select or deselect any of the claims, release the selected claims for continued adjustment processing, or cancel the adjustment. This capability gives added flexibility in performing mass adjustments. (1569) The mass net verification panel allows claims to be removed from an adjustment for any reason, including zero impact 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 show the original and adjusted claims as offsetting transactions. Each adjusted claim has an adjustment reason code and a description of the reason code.

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 then reprocesses the claims. As with any other adjustment, a link is maintained between the original and adjustment claims. This function also can be used to select claims affected by changes in patient 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 patient liability changes.

The following table lists a representative sample of the pages that support the claims adjustment function.

interChange MMIS Web Pages for Claims Adjustment

Page Name	Description
Adjustment Header	Enables an authorized user to make corrections or adjustments to header claim information
Adjustment Detail	Allows authorized users to 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	Enables users to 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	Enables users to 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 any active or finalized adjustment request within interChange.

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

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

Create and Process System Generated Claims/Encounters (Unique ID 1570)

System-Generated Capitation Claims

The Colorado interChange provides the capability to calculate and generate capitation payments to the Department 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, such as a case management fee.

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. The 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.

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

Special Payment Requests

The Colorado interChange has a fully functioning accounts payable system easily receiving and processing payment requests on a special request basis, at any time during the payment cycle. interChange processes emergency payment requests within one business day of the receipt of the Department's requests as our proven solution does in many of our MMIS states. HP's interChange allows for tracking and payment of specific transactions with detailed remittance requirements, such as claims, positive adjustments, capitation transactions, as well as generic transactions such as lump sum payouts. HP's interChange financial cycles result in the generation of payments to providers for payable balances. HP's interChange also allows entry of non-claim-specific financial transactions received from the Department. The Colorado interChange solution maintains the accounts payable business function for entering and processing several non-claim-specific financial transactions such as emergency provider payments, liens, and recoupments with unparalleled expertise. The following subsections describe an example of non-claim-specific financial transactions processes.

Emergency Provider Payments

interChange will process Department requests for provider payouts (manual checks) with the capability to set a start date for recoupment and a rate of recoupment—for example, total, specified amount per payment cycle, or specified percentage per payment cycle—to recover the paid amount. The system has the capability to advance pay a provider through an expenditure

(payout). When the system generates a payout, an accounts receivable also is set up to recover the advance later. Providers may send cash refunds to clear an open accounts receivable. The cash control number (CCN) and batch number of the returned check link the refund to the original transaction in the system.

File Updates

After completion of the financial processing, interChange updates the claim history and online financial files with the check number, date of payment, and amount paid after the claims payment cycle. After interChange updates claims history and online financial files, the data is fully accessible to authorized users through the interChange web-based user interface. This information also is easily accessible and readily available to providers through the Web Portal.

Recoupments, Refunds, and Withholds

Process Withholds and Recoup Payments

interChange includes a process to withhold or recoup a fixed dollar amount or a percentage of payments for MCOs or providers from current payments. HP's interChange maintains lien and assignment information and uses the information to direct or split payments to the provider or lien holder. We can recoup the money for liens by a percentage of the payment amount or a set payment rate. The flexible design of interChange processes liens against providers at the Department's request, including splitting provider checks where necessary.

interChange has a fully functioning recoupment system that allows authorized users to set up and track a recoupment case using the web-based user interface, and review regularly scheduled reports. An associated interChange panel enables users to log comments about the case. The system's audit trail capabilities track when a user makes a change and the ID of the user who entered the change. HP provides the recoupment process in our many fully certified MMISs, each according to the individual state's business rules, promoting a flexible solution for each state. HP's interChange provides the capability to set up the recoupment to take back all or a portion of the money owed by the provider across a period of weeks. With the Department's approval, we establish the recoupment as a set dollar amount or set percentage amount each week, thus lessening the effect on the provider cash flow yet validating that we have fully recouped the money owed.

Recoupments/Refunds

interChange supports recoupment and refund functions. HP provides a recoveries process in our various Medicaid contracts, each according to the individual state's business rules. HP's interChange accepts claim and nonclaim-specific adjustments, automated adjustments from accounts receivable and TPL case tracking, no-history adjustments, recoupments, mass adjustments, and cash transactions (refunds). HP's interChange also accepts retroactive adjustments to accounts for retroactive changes to patient spend-down, TPL retroactive changes, and retroactive changes to medical coverage codes (groups). The MMIS also accepts program integrity automated adjustments.

interChange allows for manual and automatic recoupment of funds using the Accounts Receivable Information and Maintenance panels, which display and maintain the information for accounts receivables (AR) in the interChange system. Using the Accounts Receivable Setup and Maintenance page, the authorized user enters the parameters for the recoupment, including the effective date. Authorized users also have access to terminate recoupments through the user interface panels. HP's interChange provides reports of open accounts receivables and the ability to obtain search results from accounts receivable panels. The interChange financial business process automatically updates and maintains payment dates and dollar amounts on the provider tables as payments and other financial activities occur—such as recoupments and adjustments—and the totals for these types of transactions are reflected within the current calendar year. HP's interChange tracks and provides accurate and current accounts receivable reporting to the provider and the Department through closure of the outstanding accounts receivables.

interChange allows the adjustment of claims history to reflect a partial recovery of payment because of TPL. During the claim adjustment process, interChange applies the refund amount to the claim and systematically adjusts the original claim 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. We accomplish this action similar to internal adjustments and log the transaction information in the claim history. HP's interChange also enables the Department to track aged recovery inventories and automatically trigger two notices to providers to collect outstanding balances of principles and interest owed based on predefined duration thresholds.

Electronic Reconsideration Process (Unique ID 1571)

Defining and developing a first level appeal process enabling providers to request review and reconsideration of their denied claims is an important feature to the Department. Enabling the electronic processing of reconsiderations will allow providers and the Department to enjoy the efficiencies of a more streamlined process. During the Design and Define Phase, HP will work with the Department to streamline this process through enhancements to the Web Portal and electronic claims processing. We propose to allow submission of reconsideration attachments in the Web Portal. The PWK segment from the 837 transaction can be used to identify the attachment control number. Subsequently we will connect the attachment to the 837 transaction during claims processing using the attachment control number. This development will be completed during Stage II of the Colorado interChange implementation.

Ultimately, when the final EDI standard has been published by CMS, HP will implement the 275 transaction through the defined change management process.

Medicaid/Medicare Dual Eligibles (Unique ID 1575)

HP understands how prompt and appropriate processing and payment of Medicare crossover claims from Medicare intermediaries reduces not only the Department's costs, but also provider administrative costs. Providing prompt and accurate payment also supports excellent customer service. The key to achieving maximum efficiencies and cost savings in this area is the flexibility

of the interChange system as well as developing and maintaining strong and positive relationships among critical parties.

Maintaining these relationships and quickly developing relationships with new carriers is integral to the success of Medicare crossover claim processing. HP has relationships with the largest Medicare Part A and B 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.

interChange provides the same flexibility in processing Medicare claims as it does for all claim types. HP's interChange supports the paper and electronic claims submission of the Department-required claim forms, including Medicare crossover claims. HP's interChange also accommodates the Department's pricing methodologies related to Medicare crossover claims. The interChange system has the same configurable rules engine with edits, audits and pricing rules applicable to Medicare processing as for all other claims. Additionally, we apply the same exceptional adjudication, reporting, online access and adjustment processing to Medicare crossover claim processing as for other claim types.

Part C (Medicare Advantage) plans allow clients to choose to receive all of their healthcare services through a provider organization. These plans assist in lowering costs of medical services, and as such are an important part of the program. The interChange system's flexibility to configure edits, audits and pricing through the rules engine enable it to be compliant with CMS and State requirements relative to Medicare Part C encounters.

National Standard Adjustment Reason and Remark Codes (Unique ID 1576)

interChange is HIPAA-compliant and supports the inclusion of other payer information on claims/encounters submitted, deducting prior payments during the pricing of claims received from third parties. The MMIS interprets national standard adjustment reason codes and remark codes and will process claims based on these standard codes according to the rules defined in the interChange rules engine. For example, a CARC code of 29, the time limit for filing has expired, received on a RA from the primary insurance company, could result in denial of the claim in interChange. Additionally, other payer information received is stored with the claim for historical purposes.

View Pricing Methodology (Unique ID 1577)

The Colorado interChange will price claims according to various methodologies to accommodate Colorado's unique member populations and pricing policies. Additionally, the system will easily support the Department's current pricing methodologies and the implementation of future pricing methodologies with minimal system changes and impacts. The Colorado interChange will process claims as directed by the Department. The proposed system will maintain the pricing method selected for a claim header or detail during processing, which will be viewable on the user interface when viewing a claim. Along with the pricing method, interChange displays the

applicable rate type and reimbursement rule used in pricing. The reimbursement rule defines any benefit adjustment factors used in pricing the claim.

Co-Pays by Health Benefit Plan (Unique ID 1578)

HP exceeds this requirement through the extensive copay rule type within the BPA rules management function. Authorized users define the criteria to be used to calculate the copay amount by selecting the variables to include in the rule from the available options. These variables include member benefit plan, patient location, provider contract, diagnosis code – header or detail, primary or secondary, dates of service, place of service, claim type, and modifier.

Authorized users can create a copay limit group through the BPA maintenance feature. As seen in the following figure, the user can specify the amount of the limit, the time period, the allowed amount, and the effective and end dates.

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Besides defining a copay limit group, authorized users can define a copay method as seen in the following figure. The copay method establishes a copay amount and can be based on the minimum and maximum allowed amount enabling a higher copay for the higher reimbursed services.

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After a copay limit group and copay methods are established, they are available for use as a variable in defining the copay rule in BPA.

Co-Pay Maximums (Unique ID 1579)

As noted in our response to Unique ID 1578, the interChange MMIS provides the ability to establish copay limit groups and copay methods. The copay limit group defines the copay limit amount, the time period, and the effective and end dates. The time period is selected from the list of available options which include per calendar month – same billing provider or regardless of billing provider, per calendar year—same billing provider or regardless of billing provider, per enrollment year, per dates of service—same billing provider, or current claim. The copay method table enables users to define the copay rate amount which can be based on minimum and maximum allowed amounts.

The copay rule can then use either or both of the copay limit group and the copay method as criteria. Additionally, the member benefit plan also is available to use in the copay rule definition. The member benefit plan given to a member is based on the medical status (aid category) code of the member as established in the medical status/benefit plan cross-reference table. The medical status (aid category) code indicates the percent of federal poverty level of the member.

Pricing Irrespective of Media Type (Unique ID 1580)

Payment rates are at the core of MMIS claims processing. The HP interChange benefit policy administration function will accommodate the complexities and size of the Colorado Medicaid Program. HP's interChange is a multipayer benefit plan solution that is table-driven, allowing the Department the flexibility to configure many different payment methodologies, irrespective of submission media type. Whether a claim is submitted using EDI, paper or the Web Portal, the base system has the capability to price claims without regard to media type and also can apply incentives based on media type if required.

The table-driven process of adding new programs and rates will allow the Department to expedite implementation of new programs or rates without experiencing the costs and time delays typically involved with a system development and installation project. The benefit plan functions of interChange have proven successful for many state Medicaid programs, including Pennsylvania, Oklahoma, Kansas, Florida, Georgia, and Wisconsin.

Colorado interChange rules management will allow trained, authorized users to identify, create, refine, and maintain business rules that effectively capture and enforce medical policy. Within Colorado interChange, various business rules will govern each claim processed—billing rules from policy and contracts, coverage rules from benefit plans, and reimbursement rules that will determine how to price and pay the claim. The disposition of edits associated with business rules will determine whether to pay, suspend, or deny claims according to the Department's policy regarding adjudication of each service.

The Colorado interChange will have a robust claims pricing system driven by user-updateable tables, such as fee schedules, provider-specific rate tables, or member cost-sharing tables—for example, member liability, member spend-down, 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 Department rules and limitations applicable to each claim type, category of service, and type of provider.

Date Spans (Unique ID 1581)

Information stored in the MMIS is date segmented to control when certain policy, rates, and coverage apply. Active date span along with inactive date is used to support maintaining historical data necessary for auditing and proper historical claims adjudication. Active and inactive date spans are present on rate segments and use effective and end dates on updateable segments.

Manage Current and Historical Reference Data (Unique ID 1582)

The interChange reference subsystem maintains the reference data with effective and end dates. Current as well as inactive segments are maintained for historical purposes. The reference segment effective and end dates coincide with the dates of service submitted on a claim. During claims processing, the claims engine will match the claim's date of service with the effective and end date for a procedure, revenue, diagnoses, and other codes. When the system encounters inactive reference data, the claims engine bypasses that entry and processes claims from the corresponding active entry.

The reference subsystem displays data through the user interface panels to allow users to view the current and historical information. All additions, deletions and updates made to the reference data are tracked through an audit trail. The audit trail provides the date of the transaction, the previous information if applicable and identifies the specific user or system entering the record as seen in the following figure that shows the restrictions related to an office visit procedure code including effective and end dates.

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Non-covered Services (Unique ID 1584)

The Colorado interChange handles noncovered services through a prior authorization workflow process. The system supports requiring a prior authorization for certain services, such as noncovered EPSDT services, and denying the claim if the service is not prior authorized.

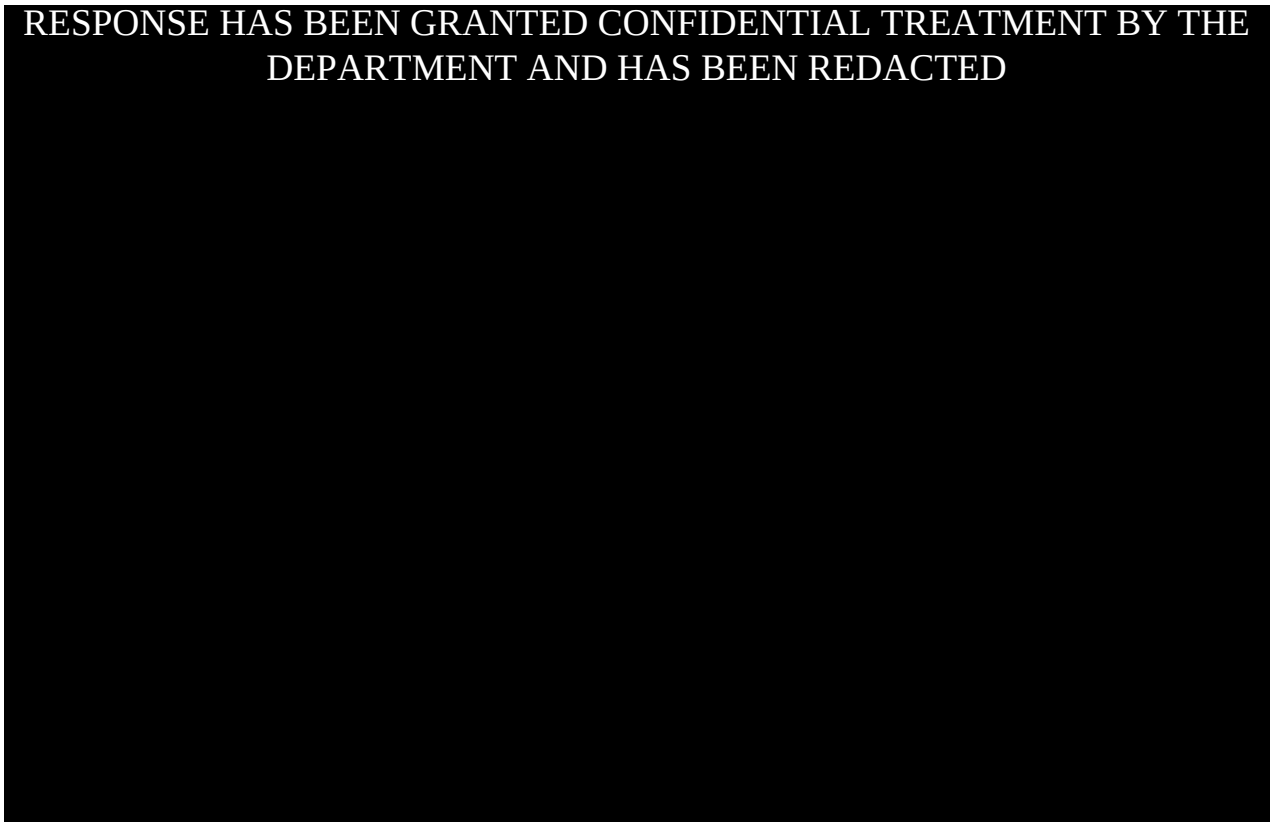
Another option is to have the noncovered services submitted on paper claims for special handling. When received, the claim would be scanned using a special batch which assigns a specific ICN

region. When these claims pass through the claims engine, they would bypass normal editing as approved by the Department rather than an outright denial. The Department could customize the outcome and handle edits differently than would apply for other claim regions.

Define Waivers as Health Benefit Plans (Unique ID 1585)

Benefit plans are customizable to take advantage of different coverage criteria for unique populations. Each waiver program is assigned a benefit plan which easily identifies the program. The unique benefit plans allow flexibility in covered age, provider restrictions and rates. Separate benefit plans also provide the State a mechanism for reporting each waiver to CMS.

The benefit plan configuration capability of the MMIS supports authorized users defining custom benefit plans that can be updated and maintained through the user interface as seen in the following figure that shows the restrictions related to an office visit procedure code including effective and end dates.



Co-insurance, Co-pay, and Deductibles from Third Parties (Unique ID 1586)

Medicaid reimbursement systems continue to evolve and are becoming increasingly complex. This complexity is driven by continued pursuit of Medicaid payment systems that better match program rates (payments) to member care needs and services delivered. Complexity also is driven by increased federal requirements placed on Medicaid programs.

The Colorado interChange MMIS will have a robust claims pricing system driven by user-updateable tables, such as fee schedules, provider-specific rate tables, or member cost-sharing

tables—for example, member liability, member spend-down, copayment, and TPL tables. These tables provide the interChange system with the data necessary for calculating the appropriate claim or detail payment for each service according to Department 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.

The Colorado interChange system will support the pricing of claims by many different reimbursement methodologies, including the following:

- Inpatient DRG
- Level-of-care per diem
- FFS payment schedules
- Crossover pricing
- Pharmacy formulary pricing
- FQHC and RHC

Additional information that affects pricing may include modifiers, provider type and specialty, claim type, and member age. The Department will benefit from the flexibility interChange offers in applying these differing payment methodologies, including using co-insurance, copay and deductibles during claim processing to appropriately adjudicate claims from third parties at both the detail and header level.

Outpatient Hospital Prospective Payments (Unique ID 1587)

The Colorado interChange system will provide a system that will support multiple programs and plans including the addition of any other State agency, U.S. territory, or political subdivision. Payment rates are at the core of MMIS claims processing and the HP interChange system is continually evolving to meet the demands of a dynamic industry. The Wisconsin base system is currently being modified to support prospective payments for outpatient hospital claims with Enhanced Ambulatory Patient Groupings (EAPC). This enhancement is planned to be in place in the interChange base system to coincide with the Colorado Stage II Core MMIS and Supporting Services Implementation. During the implementation phase, HP will work with the Department to identify required modifications to the base functional capability to meet the specific needs of the Colorado interChange, including EAPGs and other ambulatory care settings.

The process of adding new programs, pricing methodologies and rates is table-driven in the interChange system, allowing expeditious implementation of new programs or rates without experiencing the costs and time delays typically involved with a system development and installation project. The benefit plan functions of interChange have proven successful for several Medicaid programs, including Pennsylvania, Oklahoma, Kansas, Florida, Georgia, and Wisconsin. The Department will benefit from HP' staff expertise, sound implementation practices, and the flexible interChange system to address specific Colorado interChange requirements.

In the base Colorado interChange system, outpatient hospital claims are identified by reviewing the billing provider type and specialty. Covered benefit segments for the specific provider type and specialty are set up with a unique rate type and adjustment factor for outpatient hospitals. The adjustment factor is based on state policy and is maintained through the base windows for quick updates. When claims go through the pricing logic for the outpatient rate type, the claims engine calculates the price listed on max fee for the base reimbursement rate times the percentage listed on the adjustment factor for the specific provider type and provider specialty.

Prioritize Processing (Unique ID 1588)

Transaction types are scheduled through the Schedule Maintenance panel in interChange. Before finalizing the financial cycle for payment, the Department can request a delay or hold based on specific criteria, such as submitter type, even as detailed as specific providers. The Schedule Hold panel allows an authorized user to suspend the selected schedule maintenance record for the time period specified.

Currently, the base MMIS processes batch files as they are received in queue. Because of processing occurring so quickly, usually within minutes, transaction prioritization by submitter and transaction type is not needed. Delays and changes can be orchestrated after the transactions are processed but before the financial cycle.

The claims business function of the interChange base system performs rigorous claims editing and auditing, based on program defined policy and rules, to determine whether claims should be paid, suspended, or denied. We will optimize the Colorado interChange edit and audit process for automated claims processing. While the system uses numerous tables in provider, reference, member, and PA for editing, users can customize audits online through a series of easily updateable audit criteria pages. The Colorado interChange MMIS will contain the edits typically used by our Medicaid customers. HP will work with the Department to propose and define required new editing or auditing criteria to include Colorado-specific criteria for adjudication of claims. Having worked with more than 20 state Medicaid programs, we are confident we will meet the Department's business needs.

We also will work with the Department to verify the Colorado interChange is configured to incorporate the Department's existing edits and audits to include special adjudication rules or policies. This edit criterion will allow authorized users—with the Department's approval—to set criteria allowing claims to bypass the enhanced claims editing component based on various factors including the following:

- Dollar thresholds
- Member or provider-specific criteria
- Medical coding
- Other criteria as defined by the Department during DDI

The Colorado interChange will have the capability to allow for processing of special claims through manual entry to include items such as late billing, member retro-eligibility, adjustments,

mass adjustments, and edit overrides in accordance with Department instructions and for situations the Department defines.

Additionally, the interChange base financial system includes the ability to apply payment holds based on several criteria. During the Implementation phase of the COMMIT project, we will work with the Department to define other requirements relative to delaying transaction processing, based on the Department's criteria and business needs.

Limit Service Payments Based on PARs, Health Benefit Plan, Client Service Plan (Unique ID 1589)

We will maintain the Client Service Plan authorized services as PA records. Each item on the PA record allows the user to specify the approved rate per unit and the number of approved units. interChange will then compare claims submitted for the approved services against the PA to verify the approved unit rate is not exceeded.

interChange applies PA edits to claims as part of the adjudication process. If there is a PA with authorized units available for the services being billed, the claim will pay using the pricing schedule present on the PA. This will immediately deduct the amount of used units, dollars, or percentages remaining from the PA, updating PA information for use by the next claim if necessary. If the services being billed require prior authorization and no PA is available for the claim, or insufficient units or dollars remain on the PA record, an edit is set on the claim. Depending on the Department-configurable claims disposition, the claim can then be routed for further review or systematically denied.

During claims auditing, when limits are reached, the audit can be set up to allow additional units if previously authorized. This will enable the Department to allow additional services when a PA has deemed it appropriate.

interChange updates the PA records based on adjudicated claims. The system decrements the number of units and dollars used during the claims processing cycle limiting payment for services to those authorized within the Client Service Plan. The PA History panel reflects the number of units and dollars remaining. The PA History panel also includes a claims history button that the user can click to view claims related to the selected PA as seen in the following figure.

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The Claims List panel displays the ICN of each claim applied to the PA, the number of units, and amount used by the claim. interChange also automatically updates the PA record with the information from processed claim adjustments. For voids or adjustments, units or dollars are added back to the PA file, as necessary, to make certain that authorized units become available again.

Automate Health Insurance Buy-In (HIBI) (Unique ID 1590)

interChange has an automated process to identify information received from CMS that does not match with client information in the MMIS. This window is called the mismatch window. What is considered a non-match is when there is no Medicare in the MMIS for the client or the client's name does not match with what is in the MMIS. The buy-in coordinator is responsible for researching the information received from CMS, and correcting any discrepancy. There also is a buy-in error report that is created based on the transaction codes received from CMS. The transactions show when a client's name does not match with CMS records, another state Medicaid program reports as an existing buy-in, or the client is deceased and CMS changed the effective date of our record.

HP, as the fiscal agent, handles duplicate records and conflicting data from CMS through a manual process. CMS sends a monthly billing statement to the fiscal agent, to the attention of the buy-in coordinator, who then matches the number of accretions/deletions received by CMS to the number sent by the fiscal agent. Any discrepancies found result in the buy-in coordinator contacting CMS for resolution. Multiple requests may be sent to CMS before any action is taken by CMS and the issue is resolved.

Categorize and Separate Claims and Encounters (Unique ID 1591)

In the base interChange system, claims and encounters are processed through the same business rules using the same reference data. However, they reside in separate databases and are easily distinguished by the different Internal Control Number (ICN) ranges used for each. The first two digits of the ICN, or the region code, enable the interChange system to differentiate between

claims and encounters during processing. For example, in the HP interChange system developed for the State of Kansas, claims start with a 10, 11, 20 or 21 while encounters start with a 70 or 77.

Store and Identify Claims, Capitations and Encounters Separately (Unique ID 1592)

In the base interChange system, claims and encounters reside in separate databases and are easily distinguished by the different Internal Control Number (ICN) ranges used for each. The first two digits of the ICN, called the Region code, enable the interChange system to differentiate between claims and encounters during processing. Capitation transactions are maintained in the Managed Care subsystem and are entirely separate from claims and encounters.

Track Claims/Encounters Reviewed by Contractors (Unique ID 1594)

Multiple audits may be conducted simultaneously by different contractors such as OIG, RAC and CMS. The HP approach allows a specific claim to only be selected for review by one entity. To keep a claim from being audited by more than one entity the individual claim is locked and may not be adjusted or resubmitted without being unlocked. Locking a claim also prevents the provider from adjusting the claim while the audit is being conducted.

A report identifies claims which are currently locked and provides an indicator to show the contractor who originally locked the claim. A search may be conducted using the Lockdown maintenance window on a specific provider or control numbers to identify locked claims. The claims window identifies when a claim has been locked by populating the lock indicator.

Claims identified for inclusion in an audit are locked in one of three avenues:

- Systematically locked
- Individual claim level
- Spreadsheet by user

Systematically locked

The contractor submits a file with the internal control numbers they have chosen for their audit. The file is systematically loaded in the MMIS and locks the claims using a specific lock indicator assigned to the contractor submitting the file. A check is conducted before locking the claims on the file to see if the claims have already been locked for review by another entity. An error report identifies claims which are currently locked and provides an indicator to show the contractor who originally locked the claim.

Individual Claim Level

When there are minimal claims included in an audit, the claims are locked by the individual user at the time the claim is selected for review. The user places a lock indicator on the individual claim specific to their contract. If the claim has already been locked by another entity, the user receives a message indicating the claim is already locked.

Spreadsheet by User

The user may input claims from a spreadsheet to be locked. The user identifies the lock indicator to be used which identifies the contractor performing the review. If one of the claims contained in the spreadsheet is locked, the system responds to the user indicating the lock request was not successful and the spreadsheet contains claims previously locked. The user has to identify which claim(s) are locked and remove them from the spreadsheet before attempting to lock the remaining claims.

Use Provider Credentialing Information in Claims and Encounters Adjudication or Pricing (Unique ID 1595)

interChange performs monitoring of certification requirements in the provider subsystem. Provider contracts are end dated when requirements (for example, licensing, credentialing) are no longer met.

The interChange claim system performs edits on claims and encounters during processing based on defined rules. Provider is one of the major verification areas of the claim editing process. HP's interChange verifies the provider's eligibility to perform the service billed on the claim or encounter against the data on the provider file. Edits are set up to specifically check claim service dates against the provider file to make sure that the provider was enrolled and eligible to provide Medicaid services on the service date submitted.

Batch Processes (Unique ID 1596)

In the interChange base system, the encounter original submissions, replacements, and voids are made through batch 837 submissions. Our experience shows that MCOs do not make use of online processing of encounter corrections, replacements, and voids because such a process does not align well with their standard business model.

Apply Managed Care Benefits Used to FFS Benefit Limits (Unique ID 1598)

The interChange claims business function performs rigorous claims editing and auditing that will be based on the Department's policy and rules, to determine whether claims should be paid, suspended, or denied. We will optimize the Colorado interChange edit and audit processes for automated first-pass claims processing. This will include business intelligence for multiple same-day surgeries, duplicate, and suspect duplicate checking, depending on the Department's specific criteria and requirements. For example, 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, member, and PA for editing, users can customize audits online through a series of easily updateable audit criteria pages.

In the current base system, claims auditing does not use encounter history for claim adjudication; however, interChange maintains encounter history, so it is possible. At least one of our fiscal agent states does use encounter history for claims adjudication, for instance, in duplicate auditing and lifetime service limits. During the implementation phase of the project, HP will work with

the Department to define requirements to load encounter history for auditing purposes. This approach will allow the Colorado interChange system to capture benefits used in the managed care plan and then audit the benefits used when a client returns to the FFS program.

COFRS Interface (Unique IDs 1600, 1627)

(1600) HP will accept data supplied by COFRS interface using interChange Connections ESB platform, and store required linking fields within the Financial Data Store. The linking details will be available through the interChange application as demonstrated in the following screen capture figure.

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The COFRS data exchange interface will be further defined during the Design and Define Phase.

(1627) The interChange system provides a fully functioning financial system that provides detailed reporting and appropriate audit trails to enable immediate identification of payment balancing issues between the State financial reporting system (COFRS) and the interChange payment file. The Financial Operations team will use the interChange financial reports and information displayed in the interChange user interface to balance information between the two systems, research discrepancies and resolve the discrepancies. The Financial Operations team will work with the State to resolve payment balancing issues within 3 business days. Unique ID 1605 describes in detail the reconciliation processes HP will use to identify payment balancing issues.

Additionally, during the implementation phase of the project, HP will work with the Department to define the payment interface between interChange and COFRS. HP has experience working with other states to interface with state financial and accounting systems and understands the areas within interChange that will require modifications to allow data exchange with COFRS.

Distinguish Claims/Encounter and Capitations by Funding Streams (Unique ID 1601)

The base interChange system assigns fund codes to track funding sources from which services will be paid. During the implementation phase, HP will work with the Department to configure the specific fund codes for the Colorado interChange system to support Colorado-specific requirements. Depending on the parameters chosen, distinct fund codes will be assigned to claims, encounters and capitations.

Each state accounting system is unique. One of interChange's strengths is its Financial subsystem which provides a solid backbone from which to support accounting and financial functions. Existing capabilities for the base interface systems includes the following:

- Fund code definition and configuration
- Definition of elements used to assign fund codes
- Configuration of fund code assignment
- Definition of state-specific accounting codes
- Configuration of state-specific accounting codes
- Configuration of percentages by fiscal year
- Configuration of federal category of service (COS) codes and percentages
- Interface changes

Reasonable and Customary Charge Information (Unique ID 1602)

The Colorado interChange contains a robust claims pricing system driven by user-updateable tables, such as fee schedules, provider-specific rate tables, peer group rates and standard rates for services billed. Standard rates are broken down by rate type allowing configurable flexibility in rate assignment and use in pricing claims. Usual and customary rates as supplied by the Department will be maintained using the user interface by authorized users.

These tables provide the interChange system with the data necessary for calculating the appropriate claim or detail payment for each service according to the Department's rules and limitations applicable to each claim type, category of service, and type of provider.

The Colorado interChange will support the pricing of claims by many different reimbursement methodologies, including the following:

- Inpatient DRG
- Level-of-care per diem
- FFS payment schedules
- Reasonable and customary charges
- Pharmacy formulary pricing
- Crossover pricing
- FQHC and RHC

Additional information that affects pricing may include modifiers, provider type and specialty, claim type, and member age. The Department will benefit from the flexibility interChange offers in applying these differing payment methodologies. Medicaid reimbursement systems continue to evolve and are becoming increasingly complex. This complexity is driven by continued pursuit of Medicaid payment systems that better match program rates (payments) to member care needs and services delivered. Complexity also is driven by increased federal requirements placed on Medicaid programs.

Electronic Appeals (Unique ID 1843)

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. 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.

The appeals submission process uses a proprietary file layout. There are two types of appeals: nonclaim related (that is, pre-authorization or appeal on behalf of member) and claims related (that is, dental, institutional, or professional claim).

Nonclaim related appeals are initiated from the portal menu using the pre-appeal assessment capability. There are multiple steps in the appeals process. The user enters member information and that information is validated by the payer system. The provider information is pre-populated 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 appeals can initiate from the portal menu using the pre-appeal assessment (if the user answers that they want to appeal a claim) claims 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 pre-populated in 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 member 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. The appeal must be associated with at least one service line on the claim.

Trading Partner Management (Unique ID 1603)

Working with external trading partners is an important part of providing a good experience for providers and keeping the system running smoothly. The Healthcare Portal solution allows the billing providers to register their trading partner as part of the provider enrollment process. The

Trading Partner Management function of interChange Connections will store the trading partner contact information and the HIPAA transactions the partner can send and receive. This verifies that interChange Connections can properly receive and track information from registered trading partners. It also facilitates ongoing communication and testing with trading partners as transactions are added or modified to meet the changing needs of Colorado Medicaid.

Manage AP/AR Transactions (Unique ID 1605)

The Colorado interChange includes an enhanced financial management business system providing an IT solution supporting the Department's business requirements. Our proposed Colorado interChange solution includes a flexible financial management business system meeting the changing needs of Colorado's dynamic Medicaid program, as well as the changing and demanding needs of CMS 7SC including MITA. The Colorado interChange, our proven HP solution, along with our experienced Financial Operations team, provides a Medicaid financial management program unmatched by any competitor and prepares the Department for current—and future—Medicaid needs.

The Colorado interChange solution is a full function set of tools that supports the various standards required for the State's MMIS environment. Our Colorado interchange solution is compliant with Generally Accepted Accounting Principles (GAAP) as promulgated by the Government Accounting Standards Board (GASB), federal and State rules, and regulations, and provides the internal controls necessary for continued Sarbanes Oxley compliance. Our integrated solution provides the flexibility to track and report Colorado Medicaid Program transactions across the multitude of formats and structures needed to effectively manage and report the financial operations of every health program administered by the State.

The fully integrated Colorado interChange links transaction detail—such as claims, adjustments, payments, receivables, cash receipts, recoupments, and voids—to related records and the various levels of detailed reporting the State requires. The MMIS is flexible with the requisite internal controls to enable accurate financial reporting on actual performance and an integrated module for forecasting of budgeted expenditures.

The level of reporting detail available is enhanced by implementing various specific assignments of data categories to each transaction processed by the MMIS:

- **Program alignment**—We identify each financial transaction detail to a specific program, grant, waiver, or State program as needed to meet the internal reporting objectives of the State agencies.
- **State Category of Service (SCOS)**—We tag each transaction with the appropriate level of SCOS for use in proper reporting to CMS.
- **Fiscal string**—We stamp each transaction with a fiscal string. We base each fiscal string on the agency, project, fund, and other data needed to record the detailed transactions in state systems accurately.

The following are several proposed features our solution provides as part of an encompassing system support to the finance environment for the State:

- Maintains provider accounts receivable (AR) and deducts appropriate amounts from payments due the provider
- Generates electronic and hard copy media remittance advices (RAs) for providers
- Maintains sufficient controls to track each financial transaction, balance batches, and maintain appropriate audit trails on the claims history file
- Maintains an interface to the Colorado Financial Reporting System (COFRS) to transmit financial data
- Tracks financial transactions by source, including fraud and abuse recoveries and provider payments

The Colorado interChange has a fully functioning accounts payable system easily receiving and processing payment requests on a special request basis, at any time during the payment cycle. The Colorado interChange allows for tracking and payment of specific transactions with detailed remittance requirements, such as claims, positive adjustments, capitation transactions, and generic transactions such as lump sum payouts. The MMIS financial cycles results in the generation of payments to providers for payable balances. The Colorado interChange also will allow entry of nonclaim–specific financial transactions received from the State. Additionally, we maintain the accounts payable business function for entering and processing several nonclaim–specific financial transactions such as emergency provider payments, liens, and recoupments with unparalleled expertise. We continue to maintain a comprehensive operating procedure manual to promote standardized processes.

The Colorado interChange solution meets the accounting function requirements through the financial component, which delivers the following MMIS reporting capabilities:

- Access to MMIS financial data, including payments made, overpayment tracking, and program data for programs
- Reporting of key performance indicators (KPI)
- Operational reporting including online, parameter-driven, flexible reports throughout the financial transaction reporting process

The solution supports the established and future reconciliation processes by enabling research and resolution of data discrepancies. As with balancing a checkbook, the Financial Operations team uses experienced staff members and various financial reports to account for issued items and validate balances after every payment cycle. We perform daily, weekly, and monthly balancing processes to improve the data integrity across the Medicaid enterprise. The Colorado interChange balances the weekly financial cycle by comparing payments due with payments issued to providers to verify accuracy. At the end of each month, we perform a complete

reconciliation of incoming and outgoing transactions. This reconciliation includes detailed accounting for payments issued to providers, deposits from providers, manual checks issued, and reissued checks. Reconciliation accounts for monies with a zero dollar discrepancy. HP thoroughly documents reconciliation so the State and HP Finance are fully prepared for audits.

The Colorado interChange solution provides extensive online audit trail capability. During the financial processing cycles, the MMIS establishes an audit trail to reflect:

- Transaction flow through the process
- Codes and tags set
- Adjustments or corrections
- Dates changes were made

If data is changed, this audit trail also shows the originally entered data and the data that was changed. From the time a transaction enters the financial processing system, the Colorado interChange tracks it as it moves through final resolution.

Besides working with the Department, we will regularly interact with CMS, providers, and other Medicaid vendors. This includes the following responsibilities:

- Adherence to GAAP
- Appropriate disbursement of funds
- Accurate and timely provider payments, remittance advices, and financial reporting
- Processing nonclaim–specific financial transactions
- Expedited collection of money because of the state

Track and Pay Clients for HIBI and Medicare Buy-In (Unique ID 1611)

HP's extensive experience with other states demonstrates that the Colorado interChange can capture and display all cash collections, post payment recoveries, cost avoidance data, Medicare Buy-In and HIBI in order to provide the data needed for reporting and increased cost avoidance. HP's operational processes and interChange system enable the fiscal agent to work seamlessly with the Recovery Audit Contractor to maximize cost avoidance.

Buy-in payments to clients are coordinated in the interChange system between the Buy-in and Financial subsystems. The interChange Buy-in subsystem contains the rules for calculating and triggering the Buy-in payments to clients. The Financial subsystem will then process and track payments made as determined by the Buy-in rules.

Currently the MMIS has three panels that monitor the Medicare buy-in premiums. First is the Buy-in Coverage panel which shows the monthly premiums for both A and B, and the accumulated premium total paid so far for the client. The next two separate panels are the Buy-in Actions from CMS for A and B. These two panels show the monthly premium along with the transaction code received from CMS. The transaction code allows the system to know if this is a new buy-in person, an ongoing buy-in person, an adjustment to a previous record, or if the buy-in has termed. This panel also shows debit or credit transactions and allows the user to double

click on each transaction code to give the description of the transaction code received. Any type of discrepancy found is researched by the fiscal agent.

Allow Providers to Report Client Payments (Unique ID 1612)

The base interChange EDI system, Connections, uses the 837 transaction standard for all claim submissions. The system can map and capture all data submitted in compliance with X12 requirements for 837 transactions, including client payments such as PETI, copay, co-insurance, and deductibles.

After captured on the claim, the claims engine will use client payment information during processing to appropriately price the claim according to the defined business rules. After the claim has been adjudicated and finalized, the financial Remittance Advice or electronic 835 will display client payments as required.

Distinguish Between Medicaid and Non-Medicaid Reimbursement (Unique ID 1615)

The base interChange system assigns fund codes to track funding sources from which services will be paid. Fund codes will be used to provide the ability to distinguish between Medicaid and non-Medicaid programs (for example, CHP+ and State only programs) claims/encounters and reimbursement. During the implementation phase, HP will work with the Department to configure the specific fund codes for the Colorado interChange system to support Colorado-specific requirements. Depending on the parameters chosen, distinct fund codes will be assigned to claims, encounters and capitations.

Additional information regarding fund codes and processes are also contained in our response to User ID 1601.

Apply FFP Rate to Claims/Encounters and Capitations (Unique ID 1616)

After the claim/encounter has processed to finalization, the interChange financial subsystem will assign the FFP rates during the financial payment cycle. The rate is determined based on the fund code assigned to the claim/encounter or capitation in conjunction with the claim paid date. The FFP is populated at either the detail line or header, depending on payment methodology. The FFP rates are then used to identify the correct funding and report the payment data accordingly.

Funding Source (Unique ID 1617)

The Colorado interChange solution is compliant with Generally Accepted Accounting Principles (GAAP) as promulgated by the Government Accounting Standards Board (GASB), federal and State rules, and regulations, and provides the internal controls necessary for continued Sarbanes Oxley compliance. Our integrated solution provides the flexibility to track and report Colorado Medicaid Program transactions across the multitude of formats and structures needed to effectively manage and report the financial operations of every health program administered by the State. The core interChange system will use assigned fund codes to report and track expenditures by funding source.

The Payment and Expenditures panel, as seen in the following figure, allows users to view funding.

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

The funding amounts are based on the fund code and the actual payment and service dates. Funding amounts are tracked to the appropriate fiscal year based on the dates associated with the expenditure. Reassignments of expenditures occur through transaction reprocessing such as adjustments, depending on transaction criteria and defined fund code rules.

Federal Match Rate Reporting (Unique ID 1618)

The Colorado interChange financial subsystem will assign the FFP rates to recoveries and offsets during the financial payment cycle. The rate is determined based on the fund code assigned. The fund code is assigned and reported based on the original payment date, rather than the rate associated with the date of recovery or offset. The FFP rate is populated at either the detail line or header, depending on payment methodology. The FFP rates are then used to identify the correct funding and report the payment data accordingly.

Return to Provider (Unique ID 1619)

Please see RESPONSE 40l for a full discussion of mailroom processes, including managing paper claims. Claims that do not meet the minimum data requirements are routed and returned to

the provider (RTP). Before mailing the RTPs, a cover letter is added to identify the missing or incorrect data, giving providers the information they need to correct and resubmit their claim.

Electronic Appeals (Unique ID 1843)

The robust functional capability of the HP Provider Portal allows users to conduct appeal functions online. The Provider Portal will allow users to file and track appeals. This includes the following:

- **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 state 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.

For a detailed discussion on these processes and tools, see RESPONSE 40d.

Accounts Receivable (Unique IDs 1620, 1621)

The Financial subsystem of the Colorado interChange will have a robust Accounts Receivable (AR) solution.

Payable funds made in a scheduled payment cycle are subject to recoupment to satisfy an AR unless otherwise restricted using the interChange panels. The Department will define the length of time before an AR transaction is considered delinquent. These AR are then reported weekly and the AR analysts use system-generated letters to attempt collections and escalate as defined by the Department should the providers not respond. (1620) The notification letters can be sent by paper, email, or posted to the provider through the secure portal.

The extensive supporting interChange reports and State budget monitoring reports will generate from each financial cycle and monthly to support quarterly federal reporting and State fiscal planning on the weekly, monthly, and State fiscal year-to-date basis. The BIDM vendor can export for report production and predictive modeling the interChange Voucher Detail that is produced from each financial cycle, its supporting partner the interChange Monthly Budget Monitoring report, and the strength of the MARS subsystem data tables used to produce the actual federal reports.

(1621) The base interChange being proposed for Colorado includes AR functions described, including the following:

- Identify delinquent accounts both individually and in mass, with the proper authority based on a user-defined accounts receivable threshold
- After delinquent accounts have been identified, generate a report
- Allow future claims or encounters to hit against any AR uncollectible accounts
- Differentiate between federal and State funding for any written-off accounts to make sure any recovered money is appropriately allocated
- Perform accounting functions on individual providers, including a full query history of open and uncollectible AR
- Correct AP/AR and payment information with the proper authority
- Allow for claim-specific AP/AR at both header and detail levels

Access (Unique ID 1623)

The Provider Portal allows providers to search for payments meeting their specified criteria. Possible search criteria include, payment method payment type, Electronic Funds Transfer (EFT) payment ID, check number, claim ID, remittance ID and the issue date for a settlement or payment. Only the payments for the logged in user are included in the search results. When a provider uses claim ID as a search criteria, the most recent payment that includes that claim will be the one displayed. Both providers and their delegates have access to the payment history search capability.

When the payer system returns the list of payments, the list includes both check and electronic payments that meet the search criteria. Additionally, although neither a check nor an electronic payment is made, financial activity that results in a net zero payment to a provider also is included in the results. Because this capability is presenting payment information electronically, it must be data-content compliant with the Health Insurance Portability and Accountability Act (HIPAA) 835 transaction regulation. Only data that exists on the 835 can be displayed.

From the search results, providers and delegates can select a specific payment to view the details of that payment. The details will include the claims for which payment was made, accounts receivable activity, cash receipt activity, and capitation payments. Additional detail filters can be applied to narrow viewing to a specific member, claim, or service date range.

From the search results, providers also can chose to view a PDF version of the associated RA for this payment.

For a more complete discussion, please see RESPONSE 39l.

Provider Payment Cycles (Unique ID 1624)

HP will provide file transmissions, payment cycle reporting, and payment data to the State, on a schedule determined by the Department. Financial cycles in most of the states we serve, run weekly to allow time to run a full cycle. The Colorado interChange will support a provider payment cycle at least once per week. The Financial Scheduler Panel allows an authorized user to define the financial cycles. For example, expenditures and capitations can be set up to be generated during the week and scheduled to run on a week day, if desired. Overrides are available in the schedule to temporarily change the cycle dates to allow for holidays and special cycles, if needed. Paid dates can be set directly for the overridden schedules.

Demographic-based Rates (Unique ID 1714)

Demographic-based rates are common in HP's fiscal agent states. Whether full capitation, per member per month case management fees, or Medical Home administrative rates, payments can be based on a variety of multiple factors, such as the most common demographics of age, gender, or ZIP code.

Make Provider Incentive Payments (Unique ID 1715)

Provider incentive payments have grown in popularity among Medicaid programs over the past decade. HP has been in the forefront, working with our state customers to establish these payments. HP does have the ability to make the lump sum incentive payments to providers based on a variety of factors.

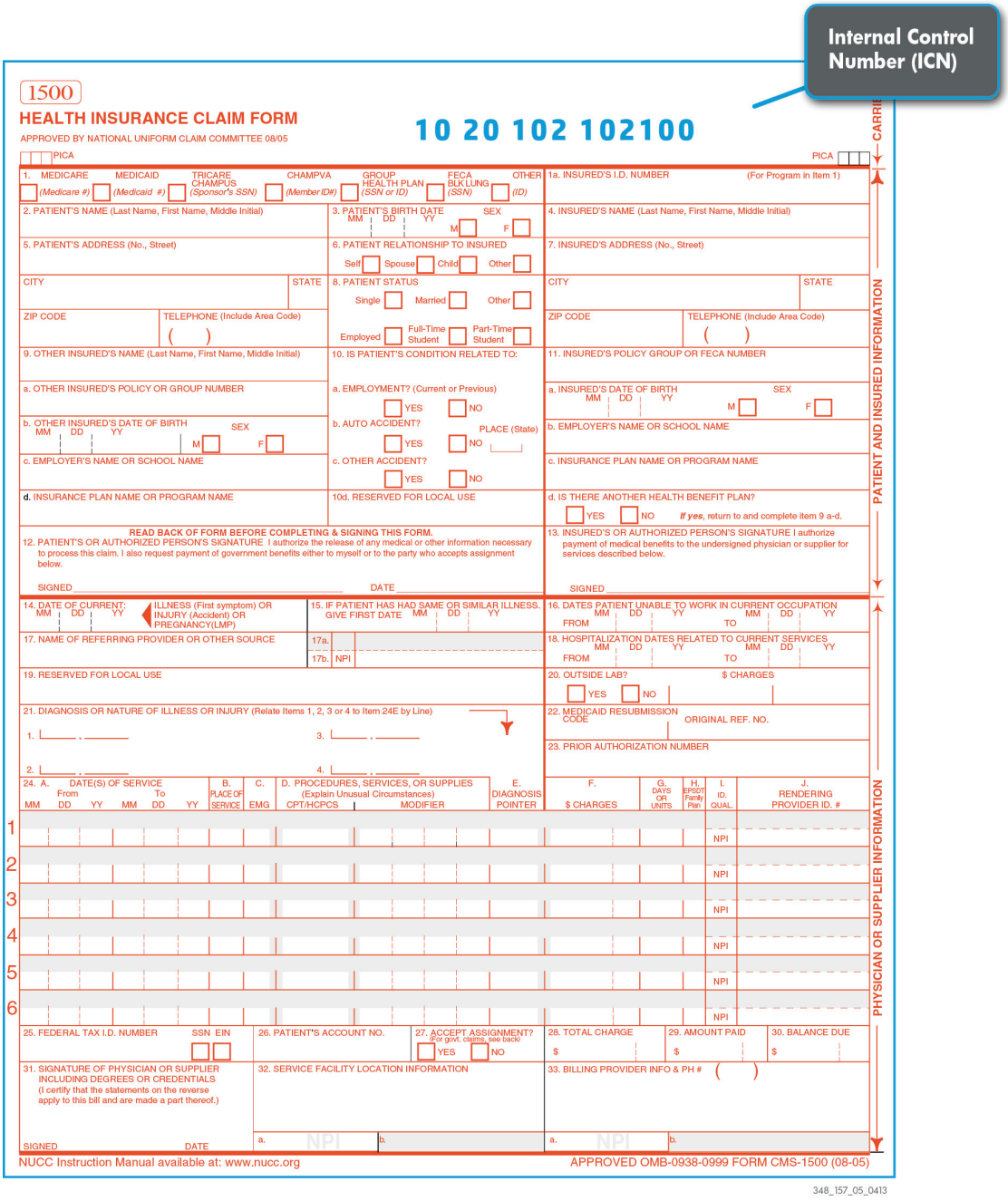
The most nationally recognized example is the Oklahoma Patient Centered Medical Home program. SoonerExcel is their performance-based payment module that recognizes achievement of excellence in improving quality and providing effective care. The SoonerExcel "bonus" payments are made to qualifying providers that meet or exceed various quality-of-care targets within an area of clinical focus selected by the State. The Oklahoma Healthcare Authority determines eligibility for the performance payments based on analysis of claims data.

Quality Control of Electronic Images (Unique ID 1629)

Mail is opened, screened and prepared for imaging. Hardcopy claim forms and adjustments, adjustment/reconsiderations, MED178 sterilization forms and other documents that need to be imaged are passed through the OPEX scanner. The OPEX DS2200 has fully integrated CertainScan™ software. As the item is being scanned the image displays on the OPEX monitor so the scan operator can review the image quality and reject it if the quality is not acceptable.

The OPEX scanner sprays each document with the year and Julian date of receipt as a component of the unique document control number assigned to each item. Paper claims and adjustments are assigned an Internal Control Number (ICN) that includes the year and Julian date, batch number, and sequence of the claim or adjustment. This ICN will track the claim through the entire claim life cycle. The Colorado interChange 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 numbering logic contains a two-digit region code that is used to indicate media type and the presence of attachments for hard-copy claims. This code also is used to denote special handling—for example, for timely filing overrides or other Department-requested special handling.

The format of the ICN is RRYYJJJBBBSSS, where:

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

The quality control process for hardcopy document images will be described in the Quality Assurance Control/Quality Management Plan which will follow the Deliverable submission, review and approval process.

Images captured during the scanning process are stored on IBM OnDemand, our EDMS solution. Our routine quality review process includes a random sample review of images to verify legibility. In the event an image is determined to be illegible, the QA staff member will submit a rescan request to the mailroom. The mailroom staff will pull the appropriate hardcopy document and rescan it. Hardcopy documents are retained for the specified retention period. However, hardcopy documents will not be destroyed until a random review of the images has passed our internal QA review.

Data Entry Validation (Unique ID 1630)

HP takes pride in our high data entry accuracy rate across our Medicaid accounts. We have had no missed service level agreements on data entry quality or timeliness in more than five years. Our solution to high performance in this area is a mixture of tools and training.

Paper claims are scanned in the mailroom. Scanning 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 data entry software system for traditional indexing and OCR repair. Trained data entry operators validate the information presented to them.

As a best practice to maintain quality control in our entry operations, we conduct a daily random sample of keystrokes. An image of a paper claim is viewed side-by-side against the keystrokes made in the data entry software. If discrepancies are found, the claim is immediately pulled and corrected, documented in the performance dashboard, and discussed in the next weekly data entry team meeting to devise and implement preventive measures for not repeating the same error.

The Department will see high-quality data entry from the HP team.

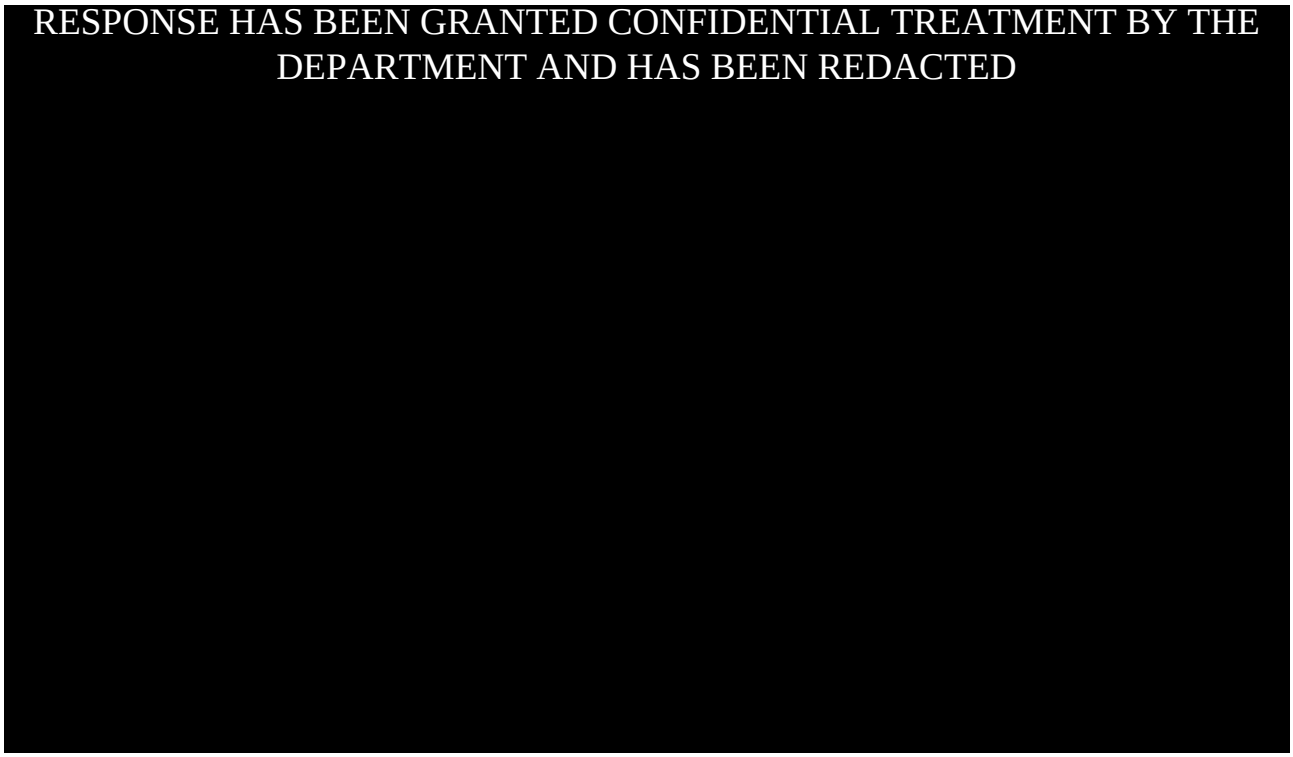
Data Sharing (Unique ID 1505)

HP has extensive experience providing data extracts of selected client information to third parties when required by our Medicaid state customers. The data needed can be extracted and sent in a variety of formats if there is a onetime need, or an interface can be established for automated

data sharing. The Department will define and approve any data sharing before release of any information.

Store Premium Assistance/Payment Details (Unique ID 1613)

HP will establish HIPP cases through the interChange HIPP panels, verify the existence and effectiveness of HIPP coverage, maintain and store the policy information, and store and track all premium payments to policyholders. The following HIPP panels figure demonstrates the HIPP subsystem panels within interChange.



The HIPP Information panel stores information about the policy and the policyholder.

It is through the Base Information panel that the user can view the cost-effectiveness of paying the premiums for the client. The Total Purchase cost is compared to the Average Expend data. The average expenditure is the total cost paid for Medicaid claims. The purchase cost is the cost to carry the insurance for the client.

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The HIPP Policy/TPL Policy panel allows access to HIPP information.

Edit Claims/Encounters for TPL Coverage (Unique ID 1632)

The Interchange system is highly qualified to maintain and process TPL information. HP will cost avoid claims using real-time technology by using the claims rules engine to define services covered by the plan and using the most current third-party liability (TPL) and carrier information available. Additional information regarding how HP will collect third-party information is provided in our response to User ID 1635.

interChange's TPL subsystem will maintain the identification of Medicaid eligible recipients who have TPL resources responsible for medical payments. This will establish compliance with the federal mandate that the Medicaid program be the payer of last resort when reimbursing healthcare providers for services rendered to eligible recipients.

Edit Claims/Encounters to Cost Avoid or Pay and Chase (Unique ID 1633)

Third Party Liability supports the State's efforts to responsibly reduce the cost of the Medicaid program, and to recover monies due from third parties, using both Cost Avoidance and Pay and Chase methods to optimize the State's use of resources. Cost Avoidance is the preferred method, and is supported in real time to prevent payments from being sent by Medicaid when a member's third-party coverage should pay instead. This is done through the claims rules engine – Other Insurance (OI) rules.

Pay and Chase claims are identified and paid through the claims rules engine based on procedure code, category of service and/or eligibility data. When a Pay and Chase claim is processed the EOB/ESC on the claim is set to a Pay and Chase edit, which can then be reported and used in recovery efforts.

Produce TPL Data and/or Cost Avoidance Reporting (Unique ID 1634)

HP's extensive experience with other states demonstrates that the Colorado interChange will capture and display all cash collections, post payment recoveries, cost avoidance data, Medicare Buy-In and HIBI in order to provide the data needed for reporting and increased cost avoidance. HP's operational processes and interchange enable the fiscal agent to work seamlessly with the Recovery Audit Contractor to maximize cost avoidance. Additionally, interchange is scalable so that it also can support pay and chase functions as well.

Capture TPL Health Insurance Coverage (Unique ID 1635)

HP will recommend and perform data exchanges with other contractors, insurance carriers, governmental agencies and other entities as authorized and directed by the Department. HP understands that maximizing TPL collections requires a series of electronic exchanges that use specially selected multiple match keys performed on the widest network of carrier files. Each successful data exchange provides the Department an opportunity to reduce overall expenditures by making sure Medicaid is the payer of last resort. HP data matches will identify new healthcare coverage resources resulting in enhanced TPL recoveries and increased cost avoidance. By performing cross matches with eligibility files from health insurance, commercial carriers and other governmental agencies, HP can identify and verify previously unknown third-party coverage information for Colorado's Medicaid members.

HP has many years of experience in performing data exchanges with third parties and expertise in using the data obtained to lower the cost of Medicaid expenditures for our state clients. As one example, for the state of Kentucky we have been exchanging data with government agencies for 25 years. We are in the process of adding eight commercial carriers for Kentucky. HP accepts proprietary file layouts and converts them to the CMS-recommended Payer Initiated Eligibility (PIE) transaction layout.

TPL Billing and Coverage Information (Unique ID 1636)

HP produces remittance advices in nontechnical language that is easily understandable. Provider remittance advices are produced in a comprehensive and user-friendly document that provides weekly and year-to-date provider earnings information on paid, adjusted and denied claims as well as claims in process and pending. The remittance advices also contain error codes and TPL information where appropriate.

Additionally, providers can receive data electronically. Colorado's interChange will provide financial payment data using HIPAA transaction set 835. In the HIPAA-compliant electronic 835 transactions, the third-party billing information will be reported in the Corrected Priority Payer Name segment, when it is believed that another payer has priority for making a payment on the claim.

interChange provides the HIPAA-compliant eligibility benefit information using HIPAA transaction set 271, where the third-party coverage and carrier information will be reported in the Subscriber Eligibility or Benefit Information loop, when it is believed that the member has Other

or Additional Payer coverage. The 271 provides the name and address of the insurance company, the policy number, the type of coverage detailed in the policy, and the subscribers name.

Trauma Indicators (Unique ID 1637)

The claims processing subsystem checks each claim for the presence of accident/injury diagnosis codes. Certain diagnosis codes are identified as injury or trauma codes on the reference system database. The system pays the claims and reports the payments for the recipient to allow tracking and potential case recovery collection by the TPL staff.

Adjustments from Medicare (Unique ID 1638)

HP understands how prompt and appropriate processing of Medicare crossover claims from Medicare intermediaries reduces the Department's and provider's administrative costs. Providing prompt payment also supports excellent customer service. Our experience and our system capabilities related to Medicare enrolled clients are discussed in RESPONSE 40b.

interChange can accept and process adjustment transactions for Medicare enrolled clients.

Adjustments from Third Parties (Unique ID 1639)

The Healthcare Portal solution allows the trading partner information to be registered for the Third Party Payer. The Trading Partner Management function of interChange Connections will store the trading partner contact information and the HIPAA transactions the partner can send and receive. This verifies that interChange Connections can properly receive and track information from the registered Third Party payers. The transactions received from the Third Party payers will be validated for compliance and translated, in the same manner as the crossover claims.

The Colorado interChange accepts claim and nonclaim–specific adjustments, automated adjustments from AR and TPL case tracking, no-history adjustments, recoupments, mass adjustments, and cash transactions. interChange 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.

Apply Recoveries to Client History (Unique ID 1640)

HP will prepare and submit retroactive Medicare Part A and B crossover billing reports to Medicare or the provider as appropriate. For post pay billing, the TPL subsystem bills the providers to contact Medicare part A and B. If any payments (either full amount or partial) are received or recouped from the provider, the monies will be applied to adjust the claim.

Support Medicare Buy-In Processing (Unique ID 1641)

The MMIS supports the ability to generate automatic accretions on a daily or weekly basis for Medicare Buy-In eligible clients. Deletions and change records are generated on a weekly basis. The MMIS subsequently generates Part A and Part B Buy-In transactions sending files with the

appropriate demographic information for CMS submission. Generated and sent Buy-In records are reported out daily.

The Buy-In subsystem has the following processes in place:

- **Accretions Process—**This process generates accretions for Buy-In eligible clients.
- **Deletions Process—**Generates deletion records for clients that have lost eligibility or have received a date of death on file. This process also generates change records for the Buy-In Eligibility Code changes and when there is a difference between the Medicaid ID that CMS has on file and what the MMIS has on file.
- **Sending Process—**This process retrieves the transactions from the database and uses the appropriate demographic information to generate the outbound records, which are then sent to CMS.

After these processes are complete, there are jobs that generate reports with the records that are sent to CMS. As an example, in our Oregon system we generate the following reports related specifically to the outbound records:

- **Buy-In Part A Outbound Report—**This report lists all Part A records sent to CMS
- **Buy-In Part B Outbound Report—**This report lists all Part B records sent to CMS
- **Buy-In Planned Deletions Report—**This report lists all deletion transactions that are queued to be sent out

Apply, Track and Document Claims/Encounters Recovered Monies (Unique ID 1642)

For post payment billings, HP monitors outstanding accounts receivables and uses automated rebilling processes to resubmit claims to the carrier for reprocessing. After a claim is billed for post payment recovery, an accounts receivable is established, maintained and tracked in interChange. The AR is used for tracking the recovery activity. Financial reports are created that list all billings/AR's and the amount outstanding and recovered. For post pay billing, when we receive payment from the provider, a history only check related adjustment is created to apply the money collected at the claim level or specific detail level.

Partial Recoveries (Unique ID 1643)

interChange will allow the adjustment of claims history to reflect a partial recovery of payment because of a third-party payment. The Colorado interChange will apply the refund amount to the claim at the level corresponding to the allowed charge. The disposition is tracked in the same manner as full amount recoveries and is reported as a recovered amount on the financial reporting.

For more details regarding our TPL capabilities, please reference RESPONSE 40e.

Provide Necessary Data to BIDM Vendor (Unique ID 1644)

HP will work with the BIDM vendor to define data necessary to be extracted from the Colorado interChange system and provide it to the BIDM vendor to complete the third-party section of the CMS-64 and other Department reporting needs. Cash collections and post-payment recoveries AR's will be sent using extracts from the Financial system. Buy-In data will be extracted from the Recipient system.

Track TPL Recoveries (Unique ID 1645)

HP will identify and store member other insurance information on the Colorado interChange resource database. Information for cost-avoidance will be verified.

HP will systematically generate Medical Service Questionnaires within the MMIS. This is designed to trigger when claims with accident/trauma procedure or diagnosis codes are adjudicated during claims processing. The questionnaire is mailed to the client. The system will track each letter and send a follow-up letter if there is no response within the time frame designated by the Department.

For post payment billings, HP will monitor outstanding accounts receivables (AR) and use automated rebilling processes to resubmit the claims to the carrier for processing. After a claim is billed for post payment recovery, an accounts receivable is established. This AR is maintained and tracked in the Colorado interChange. This AR can be used for tracking the recovery activity for the AR. Additionally, the system will generate a financial report that lists all ARs and the amount outstanding.

After billing claims to the insurance carriers, HP will monitor adjudication through the claims tracking portion of the automated accounts receivable system.

HP is currently administering a similar Health Insurance Premium Payment System (HIPPS) in other states such as the Kansas and Kentucky interChange systems, and will draw on that knowledge and experience to maintain the programs, systems, and procedures used to administer the HIPPS as an integrated component of the Colorado interChange MMIS.

FFP Rates Applicable at Original Adjudication (Unique ID 1646)

HP will report TPL and Financial recoveries after reading the client's eligibility information to determine the correct method to compute the federal share. interChange will use the client eligibility information applicable at the time of original adjudication. We will provide this information to the State for federal reporting.

TPL Recovery Automation (Unique ID 1647)

HP will use the X12N 835 transaction set to apply TPL recovery dollars by uploading the recovered monies to the appropriate claims at the service level. HP has implemented this process in the Kentucky interChange system and will draw on that knowledge and experience to implement and maintain this process as an integrated component of the Colorado interChange MMIS.

Post Payment Recovery Automation (Unique ID 1648)

HP will provide a recovery process based on the federal and State's business rules. Colorado's interChange will accept claim and nonclaim specific adjustments, automated adjustments from accounts receivable, TPL case tracking, no-history adjustments, recoupments, mass adjustments, and cash transactions (refunds). It also will accept retroactive adjustments to accounts when a member's TPL data changes and is updated in the database. The MMIS also accepts program integrity automated adjustments. Additionally, in the Wisconsin base system a system-generated adjustment (SGA) process runs 120 days after the bill is sent to the provider, if we do not receive a response from the provider.

Maintain Ongoing Training Programs (Unique ID 1182)

HP develops and delivers high-quality, learner-centric training programs to Contractor and Department staff in the use of reference functions by using a process-driven methodology to create, present, and evaluate training. Our approach and expertise facilitate the application of the new skills learned, allowing users to apply skills learned successfully and efficiently.

HP staffs the project with seasoned instructional design and training specialists so the training material matches organizational learning objectives, addresses core competencies, and provides the functional knowledge required for users to integrate the Colorado interChange functional capability into their daily business routines.

Approach to Planning, Managing, and Delivering Training

Supporting Medicaid programs in 20 states, HP continually evolves training methods. For more than 40 years, we have helped users and providers understand how to navigate the systems and tools that support a state's Medicaid program. As we develop training modules for delivery, HP will adhere to the Deliverable submission, review and approval process as described within the Resource Management Plan.

We have capitalized on the available knowledge and numerous changes in technology to make the delivery of training more efficient, effective, and accessible for our customers as follows:

- Our trainers use the most effective classroom training methods for adult learners, based on current research.
- When classroom training is not possible, live virtual instruction across the Internet helps to reduce costs and reach a broader audience while enabling the interactivity of a classroom experience.
- Web-based courses are a quick, easy way for users and providers to learn at their own pace, on demand.
- A Learning Management System (LMS) administers registration and tracks attendance for HP and State staff members, allowing instant access to training-related statistics. The LMS

also allows HP to track delivery timeframes and adhere to the Department's required course delivery.

Web-Based Courses

HP will create web-based courses using Qarbon's e-learning products. Qarbon offers a familiar experience to those accustomed to taking web-based courses and also are user-friendly for the novice. Each application in Qarbon's line stands alone; however, by integrating them, HP instructional designers can create web-based courses that work with the virtual training offered by training specialists.

Students can interact with the tutorials to give them the hands-on experience that helps drive understanding and retention. Courses will be designed to allow users to learn at a self-driven pace and repeat exercises as needed.

HP will integrate quizzes and surveys into web-content using ViewletQuiz. Quizzes are completely customizable, including multiple question/answer types.

Approach to User Training

Classroom courses will be hands-on and designed based on participants' job role or function. Handouts will be in the form of a course training manual that participants may keep, featuring screen illustrations and step-by-step instructions for accessing information. Trainers will demonstrate actions in a training environment and ask participants to follow the same steps in class. Users also will perform exercises designed to facilitate comfort level with the application.

Organization and Staffing to Support Training

A lead training specialist will direct the training effort for this project and coordinate with two instructional designers responsible for the design of the overall learning solution to accomplish specific and measurable learning objectives. Two trainers will then deliver the course material for classroom and virtual learning courses. Additionally, the training team will deliver training during the implementation phase Provider workshops. By working with both system users and Providers, HP's trainers can offer a better overall training experience, and a more consistent training program.

For more details on HP's training program, please refer to RESPONSE 38d.

Maintain Paper/Electronic Identifiers (Unique ID 1472)

The robust rules engine within interChange, as discussed in detail in RESPONSE 38l, will allow the Department to restrict paper claims submission to certain providers or provider types. The Form Edit process is the first step in claims processing through the rules engine. Rules can be configured to deny paper claims from certain providers or provider types.

The interChange system includes an EDI Restricted indicator on the Provider Other Data panel that identifies whether a provider has been restricted from billing electronically. Additionally,

when a provider designates their trading partner in the EDI subsystem, EDI updates the 835 Data on the Provider Other Data panel.

ID Discrepancies Reporting (Unique ID 1649)

HP will provide reports to the system of record for client ID discrepancies. The report format and delivery protocol will be defined during the Design and Define Phase, and will be managed using interChange Connections ESB platform.

Concurrent Code Sets (Unique ID 1651)

interChange is a table driven platform allowing flexibility in data storage and provides the user with an interface to view the data used for processing. This flexibility supports the ever changing CMS directives that occasionally overlap, creating a need for processing claims under different code sets or versions. One example of different codes sets used in interChange is the CMS transition from CMS-DRGs to Microsoft-DRGs. More recently the switch from ICD-9 to ICD-10 will require interChange to make both code sets available for processing.

HP is in the process of implementing ICD-10 in the Wisconsin base system, allowing the Department to take advantage of the implementation of this change with the Colorado interChange installation during DDI.

Appeal Processing (Unique ID 1652)

The Healthcare Portal supports online submission and viewing of claims, remittances, and payment information. Claims submission capabilities through the Healthcare Portal offer the following benefits:

- Meets current HIPAA, UB04, and CMS 1500 standards
- Ease of use because the format resembles paper claims forms
- Accommodates full and valid entry of every claim type
- Pre-populates provider (submitter) information into the claim
- Verifies client in step one of claim submission
- Provides a predictive search feature on many fields—characters keyed by the user narrow the list of choices
- Walks the portal user through the multiple steps of entering a claim using a wizard, enabling the user to go back to previous steps if necessary as header information remains visible as the user progresses through the entry steps

Additionally, using configuration options in the portal, HP will work with the Department during the DDI to determine what options to make available to providers regarding claims appeals, copy, and voids. When inquiring on claims, providers can request claims information based on claim,

member information, service, or date range. Providers can view a list of claims matching the request criteria with the capability to view summary or details about the claim.

Lock-in and Lock-out Functionality (Unique IDs 1653, 1654)

interChange does support lock-in and lock-out capabilities for clients. The Healthcare Portal allows providers to easily request member eligibility, and verify the member's eligibility status and scope of coverage and coverage type, including lock-in and lock-out information. The Healthcare Portal product provides a user-friendly display of information that we can return within the HIPAA 271 transaction data content.

Encounter Editing and Pricing (Unique ID 1655)

The Colorado interChange system will process claims and encounters through the same claims engine code using the same reference data including rules and rates. Claim and encounter ICNs are assigned unique region codes that allow the system to differentiate between a claim and an encounter. Disposition information is configured based on the region code and can be used to apply edits only to encounters or only fee-for-service claims, or both, depending on the Department's requirements. Additionally, encounter claims reflect a zero dollar true paid amount with a calculated system price that is stored separately for review and analytical comparison purposes.

MCO Provider Networks (Unique IDs 1656, 1657)

(1656) interChange will allow providers to be linked to MCOs and listed as a fee-for-service provider within the provider file. Additionally, the managed care organization's network will show providers affiliated with the MCO.

As relationships change, interChange can track any modifications, such as a provider leaving an MCO's network or an MCO leaving Colorado Medical Assistance.

(1657) interChange captures all provider-related information as an encounter is processed. This includes any rendering, attending, or supervising provider information. The provider-related information is stored in the claims subsystem of interChange.

Identify Multiple Providers Associated With Claim (Unique ID 1658)

The MMIS claims subsystem supports validating and storing all associated provider IDs as billed on a claim, and as required by the 837 standard transactions. These providers are used for coverage and payment decisions according to State policy.

Authorization Access (Unique ID 1659)

For a full description of Prior Authorization features and benefits, please see RESPONSE 40c. When inquiring about 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.

Authorized system users of interChange can view the same information through the Prior Authorization base and detail panels. Besides viewing the number of authorized units, the number of units used, and the number that remain, users can view the claims associated with the units used.

Premium Calculations for Protected Clients (Unique ID 1660)

The Colorado interChange stores two addresses for each client, street address and mailing address. When calculating premiums, the street address is used. This allows the residential ZIP code of protected clients to be used for calculation, while protecting their privacy.

Provider Identity Validation (Unique ID 1698)

The CMS 6028-FC rule states that fingerprints must be collected and criminal background checks conducted on high-risk providers—including those who maintain a 5 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. Please see RESPONSE 40d for a full explanation of the HP solution to this and other requirements of the ACA Provider Screening Rule.

Operations Management, Program Integrity (Unique IDs 1597, 1604, 1606–1610, 1625)

HP's proven, certified interChange MMIS maintains accurate financial data and transactions in support of program integrity. Following are brief descriptions of how HP will meet the Program Integrity requirements. RESPONSE 39f provides more details regarding these requirements.

(1597) interChange enables users to suppress claims processing based on criteria determined by the Department post-claims processing can hold the claim. For example, if a client's ID is changed to reflect a new plan, the claim needs to be adjusted but not paid again. HP's interChange creates a new claim with the new client's ID behind the scenes and does not re-notify the provider.

(1604) HP's proven interChange MMIS maintains accurate financial data and transactions. The interChange, along with the financial subsystem can perform accounts payable (AP) and accounts receivable (AR) functions. HP's interChange allows an AR to be set up and a percentage to be set for how much to retrieve from the provider. This is performed using the AR panel that allows the authorized user to access AR data for providers. Users can set up recoupment limits at the payee level using the AR MAX panel in the provider subsystem. There is a panel in both provider and financial to set up maximum recoupment amounts. The provider panel is titled Provider Account Recoup Maximum and the financial panel is titled Payee Max Recoup.

(1606) interChange enables users to track and manage existing cases and AR/AP overpayments. The User Interface panels are used to track and maintain the AR/AP refunds. Additionally, the financial transitions are posted on the provider's Remittance Advice (RA) and on various financial reports.

(1607) interChange enables users to complete and track full and partial adjustments to claims or encounters. Claim adjustments are processed in the financial extractor process during the weekly payment cycle. During the cycle, the second claim is compared to the original claim. The net amount payment is calculated. If the net payment amount is positive, a payment record is created. If the net payment amount is negative, an AR is created. The adjustments are then shown in a separate section of the provider's RA. The RA will show the original and second claim.

(1609) Financial transactions can be defined by the type and category. Each financial transaction is assigned a reason code that defines the type and category. The type defines the transaction—for example, an AR, payout, void, or adjustment. The category generally includes the payee type, reason codes, and funding codes. The payee type may include providers, clients, State agencies, and TPL carriers. The reason code defines the purpose of the transaction and is assigned by the system or UI panel, depending on how the transaction is created. Examples of reason codes include cost settlements, audits, or TPL recovery. The funding code is used to define who will pay for the transaction. Examples of funding codes include 100 percent Medicaid or the CHIP.

(1610) interChange can accommodate prospective payments not based on claims or encounters and still be able to recover payments based on user-defined criteria. The AP Expenditure panel allows the authorized user to generate advance payments that can be linked to ARs. It is a two-step process. A payout is created with an AR—with a forward date. This will track payouts and validate recoupment.

(1625) The interChange system can provide authorized system users with the capability to withhold or suspend provider payments after adjudication and before a final paid claim status can be performed. The Financial Fiscal Pend panel can be used to hold claims based on several criteria such as a provider with a dispute or a court case. Claims balancing reports are also generated to verify the integrity and accuracy of the data.

8.5 – Operations Management	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1583, 1593, 1608, 1622, 1626	**NO**

Additional Information (Unique ID 1583)

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—for example, if an attachment is expected but not received. If the additional information is not received before the specific number of days elapse, the claim would automatically deny.

Identify Episodes of Care (Unique ID 1593)

Episodes of care will be tracked through Optum Episode Treatment Grouper (ETG). This tool captures diagnosis codes and procedure codes from claims and encounters, grouping relevant services provided to a client, and sets pricing based on the episode. The Optum ETG product contains nearly 1000 ETG's to categorize episodes. The software can accurately identify episodes regardless of the treatment location or length of time between claims.

Monitor AP/AR with User-Defined Reporting and Alerts (1608)

interChange enables users to monitor the AP/ARs with user-defined reporting and alerts that can be set to notify authorized system users of changes in values. Alerts can be sent internally and externally from the workflow system. Business rules can be assigned to determine when to generate them.

Apply Online Payments (Unique ID 1622)

The Provider Portal currently does not allow application of online payments. Currently, the Provider Portal only has the capability to set up online banking for deposits from the plan to the provider. HP will work with the Department to fully understand this requirement during the requirements validation phase and make the necessary changes to the Provider Portal.

Post-Processing Edits or Flag Claims (Unique ID 1626)

interChange—working with the claims subsystem—can accept data from the BIDM to set post-processing edits or flag claims to suspend payment before final paid claim status and indicate the reason for which the claim was suspended. We understand the importance of appropriately flagging and suspending payment for these claims to prevent potential wrong doing and are committed to establish timely and accurate processing of data from the BIDM.