RESPONSE 39d

8.6 – Program Managements	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1224, 1663-1665, 1667-1691	**YES**

Description of Offeror's Approach

HP brings extensive experience directly to the Department through key personnel and staff knowledgeable in fiscal agent operational processes, lessons learned, and tools. Our proposed local Colorado team will bring years of experience in design, development, implementation and operations. The local team will receive support and management from HP's Capability Leaders. These leaders have led successful fiscal agent operations and now oversee functional teams, for example, in claims, provider relations, and finance, deployed across our Medicaid projects nationally.

HP has supported Medicaid program management for more than 40 years. We are committed to developing a relationship with the Department by using our proven operational processes developed through the years of continual improvement providing fiscal agent services. Our years of experience and the many states we have supported with Medicaid operations uniquely position us to deliver outstanding performance in supporting the Department in their program management processes. Strategic planning and policy making will be enhanced with the instant access to data and reports.

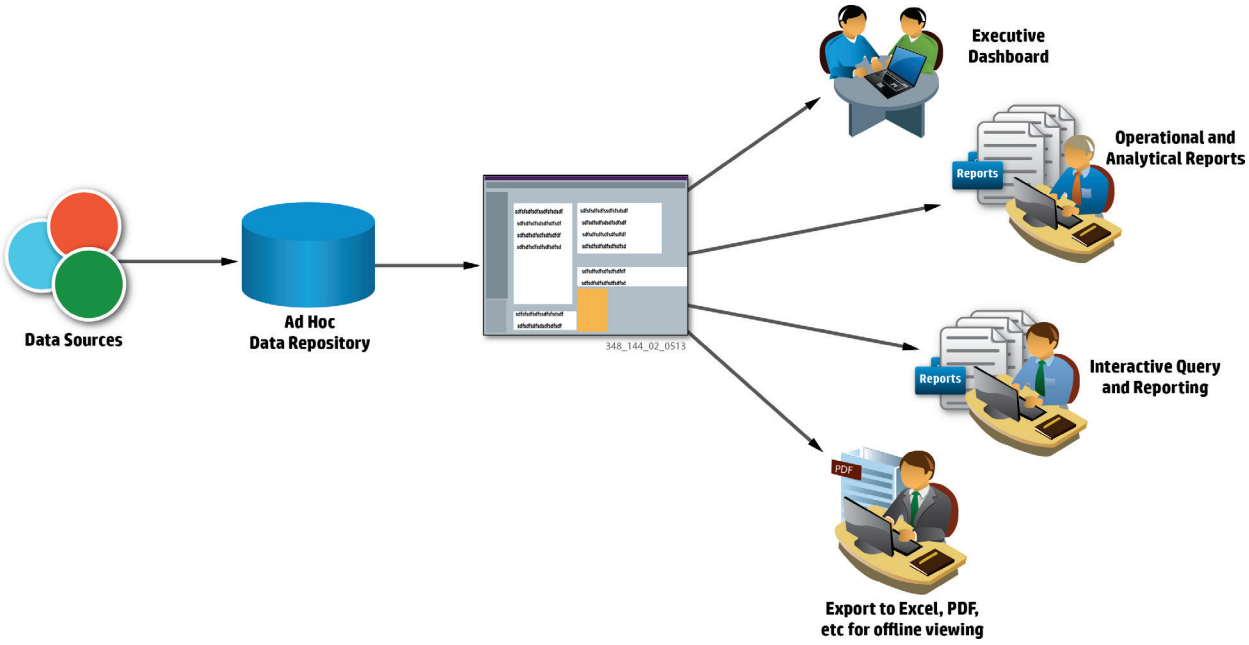
HP achieves success by delivering timely and accurate data using proven tools including:

- **MMIS Ad Hoc Reporting—**A centralized ad hoc data repository and specialized reporting data model will be available at the detail claims level giving ad hoc access to MMIS data elements using the BusinessObjects Web Intelligence toolset. The key differentiator with HP Ad Hoc Reporting environment is access to more data elements than other niche reporting vendors. The interChange MMIS ad hoc has an easy to use toolset that provides the ability to ask program questions and get data that can be turned into informed decisions quickly on the user's desktop.
- **Program Management Analytic Reporting—**HP Program Management Analytic reporting is an online reporting analytics tool that enables direct interaction with program data related to Provider Participation, Client Enrollment, Claims Throughput, and Expenditure by Fund Code. This style of reporting provides intuitive operational reporting that help support daily activities while providing guidance for improvements in policymaking and operations.
- **Decision Support Solution including Ad hoc reporting capabilities—**HP introduced the first user enabled Decision Support Solution for Medicaid and continued to expand and

refine our approaches during the past decade and a half. While our original DSS offerings focused on access to MMIS data, our next generation of efficient, effective management reporting solutions combines analytics and innovative presentation methodologies for a market-leading solution that delivers long-term value of deep analysis through the life of the contract.

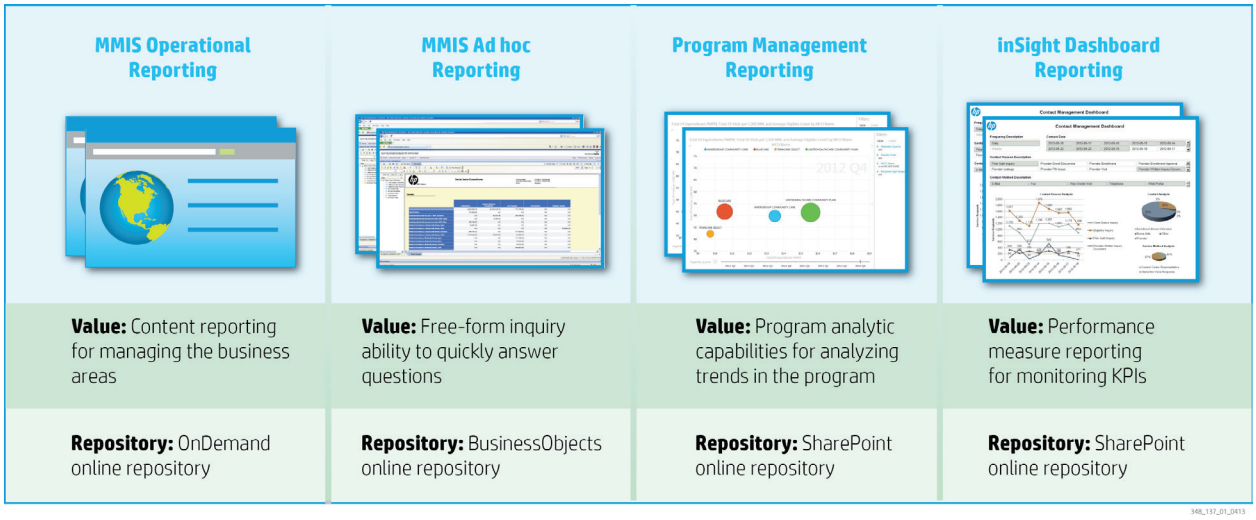
At the core of the effective management reporting process are a data model and the balance and control processes that validate the accuracy of the data loaded for reporting. Our operational procedures balance each load of data to the reporting environment. On this strong foundation we build out ad hoc, dashboards, and program analytics capabilities. The following figure provides an overview of the process to manage the gathering of data, storage of the data, and the various access channels the authorized users have to gather reporting outputs.

interChange Production Reporting Environment



This environment has been carefully thought out to serve the many aspects of an efficient and effective reporting solution. The needs of managers who want key performance indicators in a dashboard are different from the needs of an analyst performing ad hoc, while the user of program analytics needs additional online reporting presentations. Besides the reporting presentations, is the ability to pull data from the interChange reporting solution for analysis within local desktop tools. Each of these styles of reporting is critically important and together these capabilities comprise the overall interChange reporting solution. The following figure summarizes the many avenues of the reporting solution.

interChange Reporting and Analytics Summary



Each of these reporting outputs provides direct values to their identified stakeholders and is viewed through online access of the reports. The reporting repositories are where the users will find a comprehensive list of available reports and their intended use for the business area support.

Program Management Analytic Reporting

The interChange production reporting solution is an extremely powerful and flexible dashboard tool. HP delivers this capability through direct access to the detailed data for ad hoc reporting as well as providing data cubes that provide interactive insights into business trends.

This can be illustrated by seeing how this tool best positions the Department and our analyst staff to monitor payment processes and predict trends. The following figure is an example of a trend analysis report. This particular report is presenting the Emergency Room Expenditures for the various managed care plan populations.

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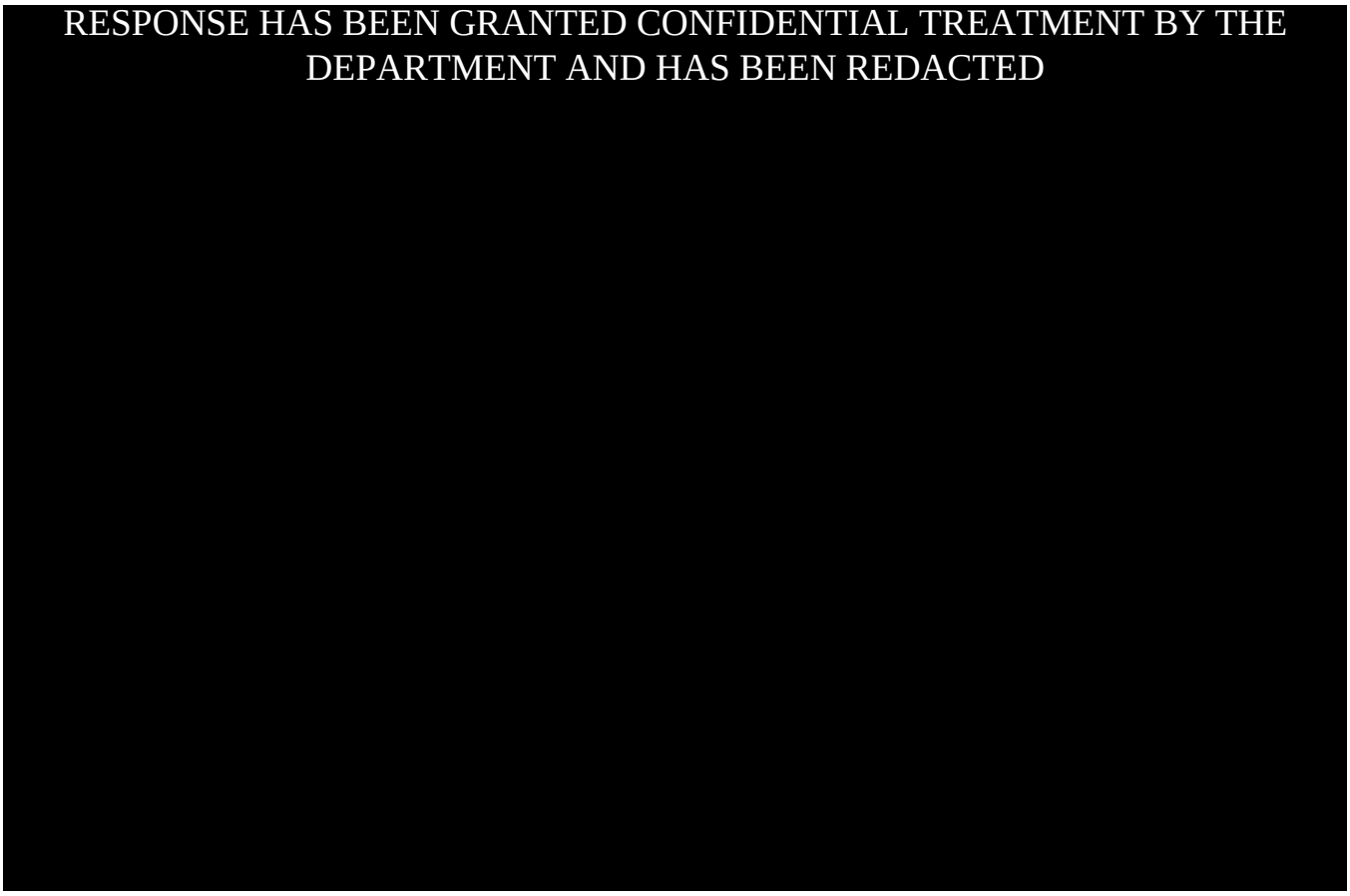

By using the "Time Slicer" at the bottom of the analytics report, the analyst can watch the bubbles change over time. Such an analysis tool is invaluable when investigating trends in the programs, including the trends in payments. The proposed solution is built on a strong foundation of accurate detailed data combined with the right COTS analytic tools that make analysis easy for the authorized users of the reporting system.

For the Department, this means HP will work effectively to support strategic planning, policy making, monitoring and oversight activities. No other contractor has the depth of experience and success we bring to fiscal agent operations.

Program Management

Successful program management requires accurate, timely, and relevant data to drive analysis of program strengths and weaknesses, identify areas for improvement, and develop data driven changes in program policy. The HP Team's approach to Program Management is not about running a series of reports, but about true review and consultation to support the Department's strategic planning, policy-making, monitoring and oversight activities.

User-Defined Services (Unique ID 1663)

The proposed Colorado interChange is a web-accessed modern healthcare management system that integrates a highly optimized business rules engine (BRE) to provide the right rule at the right time.

interChange BPA rules are responsible for most 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 defines and processes the following 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 on appropriate pricing methodology to apply
- **Assignment plan rules—**What services to carve-out of a capitated managed care plan
- **Edit rules—**Most edits that are rule-driven through configuration
- **Audit rules—**Most audits that are rule-driven through configuration
- **Copay rules—**Client responsibility amount
- **TPL rules—**What services are covered by carrier-specific rules allowing cost avoidance and recovery

The nature of managing changes to the processing rules of the MMIS changes as compared to historical MMIS solutions that had the business rules buried in program code. Instead of a technical resource making a coding change, through the interChange BPA Rules Engine the work is now performed by authorized business analysts to define and maintain the business rules. A complete discussion of the rules engine is located in RESPONSE 38l.

Unduplicated Participants (Unique ID 1664)

The McKesson VITAL Platform provides the ability for Colorado Medical Assistance program HCBS waivers to be defined and managed in the System as Health Benefit Plans by associating coverage with the appropriate clients during the eligibility refresh process. Clients can be loaded into the Platform with waiver affiliation data, if known. When waiver affiliation is not included in the eligibility refresh file, Platform users can manually insert waiver affiliation data after it is identified during the enrollment and/or needs assessment process.

Besides tracking waiver eligibility, the Platform also provides the ability to identify, track, and report unduplicated participants enrolled in 1915C programs, other waiver programs, and other long-term care services. This is accomplished by data refresh or manual designation of participants enrolled in the 1915C programs, other waiver programs, and long-term care services, made by users within the Platform. Regardless of the source of data, the Department can generate reports from the Platform to identify and track clients enrolled in waiver programs.

Data to the BIDM (Unique IDs 1665, 1224, 1680)

Our strategy for supporting the BIDM vendor with data for federal reporting is to use our base transferred MMIS reporting, which has been CMS-certified. A full discussion of the solution is found in RESPONSE 38g and RESPONSE 38u. HP will work with the BIDM vendor on the new CMS reporting requirements through the modernization team, data analysts, and applicable

business teams that include producing the new T-MSIS reporting requirements. The data provided will be all inclusive for reference files, data to complete financial and utilization reporting, and information needed to complete federally required reporting.

Accept Results of Third-Party and Department Surveys (Unique ID 1667)

Surveying stakeholders is important to the Department's strategic planning and program management. Surveys are only effective if the results are compiled in a usable and meaningful manner. To best serve the Department's need, HP has developed a plan to interface with the survey tool used, bringing the survey results into the inSight Dashboard reporting tool. For more information on inSight, refer to RESPONSE 38u.

Reports (Unique ID 1668)

HP operational reporting provides a detailed catalog of reports for each MMIS business area stored in a permanent state for continual viewing and use across time. HP will deliver a base set of reporting, housed in the OnDemand EDMS that supports maintenance and operations of the MMIS. The HP MMIS report management solution includes standard built-in features, allowing the active management of the business functions supported by the MMIS. Users can select schedules to indicate when ongoing standard reports should be executed within the automated processing cycles. The operational reports created during the update processes are automatically transferred for permanent storage in the EDMS. Through the EDMS the users have direct, secure, online access to the current and historical copies of the reports. These reports provide data that help support daily activities while providing guidance for improvements in policymaking and operations.

Encounter Records (Unique ID 1669)

State-funded programs are entered into interChange as benefit plans, with their rules configured in the rules engine as with other benefit plans. This allows data to be captured and reported using the same methods and processes as the federally funded programs. Encounters for State SLS and FSSP can be loaded into the system. Reporting can be limited to the State programs, the Federal programs or a combination of both.

Health Risk Assessment (Unique ID 1670)

The VITAL Platform provides the ability to support and track the results of a health risk assessment at time of enrollment for Department-specified program type/aid categories, prior history of assessment, and other criteria defined by the Department by aggregating data from multiple sources into a data repository. This data is then presented in a comprehensive client record that is maintained within the Platform. Please see RESPONSE 39g for more details on health risk assessments.

Rate Setting

Payment rates are at the core of MMIS claims processing. The HP interChange Business Policy Administration (BPA) function will accommodate the complexities and size of the Colorado

Medicaid Program. It is a true multi-payer 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.

Rules management interChange will allow trained, authorized users to identify, create, refine, and maintain business rules that effectively capture and enforce medical policy, including rates. 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 Department policy on how to adjudicate each service.

Rates by Provider Type (Unique ID 1671)

Pricing and setting of reimbursement rates is managed by authorized users using the interChange BPA Rules Engine. The date-specific covered benefit segments and rate tables in the Colorado

Core MMIS provide the capability to vary prices by provider type, specialty, provider contract, geographic location of billing provider, geographic location of performing provider, or any combination of these factors. We maintain usual and customary fees on date-specific tables in the provider functional area. Capitation rates cells are maintained through the managed care function. The reference function allows for flexible rate tables including anesthesia base rates, administration fees, conversion factors, and early and periodic screening, diagnosis, and treatment (EPSDT) schedules.

Capitation Rates (Unique ID 1672)

We understand a primary goal of a reimbursement system is to provide rates sufficient to allow the provision of quality care and to minimize provider appeals while controlling costs. The administration of capitation rates is accomplished using the interChange MMIS which provides the ability to enter, upload, and change the capitation payment rates used for specific managed care entities and primary care physicians. Authorized users maintain capitation rates through the managed care business functional area. The system offers the flexibility to update each rate cell through either interChange online Web pages or through a spreadsheet which can be uploaded.

When the department makes a policy decision requiring a change to the capitation rates in mass, authorized users access a mass adjustment capitation panel as shown in the following figure.

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Mass capitation adjustments are accomplished by the authorized user entering criteria for the mass adjustment to complete the transaction. This level of flexibility provides the Department a speedy solution to changes requiring immediate attention.

Multiple Rates by Entity (Unique ID 1673)

HP can successfully accommodate policy mandates requiring multiple rates and types of payments for multiple health benefit plans associated with a managed care organization. interChange supports the capability to maintain multiple capitation rates using effective dates for each provider, client, and program. This is accomplished by uniquely identifying rates in a relational database which precludes overriding of historical rates when updates are entered. We base the rates for the clients on the demographic profile of the client such as age and gender. The flexibility of the system also allows for rate overrides. For example, we can use the rate in the capitation rate cells or use the one for the specific provider in the override table. Sound and proven system design allows for accurate payments based on known information at the time of the capitation runs. HP will use the State-defined factors for calculating per-member per-month (PMPM) payments made to each entity. We base the payment on the following:

- Age
- Sex
- Category of eligibility
- Health status
- Geographic location
- Number of eligible days in the month

We use the current client eligibility data within the managed care subsystem processes to calculate the monthly capitation payments. We exclude terminated, dis-enrolled, and deceased clients from the monthly capitation payment to the MCO. Periodic reconciliation of client files is conducted. We also balance these against the MCO and PCP tables. If retroactive changes occur

to a client's eligibility, interChange picks up and adjusts the reported data to the previous capitation payments made for the client. Additionally, if a client changes plans, we generate a reconciliation and transfer of the capitation along with the changes. A history of the capitation rates can be viewed through the online audit trails.

Fixed and Variable Rates (Unique ID 1674)

interChange supports managed care entity rate management by providing robust capitation functions to develop combinations of fixed and or variable rates for managed care entities. The system includes the flexibility to pay capitation, premium, case management fees and medical home payments. interChange fully supports PMPM rate structures. The feature also allows capitation payments to be made using the appropriate rate for the time being paid.

interChange can accommodate client dynamics dictating the system to handle prorated (variable) capitation payments to the days the client is actually enrolled with the managed care provider in the given payment period, or the system pays a flat monthly rate based on the payment requirement for the particular managed care program.

interChange will make capitation payments to MCOs and other providers on a schedule defined by the Department. interChange enables authorized users to set capitation payments at provider-specific rates based on client demographics, including eligibility program, place of residence, age, gender, and risk factors. The system has standard capitation rates that can be overridden by provider-specific rates. interChange stores the capitated rates for the respective managed care programs in an easily maintainable and user-friendly browser environment.

Encounter Pricing (Unique ID 1675)

Program management will benefit from the robust claims engine within interChange that can parse information based on State-defined rules. Authorized program administrative users will have the flexibility to alter the rules, edits, and audits and thus provide accurate and timely payment to the MCOs and providers. interChange has added capability to pay capitated services and fee-for-service (FFS) on the same clients in the same month based on rules and client eligibility files.

The interChange claims engine can identify capitated services, allowing FFS claims to be denied if directly submitted by the provider or MCO. This helps the Department avoid costly overpayment and recoupment on those capitated services.

Also driven by the rules in the claims engine, interChange can process services carved out of the managed care program as FFS claims. interChange can identify effective dates of enrollment, allowing providers to be paid for pre-enrollment services and for other periods of transition when the client is not covered through capitation. Emergency services also can be set to bypass the capitation edits, allowing the client to get needed service immediately.

Risk-Based Rates (Unique ID 1676)

interChange enables authorized users to set capitation rates based on client demographics, including eligibility program, place of residence, age, gender, and risk factors. The system has standard capitation rates that can be overridden by provider-specific rates.

Pricing Updates (Unique ID 1677)

The HP team provides the needed support for the Department. HP receives code set updates on a routine basis, such as weekly, monthly, quarterly or annually; we also capture the code set changes on a Department-defined frequency and as needed basis. These code sets can include procedure codes, diagnosis codes and other code and rate sets obtained from external sources. Before the effective date of the code set changes, interChange uses batch processes to load code set data after capturing the code set data from the authorized code source, or authorized users can enter rates directly into interChange.

Audit trail data is used to identify the most recent pricing update on each active code. A report is generated after each update period showing the active codes and their most recent pricing updates. This report will identify active codes that have not had a pricing update based on the most recent update.

Reference Management

Accurate, accessible, and easily maintainable reference data is the critical link between the interChange MMIS and state healthcare policy. The Colorado interChange will reflect one of HP's newest rounds of innovation, @neTouch—a family of features designed to streamline working with MMIS interChange. Users can apply and maintain complex policy with maximum efficiency, exceptional productivity, and personalized flexibility. This provides the Department the benefit of faster implementation of new policies and data improving healthcare, preventing fraud and reducing costs.

Serving as the central component to reimbursement policy, the Colorado interChange reference business function is a flexible and reliable solution maintaining the data files required to accurately process claims. The Colorado interChange reference functional area enables authorized users to flexibly, quickly, and easily update the data tables through intuitive and user-friendly online web panels and automated batch updates, and administer policies governing the Colorado Medicaid Program. The reference business process will contain tables of information needed to process claims, and support associated assistance programs and various reimbursement methodologies. These reference tables will store service, revenue, diagnosis, and other codes and data elements required to price claims based on specific procedures, providers, and other criteria defined by the Department.

Mass Updates (Unique ID 1678)

As healthcare changes more rapidly than ever, it is essential that the Department has the technical and operational support necessary to take a code set from receipt to program inclusion, be it: Current procedural Terminology (CPT), Healthcare Common Procedure Coding System

(HCPCS), International Classification of Diseases (ICD), National Drug Code (NDC), Current Dental Terminology (CDT) or revenue codes. The overall reference data management provides an efficient structured process for managing complex healthcare policies for accurate claims processing.

We manage and control update and maintenance processes by using interChange Workflow, a business workflow to manage the update process. interChange Workflow is the blending of interChange UI, K2 blackpearl workflow COTS product, and Corticon business rules engine COTS product. The Code Set Management Workflow process guides the user through the business process as defined by the workflow and business rules. The workflow moves the process through the steps informing the users when they can perform their step and puts the link to the notification in their work queue or email box.

The predefined rules determine the path the application will take. As the process moves along through each step, interChange Workflow records the information and managers can view statistics of the business processes to identify and remedy bottlenecks. They also have an immediate view into a specific notification for visibility of its current step, steps completed, and next steps. Using the defined workflow and business rules engine provides the Department with consistent, timely, and auditable business processes.

Before the effective date of the code set changes, the interChange MMIS uses batch processes to load code set data after capturing the code set data from the authorized code source. Each batch job generates output reports that list appropriate counts such as the number of adds, deletes, and changes. The following figure provides an example of a summary report from the CMS annual HCPCS update process. As the following figure shows, the report provides the details on the changes related to procedures and modifiers.

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The batch jobs also create error reports for verification, system analysis, and maintaining data integrity.

Additionally, the HP design of processing rules within the rules engine prevents updates that do not follow the defined criteria. Online access validates users for view or update capability. Transaction type and update details are available online or for report download. Reports listing changes, the sources of the changes, and reasons for the changes are available with the base MMIS. The Colorado interChange will have a broad set of loading processes already defined and operational, along with a robust set of reports already configured to make sense in a production context, and the integration of the processing rules within the uploads. We will work with the Department during the DDI Phase to confirm the reports or notices desired to support this requirement.

Manual Updates (Unique ID 1679)

Proper management of the program requires tight security for those who are granted the authority to make changes to reference files controlling the processing of the system. The interChange MMIS uses role-based security to control access to the database and supporting reference tables. User access to view and update reference files will be defined by the Department. Only with the Department's approval is a user granted the appropriate access based on their role to view and update reference files. Online access will validate users for view or update capability. Transaction type and update details are available online or for report download.

Best security practices also support management of the changes users are making to the system. Providing the tools for the Department to audit user changes is one of the features of interChange. Authorized users—whose role provides access to the reference database and permission to add, delete, or change information at the Department's request—complete online updates that are smaller in volume. To protect the integrity of the data, these updates go through an online edit process. A reference data maintenance analyst verifies the additions, deletions, or changes to the reference database. To complete this task, the analyst reviews the online web panels or a reference file update report. If information is incorrect or needs to be changed, the analyst or user with update authority on the Reference team makes the correction and verifies the changes. Within the interChange web panels are "notes" sections that allow for the tracking of changes entered by a user. The following figure provides an example how users document the reason for the update. HP selected the authorization code web panel to illustrate this feature.

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An audit trail tracks reference file updates to support the Colorado Medicaid Program and is available for Department review. Additionally, updates are end-dated, not deleted, preserving the data integrity while archiving historical information for claims processing and the Department's reference.

Code Maintenance (Unique ID 1681)

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 is to serve as the repository of data and business rules required for claims adjudication and pricing, PA determination, 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 audit trail for table value changes.

Reference data provides authorized users the flexibility to update the data tables through the interChange web screens and administer policies governing the Colorado healthcare programs.

The reference business area contains tables of information needed to process the approved claim types, support associated assistance programs, and enable various reimbursement methodologies. The tables store the HIPAA standard codes and data elements required to price claims based on specific procedure codes, providers, and other criteria defined by the Department.

The interChange MMIS provides easy to use web interfaces to maintain revenue codes, allow users to inquiry by the revenue code and make online updates to the base revenue code information, coverage information, restrictions, service limitations, and pricing information. interChange web screens edit the user-entered information and send appropriate error messages to the user to correct them before saving into the database.

interChange Business Policy Administration (BPA) rules engine supports the following:

- Revenue code coverage information, maintained and configured using interChange BPA—Benefit Plan Rules configuration web screens
- Revenue code restrictions and automatic error codes, maintained and configured using interChange BPA—Benefit Plan, Provider Contract and Form EDIT Rules configuration web screens
- Revenue code service limitations, maintained and configured using interChange BPA—Audit Rules configuration web screens
- Revenue code pricing information, maintained and configured using interChange BPA—Reimbursement Rules configuration web screens

interChange maintains effective/end date and Active/Inactive date for the revenue code-related reference data segments. We highlight a sample revenue code search in the following figure:

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The user-friendly response with base revenue code information is shown on the following figure.

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Reference Library (Unique IDs 1682, 1683)

HP offers the Department superior reference data management capabilities. Our table-driven, user-configurable BPA functions as a reference library by allowing authorized users to view the code and data files. The Colorado interChange simplifies research of reference data and maximizes efficiency.

HP interChange provides user-friendly search capability to search by individual code values and displays search results, as depicted in the following figure.

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The interChange MMIS provides search capability based on procedure description, as shown in the following figure where we searched on the word OFFICE.

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The interChange MMIS maintains diagnosis and procedure codes and associated narrative short and long descriptions in the respective tables. The following figure depicts an example of short and long descriptions for an office visit through the BPA information.

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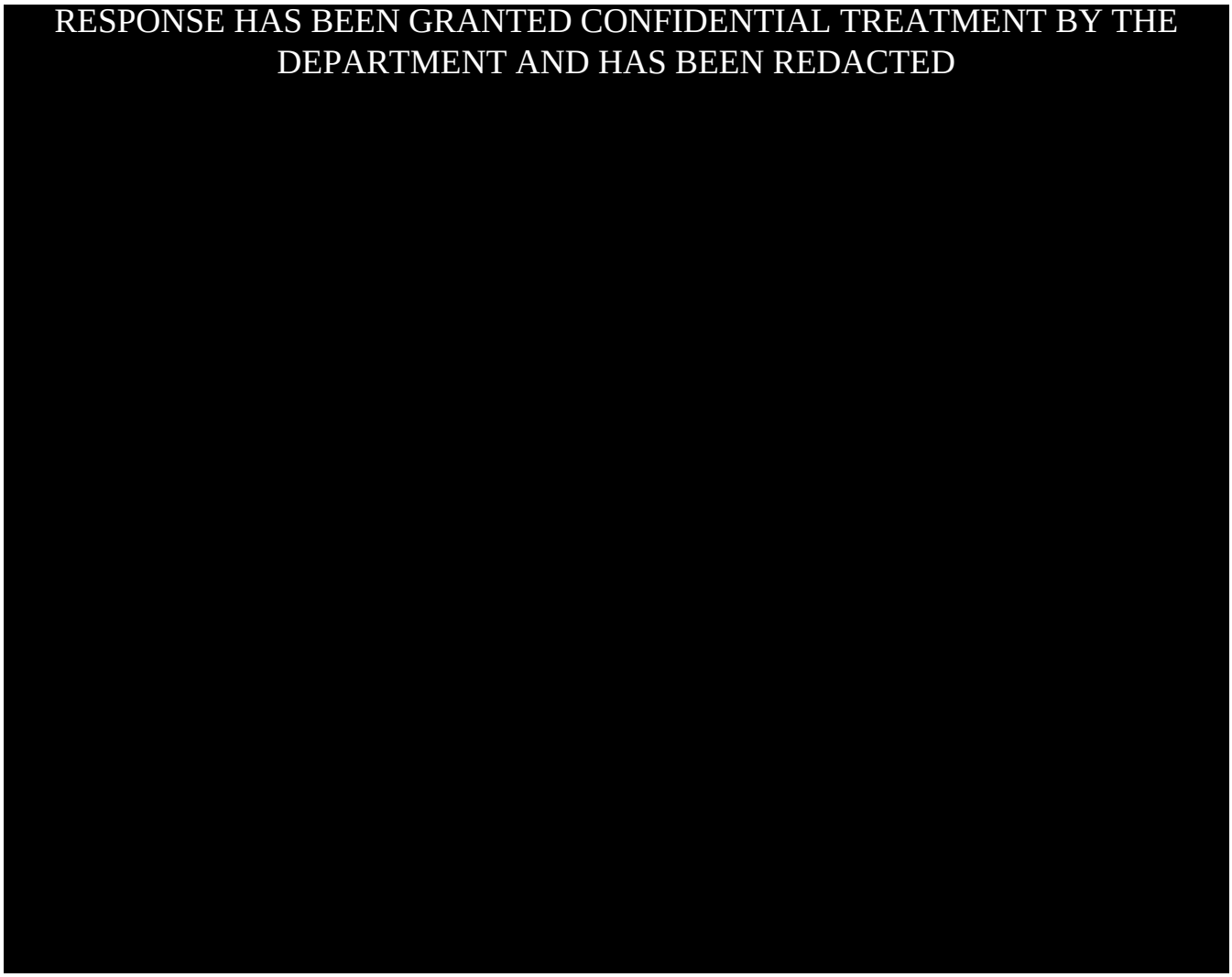
interChange allows authorized users to update or change the short and long descriptions through the web-based user interface.

The interChange MMIS uses grouping tables and web screens to maintain and organize related diagnoses codes into a particular group for claims adjudication. The following figure provides an example of a Diagnosis Group.



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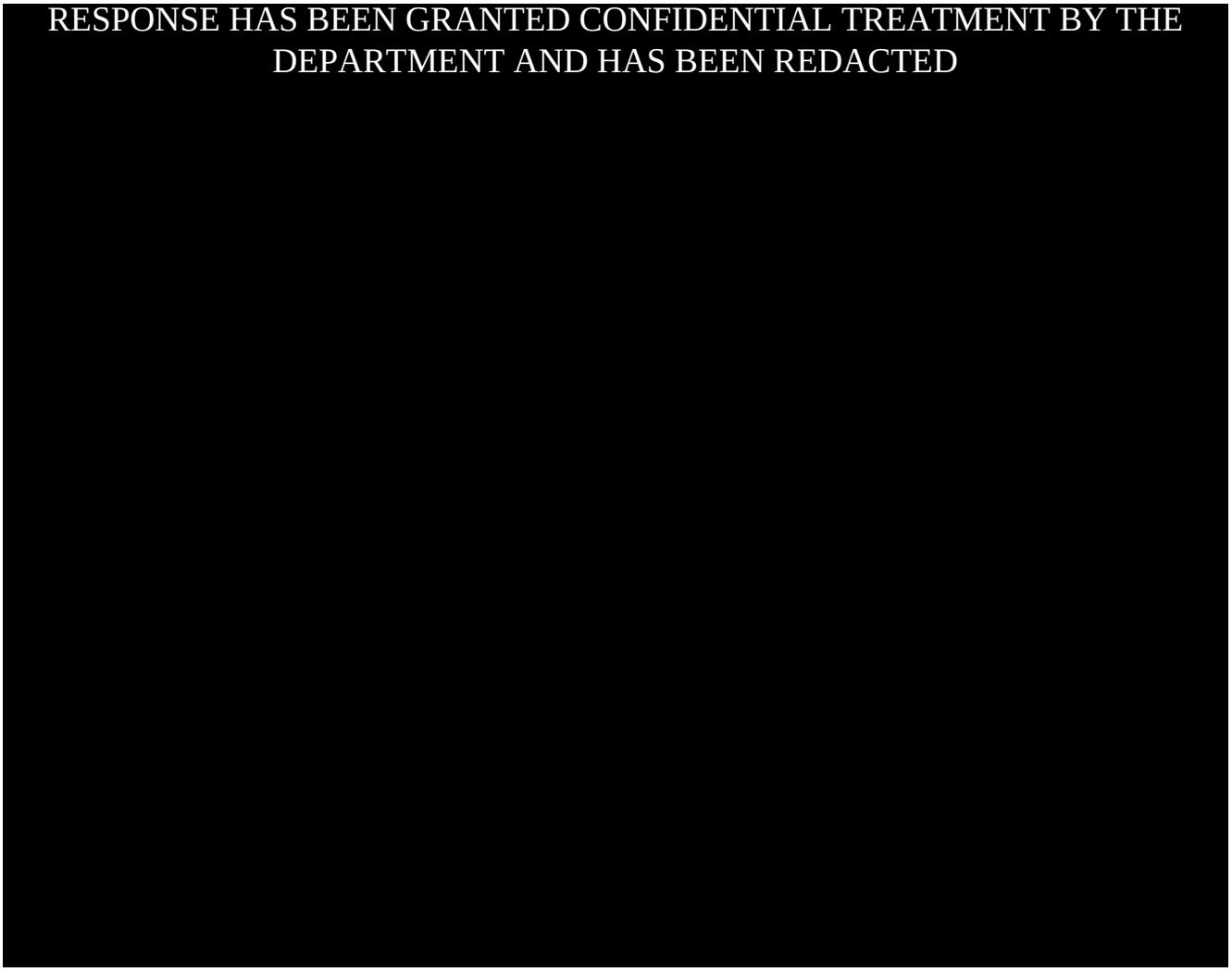


The interChange web-based user interface streamlines and simplifies research of reference data.

Episode of Care (Unique ID 1684)

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.

Data used by Optum ETG includes but is not limited to:

- ICD diagnoses and procedures
- HCPCS/CPT/CDT
- Procedure modifiers
- Revenue codes
- Bill types
- Places of service

- Provider taxonomy
- Provider type

Modifiers (Unique ID 1685)

The interChange system accommodates the addition or removal of any modifier on any procedure code including procedure code modifier relationships. Program management controls are supported by allowing only authorized users to make changes. The interChange MMIS uses role-based security to control access to the database and supporting tables. Users will be granted the appropriate access based on their role to add or remove modifiers, on any procedure, or procedure code modifier relationships.

EOB Crosswalk (Unique ID 1686)

interChange reports error codes for each claim header and detail on the remittance advice (RA). For HIPAA-compliant electronic 835 transactions, we use national adjustment reason codes and healthcare remark codes to convey this information. We report the codes that apply to the claim, adjustment, denial, or financial transaction in the corresponding area of the RAs. On paper remittance advices—as allowed by HIPAA standards—we print the detailed message text of each applicable error code, including suggested corrective action, for the provider's convenience. This detailed, thorough error reporting helps providers understand and correct billing errors in resubmission of the claim.

HP will publish to the Provider Portal an electronic searchable crosswalk of the HIPAA adjustment reason codes and remark codes to edits that are used in the interChange system.

Publications (Unique ID 1687)

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

Providers have access to manuals and bulletins through the HP Healthcare Portal. The publications and bulletins will be viewable online or available to be printed. By using the point-and-click web technology to find numerous resources in one site, providers can view various documents without having to scramble to find last week's mail filed away someplace in their office. These self-service functions minimize providers' time spent searching for information and gives them time back to spend with their clients which may lead to improved outcomes.

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

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

Our publications manager works with the Department on the creation, approval, and posting of provider education material and public-facing documents.

Effective Dates (Unique ID 1688)

The Colorado interChange maintains current and historical reference data with their respective effective and end dates. This includes modifiers, provider types, and third-party resource codes, among other data fields.

interChange validates transactions for data integrity such as confirming that the data reference date segment falls within the proper effective/end date and active/inactive date. The interChange claims engine uses the appropriate reference data segment defined for the claim's date of service that falls within the effective/end date and active/inactive date.

Function Natively With NPI (Unique ID 1689)

The Colorado interChange transfer system will be compliant with all the standards listed, without the need for crosswalks or mapping tools. interChange has been upgraded to function natively under the latest regulatory standards (including NPI/taxonomy and 5010), and ICD-10 will be implemented in interChange before construction on the Colorado interChange begins. The Colorado interChange will be installed and configured to function with both ICD-10 and ICD-9 codes if needed.

Validation and Pricing (Unique ID 1690)

HP Medicaid claims/encounter processing represents unparalleled flexibility. The interChange claims engine uses the appropriate reference data segment defined for the claim's date of service that falls within the effective/end date and active/inactive date during claims and encounter processing. interChange reference files support processing of all approved claim types and reimbursement methodologies.

The base MMIS keeps versions of reference information and update transactions in the database tables. The interChange web interface allows only add/update actions and does not allow a user to delete data. When we need to update or correct information, interChange sets the old or incorrect code segment to an INACTIVE status using the INACTIVE date option provided in the screens.

An add/update transaction follows to establish the new or corrected data. interChange maintains the versions of the data record. This audit trail provides documentation used in research, such as an authorization code indicating the reason for the change, the ID of the user that made the change and a free form note field that allows a description of the change.

interChange validates add/update transactions for data integrity such as confirming that the data reference date segment falls within the proper effective/end date and active/inactive date. The interChange claims engine uses the appropriate reference data segment defined for the claim's date of service that falls within the effective/end date and active/inactive date.

Archived Data (Unique ID 1691)

The Core MMIS keeps versions of reference information and update transactions in the database tables. The interChange web interface allows only add/update actions and does not allow a user to delete data. When we need to update or correct information, interChange sets the old or incorrect code segment to an INACTIVE status using the INACTIVE date option provided in the screens.

An add/update transaction follows to establish the new or corrected data. interChange maintains the versions of the data record. This audit trail provides documentation used in research, such as an authorization code indicating the reason for the change, the ID of the user that made the change and a free form note field that allows a description of the change.

interChange validates add/update transactions for data integrity such as confirming that the data reference date segment falls within the proper effective/end date and active/inactive date. The interChange claims engine uses the appropriate reference data segment defined for the claim's date of service that falls within the effective/end date and active/inactive date.

8.6 – Program Management	**In Production?** **YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1666	**NO**

Data for Financial and Utilization Reports (1666)

The interChange Voucher Detail that is produced from each financial cycle and its companion the Monthly Budget Monitoring report—coupled with the data provided to the BIDM vendor for report production and predictive modeling.

RESPONSE 39e

8.7 – Business Relationship Management	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1195, 1198, 1199, 1207, 1297, 1692	**YES**

Data Privacy, Security, and Integrity with Access Limited by Staff Role

An integrated security framework manages access and exchange of information deployed across the applications to help support privacy, control data integrity, and manage role-based access and authentication to the proper applications, panels, and data.

The Colorado interChange provides role-based security access across the MMIS solution. We grant access on a defined needs basis, with business groups having profiles established within the security solution. As we add Colorado interChange users, we authenticate and authorize them according to their defined and assigned profile. This role-based approach limits the access to the specific business areas, specific online user panels, and specific features—add, update, or inquire—of the user panels, as needed, to maintain proper security.

Infrastructure Security and Integrity With Industry-Leading COTS

Industry-leading applications are used to protect the system. HP uses tools—identified in the following table—to provide security at each level of the infrastructure and within applications.

COTS Tools Provide Security

Function	Purpose	Vendor	Tool Name
Network Intrusion Prevention/Detection	A NIPS solution provides protection of the data network from abnormal network traffic patterns and potential intrusions	HP	Tipping Point
Host Intrusion Prevention/Detection	A COTS solution to protect system servers and hardware from denial of services or other external attacks.	McAfee	McAfee Host Intrusion
Network and Data Encryption	Encryption protects the integrity and vulnerability of data-in-motion across the networks.	HP	3Com Network Components
Role-based Data Access	Access to data is managed and restricted based on the user's role within the organization and their need to access that data.	HP	interChange function

Function	Purpose	Vendor	Tool Name
Server Anti-Virus Solution	Anti-virus software to protect system servers from infection of malware or other viruses	McAfee	McAfee Anti-Virus Solution
Firewall Technology	Provides perimeter network security, barring access from unauthorized users and applications	Cisco	Cisco ASA
Network Address Translation (NAT)	The use of NAT technology hides actual system IP numbers from being transmitted across the networks. IP numbers are translated to actual IPs numbers within the security of the internal networks and firewalls.	HP	3Com Components
System Penetration Testing	Penetration testing provides the ability to scan the networks, both internally and externally to reduce risks with the configuration and protection of the networks.	HP	Nessus
Policy Compliance Management Monitoring (PCM)	Continual scanning of servers and infrastructure confirms that security levels are in place and current.	HP	HP Security Services
Automated Log Monitoring	Provides centralized logging collection and auditing of network devices and servers	HP	ArcSight

Securing Workspace and Meeting Facility Requirements

Our Global Security Group (GSG) is accountable for developing and implementing HP security strategies. The GSG team works with our business units and global functions to provide security programs that deliver optimum value to HP and our customers. We will use HP corporate security strategies for our proposed facility. Security and safeguarding HP assets and dedicated and secure State areas are a top priority. Our facilities are protected through keycard access at entrances and sensitive areas with surveillance cameras at appropriate points within the facilities.

Besides the physical security provided, we will implement HP security policies and train employees annually on proper security procedures, HIPAA Privacy and Security, and safeguarding of assets. Physical security and the daily execution of our corporate security procedures will provide maximum protection in each area of MMIS operations.

Because security risks constantly change, HP will regularly work with the Department to evolve the system and data security plans in response to advances in technology. We will meet federal

regulations regarding standards for privacy, security, and individually identifiable health information as identified in HIPAA and Public Law 104-191, titled "Administrative Simplification."

Incident Management

HP defines an incident as an unplanned interruption to IT Service or a reduction in the quality of IT Service. HP uses the Incident Management process to manage IT service disruptions to restore regular service operation as quickly as possible. The overall goal is to minimize adverse effects on Department's business operations.

Incident Management includes the following seven sub processes:

- Incident Identification
- Incident Logging, Categorization, and Prioritization
- Incident Diagnosis
- Investigate and Diagnosis
- Resolution and Recover
- Management Review
- Incident Closure

The following figure provides a high-level Incident Management process flow, the subprocesses, as well as key roles in the process. The figure matches the HP Incident Management personnel, listed on the left-hand side of the figure, to the activities they manage within the process. The Incident Management process focuses on the rapid restoration of regular service operations, minimizing impact to your business and Department users.

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

The first step in Incident Management is acknowledging and accepting ownership of the incident, then documenting critical information in the incident tracking tool. An initial investigation validates and classifies the incident, determines the level of priority, and assigns it to the appropriate support team for resolution.

After an initial diagnosis, incidents associated with known errors are quickly resolved by applying approved solutions or workarounds. Incidents associated with an existing or "parent" incident that has not yet been resolved are assigned to the technical support team already working on that incident's resolution. Technical support teams perform additional diagnostics, as necessary, to identify and implement an appropriate solution or workaround. During the diagnosis, if key triggers are met, contingency plans will be executed to mitigate the impact of the associated incident. The plans and their triggers will have already been defined as a part of the planning process. To finalize the incident, the solution or workaround is verified and confirmed with the affected users.

While an incident remains open, the service desk function within ITIL monitors and reviews incident status, communicates to affected users, and updates incident records as necessary. Based on severity, we manage the defined escalation procedures to facilitate resolution by establishing bridge lines with our technical support team; alliance partners and vendors; Department technical support teams; and Department/HP leaders. The focus of Incident Management remains on the

restoration of regular service operations as quickly as possible, minimizing the business and user impact.

The Incident Management process includes the following key roles and responsibilities:

- The **Authorized User** contacts the Service Desk to report incidents impacting service availability. The Help Desk then performs the following activities using the defined processes:
  - Discusses which services are impacted, and not impacted
  - Provides a detailed report of the incident
  - Functions as a contact-point if HP needs additional information related to the incident
  - Provides a positive confirmation of the incident resolution, before record closure (depending on client specific incident handling procedures)
- The **Case Administrator** is the first person the user will talk to on an initial entry into the process (this includes support for any self-help portal in place for the Department)
- The **First Level Support Representative** is the initial point of contact for some qualified incidents from Operations Management or self-help users
- The **Support Specialist** (includes multiple levels of support) provides elevated levels of support focusing on:
  - Complex issues related to operation aspects that cannot be resolved at first level support
  - Understanding the IT environment and technical challenges
- The **Tactical Incident Manager** (TIM) is responsible for process adherence within a specific domain or across domains, and assists the support staff in executing the process. The TIM also is responsible for:
  - Managing and coordinating the daily activities necessary to move forward within the process for a given service domain, including resolution tasks when required
  - Managing support staff performance to program SLAs
  - Creating and implementing action plans when necessary to facilitate resolution
- The **Incident Life Cycle Coordinator** monitors and tracks each incident through the Incident Management process. They verify no incident gets delayed or misdirected in any area of the Incident Management process.
- The **Strategic Incident Manager** evaluates escalated incidents and provides the directions and communication needed to resolve the incident quickly and efficiently.

Change Management

Change management includes complete life cycle support of the system, changes, updates, and maintenance to system components and affected operating processes. The scope includes identifying and tracking regular enhancements to the Colorado interChange solution and changes to the scope of requirements agreed to by the Department and HP. Change requests that affect the cost, schedule, or contract are classified as scope changes and require additional analysis and review.

In the Start-Up Phase, HP will establish the Colorado interChange change control process that will continue into operations. In the initial planning phase, the Department and HP will identify the stakeholders who will comprise the change control board and name the staff members who will lead the process. The leadership team structure for the change management process that has proven most effective is a small, focused group of leaders who also are directly responsible for the project's success.

With this project-level change control process, the Department and HP can administer project activities quickly while enabling a clear communication path to issues that affect the overall project. The group will review proposed changes against the RFP, proposal, and requirements specification document and weigh need against risk. This collaborative team can take any of the following steps:

- Referral to the Change Control Board (CCB) for review and assessment of project effect
- Approval as an in-scope change, to be operational on the operations start date
- Approval as an out-of-scope change that should be implemented as part of the ongoing system operations after the operations start date, requiring agreement on cost, priority and target date
- Request for additional information to make an informed decision
- Change in priority based on other activities or criteria, such as availability of appropriate resources from HP or the Department

Smoothly implementing system changes and enhancements is critical to the quality and effectiveness of the Colorado interChange solution. Our approach to Change Control, outlined in the following figure, brings the following benefits:

- Reduced project risk by preventing unnecessary distractions from critical project objectives
- Improved flexibility through streamlined effort resulting from a strong toolset with corresponding process improvements
- Clearer project focus through the discipline of a well-documented change management process

- Streamlined decision-making from easy-to-access reports of change requests, hyperlinks to change request documentation, and online access to relevant background information
- Increased efficiency through common knowledge and understanding for project team members

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

- **Mock configuration—**A single-purpose environment to store the official benefit plan administration and other configuration code values of the Colorado interChange solution. This mock environment allows the configuration and validation of benefit changes outside the production environment, giving greater control to managing new or changed benefit policies.
- **Development and integration test—** This environment is used by developers to experiment, develop and unit test solutions. The individual developers, per the developers guide, are setting the standards for batch, online, and service integration environment standards support this environment.
- **System testing—**This environment provides end to end testing. Within this environment, testers will review the major scenarios of the MMIS. The number of testers increases

compared to the integration level testing which was more focused to specific testing to implemented changes.

- **User acceptance testing—**The environment used by the state to validate the business features meet the finalized requirements. This environment also allows vendors to submit test transactions. This is the final quality assurance stop before the application migration to the production environment.
- **Production—**The final stage of change management release housing the components which together support the clients, providers and support user personnel of the Colorado interChange (Note: Performance testing will be performed in the production environment during the DDI).
- **Production disaster recovery (Staging)—**A production like environment used to support MMIS disaster recovery business needs.
- **Training—**This environment provides the users with the latest copy of the application for user training of the features which are ready for implementation. The environment is rebuilt as needed to support the user community training needs.

Security Control Implementation and Status Information (Unique ID 1195)

Our proven approach provides defined checkpoints for Department reporting and review. Working with the Department, HP identifies clearly defined management, operational and technical (physical) controls to prevent potential threats, unauthorized access, or disclosure of sensitive information. The controls provide objective evidence to demonstrate compliance with state and federal security and confidentiality laws. A full discussion of our Security Control Implementation and Status Information solution is found in RESPONSE 38e.

Release of PHI and Privileged Information (Unique IDs 1198, 1199)

(1198) HP will continue to use our best practice procedures to prevent unauthorized exposure of PHI, PII, or other sensitive information. Whether the request for information is electronic or paper, HP complies with the regulations and requirements for the handling of PHI, PII, or other sensitive information. (1199) HP will obtain written Department approval before releasing or disclosing PHI or privileged information to any non-Department entity.

Having safeguarded the operation and integrity of Medicaid data for more than 40 years, HP is skilled at applying state-of-the-art security technologies, systems access restrictions, and procedures that protect the integrity and the data of the Colorado interChange.

The privacy and security team on the Colorado account will be proactive in its approach to the protection of PHI. This team has created and enforced account polices for the protection of both paper and electronic PHI for other Medicaid accounts. The policies include rules that PHI is kept in locked cabinets—not left unattended on desks or printers—and that computer stations are locked when not in use by an authorized user. The following figure shows the plan for tracking privacy and security activities.

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

Our corporate privacy and security teams meet monthly with their counterparts on the Colorado project and review a detailed work plan that tracks privacy and security activities. The work plan tracks several HP self-audit activities initiated to check privacy or security concerns. These activities include desktop audits to check for unattended PHI or unlocked computers, facilities audits, random workstation audits (such as monitor compliance with encryption requirements, antivirus software, and screen saver lock), and badge access reviews.

The Department can count on the HP Privacy team to be aware of Colorado-specific statutes and regulations that provide additional restrictions or requirements on the release of PHI and PII.

HIPAA Incident Reporting

Each employee is aware of the requirement under HIPAA and HITECH to prevent and report privacy and security incidents. The account privacy staff reviews known incidents and promptly reports privacy incidents to the Department. Our policy is to report data breaches to our customers and law enforcement officials based on the requirements in the customer contract and relevant security breach laws and regulations.

Our post breach review procedure includes analyzing system and procedures to validate that we are taking appropriate remediation and performing source analysis. HP has a proven record of transparency and responsiveness in privacy incident reporting and complete follow-up investigation, mitigation, and remediation. It will be clear to the stakeholders what has occurred

and where that item is in research, process, or remediation, alleviating the pressure for State stakeholders to monitor and track the outcomes.

Role-Based and Group-Based Security (Unique ID 1207)

HP understands security of program information is paramount, and that drives our approach to protecting and maintaining data entrusted to our care. We use a role-based security approach for processes and policies and audit logs documenting data access information. We update and track user security profiles, implement security processes and policies with the security administrator, and work to meet future State-specific data security requirements. We maintain report access by the individual user security profile, which we can manage at the report level. This approach lets users access data required to perform their job while restricting access to only those authorized.

Besides individual security, the Colorado interChange provides group level role-based security with business groups having profiles established within the security solution. As we add MMIS users, we authenticate and authorize them according to their defined and 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.

Secure and Reliable Data Exchange (Unique ID 1297)

The Colorado interChange Connections component of our solution establishes the interoperability necessary to effectively distribute information in the Colorado interChange and across the Medicaid enterprise. It simplifies sharing standard transaction sets with trading partners through the Microsoft BizTalk Enterprise Service Bus (ESB), file-tracking system, HIPAA-compliance validation, and monitoring framework. HP uses interChange Connections as the backbone and message manager for exchanging data across the Medicaid enterprise.

With its security, encryption, integration, and messaging capabilities, interChange Connections provides the foundation for interacting with other entities—designed to be the middleware between multiple systems and across multiple platforms. When using Colorado interChange, a business user is unaware of the technological differences that may exist between a service's platform, architecture, or network protocol. interChange Connections handles the file and transaction routing, pre and post process, translation, and connectivity supporting various data connections and transport protocols, simplifying the integration effort with external entities.

One of our principle objectives in designing Colorado interChange was to continuously achieve higher levels of MITA maturity across the Medicaid enterprise. The modular design of the MMIS is flexible to meet future MITA needs and architecture requirements. For example, interChange Connections will be used to meet several of the Affordable Care Act (ACA) 1104 requirements that deal with the exchange of standard transaction data and the infrastructure that supports such systems.

The Colorado interChange provides the framework for addressing future architectural requirements. The following table summarizes how the MMIS addresses MITA requirements.

HP Colorado interChange Addresses MITA Requirements

MITA Requirement	How the HP Solution Addresses the Requirement in the Future
Interoperability	interChange Connections simplifies sharing standard transaction sets with trading partners through the integrated ESB, file-tracking system, HIPAA-compliance validation, and service-monitoring framework.
Workflow Management	interChange workflow standardizes business processes, enhances efficiency, optimizes outcomes, and advances MITA maturity.
Rules Engine	Business processes are supported by business rules that are defined for the Colorado interChange and are standardized to make them consistent throughout the enterprise.
Business Maturity	The Colorado interChange will deliver business services regardless of the underlying technology and will automate and standardize processes using business rules.

interChange Connections includes notifications configurations, which allow notifications of success or error to be configured at both the individual user level, and individual transfer level. This level of notification customization allows HP to deliver the correct notifications to the correct parties without the need to mass mail.

Electronic Tracking Mechanism (Unique ID 1692)

The Electronic Document Management System (EDMS) monitors, tracks, logs, and moves files throughout interChange. EDMS provides a complete file audit trail with real-time, processing-stage updates. EDMS identifies the archived location of source documents, facilitating data retention and destruction processes. Access to EDMS content is carefully controlled using role-based security to verify compliance with HIPAA privacy and security requirements regarding security of PHI. Additionally, HP will establish the appropriate procedures regarding the disposition of PHI and will implement reasonable safeguard to protect PHI when purging source document in accordance with Department retention and purge time frames.

RESPONSE 39f

8.8 – Program Integrity	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1222, 1258, 1453, 1597, 1604, 1606-1610, 1625, 1642, 1643, 1693, 1694, 1698 – 1699	**YES**

Description of Offeror's Approach

Program integrity is a critical function and service of the Colorado interChange. Program integrity handles such functions as audits, medical review, and potential fraud and abuse investigations with analysis and trending of Medicaid information and data. HP will support this function with interChange MMIS, which includes data from the provider, client, and financial subsystems. To support the Business Intelligence and Data Management (BIDM) system, we will securely provide accurate data to detect and prevent fraud and abuse and identify patterns that may lead to improvements and cost savings for the Colorado Medical Assistance program.

Data (Unique IDs 1693, 1694)

(1693) Data elements as required by the Department and additional data required for appropriate analysis of the Colorado Medical Assistance program will be housed in the interChange MMIS and accessible through the HP ad hoc data warehouse system. The data warehouse system will provide authorized users quick access to accurate and complete MMIS data such as the following:

- Financial transactions
- Reference data
- Provider data
- Third-party liability (TPL) data—including cost-avoidance interface with the TPL vendor
- Client data
- Claims and encounters data—including adjudicated, suspended, adjusted, and voided claims or encounters

Following implementation, the data warehouse system will store six years of historic claim data and nonclaim data. As claims and transactions are processed, the new data will be added to the data warehouse.

(1694) To transfer the legacy MMIS-based SURS data to the BIDM based SURS program, we will implement data conversion programs. The data conversion programs will convert the applicable data into the new MMIS database. The BIDM group will extract and load the SURS data into the BIDM repository.

(1697) Within the client portal, HP will make optional modifications to the web portal to allow clients the ability to send referrals, that includes the EOMB, to the Department's Program Integrity Section when a client identifies services on an EOMB that were not actually received.

Provider Enrollment (Unique IDs 1698, 1699, 1453, 1222)

An effective piece of the Colorado Medical Assistance program is preventing abusive or fraudulent entities and individuals from enrolling in the program. HP's understands that the Department's current procedures and policies and rules from the Affordable Care Act (ACA) are important to protect Medicaid dollars, promote program integrity, and support quality care.

(1698) To promote the integrity of the Colorado Medical Assistance program, HP will validate provider identity through fingerprinting, as specified in the ACA Provider Screening Rule. We have worked with other states to successfully implement this requirement by working with LexisNexis.

LexisNexis has a robust fingerprinting offering that HP will employ for the Department. LexisNexis is one of the few FBI-approved fingerprint channelers and a trusted resource for completing fingerprint-based criminal background checks. As an approved channeler for the FBI, LexisNexis complies with the policies and requirements established by the FBI for channeling and outsourcing of fingerprinting based on criminal background checks.

(1699) Besides fingerprinting, authorized system users can view, search, sort, and flag providers that are identified with sanctions, terminations, and exclusions. In interChange, the Provider Contract panel features an "enrollment end" reason. The values used are easily maintained in related data. A specific "end" reason is used when providers are terminated because of sanctions, terminations, or exclusions.

interChange interfaces with CMS for the Medicare Exclusions Database (MED)—formerly known as OIG/LEIE. The sanctioned information is stored on the Provider - Related Data – Other – Sanctions panel in interChange as shown in the following figure.

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

The Department also may enter state specific sanctions in the table. This information is used when enrolling and re-enrolling providers to alert the enrollment staff of sanctioned providers. Monthly reports are generated listing enrolled providers, providers in the process of enrolling, owners, and managing employees found on the sanction table. Additionally, "termination" reasons (enrollment status) also can be set up to identify providers terminated by CMS/OIG. The enrollment status values are easily maintained using the Provider - Related Data – Codes – Enrollment Status panel.

(1453) interChange enables users to capture the provider termination or denial reason, as determined by Department business rules, with searchable reason and explanations. Additionally, the end date also is captured. The end reasons are easily maintained on the Provider - Related Data – Codes – Enrollment Status panel. Reasons for denial of a specific enrollment application are stored on the Application Status Reason panel. The various reasons for denial are stored on the Provider - Related Data – Codes – Letter Reasons and Text panel.

(1222) HP will work with the Department to implement the ACA Provider Screening Rules in the Provider Enrollment tool. We also will use LexisNexis for provider credentialing and background checks. Staff members will pull information from a large database provided by LexisNexis that contains 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, managing employees, and partners.

LexisNexis compiles reports on companies and individuals associated with a Tax ID or Social Security number. These reports can include such information as civil judgments and liens, bankruptcies, court and regulatory rulings, negative news, and felony charges. LexisNexis also 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 allies and individuals with more than a State-defined percentage interest in the business. We will work with the Department to define processes for providers with negative information identified during screening and determine the frequency of file submissions to LexisNexis.

Financials (Unique IDs 1258, 1604, 1606, 1607, 1609, 1610, 1625, 1642, 1643, 1597)

HP has extensive, long-term Medicaid experience in financial management. We support 20 Medicaid systems in 20 states and perform 2.4 billion Medicaid transactions annually. To successfully monitor provider compliance, detect fraud and abuse, and identify the appropriateness and quality of care, HP understands that the processing of claims and financial transactions must be performed accurately and according to the Department's policies and procedures.

(1258) HP will support the financial process by developing a customer interface developed during DDI to send appropriate accounting information through COFRS for each program integrity and Department's recovery, offset, or adjustment. The customer interface will produce reports to validate that everything remains balanced and accurate.

Accounts Receivable and Accounts Payable (Unique IDs 1604, 1606)

(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. interChange allows an AR to be set up and a percentage or specific dollar amount to be set for how much to retrieve from the provider each cycle. This is performed using the AR panel shown in the following figure that allows the authorized user to access AR data for providers.

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

The user also 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.

During the financial cycle, payments are applied to open ARs. Claim adjustments that result in a negative payment will automatically create new ARs. The system also creates ARs for negative capitation records.

The AR Mass Adjust panel can be used to transfer ARs from one payee to another. It also allows the mass update of recoupment percentage, amount, and status. A set hierarchy for AR recoupment can be further defined. Basically, the same cycle adjustment ARs are recovered first, followed by the oldest AR.

(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.

Payments (Unique IDs 1607, 1609, 1610, 1625, 1642, 1643, 1597)

(1607) interChange enables users to complete and track full and partial adjustments to claims or encounters. Claim adjustments are processed real-time and during the weekly financial payment cycle the determination is made related to setting up an AR. 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 why the transaction is being done and is assigned by the system or User Interface 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 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 system can provide authorized system users the ability to withhold or suspend provider payments after adjudication and before a final paid claim status can be performed. The Financial Payment Hold screen shown in the following figure can be used to hold claims based on several criteria such as a provider with a dispute or a court case. When entering the payment hold criteria, the user also enters a banner message to display on the provider's remittance advice.

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

Claims balancing reports are also generated to confirm the integrity and accuracy of the data.

(1642, 1643) interChange enables users to apply, track, and document recovered (and partially recovered) or recoverable monies (and partially recoverable monies) to the appropriate claims or encounters, at the level corresponding to the allowed charge. When payment is received from the provider, a history only claim is created to apply the money collected. The claim is not touched if

money is received from an insurance carrier. interChange will track the money through an accounts receivable.

For example, if a provider sent in a check because they inadvertently billed for services that they did not perform, the payment (cash receipt) is entered into the Financial Cash Receipt Information (FCRI) panel. The payment received is applied to the claim or encounter and is promptly adjusted. The following figure shows a sample screen of the FCRI panel.

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

(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. interChange can create a new claim with the new client's ID behind the scene which is not apparent to the provider.

8.8 – Program Integrity	**In Production?** **YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1285, 1286, 1608, 1626, 1695, 1696, 1697	**NO**

This section addresses two requirements and one optional requirement that are not in production in the interChange system.

Program Integrity Requests (Unique ID 1285)

HP recognizes that accurate data and reporting supports the integrity of the Colorado Medical Assistance program. Requests, such as program integrity requests, can have weights assigned to the request based on difficulty or other criteria jointly defined by the Department and HP. This will verify that the requests are properly addressed and processed promptly.

Assignments and Managing Capacity Levels (Unique ID 1286)

VITAL does not currently provide the ability to assign authorized system users and manage capacity to case managers at the agency or program level, PAR reviewers, or program integrity reviewers. A workflow can be built that will, as a built-in feature, allow task assignment configuration for certain authorized individuals or groups.

User-Defined Reporting and Alerts (Unique ID 1608)

interChange also enables users to monitor the AP/ARs with user-defined reporting and alerts 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.

BIDM Data (Unique ID 1626)

Additionally, 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 because of potential wrongdoing and are committed to timely and accurate processing of data from the BIDM.

Identification of Claims/Encounters at the Detail Level (Unique ID 1695)

interChange enables users to identify claims or encounters and, previously, subject to audit or recovery down to the claim level, however, it does not occur at the line detail level.

If an edit is posted, it is posted on either the header or the detail. Claims/details that were denied can be identified based on the edit. However, TPL recoveries on claims do not get applied at the detail level. When money is received from other insurance, the claim is completely voided and applied to a TPL AR. Changes to the system would be necessary to track this at the detail level. We will modify interChange to meet this requirement.

Pre-Payment Reviews (Unique ID 1696)

Effective safeguarding the state and federal tax dollars spent for providing quality healthcare requires monitoring healthcare and transaction activities that appear outside the norm of their peer groups and current practice and consumption patterns from all angles of the healthcare delivery spectrum. HP will provide the ability to conduct prepayment program integrity reviews independently of receiving information from the BIDM. The prepayment analytics identify fraud, waste, abuse, upcoding, unnecessary services and other irregular billing or service practices (1696). The interChange MMIS provides the ability to place a particular provider on review and suspend their claims for a particular procedure, claim type, place of service, or combination to facilitate identification of fraud, waste, abuse, upcoding, and unnecessary services.

Data (Unique ID 1697)

Within the Client Portal, HP will make optional modifications to the web portal to allow clients the ability to send referrals that includes the EOMB, to the Department's Program Integrity Section when a client identifies services on an EOMB that were not actually received.

RESPONSE 39g

8.9 – Care Management	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1585, 1664, 1670, 1700-1706, 1708, 1709, 1751, 1873	**YES**

Care Management Overview

The HP team proposes the McKesson Versatile Interoperable Technology Advancing Lives™ (VITAL) platform to support the Department's objectives of implementing a comprehensive clinical software system to support the collection of business processes related to managing the health of the Medicaid population, establishing cases, managing cases, and managing the registry.

The VITAL platform will provide the features and interoperability to facilitate comprehensive utilization and care and case management of clients—including alerts, work lists, and dashboards—by integrating multiple data sources and tasks into a single workflow. Concurrently, the software system will serve as a repository for the collection of information about the needs of the individual client, plan of treatment, targeted outcomes, and the individual's health status.

The platform is easy to use and has an intuitive interface. Its features increase efficiency and enforce clinical integrity with care management services and include the following:

- A comprehensive client record to quickly understand the needs of a selected client
- Features to create and assign cases quickly with only a few clicks
- Comprehensive assessments to generate integrated care plans encompassing physical and mental health needs and co-morbidities
- Embedded clinical content including assessment modules for more than 25 chronic conditions and barriers to care
- Dynamic care plans in which problems and goals are easy to prioritize, update, and report
- A clinical variables tab to track client progress toward positive health outcomes
- Automated referrals and case tracking among utilization management, case management, and disease management departments
- The ability to capture notes and attach documentation from external sources to the client record
- Automatic follow-up reminders and events scheduling

The VITAL platform has been implemented for more than 90 managed care customers since its first release in December 1997. Today, 71 individual organizations and health plans use the platform, covering about 18 million lives with approximately 4,000 users. HP will provide the Department with proven tools and services to stay ahead of a rapidly evolving industry. We are ready to identify and implement additional measures and activities to help you achieve revenue goals, and we offer differentiators that truly set our care management services apart from our competitors.

Care Management Tool Functional Capability

The following table briefly describes how the VITAL platform meets the Department's requirements for care management.

VITAL Features Meeting Care Management Requirements

Requirement	VITAL Platform Function
Collection of business processes related to managing the health of the Medicaid population	The VITAL platform includes tools to support Medicaid initiatives by applying clinical criteria to proactively identify Medicaid client gaps in care and then alerting care managers and providers to take action to close those care gaps. Today the VITAL platform is used by 33 different payer organizations to manage more than 5 million Medicaid lives. Key statistics include the following: • Covered lives of largest Medicaid client—1.2 million • McKesson customers using the VITAL platform for Medicaid-only lines of business—14 • Average covered Medicaid lives across the plans—142,000 • Longest running contract covering Medicaid lives—13 years (since 1999)
Establishing Cases	The VITAL platform includes an intuitive user interface to quickly and easily establish a new case based on a real-time referral, eligibility data refresh, or manual ad hoc case creation by the user.
Managing cases	The VITAL platform is designed to enhance workflow efficiencies, including case management processes. The VITAL platform includes a Case Management screen that allows management personnel to view case distribution across Care team staff members and reassign cases with one mouse click.
Managing the registry	Because the data fields stored within the VITAL platform are reportable, the Department can use the platform to track and monitor the client registry, including open cases, benefit eligibility, interventions, and outcomes.
Collection of	The VITAL platform integrates data from multiple sources—such as

Requirement	VITAL Platform Function
information about the needs of the individual client	eligibility files and claims data—to build a comprehensive collection of individual client needs to be monitored and tracked across time. Within the platform, the Client Summary screen provides a view of the most recent information related to the client—including open cases, recent authorizations, medications, benefit coverage, outstanding reminders, and recent diagnoses. Additionally, the VITAL platform provides a Client Summary Report that allows users to print or display selected elements of the client record. This report includes client demographics, coverage, cases, goals, problems, and notes.
Plan of treatment	The VITAL platform includes InterQual® Coordinated Care Content assessment modules to address common chronic conditions and associated barriers to care. The comprehensive assessments generate client-specific care plans that encompass physical and mental health needs and co-morbidities. With the Content Customization feature, the Department can customize assessment sections, subsections, questions, rules, alerts, and notes. Furthermore, the Content Customization tool allows users to configure problems, goals, interventions, instructions, educational components, and notes. The InterQual Content Customization tool is a simple editing environment that can be used to easily configure InterQual Coordinated Content that is already built into the VITAL platform into a custom assessment format.
Targeted outcomes	The VITAL platform supports targeted outcomes by identifying gaps in care and then establishing care plan goals to achieve outcome targets. The platform allows for outcomes to be tracked across different levels including at the client level, by provider, by care manager, and by plan.
Individual's health status	With the VITAL platform, care team members and health plan staff members from different departments can access the same client record to monitor an individual's health status. Users can read and write to the same client record and each department or user group can assign its own set of read or write privileges to support HIPAA-related policies. The platform integrates with the HP Healthcare Portal to enable collaborative care. Connecting care managers, clients, providers, and payers in this way creates a truly holistic, patient-centered program in which each party can make informed decisions.
Processes that support individual care management	Provider collaboration is a key process to support the individual care manager. The VITAL platform is linked from the HP Healthcare Portal to give physicians secure access to client care plans, gaps in

Requirement	VITAL Platform Function
	care, and the most current Department information. Providers can view their patient's care management plan and make specific care plan recommendations to be followed up by Care team personnel through a browser-based interface.
Processes that support population management	The VITAL platform is a browser-based software solution that combines utilization, disease, and case management activities into a smooth workflow; enhancing Care team coordination; and providing the foundation for a unified health management program. The VITAL platform will allow the Department to streamline each facet of care management by connecting case managers, providers, and the clients. With the VITAL platform, Department personnel can maintain comprehensive client records, complete work tasks based on reminders and alerts, and view provider notes and utilization history. With a few mouse clicks, the VITAL platform enables the following: • Create and assign cases with comprehensive User Management tab • Conduct assessments and establish a clinically sound care plan based on InterQual Coordinated Care Content, which makes it easy to manage clients with complex cases and co-morbid conditions in a single assessment • Create customized InterQual Coordinated Care Content assessments and criteria with the InterQual Content Customization tool • Evaluate, conduct, and document utilization events • Capture notes and attach documentation to a client record • Set automatic reminders for follow-up and schedule further events • Capture report and outcomes information • Refer and track clients, authorizations and cases • Trigger alerts based on client gaps in care
Promote health education and awareness	The VITAL platform includes a dedicated client web portal. This portal will be linked from the HP Client Healthcare Portal and provide access to educational health content and interactive tools, such as the following: • Online nurse advice • Wellness tools • Personal health record • Symptom adviser and alerts or reminders Clients can use the VITAL Client Portal to track care plan goals and complete health assessments that feed directly into the VITAL platform.

Requirement	VITAL Platform Function
	The VITAL provider and client web portals support consumer accountability for lifestyle behavior, compliance with prescribed treatments, and discretionary healthcare service purchasing decisions. These components integrate to positively affect care and case management programs to ultimately improve the quality of care delivered to clients and reduce future costs.
Ability to accept and store immunization information on Colorado Medical Assistance program patients	The VITAL platform is intended to serve as a single data repository, storing client health, eligibility and care management records including immunization information on Colorado Medical Assistance program patients. This data can be loaded into the platform through a standard data refresh process. When loaded, the data can be viewed and reported through the VITAL platform.

Besides meeting functional capability requirements for care management, the platform also is embedded with InterQual Coordinated Care Content, which integrates clinical integrity directly into the care management workflow to verify clients receive consistent and high-quality care. Additionally, the VITAL platform aligns with URAC and NCQA requirements and supports Medicare Advantage STARS reporting initiatives.

Waivers, Other Long-Term Care Benefits and Services, and Benefits Utilization Services

The McKesson VITAL platform supports management of waiver clients by serving as the singular workflow tool that ties utilization, disease, and case management activities together. At the same time, the VITAL platform supports provider engagement by including a provider web portal that allows bidirectional communication between primary care providers, specialists and care team personnel. This connectivity coupled with the clinical integrity of the InterQual Coordinated Care Content, which drives comprehensive mental and physical health assessments supports waiver reporting and other related requirements.

Capability to Define and Manage Waiver Clients (Unique ID 1585)

The VITAL platform enables Colorado Medical Assistance program HCBS waivers to be defined and managed in the MMIS as Health Benefit Plans by associating coverage with the appropriate clients during the eligibility refresh process. Clients can be loaded into the platform with waiver affiliation data, if known, as seen in the following figure. When waiver affiliation is not included in the eligibility refresh file, platform users can manually insert waiver affiliation data after it is identified during the enrollment or needs assessment process.

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

Capability to Track Unduplicated Waiver Participants (Unique ID 1664)

Besides tracking waiver eligibility, the platform enables users to identify, track, and report unduplicated participants enrolled in 1915C programs, other waiver programs, and other long-term care services. This is accomplished by data refresh or manual designation of participants enrolled in the 1915C programs, other waiver programs, and long-term care services made by users within the platform. Regardless of the source of data, the Department can generate reports from the platform to identify and track clients enrolled in waiver programs.

Health Management

The VITAL platform supports health management by identifying gaps in care and establishing care plan goals to achieve outcome targets. The platform allows for outcomes to be tracked across different levels including at the client level, by provider, by care manager, and by plan.

Capability to View and Track Historical Health Assessments (Unique ID 1670)

The VITAL platform provides the ability to support and track the results of a health risk assessment at time of enrollment for Department-specified program type or aid categories, prior history of assessment, and other criteria defined by the Department by aggregating data from multiple sources into a data repository. This data is then presented in a comprehensive client record that is maintained within the platform.

Besides the most current available client health data, the platform also stores and displays historical content, such as previously completed health risk assessments. As shown in the following figure, users can select the Assessments tab within the client record to view historical health risk assessments. From this screen, users can resume incomplete assessments or review the results to track client progression toward improved health status.

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

Provider Plan of Care (Unique ID 1705)

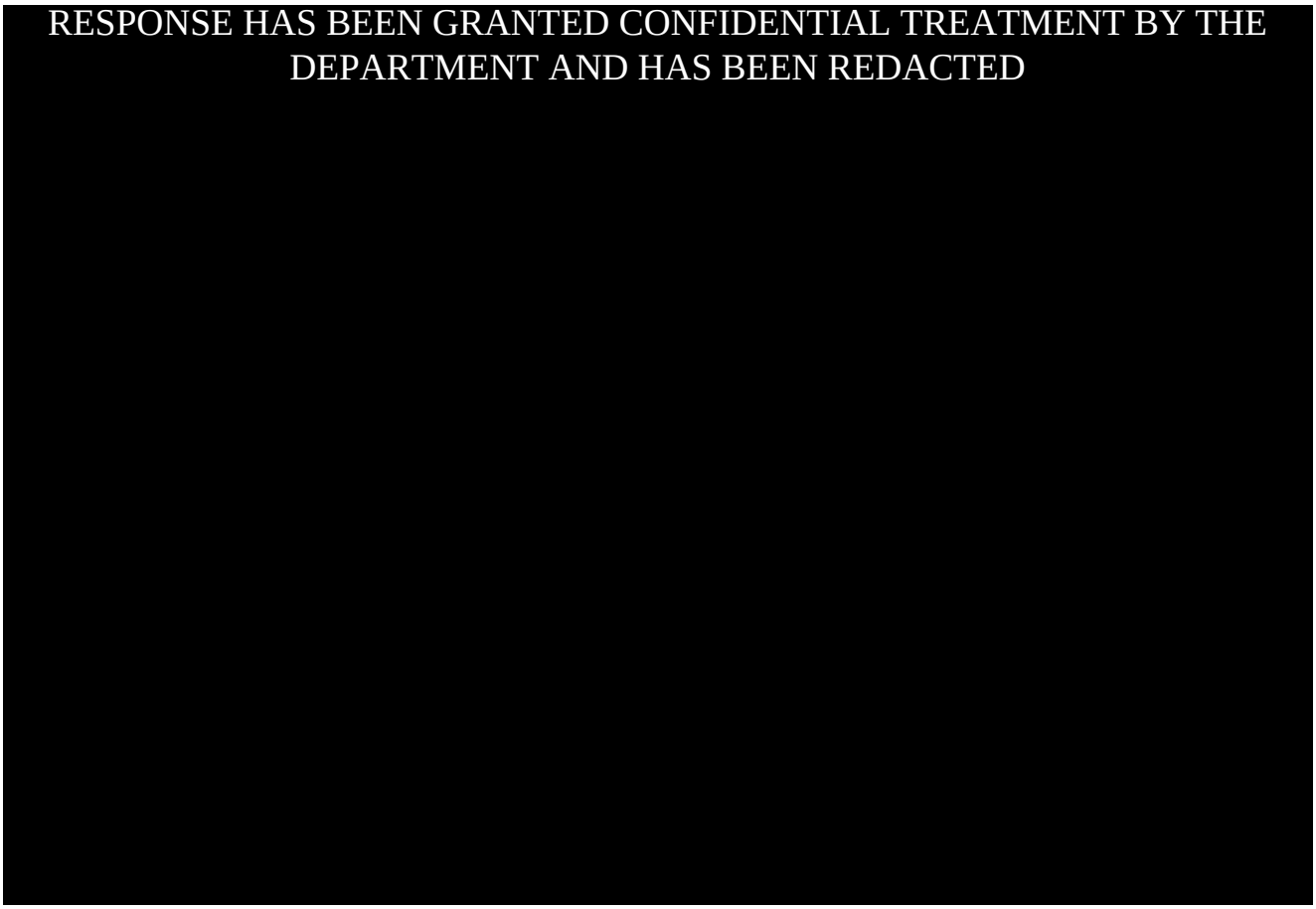
The VITAL platform encourages a collaborative relationship between care and case managers and the client's medical team by serving as a single record of care. With the VITAL platform, Department personnel can capture and store a provider's plan of care for a client and make it available to authorized Colorado interChange MMIS users. This is accomplished by adding the provider's plan of care to the client record using the "notes" feature within the platform. McKesson will provide the Department with a file layout to set up the capability to load provider notes into the client record in text format. The following figure is an example of the file layout to be used to load provider care plans into the platform. Loading the care plan data in a text format allows for care manager to annotate the provider care plan as client issues are addressed.

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

Storing Qualitative Data (Unique ID 1706)

The VITAL platform allows users to store qualitative data related to client health management with the attachments function of the notes module, as shown in the following figure. The module allows the user to document and review encounter or intervention for a client. The types of documentation include note entry, letters, completed assessments, survey reviews, and any other attachments received for the client. Because of this, different care team clients can view documentation such as calls to providers or clients, letters sent, research completed, or services coordinated.

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



The next figure demonstrates how the Department can gather documentation such as referrals to community resources within authorization records or assessments. The VITAL platform can import .PDF files so the Department can scan and import inbound or outbound communication with the Notes module. These modules collaborate to positively impact disease and care management programs.

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

Client and Population Health Demographics (Unique ID 1709)

The VITAL platform enables users to collect relevant data from available sources, such as the Colorado Regional Health Information Organization (CORHIO). This data will be used to prepopulate comprehensive client records with existing electronic medical records. The platform stores and displays detailed client information and clients may have multiple active coverage records available at the same time. Waiver affiliation and benefit information will be stored in the Client Profile module of the platform and viewable from the Benefits screen as shown in the following figure.

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

Besides coverage information, the platform stores detailed client information including demographic data, historical assessments, current and historical care plans, utilization and claims history, and clinical health data. For example, the Client Summary screen provides a snapshot view of coverage information, current case-related alerts and reminders, pharmacy claims, medications, and diagnoses as the following figure details. Each of these data sets can be drilled into to access details on each specific item.

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

Further, users will have the capability to import Department-specified program criteria as clinical variables to allow the Department to track specific measures as needed. The next figure shows examples of clinical variables that can be tracked within the client record.

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

Identification of Special Healthcare Needs (Unique ID 1751)

The VITAL platform includes Coordinated Care Content assessments. With Coordinated Care Content, the VITAL platform addresses barriers to common care, case management, and 31 different conditions or disease states. Clinical content supports the VITAL platform by bringing co-morbidities together into a single care plan for a clearer overall picture of the client's health.

The barriers and common care assessment screen shown in the following figure will help users determine the client's special healthcare needs.

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

Capability to Record and Track Special Needs (Unique ID 1751)

The VITAL platform provides the ability to identify clients with, and evaluate clients for, special needs including hearing, visual, speech, developmental disability, reading proficiency, physical disability, cognitive or intellectual disability, and cultural or religious preferences. These special needs are tracked in the platform as client-specific care plan goals, as the following figure details.

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

Disease Management

The VITAL platform includes InterQual Coordinated Care Content assessment modules to address common chronic conditions and associated barriers to care. The comprehensive assessments generate client-specific care plans which encompass physical and mental health needs and co-morbidities.

With the Content Customization feature, the Department can customize assessment sections, subsections, questions, rules, alerts, and notes. Furthermore, the Content Customization tool allows users to configure problems, goals, interventions, instructions, educational components, and notes.

The InterQual Content Customization tool is a simple editing environment that can be used to easily configure InterQual Coordinated Content that is already built into the VITAL platform, into a custom assessment format.

Early and Periodic Screening, Diagnosis, and Treatment Tracking and Monitoring (Unique ID 1700)

The VITAL platform facilitates the maintenance, for each Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) enrollee, of current and historical EPSDT screening data, referrals, diagnoses, immunization data, and treatments for abnormal conditions identified during the screenings, based on periodicity schedule. Further, the platform can link the follow-up treatments to the screenings for reporting purposes.

The platform maintains current and historical EPSDT data as part of the comprehensive client record and triggers related alerts to draw attention to missed services. Department personnel can view EPSDT data, such as screening data, diagnoses, immunization data, and treatments for abnormal conditions on the client's Summary tab.

Additionally, VITAL includes a provider facing bidirectional web portal—available as a link from the HP Provider Healthcare Portal—to allow authorized providers access to this information, and provide online, updateable document templates for EPSDT notices for authorized MMIS users.

EPSDT Follow-up Notices (Unique ID 1701)

The Department can generate manual and automatic initial and follow-up EPSDT notices based on Department-defined periodicity schedules from within the VITAL platform, using the built-in letter generation capabilities. The VITAL platform is different from other care and case management platforms on the market because it takes advantage of a full-function letter authoring software to provide an easy way to design, deliver, and manage high-volume, personalized client communications. Therefore, Department personnel can create custom and automated EPSDT follow-up letters within the VITAL platform, which can then be mailed or faxed to clients and providers.

A built-in letter editing tool provides Department users with "point-and-click" access to a central repository containing templates with preapproved content and preconfigured workflows that easily guide the assembly and generation of documents while care managers interact with clients in real time. Generated documents can be delivered in any form preferred by the Department's clients—print or electronic.

With this dynamic letter generation functional capability, the VITAL platform can be used to easily design compelling templates, incorporating complex logic, guided workflows, and real-time data that serves as the basis for the Department's fully personalized document communications—from a complex letter to a highly customized insurance policy.

Matching EPSDT Services to Paid Claims and Encounter Data (Unique ID 1702)

The VITAL platform can match and track client treatments and referrals (including EPSDT) using paid claims/encounters data based on procedure codes. When a gap in EPSDT services is identified, such as a missed set of immunizations—such as DTap/DTP, Polio (IPV), Hib, PCV, or RV—the platform will trigger an alert notifying the care manager of the gap. Further, alerts can be set up in the platform to enables users to generate automated referrals to providers and case managers. VITAL platform will provide individual alerts at the client level.

Provider Referrals for Case Management Follow-Up (Unique ID 1703)

Care management activities are most likely to result in positive outcomes when services are delivered jointly by the Department and primary care providers. To provide the best care, the Department Care team must have an infrastructure in place to support real-time interactions with clients and their providers. Therefore, the VITAL platform includes a bidirectional web portal to allow authorized providers access to patient EPSDT information that is stored within the VITAL platform, such as patient and family medical history or immunization records. Through this web portal, providers can electronically communicate care plan notes back to the Department, including referring a client to the Department for case management follow-up. The following figure illustrates the real-time-referral screen, which providers can use to refer clients back to the Department.

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

Population Management

The VITAL platform is a browser-based software solution that combines utilization, disease, and case management activities into a smooth workflow, enhancing care team coordination and providing the foundation for a unified health management program. The VITAL platform will allow the Department to streamline each facet of care management by connecting case managers, providers, and the clients.

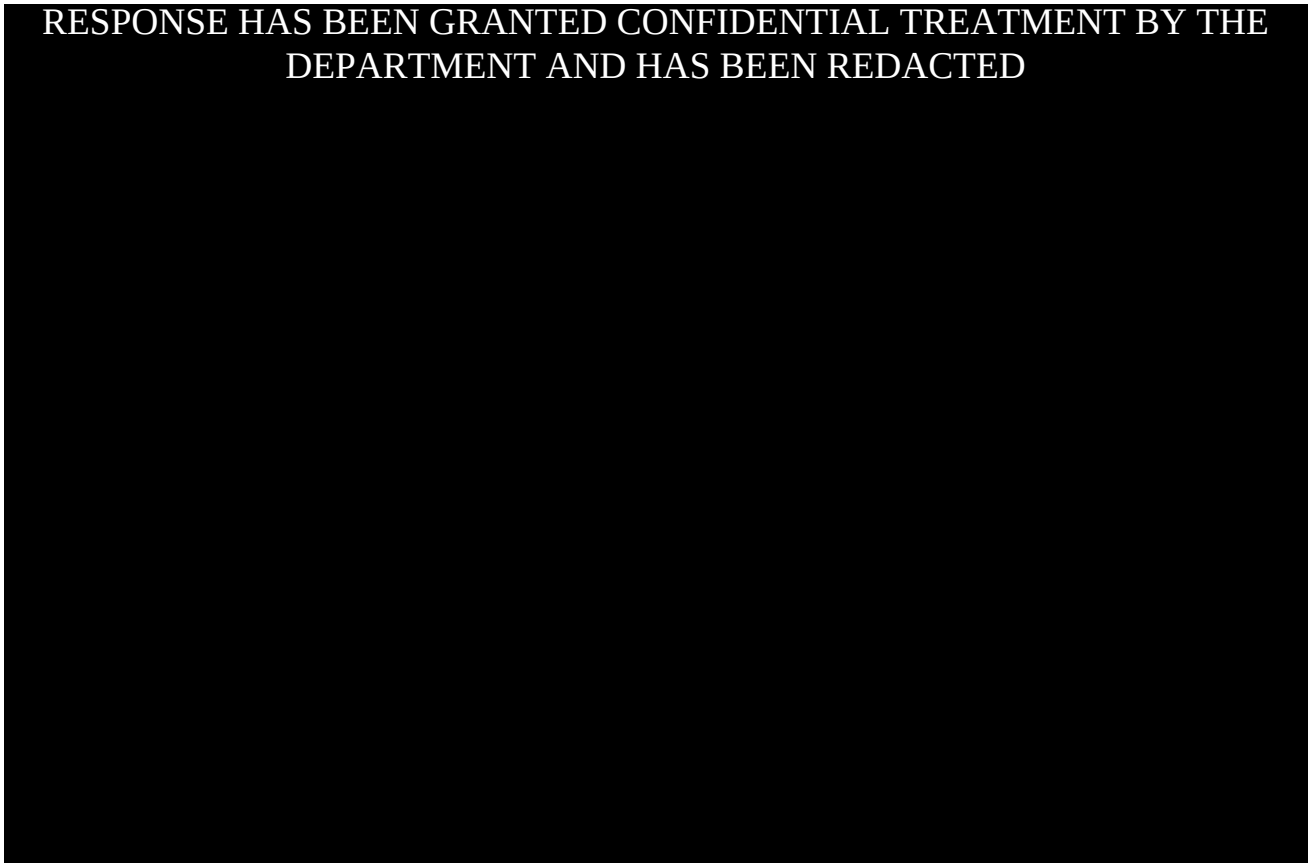
With the VITAL platform, Department personnel can maintain comprehensive client records, complete work tasks based on reminders and alerts, and view provider notes and utilization history. With a few mouse clicks, the VITAL platform makes it easy to accomplish the following:

- Create and assign cases with comprehensive User Management tab
- Conduct assessments and establish a clinically sound care plan based on InterQual Coordinated Care Content, which makes it easy to manage clients with complex cases and co-morbid conditions in a single assessment
- Create customized InterQual Coordinated Care Content assessments and Criteria with the InterQual Content Customization tool
- Evaluate, conduct, and document utilization events
- Capture notes and attach documentation to a client record
- Set automatic reminders for follow-up and schedule further events

- Capture report and outcomes information
- Refer and track clients, authorizations, and cases
- Trigger alerts based on client gaps in care

Tracking Overall Client Care Management Activities (Unique ID 1704)

The VITAL platform provides the ability to cross-reference case management activities to overall client care management by maintaining a history and running audit trail of system activity. This audit trail allows authorized users to cross-reference case management activities to overall client care management. The VITAL platform's audit logs cover data change, user logon/logoff, user page interaction, and the changes made in the application to client files. Besides data changes, the VITAL platform tracks who views PHI data in the application. The following figure represents a screenshot of the client history audit trail.



Patient Self-Directed Care Management

The VITAL platform and its related provider and client web portals support consumer accountability for lifestyle behavior, compliance with prescribed treatments, and discretionary healthcare service purchasing decisions. These components integrate to positively impact care and case management programs to ultimately improve the quality of care delivered to clients and reduce future costs.

Immunization and Other Registries

The VITAL platform imports client, benefit, and network provider data into the system from source files and uses this data to populate many fields in the system. Platform users will take advantage of the VITAL platform's standardized file exchange format to exchange data with interChange Connections. The VITAL platform provides the following six-level coverage hierarchy to support multiple plan designs:

- Group—such as waiver
- Plan
- Product
- Carrier
- Region
- Sub program

The VITAL platform will import claims, utilization and eligibility data from interChange Connections to auto-populate care and case management records. Clients may have multiple active coverage records available, and any prior coverage information is moved to history and made available from the client coverage screen. Department personnel can set and refresh reminders into the VITAL platform to alert users about benefits maximums.

The VITAL platform imports provider demographic data, including NPIs, into database tables. This information from your source system is used to populate specific fields within the VITAL platform. The provider database is searchable outside cases or episodes. The VITAL platform displays in-network status by matching provider contract with client benefit based on line of business. The provider database shows effective dates and termination dates to determine contract status on dates of service.

Data from other registries and sources also can be loaded into the platform through a standard data refresh process. These types of data may include immunization records, lab data, and HRA data. For example, lab data and biometric data can be imported into the platform and displayed in the Clinical Variables screen to be trended across time.

Health Care Services Review Notification and Acknowledgement (278N) (Unique ID 1873)

interChange Connections supports Health Care Services Review - Request for Review and Response (278) transactions. This transaction solution encompasses the transaction validation, enabling the go-forward solution to use the compliance edit logic built into the COTS package. interChange Connections can receive and send Health Care Services Review Notification and Acknowledgement (278N). Compliance edit logic built into the COTS package can be configured to support the 278N. The VITAL platform uses ASCII-based flat files for data exchange and accepts X12 278 transactions.

Waiver Program Case Management

The VITAL platform is intended to serve as a single data repository, storing client health, eligibility and care management records including waiver affiliation and immunization information on Colorado Medical Assistance program clients. This data will be loaded into the platform from interChange through a standard data refresh process. When loaded, the data can be viewed and reported through the VITAL platform.

Survey Information (Unique ID 1708)

The VITAL platform tracks and maintains survey information within the Assessments tab of the client's record. Furthermore, the Content Customization tool enables the Department to create surveys and customized assessments. After users complete an assessment or survey, the VITAL platform places a timestamp on the completed survey and displays the status. Clients can complete the customized surveys by using the Client Web Portal. Following completion, the VITAL platform can import the survey results into notes for users to evaluate.

8.9 – Care Management	**In Production?** **YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1358, 1707	**NO**

Health Plan Benefit Alerts (Unique ID 1358)

The Colorado interChange solution provides the ability to set program specific edit through the BPA user interface. Edits can trigger alerts to the client or provider in the form of letters or reports. HP's correspondence generation solution includes the ability to generate email and SMS notifications to MMIS stakeholders. Our innovative interChange inSight Dashboard reporting solution also will allow configuration of automatically triggered reporting using Microsoft SQL Server Reporting Services.

HP will work with the Department during the BPR and Requirements Validation phases to determine the alerting requirements and strike a balance between timely, targeted alerts and flooding stakeholders with unnecessary notifications.

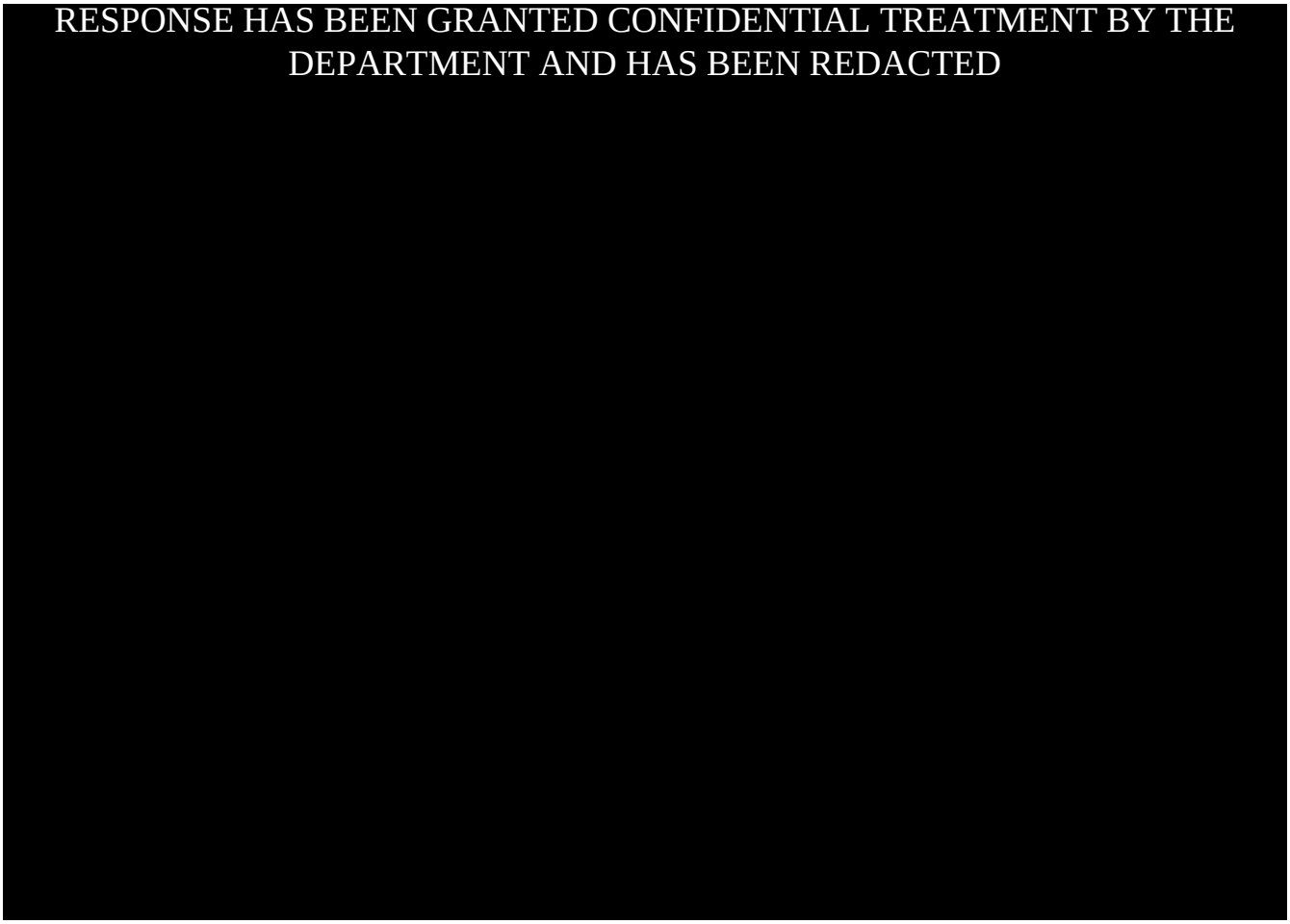
We provide additional information on Unique ID 1358 in RESPONSE 38t.

Capability to Report to Department and to the BIDM (Unique ID 1707)

With the VITAL platform, the Department can run reports based on a combination of one or more of any stored data field, including EPSDT coverage, utilization management, health management, and disease management categories. Reports can be exported to Microsoft Excel for further evaluation or viewed by approved third parties.

The VITAL platform includes a reporting function that contains prebuilt reports to cover most common case management reporting requirements as seen in the next figure. This set of standard reports contains dynamic data with drill-down capabilities from summary level to detail level.

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



RESPONSE 39h

8.10 – Managed Care	**In Production?** **YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1230, 1251, 1253, 1309, 1310, 1393, 1400-1409, 1411, 1427, 1430, 1534, 1563, 1596, 1650, 1653, 1654, 1672-1674, 1676, 1710-1720	**YES**

The flexible interChange system supports the many diverse managed care arrangements the Colorado Medicaid program has or may have in the future. We can quickly and easily add or change plan criteria in interChange. interChange's table-driven database system embraces the MITA principles by providing the Department with an interoperable, modular system with the flexibility to:

- Allow for and manage the differences in the program policy through establishing multiple Health Benefit Plans
- Identify clients and providers participating in various managed care programs
- Maintain and display managed care-covered and non-covered services and benefit limited services in the Colorado interChange for each managed care entity
- Process electronic transactions and encounters received from Managed Care Entities
- Coordinate with the Managed Care Entities and Department contractors to transmit and receive managed care-related information using system interfaces

We understand what it takes to coordinate care and services successfully to clients and provide administrative support to Managed Care Organizations (MCOs) and the Department. The robust managed care system within interChange allows for smooth interfaces with MCOs. interChange's flexible interface capabilities will accommodate the incoming daily electronic transaction updates from and to the MCO and manual updates, as necessary. The Department can assess clients' access to services quickly and completely through automated data retrieval and reporting.

Information captured by the Colorado interChange Managed Care tables and retrievable through the Managed Care screens includes the following:

- MCO geographic location, capitation rate, and organization type
- Providers within MCO network, including Primary Care Providers (PCPs)

- Termination information when an MCO contract is canceled
- Physicians who have agreed to provide gatekeeper services, number of clients assigned, and capacity to accept additional clients

Colorado interChange will efficiently support the accurate enrollment selection, rapid notification, and enrollment changes for both the provider and client business processes for managed care programs. interChange provides many options for making managed care changes, including mass enrollments or disenrollments, should a provider begin or leave the program.

HP uses interChange to successfully manage MCO enrollment and payments in several states. Within the solution, we support the capability to maintain capitation rates with effective dates for each provider, client, and program. The rates are segmented in the relational database, and therefore, are not overridden by updates. When rates need to be updated the previous rates are end-dated and the new rates are added. Rates can be based on the demographic profile of the client, such as age and gender. The flexibility of the system also allows for rate overrides.

For example, we can either use the rate in the capitation rate cells or use the one for the specific provider in the override table. Sound and proven system design allows for accurate payments based on known information at the time of the capitation runs. HP will use the Department-defined rates for determining per-member per-month payments made to each entity. We use the current client eligibility data within the Managed Care subsystem processes to calculate the monthly capitation payments. We exclude terminated, disenrolled, and deceased clients from the monthly capitation payment to the MCO.

We conduct periodic reconciliation of client files. We balance these against the MCO and PCP tables as well. If retroactive changes occur to a client's eligibility, interChange picks up and adjusts the reported data to the previous capitation payments made for the client. If a client changes plans, we generate a reconciliation and transfer of the capitation along with the changes.

Transition to Coordinated Care—Oregon's Approach

We have experience in helping clients move to an accountable care model. We have already used interChange to support Oregon's shift to this new delivery model. Coordinated Care Organizations (CCOs) are the foundation of Oregon's vision to improve care, achieve better health and lower costs. HP played an essential role in allowing Oregon to implement that vision successfully and to remain at the forefront of healthcare reform. HP's interChange system is agile and was easily adapted to support the new CCO model. Existing table-driven capabilities within interChange were used throughout the CCO project. This allowed for an expedited implementation of the new capabilities required to support CCOs.

HEALTHCARE SIMPLIFIED

Before the creation of CCOs, Oregon clients could be enrolled in up to three managed care plans simultaneously: physical health, mental health and dental health. The MCOs that provided these services were assigned a plan type indicator in the interChange system. A plan type indicator identifies each plan as a specific type of entity. For example, a Dental Care Organization

received a plan type of DCO. interChange uses the plan type indicator to determine which data elements are related and to drive processes such as Auto Assignment.

The implementation of the CCO model added a significant amount of complexity to the types of health plans available in Oregon. Multiple plan type indicators were necessary to differentiate varying characteristics of the CCOs. Additionally, many of the existing MCOs would continue to serve Oregon clients after the launch of the CCO model. Therefore, it is necessary for the interChange system to support both CCO and MCO plan types simultaneously.

interChange was easily modified to support this complex system of plan types. Plan types are stored in a configurable table which can easily be updated. HP staff simply added additional rows to the existing plan type table and inserted the new CCO plan types. Because of the table driven capabilities inherent in the interChange system, few downstream modifications were required after the plan type table was updated. Processes such as Auto Assignment, Disenrollment and Capitation were easily modified to include the new plan types and the associated logic. Usually, new data elements were added to existing tables. Those new data elements contained information specific to each CCO plan type and enabled appropriate processing. Additionally, minor modifications were made to various managed care processes, such as Auto Assignment, to support specific business rules defined by each state.

Auto assignment is the process by which eligible clients are systematically enrolled into the appropriate health plan. The process uses state-defined business rules for each plan type to determine potential enrollees and then assigns each client to the most appropriate health plan. Before the implementation of the CCO model, each Oregon client was eligible to be enrolled in one physical health, one mental health and one dental health plan. Potential enrollees were identified based on the criteria defined in Oregon's business rules. For example, Medicare clients and clients with third-party coverage were not eligible for enrollment into a physical or mental health plan. Additionally, the existence of certain medical conditions such as breast or cervical cancer excluded clients from enrollment in a managed care plan.

After potential enrollees were identified and written to the potentials table, the assignment process considered various criteria to enroll each client into the appropriate plan. A client's county of residence and ZIP code were used to determine which managed care plans were available in each geographical location. If a client had previously been enrolled in a managed care plan within the last thirty days, an attempt was made to enroll the client in the same plan again. Auto assignment also considered household status and enrolled each of the clients of the same household into the same plan.

The existing auto assignment capability was easily used to support the implementation of the CCO model. The potentials table was updated to include new data elements for each plan type. Additionally, logic was added to support the business decision that clients with certain medical conditions such as breast or cervical cancer are eligible for enrollment in a CCO, but still excluded from MCO enrollment. The assignment process was modified to support the existence of both CCO and MCO plan types. CCO plans are given preference in assignment so that non-

CCO plans only receive enrollments if a CCO plan is unavailable—if, for example, the available CCO plan is at capacity. Additionally, enrollment records for the previous 90 days are considered when selecting a CCO plan for enrollment, while MCO enrollments consider only the last 30 days.

The disenrollment process also was impacted by the implementation of the CCO model. Disenrollment is the process by which clients who lose Medicaid eligibility are systematically disenrolled from their managed care plan. While the business rules surrounding disenrollment required significant changes to support both CCO and MCO plan types, the interChange system required only minor modifications. Oregon's disenrollment process was previously configured to analyze data for the current month only. It would identify Medicaid clients with eligibility ending in the current month and set the end date for their managed care enrollment to the last day of that month. Oregon's business rules for the CCO model require the disenrollment process to look further into the future, a change that was easily supported by the interChange system. After just a few minor modifications, the disenrollment process is now able to end date plan enrollments in future months as well as in the current month. interChange can customize the disenrollment process based on plan type, so that both CCO and MCO business rules are supported.

Capitation payment processing also required modifications to support the new model of care in Oregon. The flexibility of interChange allowed these modifications to be made seamlessly.

interChange provides strong support for Managed Care and Accountable Care models as evidenced above. We address each Unique ID in the following sections.

ANSI X12N Transactions (Unique ID 1230)

The Colorado interChange MMIS can produce and distribute ANSI X12N 820 and X12N 834 transactions as standard transactions and also allows for customization using the data loops used by the Department.

The customization of the Department's data needs using the 834 loops allows for the Department to use the standard transaction sets to exchange data with the MCO/CCO. By maximizing the variable fields within the standard 834 transaction, the Department can provide supplemental data needed by the MCOs to perform their contractual responsibilities and minimize the need for proprietary files.

The 820 and 834 transactions are integrated into the interChange MMIS processing and are systematically produced based on the schedule set by the Department. Historical versions of 820 and 834 transactions are maintained in the MMIS for multiple generations to make sure the data is available when needed.

For more information about our handling of X12N transactions, please see RESPONSE 39i.

Adjudication Results from PBMS (Unique ID 1251)

A distinct advantage of the HP solution for Colorado is that we have designed interChange to be able to interface with external entities using web services through interChange Connections. Using interChange Connections allows HP to more quickly establish or change interfaces to the Department's other contractors, as business needs change. Several the states we support have a separate Pharmacy Benefit Management System (PBMS) contract and require us to accept data from that Contractor. We will develop the interface with the Department's chosen PBMS Contractor to receive adjudicated claims, capitations and encounters. We can accept data from the PBMS on a daily, weekly or monthly schedule, as required by the Department.

Data Interface/Exchange (Unique ID 1253)

HP has developed custom interfaces for exchanging client enrollment and demographic data with enrollment brokers in multiple states. We will provide and support interfaces, both inbound and outbound, to the enrollment broker contractor and other Department-defined entities.

Colorado interChange supports data input from multiple sources and across many different media, including batch transmissions; online real-time entry for State-authorized users; disks; or other media as necessary from the State, county agencies, enrollment broker, or the MCOs. interChange uses these transactions to disenroll, change enrollment and/level of care, or exempt clients from MCO enrollment. The Colorado interChange MMIS enables authorized users to enroll and disenroll clients in real-time.

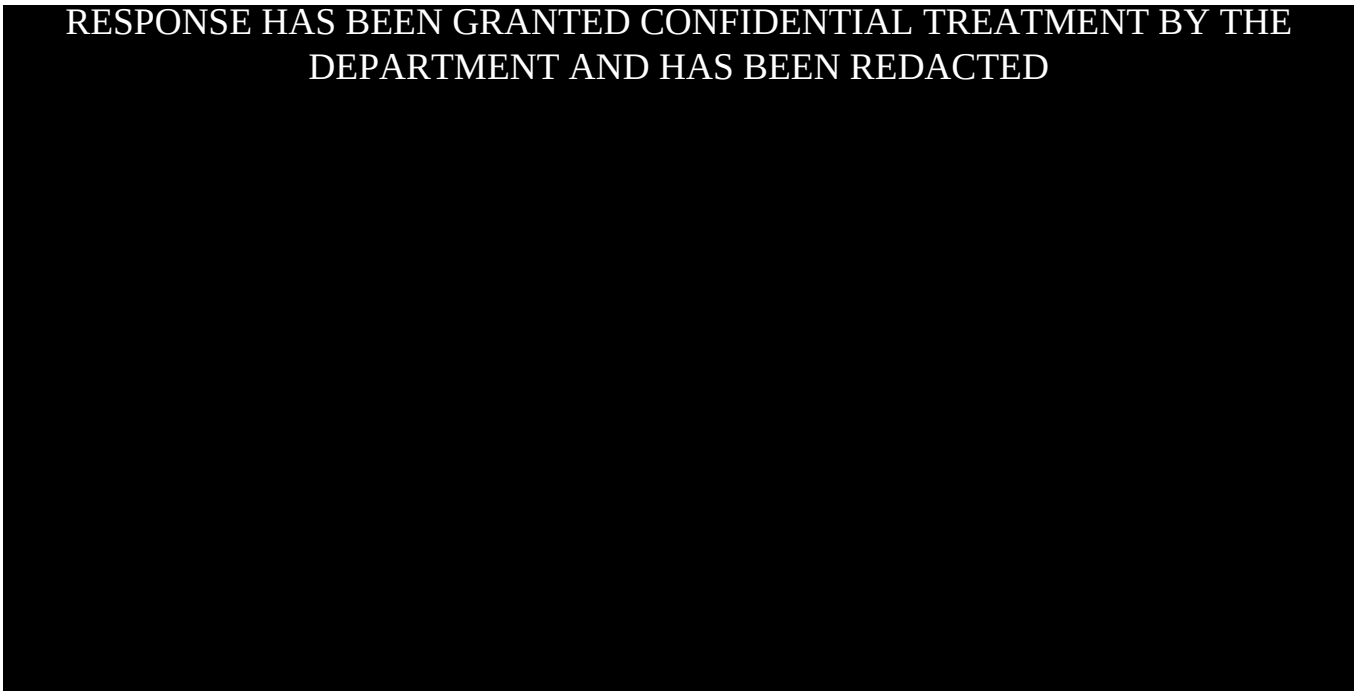
Enrollment and PMPM Payment Data (Unique ID 1309)

The MMIS maintains enrollment and (Per Member/Per Month) PMPM payment data and provides enrollment records to managed care entities through the 834 files and payment data through the 820 files. The following example shows the client MCO enrollment history.

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

Managed care enrollment and PMPM payment data are maintained in the Managed Care tables and are available to users through multiple delivery methods.

The Department can easily access enrollment and PMPM data through the online screens or through a variety of standard reports that show detail and summary enrollment and payment data. The following example shows the capitation history.



Managed care entities also can access this information using reports or standard 834 or 820 transactions downloaded through the Portal, based on Department preferences and security protocols allowing the entities to have access to the data.

Recouped Capitations (Unique ID 1310)

The MMIS provides the ability for managed care entities and the Department to view enrollee record of recouped capitations and status through the 820 files. The Department also can view capitations using the Colorado interChange user interface. The 820 files are posted to an SFTP site with MCO specific files names so the managed care entities can set up jobs to retrieve the files automatically and process them in their system.

Managed care capitation payments and recoupments are maintained in the capitation history tables and are linked together through audit trail records and other identifying elements that allow users to quickly and easily retrieve and view capitation histories.

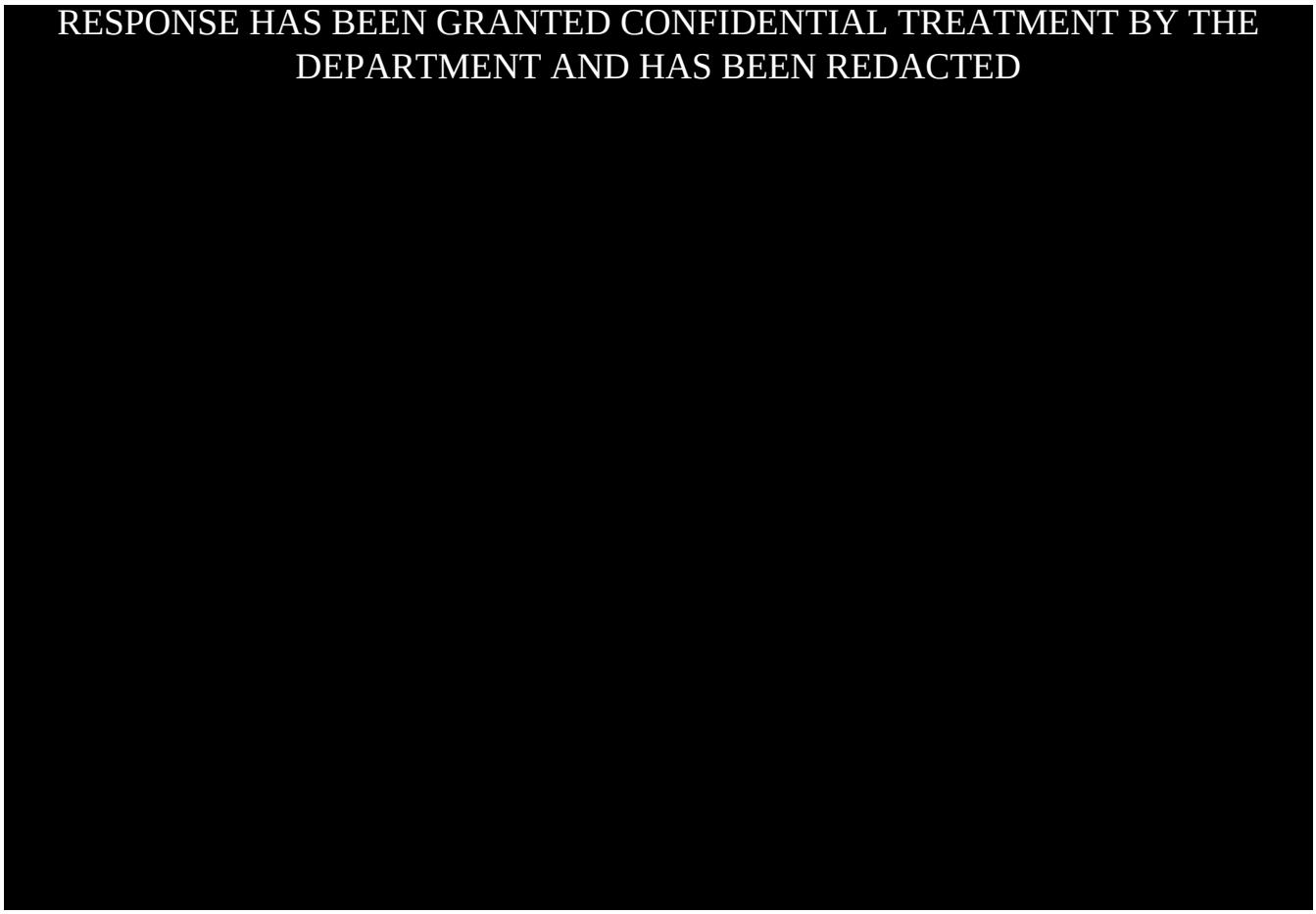
Client identification number, managed care entity payer identification number, capitation month and the capitation amount are maintained together as a unique record and can be retrieved with minimal input from users.

Based on Department established retention guidelines the MMIS will associate the initial capitation record and any subsequent recoupments, including the "enrollment end reason" allowing viewers to quickly see the whole picture of payments for a client.

Geographic Service Areas (Unique ID 1393)

The Colorado interChange MMIS allows for configurable geographic rules for defining Managed Care geographical areas comprising counties and ZIP codes, with various combinations, as seen in the following figure. It also allows for auto-assignment of clients to providers based on distance from the client's residential address to the provider's location (mileage, using latitude and longitude).

HP will perform the necessary development to support census tracks and city.



Enrollment (Unique IDs 1400, 1401, 1402, 1405, 1406, 1407, 1716-1720)

(1400, 1401) Enrollment processing encompasses multiple functions. In Colorado, the Department will define how each benefit plan may differ in the enrollment methods employed. For example, one benefit plan may require mandatory auto-assignment to an MCO if the client does not make a selection within an allotted time. Another benefit plan may include voluntary enrollment.

In the cases of disenrollment, an automatic enrollment could occur for those clients who lose Medicaid eligibility for two months or less, or otherwise specified by the Department. (1717, 1719, 1720) The enrollment method used may depend on one or several of the following items or other criteria. The following information is viewable online through the interChange windows:

- Eligibility classification (medical status code)
- Demographic location (either client or service area of MCO plan)
- Availability of the MCO to accept additional enrollments
- Previous placement in an MCO
- Other household clients' current or previous placement
- Exemption codes (to prevent enrollment)
- Age or gender of the client
- Day specific or monthly enrollment (either prospectively or retroactively)

(1402, 1716, 1717) The auto-assignment function of the interChange MMIS interfaces with the benefit plan tables to obtain the client- and MCO plan-specific information before making an assignment decision. Auto-assignment occurs only if the client identified as qualifying for mandatory enrollment does not make an MCO choice within the defined time. Auto-assignment is based on other MCO plan unique criteria as defined by the Department, including the maximum number of enrollees for a given time period, as illustrated in the following figure.

The purpose of the MCO enrollment function is to maintain enrollment information on Colorado Medicaid managed care programs. The interChange solution to address these needs includes the following:

- Auto-assign clients into the appropriate MCO or a PCP based on the Department-defined criteria and plan options
- Accept electronic enrollment transactions from the eligibility determination system for enrollment/disenrollment/level of care changes

- (1406) Process manual enrollment and disenrollment requests as directed by the Department
- Automatically disenroll clients whose eligibility criteria no longer meet the conditions and criteria for enrollment in the existing MCO
- (1407, 1718) Auto-reassign clients to their previous MCO provider if available and appropriate for their eligibility category and other criteria
- Process exemption requests as authorized by the Department
- Generate timely enrollment materials and notices
- Support lock-in and lock-out capabilities for clients
- Automatically monitor and report MCO enrollment counts and limits
- Answer inquiries about managed care enrollment and payment issues from MCOs, providers, and clients as directed
- Provide web-based access to eligibility and enrollment information to state, MCO, county, and other authorized entities
- Provide a comprehensive audit trail of enrollment activity

At the user's option, Colorado interChange can allow retroactive changes for the clients. interChange automatically adjusts the capitation payments for level of care (LOC), date-specific, or retroactive disenrollment changes affecting the capitation payments.

Colorado interChange will support online, real-time updates for auto-assignment, reassignment and choice options, by MCO or service area on a date-specific basis as directed by the Department. The lock-in period following the open enrollment period can remain in place or we can change it at the Department's option. (1406) Assignment and reassignment capabilities are highly automated, and authorized users can manually override an assignment for case-specific situations.

(1405) The benefit plan capabilities allow the Department to move groups of clients from one MCO to another or to a Fee-For-Service (FFS) arrangement, providing for mass enrollment, disenrollment and transfer of clients between Health Benefit Plans and MCOs. The following figure illustrates the online MCO mass-disenrollment function of the interChange MMIS. Colorado interChange also can prevent enrollment or reassignment of dual-enrollees according to State-defined criteria.

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

interChange provides a comprehensive online audit trail capability to monitor enrollment activity and notifications at the client-specific level. The Department-authorized users, for example, can perform efficient research and provide timely responses to inquiries about coverage eligibility and enrollment periods.

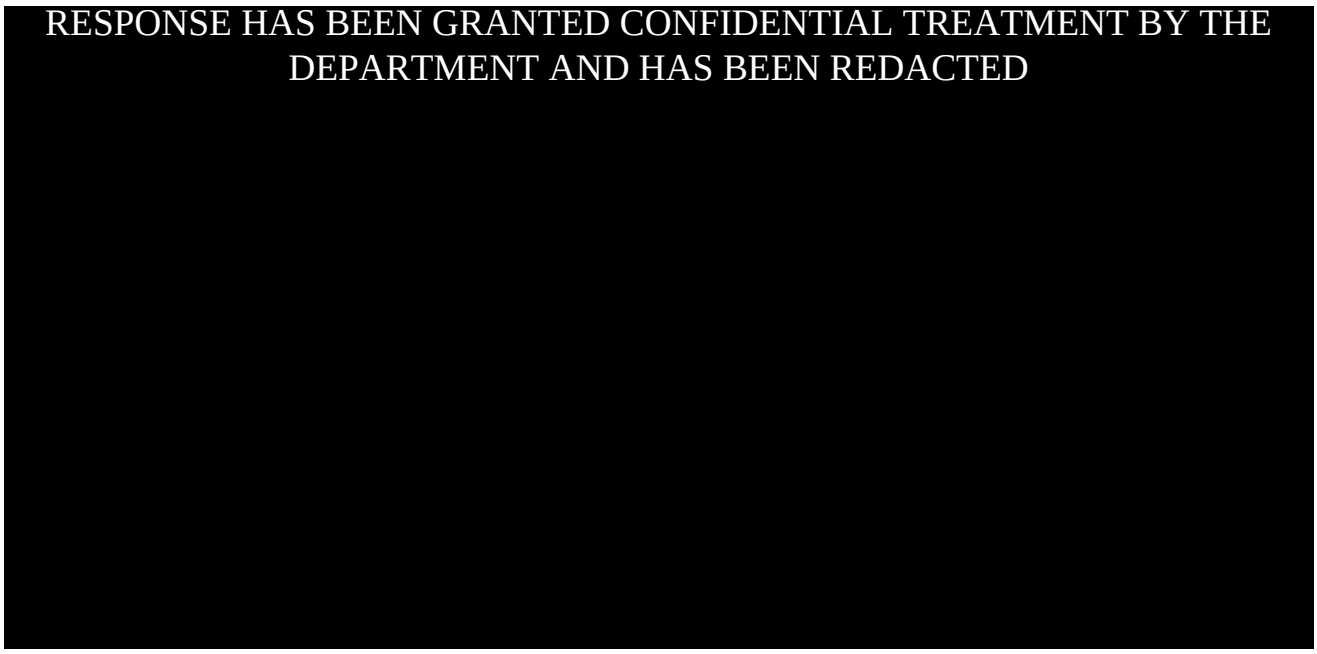
(1400) Business rules defined by the Department will prevent clients from being incorrectly enrolled. The disenrollment process confirms the client is still eligible for the Managed Care program the client is enrolled in. When a client is determined to be no longer eligible or is enrolled in error, the enrollment is ended or canceled according to the Department's business rules. These disenrollments may be viewed in the disenrollment/enrollment error report.

Configuration of Hybrid, FFS Managed Care Models (Unique ID 1403)

The interChange base system supports hybrid Managed Care models where some services are covered under a capitation payment (or administrative fee). This is configured through the Benefit Plan Administration functions. Most benefit plan changes can be made through the online interChange screens. Specific services can be "carved-out" of managed care and paid FFS by creating procedure code groups that are used by the claims engine to determine whether a claim is payable as FFS. For example, an authorized user can access a specific procedure code and link it to a procedure code group that is payable as FFS, using date-driven segments. Claims submitted for dates of service within the range of the procedure code segment will processed according to the update.

Exempted or Excluded (Unique ID 1404)

Criteria specific to Colorado'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 screens, as seen in the next figure, and will apply to both online and batch enrollment.



In addition interChange provides the Department the ability to define Special Conditions that may be used to automatically exclude a client from a Managed Care program.

Retroactive Enrollment (Unique ID 1408)

The interChange MMIS supports the ability to systematically create retroactive enrollments in circumstances such as a birth. It also can systematically disenroll clients in circumstances such as death. Retroactive enrollments can be identified as such by viewing the audit trail (the date the enrollment was entered into the system).

Retroactive Enrollment and Claims Adjustments (Unique ID 1409)

interChange supports the ability to systematically create retroactive enrollments in circumstances such as a birth. The automated capitation adjustment process will generate payments to the managed care provider in the next capitation cycle after the retroactive enrollment.

Priority of Source (Unique ID 1411)

Colorado interChange can 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.

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.

Uniquely Identify Managed Care Organization Associated with Encounter (Unique ID 1430)

Each managed care organization is assigned a submitter ID in interChange which they will use to submit their encounter claims. Just like provider IDs, the submitter ID is permanently associated with the encounter claim.

HIPAA-Compliant Transmission Response (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. 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

For each file submitted, the system returns a 999 Health Care Acknowledgment. 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.

Adjudicate Capitations for Retroactive Client Eligibility (Unique ID 1563)

interChange provides rules-based processing of capitation. As clients 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 Department rules and policy. The next monthly capitation payment will include the new dates and amounts for the client.

Processing of Encounter Corrections, Replacements, and Voids (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. If the Department determines that their MCO/CCOs would use online correction of encounters, the Healthcare Portal can be modified to support this functional capability. In our non-managed care states, providers can do online correction and voids real-time through the Healthcare Portal today. This functional capability will be used to support online encounter corrections by MCO/CCOs.

Define Accounting Codes (Unique ID 1650)

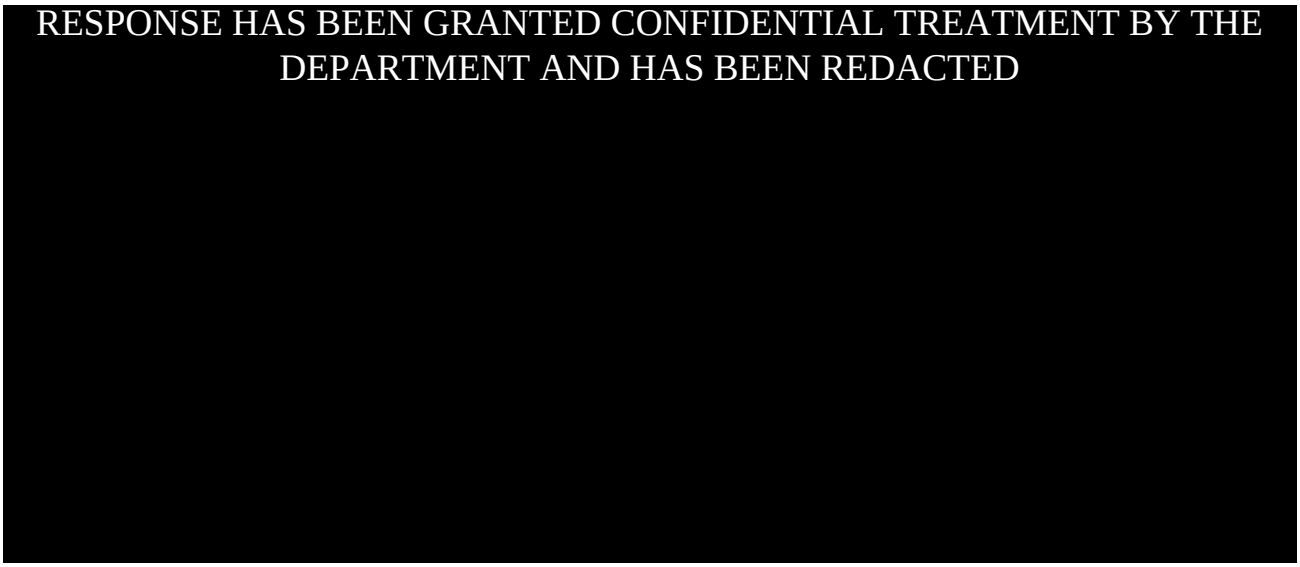
The base interChange system assigns fund codes to track funding sources from which services will be paid. During implementation, HP will work with the Department to configure the Colorado-specific fund codes. During processing, the managed care system will assign the funding, and financial will manage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

Client Assignment to Provider in Health Benefit Plan (Unique ID 1653)

interChange supports lock-in and lock-out capabilities for clients. The Healthcare Portal allows providers to easily request client eligibility, and verify the client's eligibility status and scope of coverage and coverage type, including lock-in and lock-out information. The Healthcare Portal provides a user-friendly display of information that we can return within the HIPAA 271 transaction data content. An example of the MCO Lockout screen is shown in our following response to Unique ID 1654.

Exempt from Provider (Unique ID 1654)

interChange provides the ability to exempt a specific client from enrollment with a specific Managed Care provider. This exemption is date-specific so that the exemption can be ended later, if necessary. This is supported through the lock-out feature within interChange.



Load and Modify Capitation Rates and Premium Adjustments (Unique IDs 1672, 1673, 1674)

(1672, 1673, 1674) The interChange base system has online screens that allow for the entry and maintenance of Managed Care provider-specific capitation rates and administrative fees over time. This includes the ability to establish multiple rates and types of payment for managed care entities and maintain a history of multiple capitation rates for multiple Health Benefits Plans associated with one MCO. As shown in the following example, one screen allows for the request of mass retroactive rate changes and a batch process that creates the necessary capitation adjustments because of the request(s). The Colorado interChange MMIS provides the functional

capability to split the rate into separate items, making it possible to deduct a portion of the rate or handle the rate differently from the way rates are usually handled (by a fixed payment).

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

The interChange base system can support fixed rates for Managed Care entities. We have modified the system in other states to support variable rates, depending on the services provided.

Generate Capitations Based on Multiple Risk Criteria (Unique ID 1676)

The interChange base system can generate capitation payments based on multiple risk criteria, such as client aid category/population code, gender, age, and state region. This demographic information is mapped to a rate cell, which in turn gives us a capitation rate, gender, Medicare status, age, and special conditions in this table. The geography/region is mapped, along with a rate in the capitation rate table, which uses the rate cell to map the amounts correctly.

Default Enrollment (Unique ID 1710)

The interChange system uses an auto-assignment process that creates enrollments protecting preexisting client/provider relationships and maintains client group/provider consistency. HP has customized this process for several states. For example, in one state the auto-assignment criteria includes care continuity (nursing facility, Home and Community Based Services, special healthcare needs), maintaining existing provider relationships, case continuity (keeping families together), maintaining preexisting relationships with an MCO primary care provider and equal distribution using client morbidity to spread the health risk evenly across the MCOs. The assignment reason code associated with that client is viewable on the managed care enrollment screen. This allows the Department to see the criteria used to assign that client. We will change the system to support the Department-specific criteria for distribution among multiple MCOs.

Identify Clients with Direct Access to Physicians Paid by the MCO (Unique ID 1711)

To facilitate encounter processing, MCOs are required to submit a file with the providers included in their network, which is then stored in the MMIS. When encounter claims are submitted by the MCO the servicing provider is included on the encounter. Using the provider network submitted by the MCO we can identify in-network and out-of-network providers for reporting purposes. We will work with the Department to develop Colorado-specific reports to support this requirement.

Define Rate and Pricing (Unique ID 1712)

interChange manages encounter claims in the same way as FFS claims, applying edits, audits, and logic. interChange adjudicates or rejects encounters received from MCOs based on State-defined rules. interChange receives, processes, and stores encounter data ready for use by the Department to measure performance and track utilization.

Colorado interChange can collect and store encounter data at any interval deemed appropriate between the Department and the MCOs. Whether the MCO submits data in a monthly upload or by individual claim at the time of service, the MCO can submit transactions through the web or as file uploads. Electronic encounter submissions are HIPAA-compliant through the X12N 837. interChange can process the transaction, apply the correct edits and audits, and adjudicate or deny the transaction, listing the corrections needed. interChange can perform pricing to determine Encounter Cost Value based on Department-established rules. We also can adjust the encounter claims, if needed.

Authorized users will have access and the ability to define and edit different rates and pricing methodologies within the Business Rules Engine (BRE) for encounters separately from FFS claims, as indicated in the following figure.

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

If users want the pricing to apply only to encounter claims, they simply set the encounter indicator to "Yes." Additionally, the pricing methodology can have multiple variables, including geographic location of the provider or client, client age, client plan, diagnosis codes, place of service, and provider contract.

Encounter Pricing (Unique ID 1713)

The flexible reimbursement rule feature enables authorized users to define pricing rules based on provider ID fields in a standard HIPAA transaction. For example, physician assistants can be paid a percentage of the rate on file for physicians, federally qualified health clinics can be paid a flat fee per visit, or long term care providers can be paid a per diem.

Pay Different Case Management PMPM Rates (Unique ID 1714)

Demographic-based rates are common in HP's fiscal agent states. Whether full capitation, PMPM case management fees, or Medical Home administrative rates, the provider payments can be based on a variety of factors, such as the most common demographics of age, gender, or ZIP code. Online screens support the maintenance of the rates, and batch processes use the rates when making the PMPM payments.

Lump Sum Incentive Payments (Unique ID 1715)

Provider incentive payments have grown in popularity among Medicaid programs during the past decade. HP has been in the forefront, working with our State customers to establish these payments. HP can 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.

Export Managed Care Enrollment Data (Unique ID 1427)

The interChange MMIS interfaces with multiple external entities to support our existing Medicaid contracts. Using interChange Connections, we will establish the Colorado specific third-party interfaces. Based on Department criteria, client related data can be exported using a secure FTP connection. Files are posted to an SFTP site with specific files names so the third parties can set up jobs to retrieve the files automatically and process them in their system.

8.10 – Managed Care	**In Production? YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1255, 1410, 1562, 1721, 1751	**NO**

Export Managed Care Encounter Data (Unique ID 1255)

The interChange MMIS interfaces with multiple external entities to support our existing Medicaid contracts. Using interChange Connections, we will develop the Colorado specific interfaces. Based on Department criteria, encounter data can be exported using a secure FTP connection.

Priority of Source (Unique ID 1410)

interChange provides a comprehensive online audit trail to monitor eligibility activity. The audit trail identifies the source of the update – system or user ID, the date the change was made and the before and after view of the data updated. interChange supports the ability to systematically disenroll clients based on date of death, create retroactive enrollments in circumstances such as a birth or new enrollments related to presumptive eligibility. Based on Department policy, interChange will be configured to establish the length of presumptive eligibility. For example, in some states clients receive presumptive eligibility for a period of 90 days while their application for Medicaid coverage is finalized. If the client is determined not eligible the presumptive

covered is end-dated. If the client is determined eligible the eligibility segment is updated with the appropriate benefit plan coverage code.

Various reports exist in the base interChange MMIS, including the following:

- **Managed Care Daily Date of Death Change Report—**This report lists the clients whose date of death was changed to a greater date or the date of death was removed.
- **Presumptive Title 19-Presumptive Title 21 Eligibility Overlaid with Other Eligibility—** This report provides a list of beneficiaries where P19 or P21 eligibility is overlaid retroactively with another major or dual benefit plan.
- **Medicare Part D MMA File Error Report—**The purpose of the report is to provide HP and the State with the information on the MMA enrollment rejected records. This report lists the error records received from CMS using the MMA response file. The fields in error and a brief explanation of each error will be listed on this report.

Suppress Capitation Payments (Unique ID 1562)

interChange supports the ability to suppress payments based on specific provider, provider type, claim type, or for the entire payment cycle. HP will change the base interChange system to support the suppression of capitation payments by provider, Health Benefit Plan, and client eligibility. This functional capability can be tailored through configuration.

Prioritize Managed Care Enrollment (Unique ID 1721)

The base interChange solution does not have this ability built-in today, although the current disenrollment process can be changed to accommodate it. The disenrollment process will disenroll based on specific rules that are tailored depending on the State's requirements. The auto-assignment process would also need to be tailored to give preference to a plan type over a set of plan types; these rules are already embedded in HP's Oregon implementation of interChange for auto assignment and disenrollment. The Recipient Case Enrollment screen and Real-Time Enrollment interfaces have an internal set of rules to prioritize enrollment, depending on the needs.

Special Health Care Needs (Unique ID 1751)

The notification for clients with special healthcare needs is done using the HIPAA 834 transaction for larger Managed Care entities or by using the enrollment roster for smaller entities. The 834 transaction allows states to use the available loops for local use. We have successfully used variable loops to communicate special healthcare needs to managed care entities. For example, including an indicator to identify a client's participation with a special healthcare needs program such as ADAP, allows the MCO to proactive manage critical services for that client. This capability will be tailored to support Colorado's special healthcare needs programs.

RESPONSE 39i

8.11. Electronic Data Interchange (EDI)	**In Production? YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1873	**NO**

HP fully understands and will provide the implementation of a versatile process to send and receive HIPAA-compliant transactions. HP brings a scalable, production-proven solution and knowledgeable staff to provide the best solution to the Department.

In today's complex healthcare processing world, trading partners use various transactions and transport mechanisms and have various levels of automation and disparate systems. Furthermore, complexity is increasing because of HIPAA mandates, ACA and HITECH requirements, and the Office of the National Coordinator for Health Information Technology (ONCHIT) regulations. Keeping up with these industry dynamics proves increasingly challenging.

Our interChange Connections is a comprehensive approach to ESB/EDI processing, making the Colorado interChange interoperable with the broader state healthcare ecosystem. Through the interChange Connections capability, various stakeholders can collaborate with the Colorado interChange. Your Colorado interChange solution also provides automated orchestration of secure file transfer and monitored file receipt capabilities. Extensive, consolidated reporting of transaction processing results provides a clear operational view of the data exchanges.

The following figure shows the logical production architecture we will deploy. The top left of the figure shows the various stakeholders served by interChange Connections EDI/ESB solution. The bottom right of the figure lists the service architecture transaction interactions with the rest of the Colorado InterChange solution.

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

The full-featured capabilities of interChange Connections include the features in the following table.

interChange Connections Features

Feature	Description
Communication Adapters	Integrating systems starts with the ability to connect and exchange messages through a common protocol. interChange Connections has more than 100 communication adapters available to quickly link to new trading partners and begin transferring data. Common adapters—such as HTTPS, JMS, and secure FTP—are available to support synchronous and asynchronous processing of the State's transactions. Support for these and other protocols verify that communication with the trading partners can be established quickly.
Security	Security is crucial to enterprises exchanging private information and this is especially true for an MMIS. interChange Connections uses two basic types of security when exchanging messages. Messages can be encrypted using an agreed-on public key, or they can be digitally signed using a private key certificate. These two methods are industry standards for protecting the Department's data.

Feature	Description
Routing/Orchestration	The interChange Connections ESB handles simple and complex message processing. In some cases, the messages will simply be transported to a single service. Other times, it will be necessary to guide the transaction through many services and dynamically determine the path based on the data submitted and the business rules associated with that data. interChange Connections simplifies the implementation of complex orchestrations. Additionally, the process guarantees delivery of messages using a publish-and-subscribe architecture.
Trading Partner Management	Working with external trading partners is an important part of providing a good experience for providers and keeping the system running smoothly. Trading partners will work with HP to register for and test each transaction format for which they wish to be certified. After testing is complete, 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 the Department.
HIPAA Compliance Checking	An important aspect of EDI is verifying that incoming and outgoing X12 transactions meet the HIPAA standards. interChange Connections validates X12 transactions for HIPAA compliance as they are received and before they are sent to our trading partners. A translator engine is used to check HIPAA compliance of transactions sent from Medicaid trading partners. It also validates many “Level 7” claim edits to verify transaction data meets the requirements to be processed through the MMIS. The translator engine is part of the EDI interChange Connections architecture. Therefore, the Department can expect a smooth transition to the new architecture, while gaining the benefit of the rest of the EDI interChange Connections features. Providers should be able to expect that, excluding policy changes, their transactions are edited in the way that they have come to expect.

Feature	Description
Message Translation	Another key component for systems integration is the ability to translate a message into a format that is understandable to the service that will receive it. Whether an X12 transaction or a non-HIPAA transaction, interChange Connections uses a visual point-and-click mapping tool to translate and transform messages into the appropriate format for the system receiving them.
File/Message Tracking	File Transfer Service (FTS) monitors, tracks, logs, and moves files throughout the interChange solution. FTS provides a complete file audit trail with real-time, processing stage updates through the file-tracking web interface. FTS includes detailed error notifications, which allow quick response to failed files.
Command Console/ Business Activity Monitoring (BAM)	One of the key factors in business success in the right information at the right time, which is where BAM plays a vital role. The interChange Connections BAM allows business users to monitor and analyze data from defined business process sources. By using BAM, users can get information about business states and trends in real time.

HP meets the EDI challenge by offering many mechanisms to assist the trading partner community in submitting and receiving transactions to the Colorado interChange solution. We propose using our interChange Connections EDI/ESB solution for transaction and trading partner management. Three major software components comprise the interChange Connections transaction management solution—HIPAA translator component, BizTalk ESB COTS package, and HP-developed FTS, which has been purpose-built for MMIS interoperability tracking and reporting.

The FTS component of interChange Connections monitors, tracks, and logs files within the interChange solution for trading partners. The FTS web-based management console lets users search and display tracking and audit details about files.

Additionally, FTS can be configured file by file to notify individuals, such as EDI support staff, when an error occurs during processing or a file completes. The dashboard shown in the following figure will highlight balancing errors; details can be seen by clicking the File ID.

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

HP's interChange Connections supports electronic transactions covered under HIPAA in the approved HIPAA transaction formats and code sets. This transaction solution encompasses the compliance validation, enabling the go-forward solution to use the TR3 edit logic built into the translator component. This solution approach reduces the effort to implement by using existing production-proven transaction processing configuration rules.

HP's interChange Connections EDI solution is a readily available channel for exchanging HIPAA transactions. An important aspect of EDI is verifying that incoming and outgoing X12 transactions meet the HIPAA standards. interChange Connections validates X12 transactions for HIPAA compliance as they are received and before they are sent to our trading partners. The batch and real-time submission mechanism can validate and accept or reject X12 transactions and respond with appropriate HIPAA acknowledgment transactions such as 999 and TA1.

Translation of the HIPAA-Compliant Transactions

interChange Connections offers flexible mapping that is fully compatible with each of the components of HP's EDI solution, offering the acceptance of various formats and transactions. HP's EDI interChange Connections provides the ability to translate a message into a format that is understandable to the service that will receive it.

interChange Connections stores message structures as an XML schema definition (XSD), which is stored and retrieved from a database at message processing runtime. By translating the data to XML format, interChange Connections can perform complex transformations of the data with

ease using a visual mapping editor. The mapping capability of interChange Connections includes the following:

- **Mathematical—**Add, subtract, multiply, division, round, average, and summation
- **Logical—**And, or, not, equals, greater than, less than, and looping
- **Database—**Database lookup
- **Text**—Text-based transformations such as truncating, appending, and substitution
- **Custom Scripting—**Using reference library tools for unusual or complicated transformations

interChange Connections will assemble and validate HIPAA transactions before transmission. Transport methods for HIPAA transactions include interactive submission through virtual area networks (VANs), batch uploads through the web portal, and automated submission compliant with the infrastructure and security rules of the ACA's Section 1104. These methods support the required encryption to safeguard client privacy.

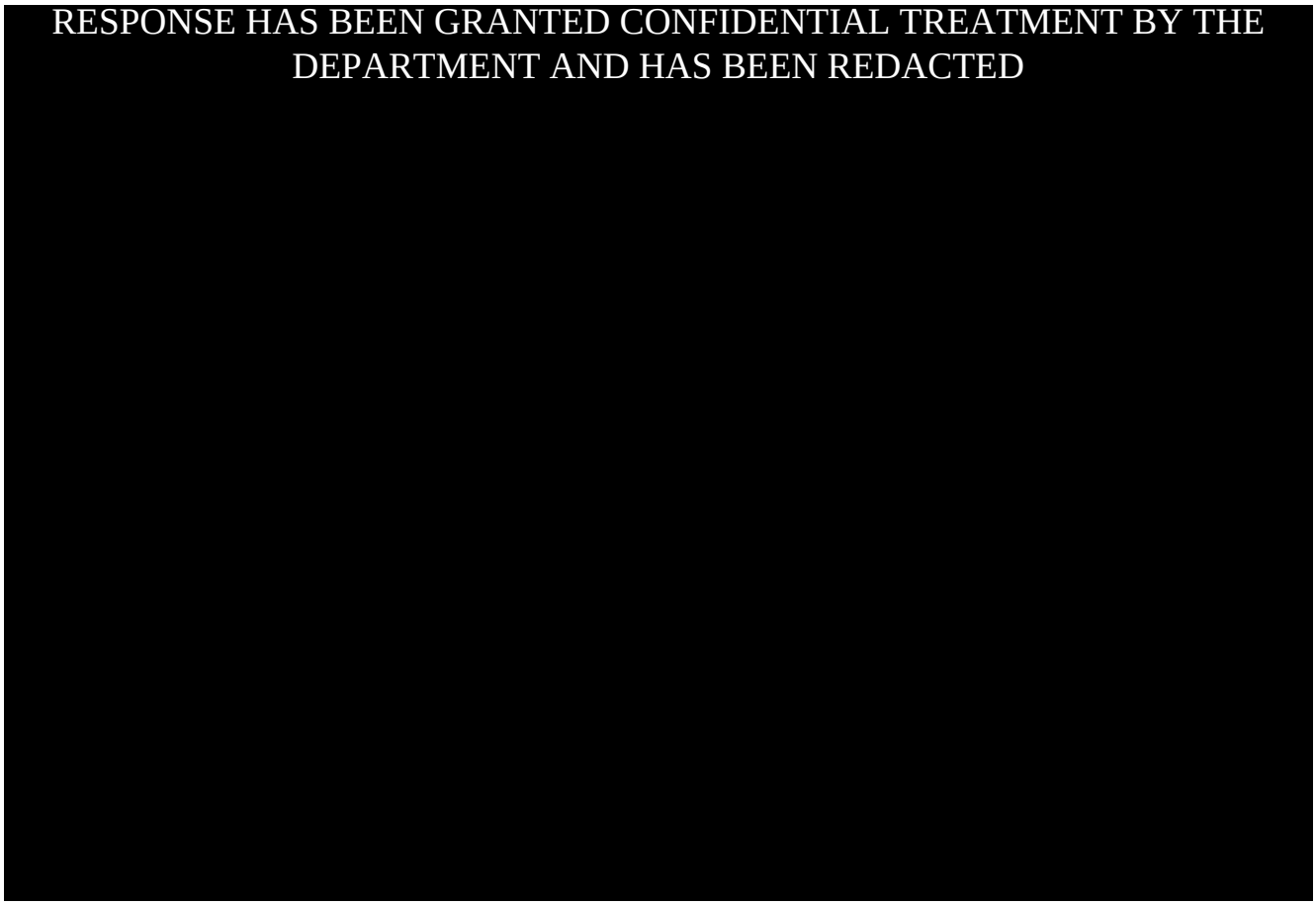
As the following table details, HP's interChange Connections will support the following ASC X12N HIPAA electronic transactions.

ASC X12N HIPAA Electronic Transactions

Transaction Number	Descriptive Name
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
820	Health Plan Premium Payment
834	Benefit Enrollment and Maintenance
835	Healthcare Payment and Remittance Advice
837D	Dental Claim
837I	Institutional Claim
837P	Professional Claim
999	Implementation Acknowledgment
TA1	interChange Acknowledgment

HP's solution enables users to handle individual transaction submission or batch files from any HIPAA submission method, whether through the web portal or direct Internet exchange.

The Healthcare Portal enables providers and trading partners to easily interact with interChange to upload and download the HIPAA transactions. The following figure shows the Healthcare Portal screen used by trading partners to upload the HIPAA transaction files.



These batch files are fully supported in terms of HIPAA compliance. The batch submission mechanism can validate and accept or reject 837 transactions at the claim level, allowing providers to get more of their claims processed after each submission.

interChange Connections supports appropriate HIPAA acknowledgment responses such as 999 and TA1—in batch and real-time modes—in accordance with the operating rules. The acknowledgment provides a HIPAA-compliant transmission response—such as acceptance message or rejection message—to the submitting provider, including managed care entities, on the success or failure of the submission of their transaction.

For HIPAA-compliant electronic 835 transactions, HP's EDI interChange Connections uses national adjustment reason codes and healthcare remark codes to convey the claim finalization and the provider's financial activities.

After finalized, HP can implement the 275 Claim Attachments X12 transaction by the federally mandated date. interChange Connections already supports Health Level Seven (HL7) Continuity of Care Document (CCD) standards and can assist in the processing of ANSI X12N 275 transactions by the federally mandated date.

Versatility to Manage Data for Other Enterprise Applications

interChange Connections uses embedded COTS products as part of the translator solution providing a highly scalable, highly available, high-performance software for accessing and integrating data from virtually any business system, in any format, and delivering that data throughout the enterprise. Data can be structured, unstructured, and semi-structured and come from any data source, such as relational database, mainframe file, or standards-based data source. interChange has successfully used this method of data verification and quality reporting of the HIPAA X12–defined file structures in Florida, Kentucky, and Georgia. The translator engine server is one of the most widely used run-time engines for validating and converting file formats, such as EDI, HL7, HIPAA, and flat files, to and from XML.

The interChange transaction management solution has demonstrated its scalability through high-volume production metrics. interChange has processed an average of more than 300,000 claims daily—processing more than 800,000 claims in a single day—while serving more than 110,000 providers and 3.1 million members in a single instance of the solution. The same high-volume success will be delivered to Colorado.

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Transaction Management Through an EDI Exchange

HP offers an unmatched solution by blending an enhanced infrastructure with our experienced team to offer the interChange Connections ESB/EDI solution. This HIPAA-compliant system is based on a four-tier architecture, which separates presentation, external (Internet) communication, application, and data layers. Reliability and performance are the foundations of EDI interChange Connections' SOA and clustered infrastructure that is built to deliver high-availability, fault-tolerant, and highly secured EDI services.

The flexible, scalable architecture allows for secure transaction management, tracking, and guaranteed delivery. It supports numerous communication protocols, file types, and integration capabilities. It can quickly integrate, manage, and automate dynamic business processes by exchanging transactions and files among applications, within or across organizational boundaries. The ESB/EDI capabilities of interChange Connections is matched by the robust business processing power of interChange, which includes real-time processing for mandated HIPAA transactions. Together, the Connections and interChange Business Services framework provides round-trip support for interactive and batch healthcare transactions.

Health Care Services Review Notification and Acknowledgment (278N) (Unique ID 1873)

interChange Connections supports Health Care Services Review - Request for Review and Response (278N) transactions. This transaction solution encompasses the compliance validation, enabling the solution to use the 278 transactions edit logic built into the translator component. interChange Connections has the capability of receiving and sending Health Care Services Review Notification and Acknowledgment (278N). Compliance edit logic built into the translator component can be configured to support Health Care Services Review Notification and Acknowledgment (278N).

RESPONSE 39j

8.12 – EDMS	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1216, 1379, 1380, 1389, 1491, 1722-1726	**YES**

Our Electronic Document Management System (EDMS) Solution

The Colorado Medicaid program handles hundreds of thousands of electronic and paper documents every month. This can be a daunting endeavor for any organization because handling this volume of work can expose an enterprise to lapses in quality and efficiency. Complications may result in turnaround time delays that affect claims processing, prior authorizations, provider enrollments, and other critical business processes.

HP's comprehensive enterprise solution for EDMS involves integrating complementary components to transform the document management experience. We place the Department in full control, with the ability to locate a single document, and determine its status and history with the click of a button. This capability includes documents originated electronically or on paper, and whether it was initiated by the Department or sent to the Department. Our proposed solution makes it possible for the Department and HP together, to provide first-class support for Colorado's client and provider communities.

HP will implement an end-to-end solution for scanning, storage, and retrieval of images to provide a full electronic document management solution, integrated with automated workflow that supports the Department's needs. This includes comprehensive document storage and easy access to documents from the user's desktop.

File Capture

Before a document or file can be stored electronically, it must first be "captured" electronically. Besides electronic transactions received, information also comes into the Colorado Medicaid program through fax and paper documents. Although less in number than their electronic counterparts, it remains as crucial to record this information and store it for reference as any other claim or document.

HP Cloud Fax Service—providing a cloud-based fax collection system allows for documents to be delivered quickly and processed accurately. Images received by fax are moved to the proper workflow based on document type. If data capture is needed, the document passes to the SunGard FormWorks product, which we discuss later in detail.

Mavro Imaging MavBridge Software Suite—scanning integration permits an operator to scan a disparate set of paper documents and allows the Mavro scanning solution to sort them by

document type and route them to the proper workflow or data capture tool. As images pass through the software, we can optimize them using a variety of image enhancement tools, such as a content-based rotation, background smoothing, and advanced forms clarity. The Mavro software is integrated with the OPEX scanner, part of our Mailroom Services solution. Built with business rules, Mavro can identify and categorize documents without manual intervention. Documents that do not meet the established Mavro business rules will be handled by our mailroom staff.

Imaging and OCR (Unique IDs 1379, 1491, 1723, 1724, 1726)

The SunGard FormWorks product is a document imaging system that will image paper forms and documents received from providers, clients, and other internal and external entities that provide information and correspondence. SunGard will deliver the scanned images to OnDemand for storage and access.

SunGard, formerly Recognition Research Incorporated (RRI), provides its EXP FormWorks for Health Insurance software as the document imaging and data capture solution. FormWorks for Health Insurance is a comprehensive automated capture solution for paper that increases the accuracy, efficiency, and reliability of an organization's data streams.

FormWorks provides solutions for major health and dental insurance organizations, state and federal fiscal intermediaries, indemnity organizations, preferred provider organizations (PPOs), health maintenance organizations (HMOs), third-party administrators (TPAs), and workers' compensation insurance organizations.

(1379)A key function of FormWorks is optical character recognition (OCR). OCR is the process of electronically reading data on a paper document and translating it to electronic data. This provides a state-of-the-art image capture solution.

(1491) FormWorks is the component used to convert paper documents to indexed, searchable electronic records. It includes the capability to OCR various formats of incoming documents requiring specific handling. These include scanned images, reports, generated letters, spreadsheets, emails, and Department-approved provider agreements, which are maintained in the EDMS. Many of these documents must be managed as records for compliance or controlled to promote compliance with HIPAA standards. We have established processes for handling these critical records.

(1726) FormWorks captures printed characters and handwritten text, and includes editing against provider and client information, procedure, diagnosis, revenue code, and NDC files. It enables direct data entry and imaging of records. This editing provides for improved accuracy of paper claims and prior authorization requests to prevent them from becoming suspended for review. If the FormWorks component detects an unreadable form, the system routes it to the Data Entry team to verify the data read by OCR. The team manually completed the recognition and then releases the document to interChange for entry into the workflow system.

Our solution in Wisconsin uses scanning, OCR, and workflow processes to manage provider maintenance and, notably, the provider agreement activity. Besides the tremendous reduction of paper and storage requirements, the process of enrolling a provider has been shortened from weeks to overnight. Quality also is greatly improved because matching a provider's signed agreement with the proper provider file is made easier.

After each document is scanned, OnDemand accepts the image files and makes them read-only. The documents are then indexed and become content searchable through the interChange user interface and the HP Web Portal. (1723) Access to EDMS content is carefully controlled using role-based security to establish compliance with HIPAA privacy and security requirements regarding security of protected health information (PHI).

IBM Content Manager OnDemand—Storage of Electronic Documents and Records (Unique ID 1725)

IBM's Content Manager OnDemand is one of the core products of our electronic document management solution. It maintains and secures the scanned images of paper forms and documents, while allowing them to be retrieved directly from the interChange user interface. OnDemand will be used to store and provide easy access to:

- Scanned paper claim images
- Attachments (for example, claims, prior authorization and provider enrollment documentation)
- Incoming correspondence sent to the fiscal agent
- Outgoing letters generated by the MMIS
- Batch reports generated by the MMIS
- Provider remittance advice images

OnDemand provides fast and easy access to content stored in a robust central repository with streamlined, automatic distribution of selected reports and documents to authorized users using configuration panels in the interChange user interface. Metadata-driven indexes are associated with documents stored in OnDemand, allowing authorized users to search for and retrieve documents quickly and efficiently.

(1724)An example of how a user would access the OnDemand data is as follows:

- Using the interChange user interface, a user selects the criteria and searches for a record.

- The interChange user interface passes the user's credentials to OnDemand.
- OnDemand validates that the user has access to view the record(s) within the search results.
- OnDemand returns pointers to the appropriate documents to the interChange user interface.
- The results are returned in the user's screen with fields filled in—such as letter number or provider ID.
- These results are provided as hyperlinks within the user's screen.
- When a hyperlink is selected, the document image within OnDemand is retrieved and presented for viewing, download, or printing.

Our EDMS solution transforms processes from manual to automated, from paper-centric to indexed, version-controlled, searchable digital documents that revolutionize the functional capability of the Department. Our solution integrates the tools needed to provide first-class support to the Colorado client and provider communities.

The OnDemand solution will reduce print, storage, and mailing costs, enabling a greener Colorado Medicaid Program. Because of the scalability and flexibility of Colorado interChange, the Department can expand workflow process and associated EDMS capability as necessary to support growing programs.

Audit Trail (Unique ID 1216)

OnDemand maintains an audit trail of actions performed on its content, including the following information:

- A time stamp showing when the content was stored in the EDMS
- Any actions taken on the content
- A time stamp showing when actions were performed on the content
- The user ID of everyone who took action on the content

Hyperlinks are displayed within the interChange solution if one or more images associated with the record being viewed are stored in OnDemand. This enables staff members to easily retrieve the image from within interChange, without having to open OnDemand to search for the document. The image viewer and the MMIS user interface work together, making document related research and verification simple for the user.

Current and Previous Document Versions (Unique ID 1380)

Each image or document file is stored in the document management system with its own unique identifier. If a new or additional document version is subsequently added to an electronic document within OnDemand—for example, a prior authorization request (PAR)—the images linked with the PAR will be shown along with the relevant timestamps and unique document IDs. Whenever a document is requested, the user is authenticated to validate whether permissions exist to view the image.

Meta-Data Indexing (Unique ID 1722)

Depending on the document source, there are various meta-data options available to support indexing. HP and the Department will use a mutually agreed-on approach for applying meta-data to these indexed documents, including converted EDMS content from the legacy system. Our document management solution can provide multiple search options, using this meta-data and database indexing for optimal performance. Version control is tightly managed by the EDMS system to make sure that no original document or image is replaced or destroyed. Our implementation of interChange will include the ability to transmit the document index for a given record to the BIDM (alongside the record itself), to enable a direct link back from the BIDM to view the EDMS image in the Colorado interChange.

Takeover Information Archives (Unique ID 1389)

As a part of the data conversion and implementation of the new Colorado interChange, archives of relevant takeover documents will be loaded into OnDemand to facilitate information retrieval later, using mutually agreed on meta-data and indexing.

RESPONSE 39k

8.13 – Case Management Tool	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1256, 1263, 1364, 1425, 1445, 1589, 1670, 1709, 1727-1762, 1831	**YES**

Case Management Overview

The HP team proposes the McKesson Versatile Interoperable Technology Advancing Lives™ (VITAL) platform as the core application to support long-term care (LTC) with the capability to expand to each client. The VITAL platform provides functional capabilities and interoperability to facilitate complete client management—including alerts, work lists, and dashboards. VITAL integrates multiple data sources and tasks into a *single* workflow to best facilitate development and delivery of recommended treatment plans to verify that the appropriate medical care is provided to disabled, ill, or injured individuals. Importantly, the platform is embedded with InterQual Coordinated Care Content—strengthening the case management process with clinical integrity.

Medical Condition Evaluation

The VITAL platform includes InterQual Coordinated Care Content to support the clinical evaluation of each client's current state of health. The clinical protocol and guidelines allow the Department to manage clients with complex conditions and yield improved health quality and reduced readmissions. This is particularly beneficial for supporting LTC programs in that the platform generates care plans to the client's conditions or barriers in real-time as health assessments are completed. The assessments are built with clinical integrity and based on InterQual criteria to result in care plans that adhere to evidence-based guidelines.

With Coordinated Care Content, the platform covers more than 30 chronic conditions and co-morbidities to encompass medical and behavioral health. These assessments are delivered in an easy-to-manage question and answer format. The platform's assessments are not only simple for the client to respond to, they are also designed to be completed in the shortest time possible. For example, our competitor's care management assessments ask duplicate questions to address co-morbid conditions, often creating frustration to the client. The platform's Coordinated Care Content assessments are different. The platform's assessments are written so that questions common to multiple diagnoses are not duplicated. They are combined into one question

As a client responds to assessment questions, the platform aggregates existing client data in near real time—including claims, EPSDT services, lab results, and data gathered from CORHIO—with the client's answers to generate a draft plan of goals and services that can then be

immediately re-prioritized by the care manager based on the client's actual needs and readiness to change. VITAL will regularly receive flat files from Colorado interChange, which can be as frequent as hourly. Each care plan includes prioritized goals with systematic instructions to assist the client with achieving each goal.

The platform is designed to enable care managers and providers to work together toward achieving positive patient outcomes. Therefore, Department personnel will have the capability to adjust or change care plans, as needed, to reflect appropriate priorities, goals, and progress.

The evidence-based content also enables the Department to meet accreditation requirements such as NCQA's Complex Care Management guidelines focusing on QI 7 and QI 8. For example, NCQA QI7 addresses complex case management requirements such as assessment of client's health status—including condition-specific issues, general health issues, and co-morbidities—and documentation of medical history—including past and present medications and treatment history.

NCQA QI 8 covers disease management requirements such as condition monitoring (including self-monitoring and medical testing).

The platform provides a mechanism for clients and providers to assess how well a condition is managed by addressing medical and behavioral health co-morbidities and other health conditions—for example, cognitive defects or physical limitations.

The ability to track and report NCQA complex case management and disease management requirements will benefit the Department in maintaining adherence to national care management standards.

Assessments use Q&A formats to determine clients' knowledge of topics such as disease, treatment plans, support systems, medical history, and medication.

Besides Coordinated Care Content, the platform allows the Department to embed links to external reference material for read-only access.

Data Analytic Report (Unique ID 1263)

When the system goes live, the VITAL platform will interact with BIDM through a data refresh process. The platform provides the ability to post member-specific data analytic reports directly to the member record as an attachment.

Access to Online Case-Related Clinical Protocols (Unique ID 1752)

The platform includes InterQual Coordinated Care Content as online case-related clinical protocols for review and assessment. Coordinated Care Content facilitates optimal care, defines problems, sets goals and suggests interventions based on a client's needs. This embedded clinical content enables users to deliver the appropriate level of intervention to each client. With Coordinated Care Content, the platform generates comprehensive assessments based on 26 clinical modules covering barriers to common care, case management and 31 different conditions or disease states. Clinical protocols support the platform by bringing co-morbidities together into

a single care plan for a clearer overall picture of the client's health. The following table outlines the care modules covered by the embedded InterQual Coordinated Care Content.

InterQual Coordinated Care Content Modules for Health Conditions

InterQual Coordinated Care Content Care Modules	
• Asthma	• Depression
• Low Back Pain	• Diabetes
• Bone Marrow Transplant/Stem Cell Transplant	• End of Life
• Case Management	• Heart Failure
• Cerebral Vascular Accident/Transient Ischemic Accident	• Chronic Pain
• Hepatitis/Liver Disease – Cirrhosis, Hepatitis B, Hepatitis C	• Chronic Wound
• Inflammatory Bowel Disease – Crohn's Disease, Ulcerative Colitis	• High-Risk Pregnancy
• Chronic Obstructive Pulmonary Disease	• Hypertension
• Coronary Artery Disease	• HIV/AIDS
• Chronic Kidney Disease	• Lupus
• Chronic Pain – Migraine headache	• Multiple Sclerosis
• Oncology (active treatment) - Cancer	• Obesity
• Rheumatoid Arthritis	• Solid Organ Transplant

Next POC Reevaluation (Unique ID 1730)

The VITAL platform maintains a running audit trail of system activity, including assessment time and date. It also allows the Department or authorized users to track assessment progress access dates and times in situations where assessments are completed in more than one event.

The platform allows users to maximize assessment time. Users can stop, save the progress of an assessment, and resume the assessment later. User can set a reminder at a specific time to resume the assessment, or the Department system administrator can configure the platform to place a reminder on the user's Reminder Log for the reevaluation after completion of assessments.

PARs Based on Special Case Issues

The VITAL platform interprets prior authorization requests (PARs) as "events" and can import them based on special case issues. An "event" is the record of a significant occurrence that happens while following or managing a client's case, such as PARs. VITAL will receive a PAR

extract from Colorado interChange on a regular schedule. Most events require authorization and the platform enables users to generate authorizations for Admissions, Referrals, and Services. Other events, such as a birth event, do not require authorizations.

Within the platform, users can create and manage authorizations, manage appeals, conduct concurrent reviews, perform discharge planning and track quality issues, and pass authorization information to and from claims systems and other data sources. A sample list of a client's events includes the following:

- **Admission authorizations—**Pre-authorization (pre-certification), diagnoses and procedures, concurrent review, and discharge from a stay at a treatment facility such as a hospital
- **Referral authorizations—**Authorization for a referral to a care provider
- **Service authorizations—**Authorization of an ancillary service and equipment procurement; for example, home care services or wheelchair rental
- **Prenatal events—**Tracks pregnancy-related information for prenatal admissions
- **Birth events—**Birth of an infant, as an event in the management of the mother's case, the baby's case, or both cases
- **QA events—**Quality review of a case or an incident related to the case
- **Appeals—**An appeal of a denied admission, referral, or service authorization or a free-standing appeal that does not have an associated authorization record

The following figure illustrates the type of events the authorized user can view for a client through VITAL.

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

Payment Service Through PAR (Unique ID 1589)

The interface of the authorized PAR with Colorado interChange creates the dollar or utilization limit for claim processing. The user will authorize the PAR using the limitations in the client's Health Benefit Plan. Any services not approved in the Client Service Plan will not be prior authorized using the PAR process, and will not be approved in interChange for claim payment.

As an option, HP can offer an Auto-Authorization Portal that integrates with the VITAL platform to help the Department limit payment for services to those described within the Client Service Plan as authorized through a PAR. This optional Auto-Authorization Portal verifies clinical necessity and eligibility by approving, denying, or requesting reviews for services. This functional capability will help the Department stay within dollar or utilization limits established by the health benefits plans.

PASRR Support (Unique IDs 1736, 1737)

(1736) The VITAL platform can create, track, maintain, monitor, and report the pre-admission screening process for each level of Pre-Admission Screening and Resident Review (PASRR). For example, the platform supports pre-admission screening information through its Events module, which tracks periodic reviews, authorizations, referrals, life events, quality reviews and appeals.

(1737) The platform supports the pre-admission screening process for long-term cases and updates to the approval process. The platform also supports the pre-admission screening process for each level of Medicaid PASRR.

Pre-Admission Screen for Long-Term Care Cases (Unique ID 1739)

The VITAL platform supports pre-admission screening for LTC cases. The platform updates client eligibility nightly. The Department can configure the platform so that it alerts the user if a change in the end date for the coverage occurs. The user can enter change-of-ownership, enter discharge dates, and perform PASRR.

Plan of Care Development and Implementation

The VITAL platform automates plan of care development based on InterQual Coordinated Care Content assessment results and data, as previously described. The platform starts with a barriers and common care assessment that, if checked, will ask questions for health conditions. A client's goals and priorities are listed in the plan of care. Each goal is assigned a number, 1 through 5, designating priority level and expands to list barriers or problems and overall status.

Case Management Activities (Unique ID 1731)

For the client's plan of care, the platform allows users to track, manage, and maintain case management activities through several functions: the Events module, User Management tab, correspondence functions, InterQual Coordinated Care Content, and InterQual Content Customization Tool. Beyond these core functions of the platform, it can import client eligibility information and automatically update the client's record to support the presentation of services and benefits.

As previously described, the platform provides an Events module to support admissions (intake and screening), referrals, and other utilization management functions.

Besides the Events module, the platform provides access to web links for coordination and facilitation activities. As the platform collects client and provider data from disparate sources, it will present the information in an intuitive, simple manner so users have the appropriate case management resources. The following figure illustrates how users can view the priorities and measure a client's progress toward completion of goals within the client's Care Plan tab.

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

Besides care plans, users can provide correspondence to clients to support the client's adherence to the care plans. The platform includes a robust correspondence module to strengthen client engagement. The correspondence module provides an easy way to design, deliver, and manage high-volume, personalized client communications. Because of this, clients will benefit from personal, timely, and persuasive documents.

Although the platform does not integrate with scheduling systems directly, users can create alerts or reminders for follow-up with clients.

Monitoring Reports (Unique ID 1733)

The platform can produce monitoring reports to determine if services approved in the provider plan of care are provided using information received through the routine claim interface with interChange. VITAL also can communicate the information to authorized users. As previously detailed, authorized users can generate application activity reports or Client Summary Reports. These reports will allow the Department to track the service each client receives. Beyond these monitoring reports, the Department can take advantage of the standard reporting package or custom reports. The platform provides a standard reporting set with SAP Crystal Reports or any existing open database connectivity–compliant (ODBC-compliant) reporting tool, but users can use a read-only version of the following reports with Crystal Viewer.

The following reports are standard with SAP Crystal:

- Admissions Authorized
- Authorization Master Report by Event Type or by Event Status
- Authorized Referrals
- Care Plan (suitable for mailing to client and PCP)
- Cases Closed
- Cases Managed
- Census (All Admissions)
- Events Not Closed
- Notes Created
- Referral and Service Line Item Details
- Target Discharges
- Outcomes (Goals) by Achievement Level or Outcomes (Goals) by Case Type (Disease)
- Top 5 Case Management Barriers by Count
- Top 5 Case Management Goals (outcomes) by Count
- User Reviews Completed

The platform is a relational database, and users can capture and report from any data housed in the history and session table using ODBC-compliant reporting tools. This level of detailed reports will allow the Department to determine if clients are receiving the appropriate level of care, as outlined in their plan.

Case Management Monitoring Files (Unique ID 1753)

The Department can create custom reports by case, family, account, or individual files. Users also can use the "Client Summary Report" to print or display the client's demographics, coverage, cases, goals, problems, and notes. The VITAL platform presents the imported client data through the client's Summary view. This displays the client's historical claims, referrals, authorization, medications, and assessment results. As significant events occur, the platform will import the event information and allow users to edit the client's record manually.

Ability to Flag Long-Term Level of Care Determination (Unique ID 1744)

The platform can flag clients for long-term level of care. New and modified authorizations are part of the extract files sent to Colorado interChange. These flagged records are then passed back to the source eligibility systems, including CBMS and TRAILS.

Client Identification (Unique ID 1751)

The platform allows users to identify clients with special healthcare needs, and inform care management or the managed care entities of these clients at enrollment or throughout eligibility. Users can add comments to the client's record or attach documentation that identifies the client's special healthcare needs with the Notes function. This information also is captured in assessments and can be part of the client's care plan.

Program Quality Surveys (Unique ID 1759)

The Department can collect, edit, and update a program quality survey of major services with the InterQual Coordinated Care Content assessments. The Department can create quality surveys with the InterQual Content Customization Tool, which provides a simple editing environment to configure InterQual Coordinated Content.

In the platform, the Content Customization Tool allows Department users to configure pre-existing assessments, or create new content for assessments. Users can customize sections, subsections, questions, rules, alerts, and notes. Furthermore, the Content Customization Tool allows the Department to configure problems, goals, interventions, instructions, educational components, and notes.

Allow the Coordination of Medical Resources

The VITAL platform coordinates care and medical resources. With the platform, the Department can integrate data from disparate sources into a single, member-centric workflow, enabling various care team members to use one system to manage members. The Colorado interChange solution connects care managers, providers, and payers to deliver a patient-centered program consolidating client information collected from claims data and other sources of personal health data for sharing among the decision-makers, including the client. The platform can obtain data from various Department systems and present a holistic view of the client.

Case Management Activity (Unique ID 1732)

As we describe in RESPONSE 39g, our platform creates, tracks, and maintains the case management activities within its automated workflow. Within this tool, users can take advantage of case management functions; such as notes, correspondence, authorizations, appeals, eligibility, and contacts. The platform connects care managers, providers, and payers to deliver a holistic, patient-centered program that centralizes client information. This allows the secure exchange of information among the decision-makers, including the client, helping the Department to engage clients with a variety of activities and preference-based access points to resources and web-based tools.

The following are some of the notable features and benefits:

- Have a 360-degree view and understand the needs of a selected client
- Capture notes, attach documentation, and send client educational materials
- Create and assign cases
- Track problems and goal achievement for clients' care plans
- Track client progress related to key clinical variables
- Conduct assessments or surveys to establish a client care plan
- Evaluate, conduct, and document utilization events
- Set automatic reminders for follow-up and schedule further events
- Capture report and outcomes information
- Refer and track clients, authorizations, and cases
- Identify clients for care management through claims data

The following figure displays how the Notes module allows users to document, as well as review, any encounter or intervention for a client. The types of documentation include note entry, letters, completed assessments, clinical reviews, and any other attachments received for the client. As a result, different care team members can view documentation such as calls to providers or clients, letters sent, research completed or services coordinated.

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Critical Incidents (Unique ID 1735)

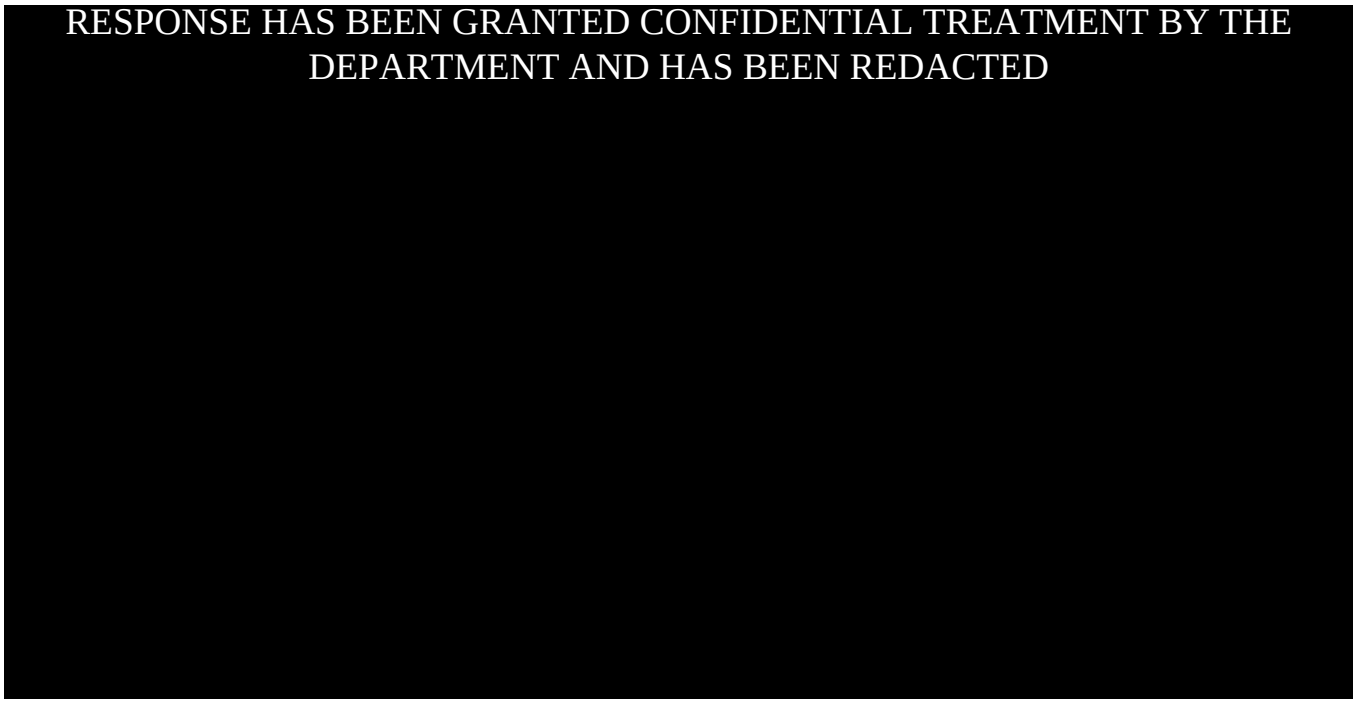
The VITAL platform allows users to enter, edit, and identify critical incidents through the Notes function. It can import authorization information using the Events module alert the user (or care manager) of required follow-up. Users can attach documentation and edit the client's record as necessary.

The platform displays the client's history and eligibility information at the individual, group and program level, as shown in the following figure. The platform can import data from the Department's eligibility database, and uses client demographic information to auto-populate many data fields in the platform. This information is searchable by these basic categories:

- Last name, First name
- Client ID (starts with, equals, or contains options)
- Date of Birth
- Alternate ID

The following figure demonstrates the client's eligibility imported into the VITAL platform.

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



The platform will allow for advanced client search as follows:

- Client coverage—such as benefit plan, benefit product, or benefit group
- Client PCP
- Facility
- Provider

Clients may have multiple active coverage records available, and any prior coverage information is moved to history and is available from the client coverage screen. The Department can set and refresh reminders into the platform to alert users about benefits maximum as seen in the following figure.

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The platform allows the Department to determine how it wants to handle its clients. If a user chooses a client with ineligible coverage, an administrator setting can allow or prevent them from creating the authorization. The platform can send a reminder to the user about changes in exit dates for coverage. Though utilization management may terminate, the platform would allow disease management to continue.

The platform supports appeals and grievances within the Events module, as described above. The Appeals function documents the appeal, as well as any action taken. It supports multiple types and levels of appeals. This allows the Department to enter appeals and track outcomes. Appeals can be customized—such as appeal types, or status—and the Department can determine certain fields and data capture. The Appeals function is shown in the following figure. Information on this report includes the following:

- Notification date
- Appeal status
- Date entered
- Appeal reason
- Event type
- Authorization number
- Appeal type
- Requested by
- Type of requester appeal
- Appeal level

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

Besides the Appeals module, we have a Quality Event module. This allows tracking of quality issues and member complaints. The initial reporting, as well as the outcome, can be tracked. The Department can define the types of complaints/grievances tracked through the drop-down table values. The appeal can be sent to another physician for review after its completion. The second physician completes the appeal and updates the authorization with the outcome, after which letters are sent.

Automated Workflow (Unique ID 1747)

The platform automates workflow functions during the care management process. For example, the platform provides a Reminders Log to help users schedule their day, manage clients, and identify important activities. When the user clicks on a reminder titled "Discharge Date Passed," the platform automatically brings the user to the admission event for that specific client. Besides scheduling and automating workflow, client's care managers can create and forward reminders to other users. If another user forwards, closes, or executes a reminder, the original user receives a corresponding reminder. This keeps the client's care manager informed while generating a user history for the client. The platform displays completed reminders in the "My Work" tab, as shown in **Error! Reference source not found.**. The My Work tab will show reminders for each client who is assigned to the user. When the user selects a reminder, the platform automatically takes the user to the correct screen to complete the action, or the user can use select the action function. Future releases will allow the Department to customize alerts and configure business rules to suit its evolving requirements.

The platform supports workflow automation by generating client follow-up. For example, when users flag interventions within a client's care plan, the platform will add a task to the user's work list to follow-up on the intervention. Additionally, users can save the progress of an assessment.

The platform also will generate a reminder within the user's work list to notify the pending assessment that requires follow-up.

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Another form of workflow automation comes from InterQual Coordinated Care Content. The platform uses the results of Coordinated Care Content assessments to generate client-specific care plans. The tailored care plans automatically address goals, list priorities, and denote barriers to common care. As seen in the following figure, the platform uses the responses to Coordinated Care Content Assessments to automatically generate the client's plan of care.

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

After the client completes the assessment, then the platform aggregates the responses into a clinically-based care plan. The platform also can automatically populate client records based on data imports. The Department can configure the platform to alert users when the client's coverage has expired. The platform can import other data, such as lab and biometric data, into

the system using standard interfaces. For example, lab data and biometric data can be imported into clinical variables using HP's standard interface.

Updated Client Information (Unique ID 1734)

The platform allows the Department to collect and maintain current and historical data across populations and programs. Users may update the client's record manually, but the platform updates the client's record automatically through the batch refresh process with interChange. The platform interoperates with commercial and homegrown claims systems, predictive modeling applications, biometric data, lab results, and authorization exchanges.

System Interfaces and Integrations (Unique IDs 1256)

The VITAL platform can interface with case management systems and link that data to client and client claims/encounter records. The platform uses ASCII-based flat files and supports common web formats such as X12, XML, and proprietary formats. The format and messaging method depends on the implementation needs of the Department. HP will work with the Department to determine the appropriate interface between interChange and platform to verify the proper alerts are triggered within the application. For example, the Department can refresh data in about new conditions and risk scores, then assign to a user's work list for follow-up.

Provider Identification (Unique IDs 1748, 1749)

The VITAL platform allows users to identify and select providers based on specialty type rather than by service type. The platform imports provider demographic data, including National Provider Identifier (NPI), into database tables. This information from the Department's source system populates specific fields within the provider's record. The provider database is searchable outside of cases or episodes. The platform displays in-network status by matching provider contract with the Department benefit based on line of business. The provider database shows effective dates and termination dates to determine contract status on dates of service. The platform imports the following:

- Provider ID
- Birth date
- Last name
- First name
- Network status (participating provider)
- Title
- Region
- Provider type
- Telephone numbers
- Specialty addresses
- UPIN number plans
- DEA number

- Office contacts
- Gender

External User Access to the Platform (Unique ID 1758)

The VITAL platform accommodates user access—such as fieldworkers who are not case managers—with role-based security in accordance with HIPAA security standards. The role-based feature allocates various application activities to different users. Each user is assigned to a security group. Each security group can be given or denied access to any of the more than 300 possible activities—such as create an event, re-assign a case, or review a case. For example, a security group of case managers could create a new case for management, whereas a security group of people belonging to the claims department may not be able to do any activities other than read the accessible data. After a user is assigned to a security group, the system administrator can change the user's individual security profile.

Though security does not go to the Field level, certain fields can be designated as read/write or read-only through the Administrator module. The Department will assign a system administrator who the HP team will train on the VITAL platform. The system administrator can assign and change security roles as needed.

The users must have valid logon information for the platform to identify the user and track activity within the platform. The ability to identify the users maintains accordance with HIPAA regulations.

Communicating Healthcare Needs to the Individual

The Department can use the robust correspondence function within the VITAL platform to communicate healthcare needs to the individual. The platform includes correspondence functional capability to strengthen client engagement. With the correspondence functions, the platform provides an easy way to design, deliver, and manage high-volume, personalized client communications. Because of this, clients will benefit from personalized, timely, persuasive documents. The correspondence function allows the platform to automate template designs that serve as the basis of document communications. Users can import templates from other sources or easily create and edit templates within a familiar Microsoft Word-based design environment. The platform uses the correspondence feature's thin-client interface to allow access to a central repository containing templates with preapproved content and preconfigured workflows to guide users in real time.

EDMS Support and Integration (Unique ID 1754)

HP will work with the Department to develop the integration that allows case managers to access information from and input information to EDMS using the single sign-on (SSO) solution. Provider correspondence, case management correspondence, and other external information are refreshed into the VITAL platform through a nightly batch refresh process. This information also can be attached to the client's record through the Notes function, as described previously.

Monitoring an Individual's Progress

Users can track and monitor an individual's progress and care plan. The platform starts with a barriers and common care assessment that, if checked, will ask questions for the conditions outlined in the following figure. A client's goals and priorities are listed in the Plan of Care. Each goal is assigned a number, 1-5, designating priority level and expands to list barriers/problems and overall status.

Client Eligibility Tracking and Monitoring (Unique ID 1729)

The VITAL platform can import the Department's claims and eligibility information. After this data is in the platform, the Department can generate custom reports to track client eligibility and changes to eligibility for specific services based on the imported claims data from the Department. If the claims import dictates a client's change in coverage, the platform can alert the user. The platform can automatically generate a reminder to the user if there is a change in the coverage end date. This is an option in the Administrator module. Users also can manually create reminders.

Client Health Demographics Information (Unique ID 1709)

Users can collect, track, and search the health demographics information related to notes, history, contacts, eligibility, correspondence, authorizations, care plans, claims/encounters, attachments, financial, and appeals within the VITAL platform. We detail in the following subsection how the platform allows users to perform basic client, authorization, and provider searches. The platform maintains a running audit trail within two tables: the history table and the session table. Users can report of information captured within these data tables. The platform does not support HIE.

Promotion of Cost-Effective Care

As detailed previously regarding the Events Module, the VITAL platform promotes cost-effective care through utilization management, automated workflow, and user management. The platform also promotes cost-effective care by keeping case managers informed of significant medical events, providing robust clinical content, and integrating data from multiple systems so clients benefit from accurate and timely case management.

Capacity-Level Management (Unique ID 1745)

The platform allows users to search, sort, and update specific case data and health demographic information. The platform can import and edit client data from the Department's eligibility database. The platform uses client demographic information to auto-populate many fields in the client's record. The Department can determine the frequency during implementation. Additionally, this information is searchable. Basic client searches find the following:

- Last name, first name
- Client ID
- Date of birth

- Benefit plan
- Alternate ID

Clients may have multiple active coverage records available. Prior coverage information is moved to history and is available from the client coverage screen.

Single View for Client Records (Unique ID 1746)

As shown in the following figure, the client's Summary view provides a single view of the most recent information related to the client, including open cases, recent authorizations, prescriptions, coverage, outstanding reminders and recent diagnoses. After the user logs into the VITAL platform, the client's Summary view shows the client's history, claims, referrals, authorizations, and medications. The client's record also displays related alerts, attachments, appeals, and related associations.

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For example, the platform displays an overview of the client's pharmacy claims within the Summary view. However, users can view pharmaceutical and medical claims within the Clinical tab. The next figure demonstrates the Pharmacy Claims tab, which outlines the Date Dispensed, Supply, Date Exhausted, National Drug Code (NDC) Description, and required refill.

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The following figure details the Medical Claims tab, which provides a single view for service and authorizations. This view outlines service dates, amount paid, units, status, authorization code, description, diagnosis, and the associated provider.

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Group Case Managers (Unique ID 1755)

The VITAL platform will allow you to group case managers by contract, employment, or other criteria for reporting and management within the User Management tab, as previously described, or as a custom report. The platform can capture and report off data housed in the history and session tables. This ad hoc reporting capability allows for robust reporting to support auditing, productivity, compliance, quality improvement, and outcomes of medical management initiatives.

Case Management by Type (Unique ID 1756)

The VITAL platform allows the Department to capture, track, and maintain case management type through customized reports. The platform allows users to print these customized reports for transmission to BIDM. The HP team will work with the Department to integrate the platform with the BIDM. This integration will be dependent up on which reporting tool the Department selects. The platform's standard reporting packing is designed for Crystal Reports. However, the platform provides OBDC database and will allow the Department to transmit the case management files electronically.

Manual Client Enrollment (Unique ID 1445)

The users can create temporary or new client records within the VITAL platform as seen in the following figure. In the application, the platform can relate client cases to pre-existing client records.

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Alerts and Reminders for Follow-Up Activity (Unique ID 1364)

The VITAL platform allows users to send a case management alert. That activity is required through the Reminders function and User Management tab. The platform can create alerts for follow-up activity based on the Department's data with a refresh process. If the Department identifies criteria based on claims; client assessments based on diagnosis, prior utilization,

services provided, age, or prognosis; quality reviews; or eligibility verifications, then the platform can import this data and create a reminder for users.

The next figure demonstrates how the platform generates reminders automatically, flagging clients for follow-up based on activity in the system. Users also can create reminders manually for themselves or other users. For example, users can request follow-up by another user, or any of the following:

- Next review due on an inpatient concurrent review or an InterQual Coordinated Care Content assessment will trigger a reminder.
- After a review is requested and assigned to a user, the user will receive a reminder that a review has been assigned to them.
- A case or event is transferred to a user, and a reminder will be generated to alert them of the new assignment.

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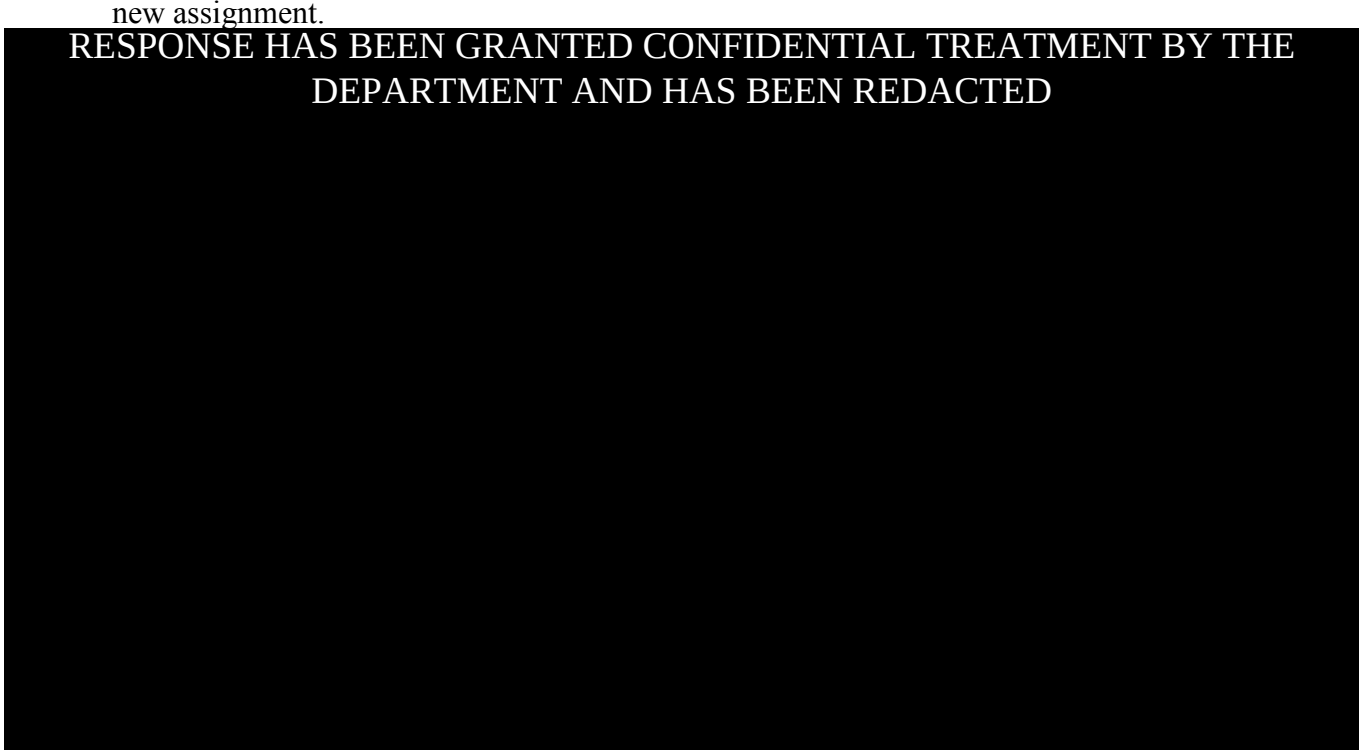


The user can sort their reminders by priority, date, or other areas. Any one of the columns in the reminder tool can be sorted in ascending (low to high) or descending (high to low) order. The user only needs to click a particular column heading once to sort the data. Additionally, users can filter reminders by activity type, including the following:

- Active
- Completed
- Past due

Reminders can be automatically placed on a user's reminder log based on various activities within the VITAL platform with specific calendar dates and times.

Correspondence and Notification Maintenance (Unique ID 1738)

The VITAL platform includes correspondence functional capability to strengthen client engagement. With the correspondence feature, the platform provides an easy way to design, deliver, and manage high-volume, personalized client communications. Because of this, clients will benefit from personal, timely, persuasive documents.

The correspondence functional capability allows the platform to develop and automate template designs for authorized users to select desired correspondence and notices from a list. These templates can serve as the basis of fully personalized document communications. Users can import templates from other sources or easily create and edit templates within a familiar Microsoft Word-based design environment. This allows users to add and record free-form text to individual or groups of case management correspondence.

The platform allows users to display, print, and save case management related correspondence within the correspondence functional capability. Users can manage creation of correspondence and notices based on user configurable event-driven criteria. Users also can select address information on correspondence and notices based on the addresses of the clients' records.

PASA Data (Unique ID 1728)

The VITAL platform can provide read-only access to PASA data through an embedded web link. When the Department goes live, the platform will be configured to display PASA information to support coordination of care between the Department and community resources.

Secure Multi-Channel Communication (Unique ID 1750)

With the VITAL platform, the Department can communicate directly with clients in the community through the integrated direct mail correspondence tools. As more clients are becoming accustomed to interacting with case managers through web services, we continue to update the platform to meet client needs. For example, in August 2013 the platform will smoothly integrate with the online Client Web Portal to support secure email messaging from client to case manager. Text and mobile communications may become available as technologies to support secure transmission of personal health information continue to advance.

Provider Web-Based Survey (Unique ID 1831)

For surveys to providers and clients on more general program topics, HP will use Survey Monkey to develop and disseminate these surveys. Surveys are completely configurable with more than 15 different types of question formats—such as radio button, scales, multiple choice, or open-ended narratives. Survey participants are sent a customizable link. Survey parameters can be set to allow only one response or multiple responses from a single workstation, as well as with other parameters. Survey Monkey offers robust reporting and analytic services. The reporting and analytics are database-driven, meaning results can be sorted and parsed in countless ways. Results are available in various formats—such as Excel files or PDF—and can be supplied to agencies and to BIDM for analysis.

When the Department goes live, the Provider and Client portals will be configured to provide a web- based survey tool to capture electronic responses and pass the information to BIDM for analysis. The integration will allow the Department to provide users with an interactive guided evaluation tool. The Provider and Client portals are available when it is convenient for the user.

Specifically, client survey results provide a picture of clients' overall health, based on their answers to the survey questions. The survey includes a customized action plan and several online programs and tools to support a healthier lifestyle. The Department can develop the survey to meet its needs. Through the Client Portal, clients have a single point of entry to a range of health and wellness programs.

8.13 – Case Management Tool	**In Production? YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1262, 1286, 1365, 1425, 1670, 1727, 1740 - 1743, 1757, 1760 - 1762, 1771	**NO**

Interface Between System and Case Management Tools (Unique ID 1262)

The VITAL platform can interface with case management systems and link that data to client and client claims/encounter records. The platform uses ASCII based flat files and supports the use of common web formats, such as X12, XML, and other proprietary formats. The format and messaging method depends on the implementation needs of the Department. HP will work with the Department to determine the appropriate interface between interChange and platform to verify the proper alerts are triggered within the application. For example, the Department can refresh data in about new conditions and risk scores, then assign to a user's work list for follow-up.

Case Manager Assignment at Agency or Program Level (Unique ID 1286)

VITAL does not currently provide the ability to assign authorized system users and manage capacity to case managers at the agency or program level, PAR reviewers, or program integrity reviewers. A workflow can be built that will, as a built-in feature, allow task assignment configuration for certain authorized individuals or groups.

Identification Reports (Unique ID 1365)

For the client's plan of care, the platform allows the Department to maintain reports that identifies providers with clients, or clients without providers who need a service that is unavailable. The platform also can produce application activity reports and client summary reports. This level of reporting allows the Department to track and report the types of services that were provided in accordance with the client's plan of care. The Department can develop

custom reports to identify providers with clients, or clients without providers who need a service that is unavailable.

Client Benefit Program Waitlist (Unique ID 1425)

When the Department goes live, the VITAL platform will store data related to Colorado Medical Assistance program client waitlists and special needs list for specific benefits or programs. This information can be refreshed into the platform to alert the users of clients that are eligible for programs.

Health Risk Assessment Tracking and Support (Unique ID 1670)

When the State goes live, the VITAL platform will provide the ability to support and track the results of external health risk assessments, as well as maintain prior history of assessment.

Comprehensive Assessment Data (Unique ID 1727)

When the State goes live, the VITAL platform will support the collection and maintenance of current and historical assessment data across populations and groups. Additionally, for assessments that are conducted within the platform, historical care plan goals and resolutions also are maintained for reference and cross-population tracking.

Spending Caps (Unique IDs 1740, 1741)

The Colorado interChange will enable authorized users to set Service Plan Spending Limits (SPSL) through the Prior Authorization business function. If required, the user can override the previously authorized service limitation by increasing the spending limit or cap on the service usage.

Critical Incidents (Unique ID 1742)

When the Department goes live, the VITAL platform will support the submission of critical incident reporting for users to view by attaching the Critical Incident Report to the member record within the care and case management tool. The electronic workflow of the interChange system will enable the authorized system user to view the critical incident case and approve or reject the submission following review. Critical incidents are linked at the client level to support patient-centered care.

Functional Assessment and Score Data (Unique ID 1743)

The platform can collect, track, maintain and transmit the functional assessment data and score to the Colorado interChange MMIS. The MMIS will transmit the information to the BIDM along with other program data on a schedule determined by the Department and HP.

Time Stamp (Unique ID 1757)

HP proposes the use of the Electronic Visit Verification (EVV) module of the Sandata Santrax Payer Management (SPM) solution. SPM is a web-based solution that measures, monitors, and provides electronic visit verification for home care services. SPM processes electronic files of authorizations, eligible clients, and home care provider agencies. Using various technologies, the

system captures caregiver arrival and departure times, location, client and caregiver IDs, and tasks performed during the visit. Rules-based claims submittal increases compliance and claims accuracy, reducing inappropriately billed services. The result is improved oversight into home and community-based services (HCBS) program delivery, streamlined claims, and reductions in fraud.

The Sandata EVV solution decreases costs, improves efficiency and supports the quality of services to Colorado's most fragile clients as follows:

- Providing access to real time home care service delivery data, monitoring tools, and comprehensive reporting on utilization
- Automating manual and paper-based processes, removing potential human error or time sheet "rounding" by caregivers
- Providing EVV options for Medicaid clients across Colorado's varied geography—urban and rural
- Providing real-time alerts to provider agencies and care coordinators for late or missed visits
- Verify that only visits verified against authorized services and limits are paid, mitigating the potential for fraudulent claims and reducing the workload for claims adjudicators and program integrity staff members
- Provide a tool to consistently manage and compare provider agencies and establish benchmarks for care delivery to implement Pay For Performance (P4P) programs or assess penalties

EVV controls and contains the rapidly accelerating costs for HCBS while improving quality and integrity. Rather than reduce funding for vital services, EVV technology improves accuracy in service delivery and billing, promoting higher standards of care delivery, program and cost efficiencies, and transparency among stakeholders in the chain of care.

Sandata's powerful combination of patented solutions for visit verification is called the Assured Coverage program and includes the following:

- **Telephone Visit Verification™ (TVV)—**TVV uses Automatic Number Identification ("ANI") technology to validate telephone calls to log on and log off, recording time and location in real time.
- **Mobile Visit Verification™ (MVV)—**Real-time GPS technology verifies caregiver location and visits using GPS-enabled devices (mobile telephones and tablets).
- **Fixed Visit Verification™ (FVV)—**Patented technology to verify visits when no landline or cellular service is available. Caregivers press a button for a randomly generated number at the start and end of each visit. The number is then entered into the EVV system when a telephone line is available and translated to an exact date and time stamp for the visit.

Through the Assured Coverage program, the Department can be confident that multiple technologies verify visit verification is occurring at the point-of-care; helping to guard against allegations of fraud and abuse, while improving care. HP will work with each of the providers to build a customized EVV program deploying any or all of the visit verification technologies to maximize the number of visits that will be validated electronically.

Batch Survey Data Upload (Unique ID 1760)

When the Department goes live, the VITAL platform will provide the ability to upload batch survey data. HP will work with the Department to determine the information for uploading, frequency of upload, and the system receiving the data upload.

SIS Data Acceptance (Unique ID 1761)

When the State goes live, the VITAL platform will support externally created quality surveys (SIS surveys) and batch upload of the survey data. HP will work with the Department to determine the information for uploading and frequency of the upload.

Spending Caps (Unique ID 1762)

As we detailed previously, Colorado interChange Prior Authorization business function allows the authorized user to set the levels and limits for approved client services. Additionally, the Department can configure benefit limit audits within the MMIS to control appropriate claim adjudication.

When the Department goes live, the VITAL platform will support setting SPSL and client service plan authorization limits by sending a reminder to the user to alert them to the spending limit through the Create Reminder transaction record.

PETI Forms (Unique ID 1771)

The Auto-Authorization Portal also will facilitate interactive, role-based functions within the web portal where nursing facility providers can electronically submit and obtain approval for Post Eligibility Treatment of Income (PETI) forms. The optional, Auto-Authorization Portal verifies integration of the PETI submission process with the platform for inclusion of PETI information with client data.

RESPONSE 39I

8.14 – Web Portal	In Production? YES/NO
Description Addresses Requirements (Provide the range as applicable): 1176, 1188, 1200, 1219, 1345, 1377, 1381, 1446, 1451, 1457, 1471, 1473-1475, 1482, 1512, 1519, 1529, 1531, 1623, 1659, 1728, 1763-1765, 1767-1770, 1772-1774, 1818, 1842	**YES**

HP offers the HP Healthcare Provider Portal as a solution to the web portal requirements laid out in the RFP. Our commitment to Colorado and 45 years of experience in the healthcare and technology industries allows us to offer the most innovative solution to promote vitality of the Colorado Medicaid program. A core principle of our portal solution is the self-service focus for both providers and clients, which both allows for instant access to information for the user, and also reduces cost overhead for the Department. Put succinctly, HP will enable the Department to deliver more healthcare services to the Colorado residents who need them.

Our Healthcare Portal is a secure, federal and industry regulations–compliant platform, safeguarding protected health information (PHI) and personally identifiable information (PII). Our web portal solution adheres to regulations and compliance relating to the following standards:

- HIPAA
- Health Level Seven (HL7) Continuity of Care Document (CCD)
- National Council for Prescription Drug Programs (NCPDP)
- International Classification of Disease, Ninth Revision (ICD-9) and Tenth Revision (ICD-10)
- Web Content Accessibility Guidelines 2.0 (WCAG)
- ADA Section-508
- Healthcare Information Technology Standards Panel (HITSP) Data Exchange Standards for Health Information Exchange (HIE)

The proven HP Healthcare Provider Portal offers a self-service model for authorized program stakeholders; 24 x 7 access and intuitive design encourages users to navigate the site to locate necessary information without needing to call a help desk or refer to training documentation. Reducing natural resource consumption by replacing paper-based claim processes, the provider

web portal also offers a green, sustainable way to do business, while also saving the Department on mailing paper RAs and other provider communications.

HP's Healthcare Provider Portal solution can act as the web-based front end to multiple back-end payer systems. It consumes the web services these back-end systems provide, taking existing information and presenting it in new contexts, creating added value from the feature-rich functional capability and personal healthcare content in these systems.

One key capability of the HP solution is the client-focused view. The client-focused view feature enables providers and their delegates to view, navigate, and perform actions in the provider portal with a focus on a single specific client. From the client-focused view, the provider can select links to submit new claims or authorizations and view summarized details such as member demographics, coverage, claims, and authorizations in one place. They also can select an individual claim or authorization and review details. We will prefill subsequent panels that need member search criteria with the details for the member in focus.

Client-Focused View

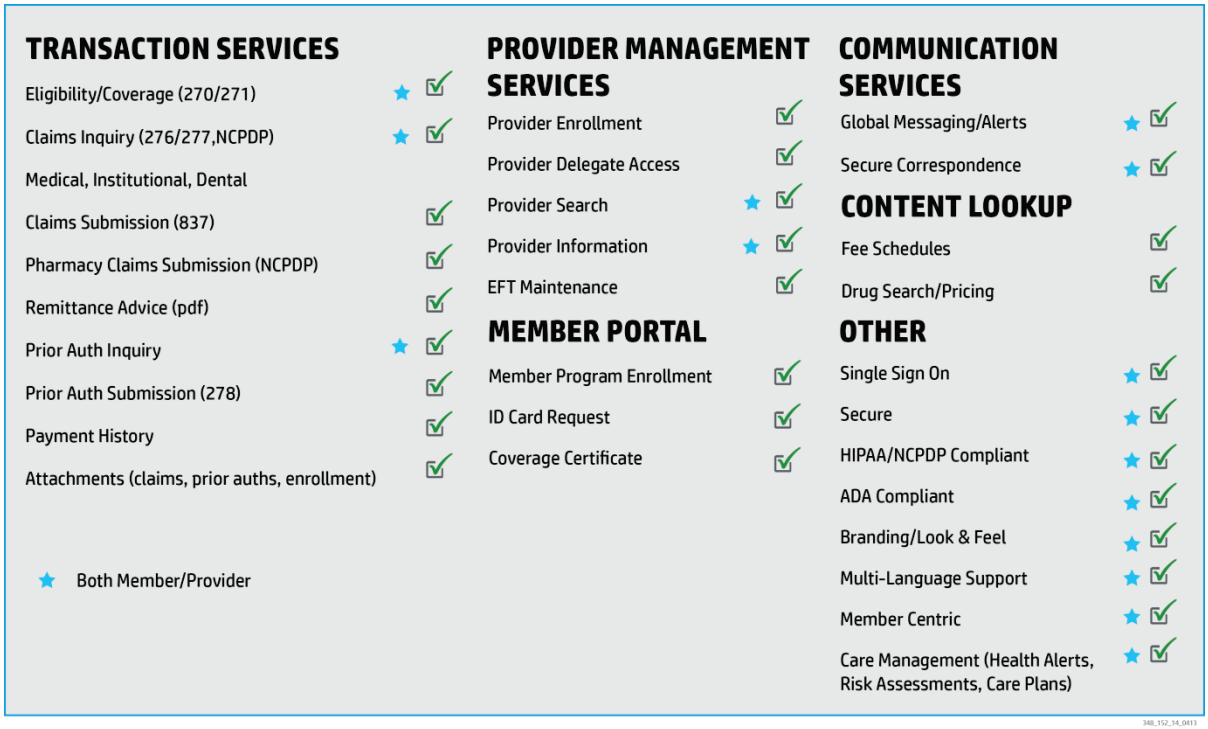
When a provider opens a member-focus view and selects the client to bring into focus, the system automatically performs an eligibility inquiry on the current date. The provider can navigate to the client's care management record by simply clicking on the Care Management link. Because a specific client is in focus, the Healthcare Portal will pass the client specific data and the provider data to the McKesson VITAL care management system eliminating the need to re-enter it. Additionally, the provider can open the client's Electronic Health Record (EHR) while the client is in focus.

The web-based application includes design benefits which will ultimately promote the continued success and vitality of Colorado Medicaid programs:

- The portal is built on the Microsoft .NET platform, a framework with extensive tools for creating and interacting with distributed web services, allowing for ease of presentation and accessibility to information.
- Modules are built on a common technology framework, allowing quick, efficient implementation of new functional capability as it is developed by the HP Healthcare Portal team.

The following figure gives a summary of the HP Healthcare Provider Portal capabilities.

HP Healthcare Provider Portal Capabilities



Electronic Enrollment (Unique IDs 1446, 1451)

(1446) The 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. A wizard guides the provider through collecting important information for creating the provider record and submitting it to the back-end system. After enrolled and registered, providers can use the Provider Portal to view and update their respective information, including service location addresses, telephone and fax numbers, enrollment data, and other contact and demographic characteristics such as languages spoken at a given location. Information gathered by the provider enrollment wizard is configurable at the Department's discretion—for example, the information can be set to be displayed, hidden, required or optional. Providers can efficiently maintain their enrollment by submitting updated credentials and licensures through the portal when they are available.

The portal captures enrollment information optimized for provider type and taxonomy from initiation through to disclosures with a wizard that guides the provider through collecting important information and online submission, replacing paper-intensive, manually driven processes. After the enrollment application is confirmed, the provider receives a message indicating that the application has been submitted along with a tracking number. This tracking number can be used by the provider to inquire on the status of the enrollment approval. A confirmation email will be sent to the provider.

Some of the information gathered by the wizard can be configured by the Department. The following figure indicates what information is gathered and configurability options.

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The following are options available to users of the HP Healthcare Portal:

- **Enrollment type—**Choices include group, facility, individual, individual within a group, and atypical.
- **Group-related information—**This can be the group an individual is associated with if enrollment type is individual within a group, or a listing of the providers associated with the group if enrollment type is group.
- **Specialties—**The provider will be required to enter one or more specialties, as the following figure highlights. One specialty must be designated as primary. The provider can choose to associate a taxonomy code to each specialty but is not required to do so. An additional taxonomy code can be entered that is not associated with a specialty.

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- **Provider identification—**The provider enters identifying information such as name and various IDs, such as Tax ID, NPI, DEA, and license numbers, as the following figure details. Surety Bond Data–related information can be entered for facility enrollment types.

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- **Addresses—**The provider must include a primary address, as the following figure details. Additional addresses can be added. Address standardization functional capability is available on this page for the different address types. This allows an entered address to be sent to a third-party address standardization service to be checked for validity. The address standardization service returns the results of the validation to the portal. The results may include an exact match, multiple possible matches, or a message indicating no matches and which part of the address is invalid.

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- **Languages—**Providers may indicate languages they speak, but this is optional, as the following figure highlights.

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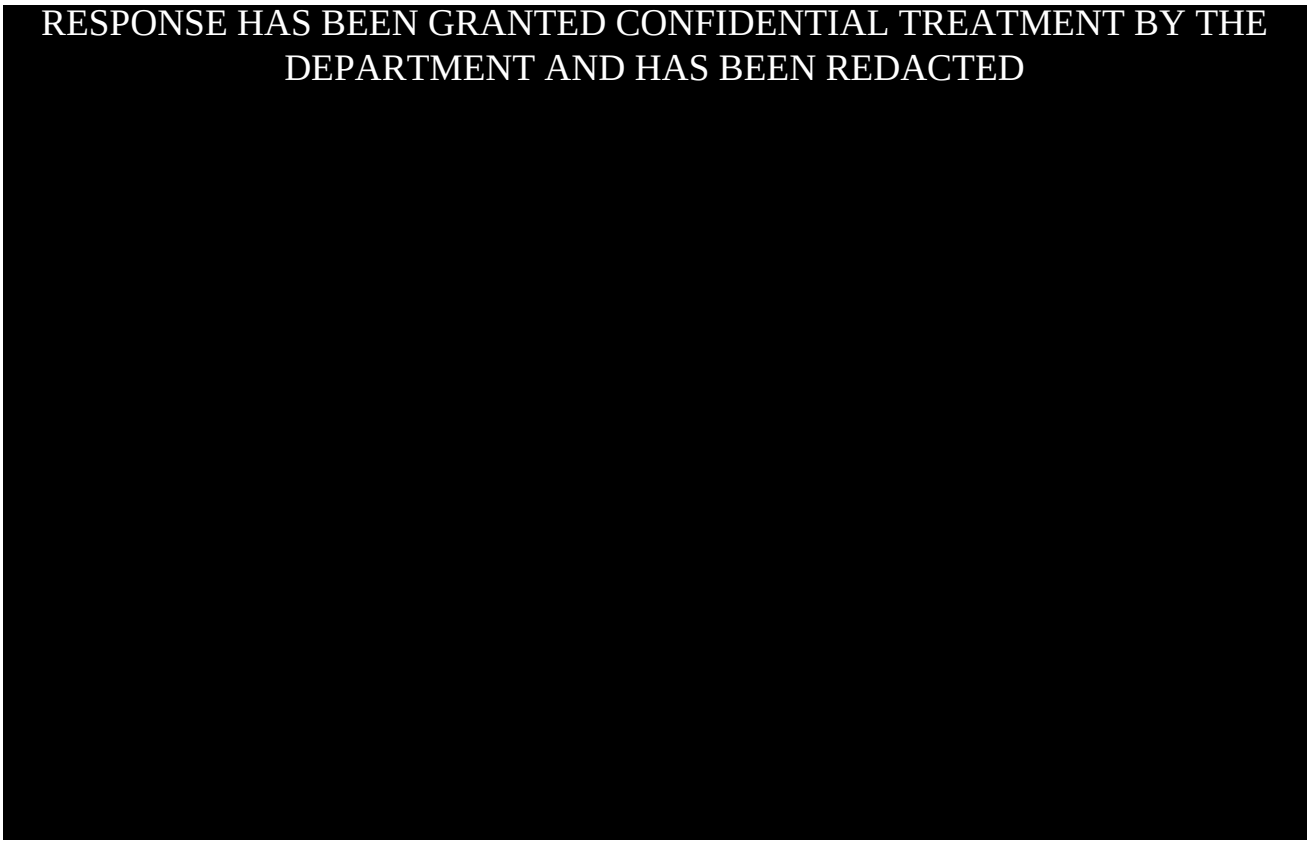
- **Banking information—**Providers have the option to have payments deposited directly into their bank accounts, as the following figure details. If he or she chooses to participate in electronic payment, the provider will be required to enter bank account information. Bank address information is entered on an optional address panel.



- **Other information—**Providers may enter commercial insurance plans that they accept, as the following figure shows. The provider may enter certifications they have and the effective dates of the certification. The provider also may enter specialty board and degree information, but this information is not required. Decertifying pharmacy information and data related to a collaborating physician also can be entered. A list of board members can be entered for group or facility enrollment types.

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- **Disclosures—**Disclosure questions are fully configurable, as the following figure demonstrates. Some of the available response types include yes or no, text, drop-down, multiple choice, and dates.

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- **Agreement—**A provider must accept the terms of the enrollment agreement to submit the enrollment, as the following figure highlights. The terms of agreement text is customer-configurable. (1451) Additionally, customers may add customized links in the Supporting Documentation panel to applicable federal and State regulations documents.
- **Attachments—**A provider may upload supporting documentation through the attachment feature. The provider selects the file to upload and clicks on upload. The attachment will be a permanent part of the record and sent to the EDMS for storage on completion of the application.

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- **Summary—**Before confirming the enrollment application, a summary is displayed to allow the provider to review the information, as the following figure details. The provider may edit the information by selecting the link for the section they wish to update. The provider may print the summary.

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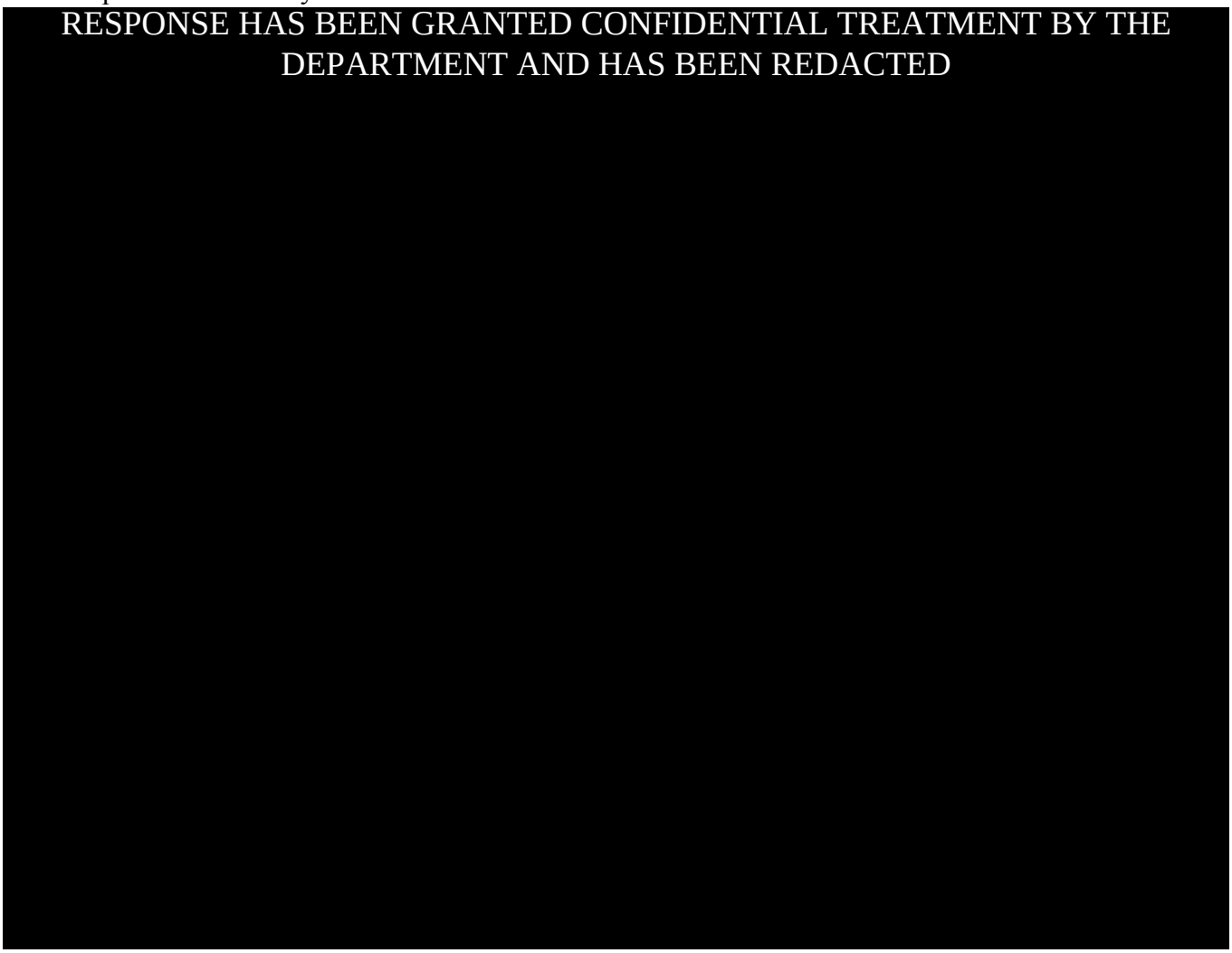

The provider is prompted for a password before the application can be submitted. A provider can check the status of their enrollment at any time using the Provider Portal. The provider will need to enter the tracking number received after the enrollment was submitted along with the tax ID and chosen password. The enrollment status will display the date the application was submitted and the current status of the application.

Secure Connection (Unique IDs 1200, 1377, 1764)

HP's interChange security single log on solution allows secure access to multiple systems from one web page. The capability will enable smooth access to other systems for authorized users, including the BIDM and the McKesson VITAL care and case management platform.

For an in-depth look at our innovative interChange security solution, please see RESPONSE 38e.

Role-Based Security

[redacted] Each user must register on the Provider Portal with at least one role: provider, delegate, billing agent, trading partner, or out-of-network provider. Each role can be configured with a set of functions that is accessible to its users. The delegate and billing agent roles are special cases. Role-based security allows providers to create delegates as subordinates and give those delegates access to some or all of the functions the provider role has available, as the following figure details.

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Likewise, a provider can associate with an already registered billing agent and give them access to some or all of the functions the provider role has available.

Claim Correction (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.

Electronic Queries and Claim Status Inquiry (Unique IDs 1345, 1531, 1818)

(1345, 1531) As the ensuing figure details, users of the Provider Portal can search and view claim details using the following search criteria:

- Claim information—Claim ID
- Member information:
  - Client ID
  - Birth date
  - Last name
  - First name
- Service information:
  - Rendering provider ID
  - ID Type
  - Claim type
  - Service from (date)
  - (Service) to (date)
  - Claim Status
- Paid date

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As we detail in the following figure, the following search criteria are available when searching for a pharmacy claim:

- Claim information
  - Claim ID
  - Prescription number
- Client information:
  - Client ID
  - Birth date
  - Last name
  - First name
- Service information
  - Service date
  - Paid date
  - Claim status
  - Provider ID
  - ID type
  - Name

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Search results are returned in a grid that allows the user to download them into a Microsoft Excel spreadsheet, as the following figure highlights.

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(1818) Providers also may drill down into a specific claim to view the full details and status of that claim, including the specific reasons for the claim's status, as the following figure details.

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From the detail view of the claim, the provider can now copy the claim, void the claim, print for their records, or initiate an appeal of the claim.

Prior Authorization Inquiry (Unique ID 1473)

When inquiring on authorization requests, 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 we detail in the following figure.

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The 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.

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Providers can view a list of authorizations matching the request criteria and drill down to view service details of the authorization response, as we highlight in the following figure.

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From this view, the provider can edit the request, print a copy for their records, or view the original request.

Appeals Creation and Inquiry (Unique ID 1512)

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. 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 Provider Portal defines two types of appeals:

- **Non-claim–related—**Such as preauthorization or appeal for the client
- **Claims-related—**Such as dental, institutional, or professional claim

To create a nonclaim-related appeal, the user enters client information that is validated by the payer system. The provider information is prepopulated based on the logged on user and is not editable. The user can add contact information for the appeal, reason for appeal, and provider notes. Attachments can be uploaded during the appeals submission process.

Providers have two ways to create a claim-related appeal. Providers can initiate an appeal from the portal menu using the pre-appeal assessment, or they can initiate an appeal directly from the View Claims Detail window of a particular claim. After the user selects the claim to be appealed, the claims data is prepopulated on the appeal. Users can appeal professional, institutional, and dental claims. Users can view the client information from the claim but cannot edit it. The user can add contact information for the appeal, reason for appeal, and provider notes. Attachments can be uploaded during the appeals submission process. The appeal must be associated with at least one service line on the claim.

The Provider Portal allows providers to view at a glance the status of their appeal in real time, as requests are being processed in the payer system. Providers can search for appeals by several different criteria. On the Search by ID tab shown in the following figure, the user must enter at least one ID—such as Appeal Service Request #, Appeal ID, Claim ID, Auth #, or Member ID.

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On the Search by Appeal Details tab shown in the following figure, the user can search by Appeal Status, Appeal Decision, Reason for Appeal, Procedure/Service Code, Date of Service Range, Appeal Submitted Date Range, Member ID, Last Name, First Name, or Birth Date. The search results are limited to the current provider.

After an appeal is located, a provider can view status, decision, and notes from the payer system. If the payer system supports it, users can view prior appeals related to a given appeal. Some appeals can be resubmitted when the provider disagrees with the outcome, as the following figure details.

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From this view, the provider can print a copy for their records or initiate a second appeal.

Payment History and RA Inquiry (Unique IDs 1471, 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. When a provider uses claim ID as a search criteria, the most recent payment that includes that claim will be the one displayed. Providers and their delegates have access to the payment history search capability, as the following figure details.

(1471) When the payer system returns the list of payments, the list includes 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 HIPAA 835 transaction regulation. Only data that exists on the 835 can be displayed.

(1623) 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, as we detail in the following figure.

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

File Download (Unique IDs 1381, 1767, 1769)

SOA INTEROPERABILITY

(1381) The Provider Portal and back end interChange processing includes flexible transaction and messaging capabilities through the interChange Connections solution which could be modified by HP to accept proprietary transactions to meet the State's requirements.

(1767) Reference files, medical code listings and even benefit plan rules can be made available for providers to download from the Provider Portal on demand 24 x 7, reducing the need for a provider to call the help desk to troubleshoot billing issues.

(1769) The Provider Portal allows users to download electronic X12 files and proprietary files—such as common applicable codes—available from the back-end payer system. The page allows the user to filter on file selection criteria and then view available files to download. The files available to download are displayed in chronological order, along with their creation date and previously download date. Files can be selected to download and then saved using standard Microsoft features, as we highlight in the following figure.

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Eligibility Inquiry (Unique IDs 1219, 1474, 1475, 1659, 1763)

(1219) The Provider Portal includes logging of provider-requested eligibility queries to a table in the interChange database, verifying the Department can produce a list of eligibility requests that were submitted by a specific provider for a specific client, including the date and time of each request. The Provider Portal passes to the back-end system the following information for each request/transaction performed on the portal:

- User ID of the logged in user on whose behalf the portal is requesting an operation
- The back-end system key that uniquely identifies the client, provider or employer group that is associated with the Portal User ID
- The date and time of the request
- The registered user's display name

(1474) The Provider Portal delivers secure access to eligibility coverage details—such as eligibility status, scope of coverage, and coverage type—as we detail in the following figure. The portal includes a user-friendly display of information returned within the HIPAA 271 transaction data content. (1475) Information—including covered services; coverage limitations; service usage; spend-down information; primary care physician; managed care assignment; long-term-care (LTC) information; early and periodic screening, diagnosis, and treatment (EPSDT) information; service periods; and other insurance information—may be displayed based on their availability within the back-end system.

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Further details regarding coverage are available using a link to a Detail page. (1659, 1763) The information may include the name of the coverage and a text description of the coverage; a list of services and the associated copay for those services; a listing of deductible information (individual versus family deductibles); a listing of benefits, and the associated limits for each of those benefits (six physical therapy visits in one year, or $5,000 of orthodontia services in a lifetime). The portal can display the amount of a deductible or limit, the amount that has been met or accumulated, and the amount that remains based on their availability within the back-end system. The information presented depends entirely on the customer's coverage and what the payer or customer wants to convey to the provider regarding the customer's coverage and benefits. The information can be further detailed by "in network" and "out of network," if that is applicable to the customer's coverage. The information also can be broken down by "individual" and "family," if applicable to the customer's coverage.

The Provider Portal also allows a verification identifier to be included in the eligibility response, as the following figure highlights. This identifier can be used as proof or verification of the eligibility response. The use of the verification identifier is configured by the customer and depends on the customer's payer system's ability to generate and return such an identifier.

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As the following figure details, a user may view information on a customer's other insurance coverage as known by the payer and returned from the back-end system. This information is available through a separate link to another detail page. The other insurance information includes the identifying information for the coverage, the type of coverage, an indicator whether the coverage is the primary coverage for the client, and the effective dates for the coverage as known by the back-end system.

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Electronic and Claim Submissions (Unique IDs 1519, 1765, 1768, 1773)

(1519, 1768, 1773) The Provider Portal allows users to submit professional, dental, and institutional claims, including information that applies to individual services. This feature provides the following benefits:

- Meets HIPAA, UB92, and CMS 1500 standards
- Takes users through the multiple steps of entering a claim using a wizard; the user can go back to previous steps if necessary; displays header information as the user progresses through the entry steps, which we detail in the following three figures
- Interface that is easy to use because it resembles paper claim forms
- Accommodates full and valid entry of every claim type
- Prepopulates provider information into claim
- Enables client verification in step one of claim submission
- Provides a predictive search feature on many fields—characters keyed by the user narrow the list of choices

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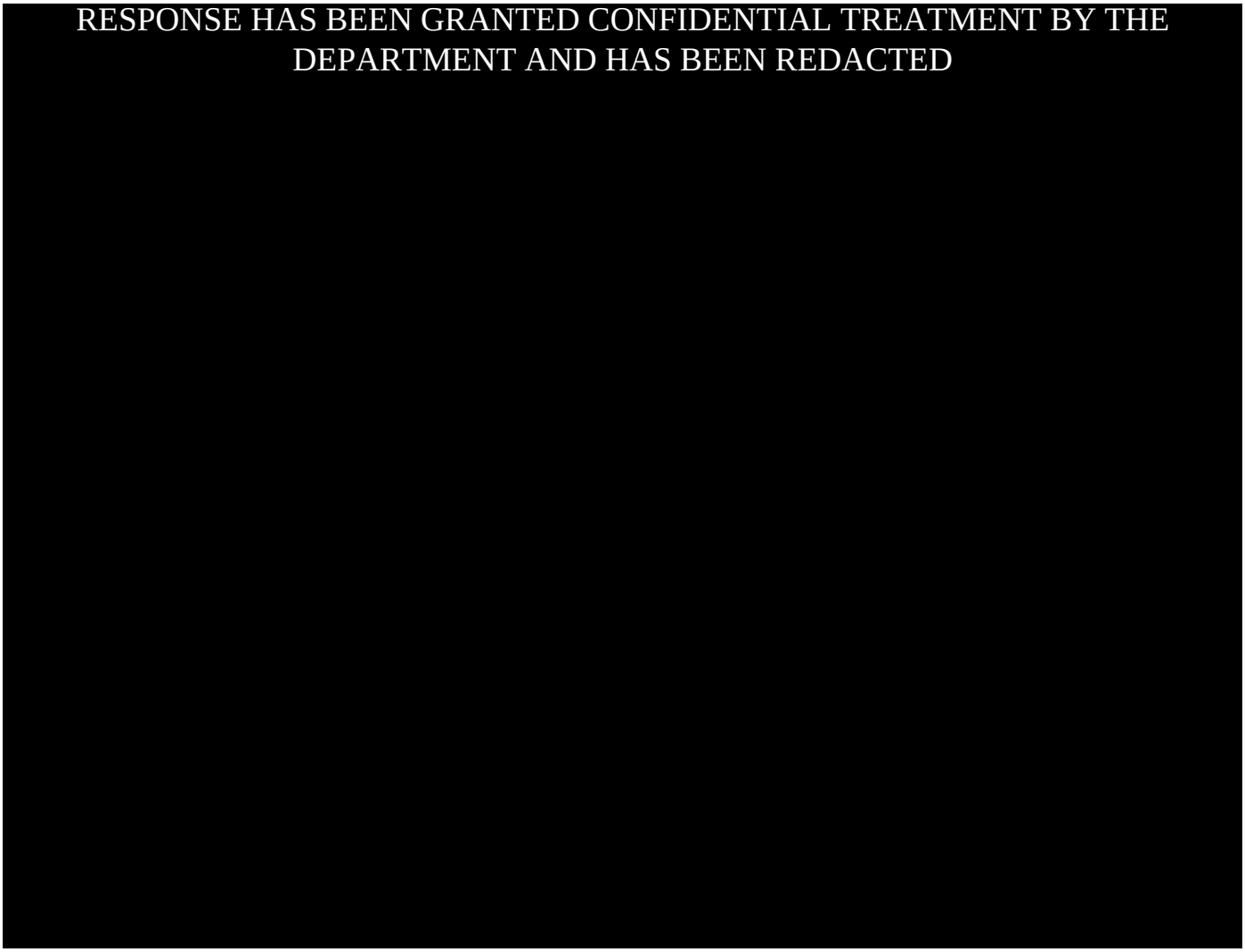

Key features in step 1 include the following:

- Billing provider information is prepopulated from the back-end system.
- Client information is validated before proceeding to the next step, reducing errors on client billing information by a provider.
- Only fields that are marked with a red asterisk (*) need to be completed.

When step 1 is completed, the user moves to step 2.

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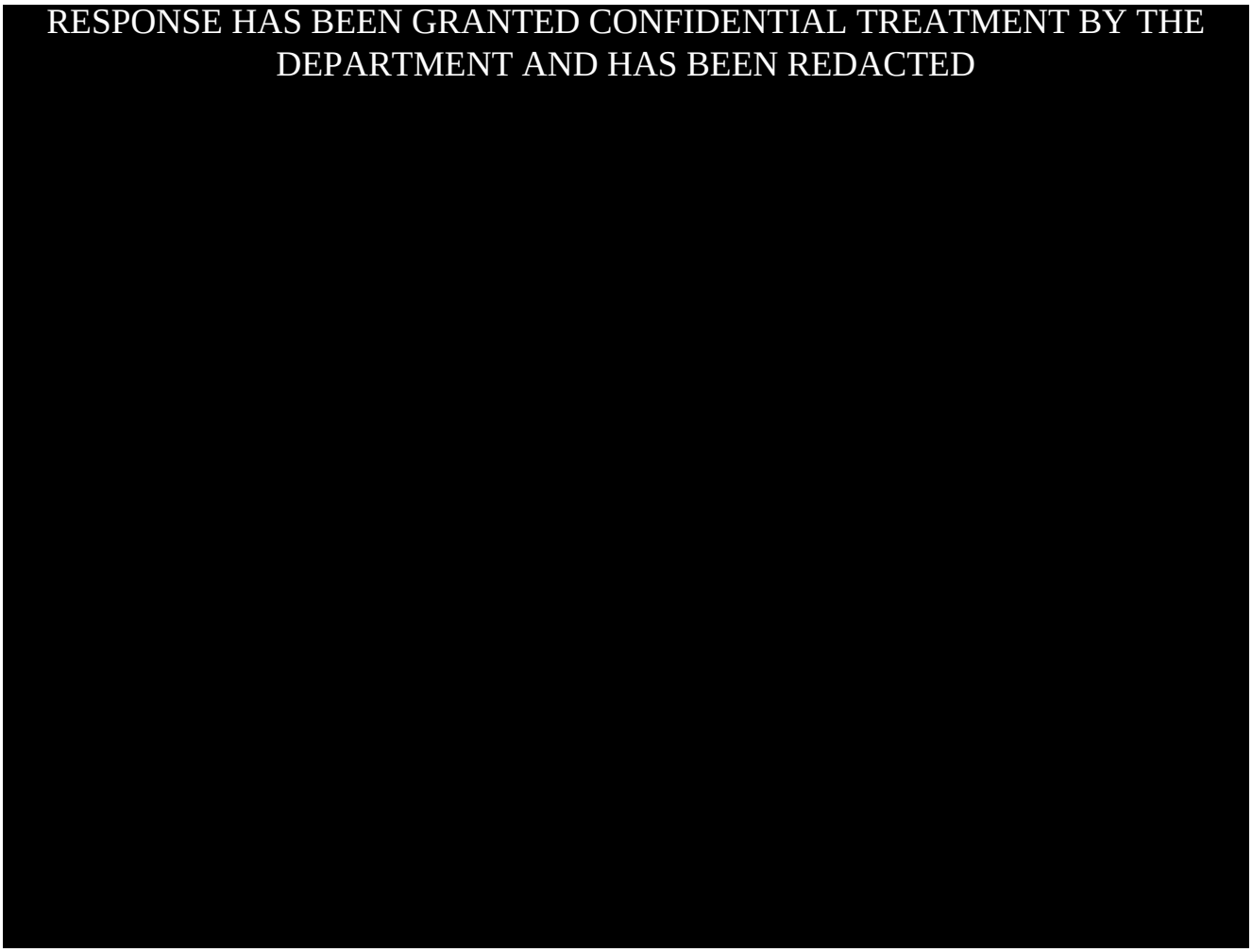

Step 2 has the following key elements:

- Provider and client summary information is displayed at the top of the panel.
- Diagnosis codes are captured.
- Client's other insurance information is prepopulated from the back-end system if it is found. The provider also can add other insurance information if desired.

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The final step 3 features the following elements:

- Service line details are added to the claim.
- National Drug Code (NDC) data is associated—if applicable—with the service line.
- Attachments are supported.

After a claim is submitted to the payer system, a confirmation is returned to the user as we detail in the following figure.

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

The Provider Portal also allows users to submit pharmacy claims using the following transaction types—billing transactions, reversal transactions, and rebilling transactions. The submitted transactions are compliant with National Council for Prescription Drug Programs (NCPDP) version D.0. 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 as many as 35 ingredients. Drug utilization review (DUR) override code, diagnosis codes, and other insurance data can be included on the submitted pharmacy claim to alert the payer of added service provided.

The portal displays a real-time response from the payer system for billing transactions that includes the transaction response status, reject codes (if applicable), amount paid, and amount of copay 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. Portal configuration allows the back-end system to determine 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. Portal configuration allows the back-end system to determine which claims are eligible for rebilling.

Prior Authorization Submission

(1765) The Provider Portal allows a user to submit inpatient, outpatient, and ancillary authorization requests that are HIPAA 278–compliant. Because the user is assumed to be the requesting provider, information from their profile is automatically filled in as the submitting provider. Additionally, the portal provides the ability to identify or search for a different provider who will perform the services being requested, or the facility to which the client will be admitted.

The portal allows users to specify as many as 10 attachments for each service line of an authorization. These attachments indicate that additional information is available. Attachments can be electronically uploaded and submitted.

When a submission is sent by the portal to the receiving system, notification is given to the user whether the transaction was received successfully by the payer system. A tracking number received from the payer system is provided to the user. The user can use the View Status feature to monitor changes to the status of the request.

Client Third-Party Liability Submission (Unique ID 1770)

The Provider Portal allows providers to submit additional third-party liability (TPL) information as part of claim submission. When submitting a claim with TPL, the TPL section can be initially prepopulated with existing information from the payer system. A provider can add new TPL records to be sent back when the claim is submitted, as we detail in the following figure.

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The portal also allows providers to submit additional TPL records for clients when they are verifying the client's eligibility. Similar to claim submission, the Eligibility Verification screen initially shows the existing TPL information. A provider can add new TPL records to be sent back to the payer system.

File Upload (Unique ID 1772)

The Provider Portal supports secure managed file transfer for the exchange of large mission-critical files regardless of file type. Users can upload supporting files related to specific tasks within the portal.

Secure Correspondence by Electronic Communication (Unique IDs 1457, 1774)

(1457) The Provider Portal has the capability to publish providers communications approved by the Department on various topics including provider enrollment. The information can be published in a variety of ways. The broadcast feature detailed in the following sections can be used and can be on the public non-secure portion of the portal or on the secure provider portion. Another option for publishing or communicating with providers is to add supporting enrollment documents under the resources tab on the secure portal.

The resources tab as indicated in the following figure on the secure portal provides the capability to include State specific links or documents such as training schedules and enrollment, Diabetic Supply program information, various forms including prior authorization, maximum allowable cost information, preferred drug list information, prescriber lists, and pharmacy meetings.

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The downloads link will open additional links for the provider as seen below under the External Source Links such as forms and newsletters.

(1774) As part of the Healthcare Portal, we will configure the solution to include the following:

- Web announcements
- Training schedules and enrollment
- Information on the diabetic supply program
- Various forms including prior authorization form
- Information on maximum allowable costs
- Information on preferred drug lists
- Information on prescriber lists
- Pharmacy meetings

We will coordinate with the selected PBM vendor and the state to gather the content and publish the most recent versions of this information on the portal for the provider community.

The K2 blackpearl workflow engine and Colorado interChange MMIS portal will support workflow access, configuration and delegation of task assignments, and efficient execution of the business processes developed for the Department.

Broadcast Messaging (Unique ID 1482)

The Provider Portal allows the Department to electronically communicate technical issues that would prevent users from performing tasks within the Provider or Client portals. Date-sensitive broadcast messages can be configured to display in the portal to immediately notify users of upcoming changes or important announcements. The Provider Portal solution will make important notices, alerts, or banner messages available to providers for configurable periods or at

log on. These messages can be targeted to individual providers, specific provider groups, or system-wide and can require acknowledgment by providers and their delegates so the messages are displayed only once.

This function enables administrators to create and maintain one-way broadcast messages that can be displayed on the Provider Portal, as we detail in the following figure. The message can be broadcast on the secure home page, public welcome page, or both pages.

The need to create a broadcast message can arise from system outages, system upgrades, new features added, important information messages, and various other reasons. An unlimited number of broadcast messages can be entered.

Each broadcast message record has an associated effective and end date along with a priority to indicate in which order to sort broadcast messages. Broadcast messages are displayed in sorted order based on highest priority first, and within priority it sorts by effective date with the most recent date first and then by message text. Broadcast messages also can include a Department-configurable URL.

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Email Subscription Service

The Provider Portal allows a provider to subscribe for email notifications generated from the payer system, as the following figure highlights. This portal feature supports back-end processing to verify the desired notifications are being delivered to the appropriate providers at the accurate email address. The number and type of notification categories available are configurable by the client and should be in line with current notifications generated on the back-end.

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External Source Links

The Provider Portal provides the ability to maintain a Download page—shown in the following figure—on the portal for information that the Department wants to make available to providers. The Download page includes client-defined links to take users to other pages or download files defined by the client. This download page is configurable to allow the Department to appropriately categorize information together under section headings.

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Preferred Drug List

The Provider Portal allows providers to view a print file of a plan's drug formulary in PDF. To display the correct information, the provider must select the benefit plan and benefit year from a list. When viewing a formulary, the provider has the option of printing it.

Training (Unique IDs 1176, 1188, 1842)

The following two subheadings address the Unique IDs above.

Training Materials (Unique ID 1176)

(1176) HP will design and develop HIPAA-compliant course material using the knowledge gained from needs assessments, extensive experience with interChange implementations, and a base of existing material. Training will use concrete examples of information created, maintained and used for the Department. Examples using PHI-type data will be reviewed to verify that the data has been "scrubbed" and does not include live data.

Web-Based Courses (Unique IDs 1188, 1842)

(1842) The Provider Portal is fully equipped with illustrated online help guides to assist providers in using the portal. Online help guides are available for all Portal capability including provider enrollment, Registration and Attestation and claims submission. As changes are made to Portal functional capability, the online training guides will be updated and posted at least 30 days before the change being implemented. The Portal provides two means to notify providers when updated training is available—global messages and "Notify Me" notifications—so they can access the training before the change.

(1188) HP will create web-based courses using Qarbon's eLearning products. They offer 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. The following screen shot shows the support for screen captures, image projects and PowerPoint projects as methods of training material creation. HP details our comprehensive approach to web-based provider training in RESPONSE 38d.

PASA Information (Unique ID 1728)

HP is proposing to use the McKesson VITAL product to collect, edit and maintain information on Program Approved Service Agency (PASA) administration, including their contact information the Community Center Boards with which they work, and the services the agencies are approved to provide. The McKesson VITAL product creates application forms, apply business rules, and perform the analysis for approval or rejection. VITAL has a public-facing web portal that handles various screening tasks such as creation and tracking of screening forms.

8.14 – Web Portal	**In Production? YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1313, 1622, 1697, 1766, 1771	**NO**

Pictures and Biometric Data (Unique ID 1313)

Please see RESPONSE 49 for detail regarding this optional requirement.

Apply Online Payments (Unique ID 1622)

The Provider Portal does not allow application of online payments. The Provider Portal has features 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.

Provider Services Not Received Reporting (Unique ID 1697)

The Client Portal does not allow clients to forward EOMB documents to the Department's Program Integrity Section if there are services listed that were not received. HP will work with the Department to fully understand this requirement during the Requirements Validation Phase and make the necessary changes to the Client Portal.

Submit PETI Forms (Unique ID 1771)

HP is proposing to use the McKesson VITAL product to facilitate interactive, role-based functional capability where Nursing Facility providers can electronically submit and obtain approval for Post Eligibility Treatment of Income (PETI) forms. VITAL will determine if the customer is eligible for benefits under PETI based on income information.

Workflow Tasks (Unique ID 1766)

The workflows can include tasks to sort, route, and create alerts to the proper work group based on Web Portal actions. For example, a client could submit updated TPL information through the portal which would initiate a TPL Review workflow.

RESPONSE 39m

8.15 – Colorado Registration and Attestation	**In Production? YES/NO**
Description Addresses Requirements (Provide the range as applicable): 1775-1788	**NO**

Through this RFP, the Department seeks a solution meeting the technical requirements for the Colorado Registration and Attestation Program; to support the provider applications for the Electronic Health Record (EHR) incentive payment options for eligible Colorado Medicaid providers. Through this program, providers and clients will have improved access to health records, encouraging a more collaborative treatment approach that will transform healthcare for Coloradans.

"The MAPIR project is an example of how technology and innovation can help states achieve real cost containment and efficiency. Because of HP's partnership with Pennsylvania's Department of Public Welfare, 13 states are recognizing savings, gaining shared knowledge and best practices, and working to effectively promote the use of certified EHR technology."

Tom Corbett, Governor of Pennsylvania

The Health Information Technology for Economic and Clinical Health Act (HITECH) Act, part of the American Recovery and Reinvestment Act (ARRA) of 2009, established Medicare and Medicaid EHR incentive programs. The EHR incentive programs promote the use of health information technology to improve healthcare outcomes and to provide cost-saving efficiencies in the healthcare system. The Medicaid EHR incentive program provides incentive payments to enrolled professionals (EPs) and eligible hospitals (EHs) for adopting, implementing, upgrading, and demonstrating meaningful use of certified EHR technology.

HP recognizes your requirements for Colorado Registration and Attestation. We will address these requirements and needs using our Medical Assistance Provider Incentive Repository (MAPIR) solution. MAPIR is an Internet-based application that has provider facing, administrative support, and batch components.

MAPIR Multistate Collaborative

Working together and with the Pennsylvania and a collaboration of participating states, HP developed the MAPIR solution in full cooperation with CMS. This tool made it possible for 13 participating states to successfully implement the Medicaid EHR Incentive program

simultaneously in the first program year of availability. These states continue to work in partnership for the successful implementation of the EHR Incentive Payment Program as participating members of the MAPIR Multistate Collaborative. During subsequent program years, MAPIR continues to successfully deliver the capabilities specified by the Multistate Collaborative to comply with federal regulations and to minimize the operational costs associated with administering the Medicaid EHR incentive program.

The proposed Attestation and Registration solution for the Department, MAPIR, comprises four primary components:

- **National Level Repository (NLR) Interfaces—**Batch capabilities dynamically create outbound transactions to the NLR and receive and process incoming transactions to the state from the NLR.
- **MMIS interfaces—**MAPIR provides batch functional capability to interface with the Colorado interChange Medicaid Enterprise system for accepting current provider information, to request and receive aggregate claim information for administrative analysis, and to report and confirm payment awards.
- **Provider user interface—**MAPIR provides a public web application that allows eligible providers to apply for Medicaid incentive payments on a Program Year and Payment Year basis. This web application is called MAPIR Public. MAPIR Public makes it possible for providers to attest, for eligibility to be determined, and for resulting approval or payment information outcomes to be obtained. The state MMIS Provider web Portal serves as a gateway access to the Public User Interface.
- **Administrative user interface—**a web application that permits authorized Department users to review submitted applications, determine or update the current status, or apply payment adjustments where applicable. This web application is called MAPIR Admin. The state MMIS intranet portal serves as the gateway access to MAPIR Admin.

MAPIR is a proven demonstration of successful multistate collaboration, with beneficial sharing of technology, operational processes, and work products to reduce the burden on each of the states. The participating states developed a common understanding of the federal program rules and requirements, and maintained a positive diversity of opinions that accelerated the process of implementing the evolving federal regulations—supplying a broader knowledge base for effective realization of program objectives.

HP Receives National Award for MAPIR

Recognizing HP's collaboration with 13 states to develop the Medical Assistance Provider Incentive Repository (MAPIR) application, the National Governors Association presented HP with the 6th Annual Public-Private Partnership Award at its annual meeting in Washington, D.C., on February 27, 2012. The application enables members of the MAPIR collaborative to coordinate and administer federally mandated incentive payments to help eligible Medicaid providers adopt electronic health record technology.

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Supporting the Colorado Registration and Attestation (Unique ID 1775)

MAPIR is a highly configurable tool to allow for compliance with state-specific requirements as permitted by current and future regulations, and to allow for flexibility in state operational workflows. To align to the Department requirements, this attestation and registration tool supports various configuration options for the following:

- Meeting state-specific Medicaid requirements
- Aligning with state standards and operational processes
- Enabling or disabling optional capabilities not required by all participating states. For example, the option for providers to report Medicaid Patient Volume statistics on a "Panel" basis

MAPIR is a flexible, cross platform solution that was architected in line with Medicaid Information Technology Architecture (MITA) principles.

Built on a service-oriented architecture (SOA), MAPIR will fully integrate with Colorado interChange to maximize savings and improve efficiencies. The tool provides batch interfaces to the MMIS that make it possible to report payment determinations and to receive confirmation of payments made. On notification from MAPIR, Colorado interChange is then able to disburse payments or to issue adjustments as appropriate to fulfill the requirements of the Medicaid EHR Incentive Payment Program. With this tool, HP fulfills the Department's oversight requirements, including fiscal arrangements for qualification, disbursement, audit, and accountability in managing the provider payments.

Accept Provider Applications

Providers who elect to participate in the Medicaid EHR incentive program begin by registering at the federal level where they report their intent to participate with a particular state. A new National Registration and Attestation (NR&A) System—formerly known as the NLR—was developed at the federal level to allow providers to register for EHR incentive payments. Notification is transmitted from the NR&A through batch to the participant's designated state. MAPIR batch processing capabilities manage the automatic acceptance and transmission of interface files between the State and the NR&A.

On receiving a provider's registration, the Registration and Attestation tool will subsequently attempt to match the information against MMIS "seed" data based on key identifiers such as but not limited to the National Provider Identifier (NPI). Since MAPIR has full integration with the MMIS Provider Portal, when the provider accesses MAPIR to apply, the system will perform a second match based on the original identifiers and a highly customizable key that is determined by the state. This second level match makes it possible for MAPIR to fully associate each application with the appropriate provider level entity as identified in the Provider Portal.

When EPs and EHs access the Registration and Attestation tool using the state's secure web-based portal, MAPIR will immediately display a real-time view of the provider's progress to date in the EHR incentive program. This display, known as the MAPIR Participation Dashboard, simplifies the provider experience and minimizes inbound calls from providers who only wish to verify their progress level or payment history. Department users can view a real-time report of each application at any time, access reports, and review payment history.

[redacted] The Department can use MAPIR to track application and decision status, to document provider activity or specific outcomes through user-created notes, and to upload supporting documentation. This Registration and Attestation tool also will generate emails automatically to providers at key points in the application life cycle with content that is state configurable.

MAPIR supports the functional capability necessary to comply with program year 2013 requirements specified in the Meaningful Use Stage 2 final rule. As specified by the MAPIR Collaborative, MAPIR will meet the requirements for program year 2014 Stage 2 functionality well within the timeframes specified by CMS.

The following figure illustrates a sample MAPIR participation dashboard from the Public User Interface. This screen displays the provider's progress to date in the Medicaid EHR incentive program for the potential years of participation. Only the incentive applications the provider is eligible for are enabled. The participation dashboard supports the following diverse capabilities for providers:

- View a history of participation years and current or previous applications
- Identify previous program year information: years with no activity, participation in Colorado's program, participation in other state's program, and participation in the Medicare program
- Identify previous award amounts
- Determine the status of current or previous applications (other than applications that have been manually "Aborted" by the provider or an administrator)
- Create an application for the current program year
- "Abort" an active application for the current program year. Note that the provider can reapply for the current program year, if the program year and state grace period permits.
- Appeal an existing active application for the current or any previous program year

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

In the dashboard, the status will vary depending on the provider's progress with the incentive application. The status will read ***Not Started*** the first time the provider accesses the system. From this screen, the provider can choose to edit and view incentive applications in an ***Incomplete*** or ***Not Started*** status. The provider can only view incentive applications that are in a ***Completed***, ***Denied***, or ***Expired*** status.

Also from this screen, the provider can choose to abort an incentive application that is in an ***Incomplete*** status. When the provider can click ***Abort*** on an incentive application, progress will be eliminated for the incentive application. When an incentive application has completed the payment process, the status will change to ***Completed***. MAPIR administrators have access to view equivalent as well as additional information through use of the administrative application search capabilities.

MAPIR allows providers to apply as an individual, or as a member of a group. When applying as members of a group, the providers are required to capture up to four group member NPIs and to provide client volumes at the group level.

Monitor Providers

The Attestation and Registration tool supports authorized users in monitoring providers by generating reports of providers with applications in a specific status or that match the selected criteria to monitor. Additionally, a real-time interface to the Office of National Coordinator (ONC) Certified HIT Product List (CHPL) verifies provider submitted EHR Certification IDs.

Pay Incentives to Eligible Providers

The tool will calculate estimated payment amounts for providers that adopt and demonstrate Meaningful Use (MU) of a certified EHR technology, and report an approval for payment and award amount to the MMIS for processing and disbursement by implementing a CMS-approved algorithm based on the program rules for calculating payment amounts. This algorithm takes into consideration the provider type (EP or EH), the year of participation, attestation information, among others to produce the payment schedule. The Department can configure the number of payment years for an EH and MAPIR also supports the capability to enter the payment amounts for each year, for an EH provider, with a state-to-state switch. During the application submission process the Registration and Attestation tool will present a graphical representation of payments typical for the provider type. Additionally, the Department-authorized system users can use the administrative tool to review the payment amounts for a provider application and process an adjustment in the case of an appeal. For details about payment calculation, please refer to our discussion under the *Payment Calculation Function* section.

Colorado interChange processes the financial transactions using an integration approach with MAPIR. The tool performs the calculations, tracking, and communications defined by the EHR incentive payment program including verification of ability to pay and notification of payments and adjustments through the NLR file exchange process. After approving an eligible provider for payment and completing the NR&A duplicate check successfully, MAPIR will create and send a payment request file to Colorado interChange. The MMIS will create a financial transaction that will generate a payment to the provider. This output transaction will link the Registration and Attestation tool with Colorado interChange to take advantage of existing payment features. After the MMIS processes the payments, it returns payment information to MAPIR for transmission to the NR&A. We provide additional information about payment calculation later in this response section.

Provide Enrollment and Attestation Tool and Support (Unique ID 1776)

Appropriate Access and Information

Providers and authorized Department users to access, provide, and maintain information with two websites: the provider user interface, or MAPIR Public, where the providers complete the HITECH incentive applications; and the administrative user interface, or MAPIR Admin, where

the Department-authorized system users can view and administer provider applications in support of operational policy.

Secure Provider Login

MAPIR Public is integrated into and accessed from the HP Healthcare Provider Portal site, allowing secure provider logon. The Provider Portal authenticates the user and then generates a Single Logon token (SAML token) request. This request is then passed to MAPIR Public, which identifies the provider and establishes a session. Only authenticated providers found eligible to participate by the Provider Portal are allowed to launch MAPIR Public.

Provider Review and Edit of Information

Through its integrated web portal capability, the provider can review and maintain information, as applicable, including:

- Contact information for the program such as their name, email address, and telephone number
- Information specific to the attestation for the program, such as their service location and site information
- Select an incentive payee, if the Department enables this capability

Providers also can upload supporting documentation through the web portal.

Role-Based Screens

After a session has been established in MAPIR Public through the Provider Portal, the system checks the provider type and applies role specific user interface screens based on whether the provider is logged in as an EP or EH. These distinct role-based screens—for dual-eligible providers and separate screens for Medicaid-only hospitals—dynamically display the screens specific to the provider type.

Eligibility Inactivation Following Program Removal

Access to the program for providers is controlled by rules based in Colorado interChange source data. When a provider is removed from the state Medicaid program, an inactivation is fed to MAPIR. Any incomplete application will be aborted if the provider becomes inactive during the application process. Access to the Registration and Attestation tool also is restricted for non-eligible providers.

Department-Authorized System Users Review and Approval

The EH applications are currently reviewed manually and at the Department's discretion, and the EP applications can be automatically approved if the criteria is met using configuration or reviewed manually at the Department's discretion. Department-authorized system users can enter notes and can choose to place an application in a ***Pended for Review*** status back to ***Incomplete*** status, if needed. Both providers and Department users can upload supporting documentation to be maintained with the application/attestation information.

Payment Calculation Function

HP understands that professional and hospital provider incentive payment amounts are variable during the incentive program and that providers must demonstrate eligibility based on client volumes, and the use of certified EHR technology.

In accordance with the rule, professional provider incentive payments in MAPIR are based on a maximum incentive payment of $63,750 distributed across six payment years if 30 percent or more of client volume is attributable to those who are receiving medical assistance. Special eligibility rules apply for pediatricians. Pediatricians who have a client volume threshold greater than 20 percent but less than 30 percent may receive a maximum of $42,500 in incentive payments across a six-year payment period.

CMS has validated the MAPIR Payment calculation function

On the other hand, hospital incentive payments can be made across three to six years and are based on hospital-specific data including the annual average growth rate, medical assistance discharges, Medicaid transition factors, inpatient bed days, total charges, and charity care. The hospital calculation used in MAPIR has been submitted and approved by CMS. Professional and hospital attainment of meaningful use and client volumes do not need to be for consecutive years; however, years of participation count consecutively after the first year of payment.

This Attestation and Registration tool is configurable within the guidelines of the federal rule. The Department can opt to make incentive payments to hospitals across three, four, five, or six years. Based on the number of years, the percentage payment per year also will be configurable, with the restriction that no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's total Medicaid aggregate EHR incentive amount. Additionally, during a two-year period, no annual Medicaid incentive payment to a hospital may exceed 90 percent of the total Medicaid aggregate EHR incentive amount.

Payment Cycle or Payment Reporting in Conjunction with the System

Working with the Department, HP will initiate payment cycle or payment reporting as defined. MAPIR systematically and accurately determines the proper payment amount based on this defined criteria and provider-entered information, and shares Colorado interChange payment and general accounts receivable system. The approved payment will be sent to Colorado interChange through a MMIS Incentive Payment Request record sent for processing during the regularly scheduled financial cycle. The Attestation and Registration tool incentive payments will be processed in the MMIS using existing financial system features, thus reducing time and effort as follows:

- New object codes and financial reason codes will need to be created in the MMIS
- Financial processing will be done in the weekly financial cycle

- Electronic remittance advices (RA) will be used to report the payments to providers
- Incentive payments will be reported as income and on the annual 1099, along with other Colorado interChange payments

Incentive payments will be reported as system payouts on the same RA as claims and will not be separated from other MMIS financial transaction information. The Colorado interChange payment information will be transmitted back to the MAPIR application through the MMIS Payment Remittance Voucher interface and sent to the NLR through the NLR Incentive Payment Data interface.

The HP Finance team and the State accounting department will create the financial transaction using the appropriate form for the incentive payment. The transaction is submitted to the Colorado interChange financial system using the appropriate object code and budget code mapping devised by the State accounting department. The weekly Colorado interChange financial process will include the incentive payment transaction and report the reimbursement amount in the RA. By using information in the provider subsystem, the Colorado interChange will consider existing liens and negative balances before issuing the payment to the provider.

Based on the rule and subsequent clarification from CMS, states may recoup incentive payments if they are found to be in error. If necessary, the Registration and Attestation tool again shares the existing MMIS financial system features and treats this as an adjustment or void when required. This feature is a base part of the solution that exceeds the Department's requirements.

The MAPIR payment adjustment/void function allows administrative users to initiate incentive payment adjustments or voids. A record is created and sent to the Colorado interChange for processing, which creates an accounts receivable (A/R) to recoup the adjustment amount from claims payments. Information related to the recoupment is sent back to MAPIR and sent to the NLR through the Incentive Payment Data interface.

As detailed in the following figure, the MAPIR Post Adjustment window is used to initiate a payment adjustment in the MMIS.

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

CMS-37 and CMS-64 Accounting Reporting

Another feature of our solution that exceeds the Department's requirements is support for CMS-37 and CMS-64 accounting reporting. HP will work with the Department to confirm that MAPIR reporting needs related to the CMS-37 and CMS-64 are met. CMS is continuing to provide guidance to the states on how to report the incentive payments.

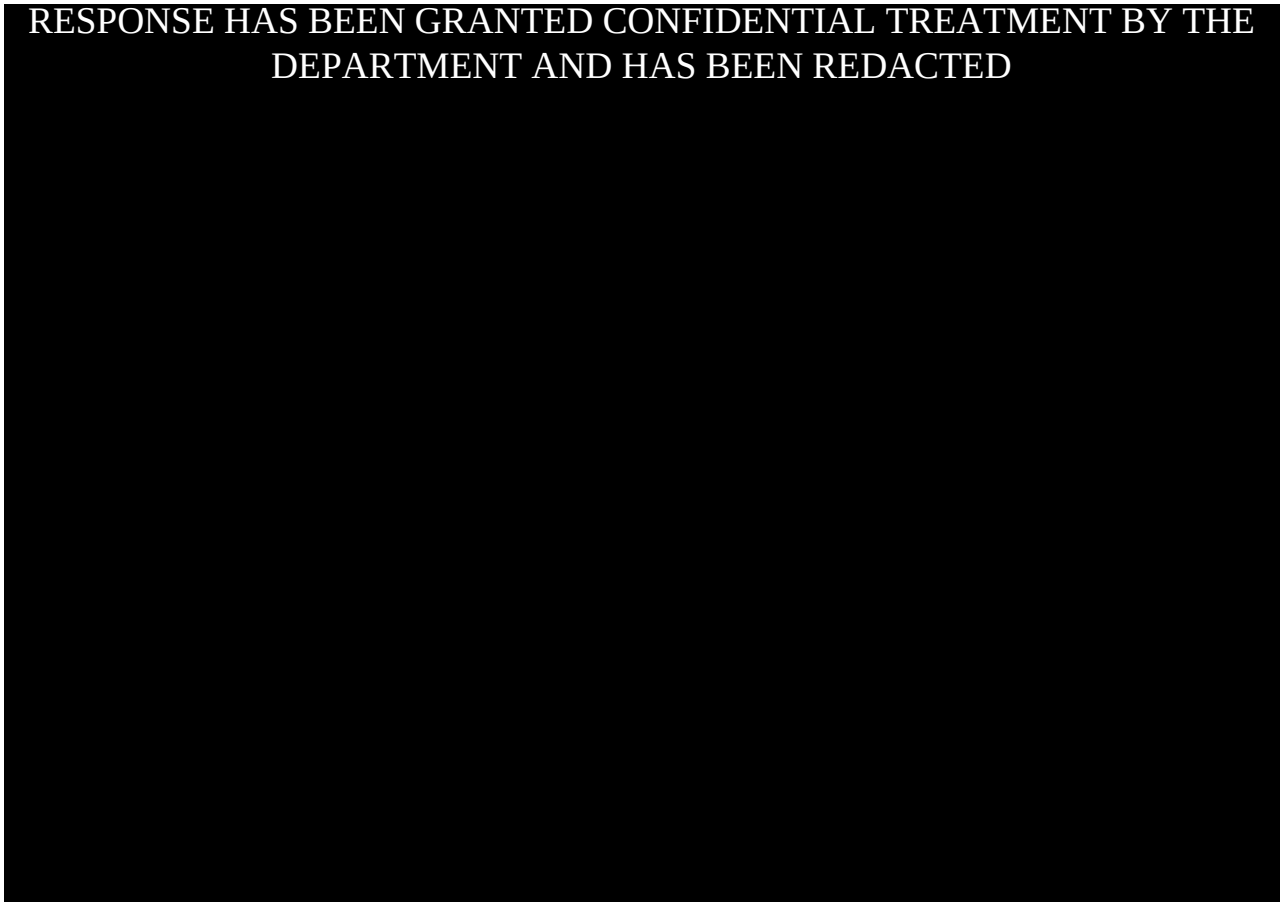
For example, CMS clarified that if pediatricians received the full physician amount because they had at least 30 percent client volume, they would be reflected on the physician line of the CMS-64. However, if they got the two-thirds incentive as a pediatrician with 20 percent to 29 percent client volume, they would go on the pediatrician line. MAPIR has been enhanced to identify the appropriate reporting indicator for Pediatricians based on the provider's specific client volume.

Appeals Support

The authorized Department user can report an appeal is in process, in the MAPIR tool, on a provider's request when they believe they have been incorrectly denied, underpaid, or overpaid. After a determination is made by the Department on how to proceed with the appeal, the authorized user can approve, deny, or apply an adjustment following the appeal determination. The Department controls and executes the appeal process as part of the operational aspect of the EHR incentive program.

Quality Metrics Review

During the attestation process, providers enter clinical quality measures into the tool. These metrics can be reviewed by a department authorized system user as part of the administrative approval process or as a subsequent review. The following figure provides a sample of the quality measures a provider is asked to answer while submitting an incentive application through MAPIR. The screen conventions are consistently applied to collection and review of Core and Menu Measures as well.



Online Help and User Manual

Our years of experience working with healthcare providers taught us that the best way to assist providers is to begin with in-depth information and easy-to-use processes, followed by support and education. These provider materials, related to the Colorado Registration and Attestation, will include two user guides—one for eligible professional providers and one for eligible hospital providers—and links to journal articles, presentations, and white papers for inclusion on the ARRA section of the website. MAPIR supports embedded capabilities to assist providers through the application process such as embedded “mouse-over” tool-tip text, as seen in the following figure, for most elements within the user interface and user manual links on the application screens.

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

Additionally, providers attesting to MU in the Registration and Attestation tool have convenient access to Department-configurable "Click Here" links to the associated CMS Core, Measure, or Clinical Quality Measures as seen in the next figure.

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

This figure illustrates the CMS information the provider will see after clicking on the link for more information.

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

We provide additional information about our provider education later in this section.

Support Data Processes (Unique ID 1777)

To support the transition of current participants in the Colorado Registration and Attestation tool, conversion and migration is required to load existing data into the MAPIR Database. This will require analysis to extract, transform, and load such data. We cover these requirements in this section.

Receive Seed Data from MMIS and Establish Provider Records

After the provider information is converted from the legacy MMIS to the Colorado interChange, HP and the Department will work to determine the process to identify the providers in the MMIS database that are eligible for the EHR incentive payment program. We will use this process to create the batch jobs necessary to create the provider information interface for MAPIR. On a regular basis as determined by the Department, typically on weekdays, this file is created for MAPIR batch process to update its own provider information. The Registration and Attestation tool relies on the MMIS provider information to maintain its own information updated. New providers must follow the provider enrollment process in Colorado interChange before attempting to access MAPIR. The initial load of this data will include records already held in the existing Registration and Attestation tool.

MAPIR houses provider-identifying information from Colorado interChange, NLR transaction data, and application attestation data in a relational database for purpose of establishing and maintaining records for providers requesting payment.

Receive Batch Files From NLR for New Providers that Signed Up for HITECH Medicaid Incentives (20-30 Fields per Record) (Unique ID 1781)

The Colorado Attestation and Registration tool batch programs process inbound NLR files received through a state standardized interface service (usually GenTran or ConnectDirect). NLR files are processed on a configured schedule determined by the Department.

Match NLR File to Seed Data (Audit Step)

This MAPIR system batch process will determine if a match can be identified between provider NLR registrations to MMIS seed data on a frequency determined by the Department. When matched, the provider is notified by email that an application can be started in MAPIR. MAPIR generates a report that includes the NLR registrations that have not been matched after a Department-predetermined period of time. New providers added to this report will be notified by email of their NLR Registration circumstance. The following figure illustrates the match process in MAPIR.

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

Send Batch files to NLR with Eligibility Approval Notification (9 fields)

MAPIR will transmit a B-7 transaction, for eligibility approval notification, to the NLR on the determination of program eligibility for a provider. The transaction will contain appropriate data elements from the following list, as determined by provider type (EP or EH), and eligibility determination:

- NPI
- CCN (for Eligible Hospitals)
- Social Security number
- EIN
- TIN
- TIN Type
- Payee NPI
- Payee TIN
- Eligibility Status
- Rejection Reasons (if ineligible)

Receive Attestation Information (More Than 14 fields) (Unique ID 1782)

NLR Attestation Information files are processed in batch, on a frequency determined by the Department, and loaded into MAPIR tables daily. Within the Registration and Attestation tool, this information is linked to the provider registration and is evaluated for a dually-eligible provider to determine if the provider is determined eligible for MU in Medicare for the current

program year. This status must be in place for the provider to receive payment for the same program year under Medicaid. Received data is retained in MAPIR.

Request (14 Fields) and Receive (7 Fields) Prior Payment Information from NLR (Duplicate Check) (Unique IDs 1783, 1784)

Before processing an MMIS payment, MAPIR sends a D-16 Request and must receive a D-16 Response from the NLR indicating that no previous payment has been made to the provider for the current participation year. File transactions are tracked as part of the application process. If the D-16 Response indicates a payment should not be made by the state, the Registration and Attestation tool process will deny the application and the provider will not be able to reapply because of the existence of payment through another state.

Provide Payment Information to NLR

On notification from Colorado interChange a provider payment or adjustment has been made, the MAPIR tool generates the payment information notification (D-18) to the NLR. Typically, these files are generated on a weekly basis.

Receive Program Switch Notifications

The files are received from the NLR as required by the program and processed through the Attestation and Registration tool. The tool can process an application for a provider who has switched to the Medicaid program as prescribed by the program rules. Should the NLR inactivate a provider's existing registration because of a program switch, MAPIR will cancel the provider's application provided that the D-16 Response has not been received.

Receive Switch Between States Notifications

MAPIR receives and processes files from the NLR as required by the program and can process an application for a provider who has switched states. MAPIR also provides the capability for authorized users to manage the payment schedule when a provider is an EH and applied for the first payment year in another state.

Send B6 Transactions to the NLR to Terminate or Suspend a Provider

MAPIR generates batch files for transmission to the NLR, and also receives and processes files from the NLR, as required by the program. MAPIR can process a change in eligibility status by sending a B-7 per the rules of the program.

Calculate Provider Incentive Payment Amount

The CMS-approved algorithm for calculating provider payments, used in the Attestation and Registration tool, has been validated by the 13 participating MAPIR states. The automated calculation takes into consideration the provider type (EP or EH), the year of participation, attestation information and phase in the program. The system also supports the capability to manage payment schedule amounts for an EH that has switched states.

Provide a Comprehensive, Searchable Data Repository (Unique ID 1778)

Specific reports are available for extract from the MAPIR Administrative tool and can be formatted using tools such as Excel. Additionally, of the information captured in the Registration and Attestation tool through the user interface, file processing, or adjudication is stored in a relational database. Advanced users or HP support staff members have the capability to perform ad hoc reporting. The Department also has the option to archive files (NLR/MMIS) used or generated by MAPIR and also uploaded files. The MAPIR Multistate Collaborative supports a group meeting regularly where state members can meet and contribute to report ideas including the following:

- Documenting, tracking, and attesting to provider usage including the MU of EHRs
- Supporting provider payment process according to federal EHR program guidelines.
- Documenting and validating payment for certified EHR systems.
- Coordinating overlapping program (Medicare/Medicaid) and multistate claims to prevent duplicate or overpayments.

Documenting, Tracking, and Attesting to Provider Usage

Information captured by the provider in the Provider Tool, including Patient Volumes and MU of EHR information, is stored in the MAPIR database. Additionally, the Department can choose to access this information in the MAPIR Administrative Tool for online use. Files uploaded by the provider or authorized Department users are available for download straight in the Administrative Tool.

Supporting Provider Payment Process

The payment information exchanged with NLR and the Colorado interChange financial system, to support payment processing according to federal EHR program guidelines, is stored in the MAPIR database. For ease of access, authorized Department users can view system-generated log entries related to the payment process are attached to the application for online viewing, or can create custom entries. HP system administrators have additional access to NLR transaction history and payment tracking information—supporting Department inquiries as needed.

Documenting and Validating Payment

The actions that take an incentive payment application from entry through payment validations for certified EHR systems are tracked and stored in the database. Additionally, there are specific screens in the Administrative Tool free-text fields allow authorized Department users to record information. MAPIR has the capability to capture both user-entered and system-generated notes in the phases of the application life cycle. EHR systems are confirmed to be certified by ONC in real time, in the Attestation and Registration tool, during the provider's application process.

Coordinating Medicare/Medicaid Information

Certain information related to Medicare and Medicaid program overlapping or multistate claims is obtained from NLR in either the B-6 or the D-16 transactions, which will assist in preventing

duplicate or overpayments. MAPIR provides functional capability to support the coordination of overlapping program and multistate claims, including:

- Calculating client volume percentages and payment amounts in accordance with the final rule. In circumstances where the hospital provider switches states, administrators can manually specify payment schedule amounts
- Loading state-specific data, such as summarized claim data and hospital cost reports, for viewing in the Attestation and Registration tool by the internal Department users for validation against provider-submitted data
- Creating payment transactions, including adjustments, in MAPIR to be sent to Colorado interChange
- Performing duplicate payment checking against the R&A and making payment determination

The provider application ready will not be considered for payment until the application is complete, and the NLR and MAPIR have verified that no duplicate payments have been made through the NLR Duplicate Payment/Exclusion Check interface.

The Department may choose to configure the Attestation and Registration tool to pend applications for review before final approval or to automatically approve or deny applications. After the review is completed, an NLR Registration Confirmation Data interface is created and sent to the NLR indicating whether the provider meets the eligibility requirements, along with a D-16 request file.

When a state informs the NLR that a payment is ready to be made and the NLR has approved payment, the provider applicant record will be "locked" at the NLR and the provider cannot switch programs or states for that payment year.

Exclusion, Sanctions, or Duplicate Payments

If the NLR indicates that a payment has already been made, MAPIR will automatically deny the application.

If sanction or exclusion information is returned on the D-16 response, a note is recorded in the administrative screen for that application. State users will use that information to make a final determination regarding the application.

As part of the Colorado interChange Provider Information interface (MMIS1), to the NLR Registration interface matching process, MAPIR confirms that the payee record for the NPI and tax identification number (TIN) combination exists in MMIS. If not, the first time the provider accesses MAPIR, an error message is displayed, as seen in the following figure.

Designated Payments

When registering at the NLR, a provider must designate a payee. If one is not identified, it is assumed that the provider is designating itself as the payee.

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This message is generated to verify that a payment can be made and to give the provider an opportunity to reach out to the State to resolve the issue.

Payee Alerts

The provider will be permitted to continue with the application process up to the final attestation screen. If providers have not taken steps to resolve the issue, they cannot submit the application.

Provide a Hosted Solution (Unique ID 1779)

To maintain technical operations and support associated with the Colorado Registration and Attestation functions, HP will provide a hosted solution at our site, including:

- Supporting hardware for:
  - A file transfer system for NLR processing (as specified by the Multistate Collaborative, MAPIR supports GenTran or ConnectDirect)
  - The MAPIR public web application integrated into the Provider Portal
  - The MAPIR Administrative application that can be integrated into the state intranet site
- MMIS-supported infrastructure components:
  - MAPIR database
  - MMIS batch jobs to exchange files with MAPIR
  - Firewall
  - Proxy servers
  - SAN storage
  - Off-site backup and security software

The Attestation and Registration tool is based on an open source technology using industry-proven tools and products and is designed to be platform-agnostic. It has proven installations on both x86-based and HP-UX hardware. HP places the utmost importance on secure access by providers to information through the web. Dual firewalls and Secure Sockets Layer (SSL) encryption through the HTTPS protocol verify that privacy and security are maintained when handling protected health information (PHI) across the Internet. User IDs, passwords, and data encryption safeguard PHI and personally identifiable information (PII).

The high-level architecture of the MAPIR solution, as seen in the following figure, takes advantage of the HP Healthcare Portal that already provides unparalleled secure access. The portal uses 128-bit encryption, superior firewall protection, SSL, failover, and load balancing to manage the volume that may be created by a large audience of concurrent users.

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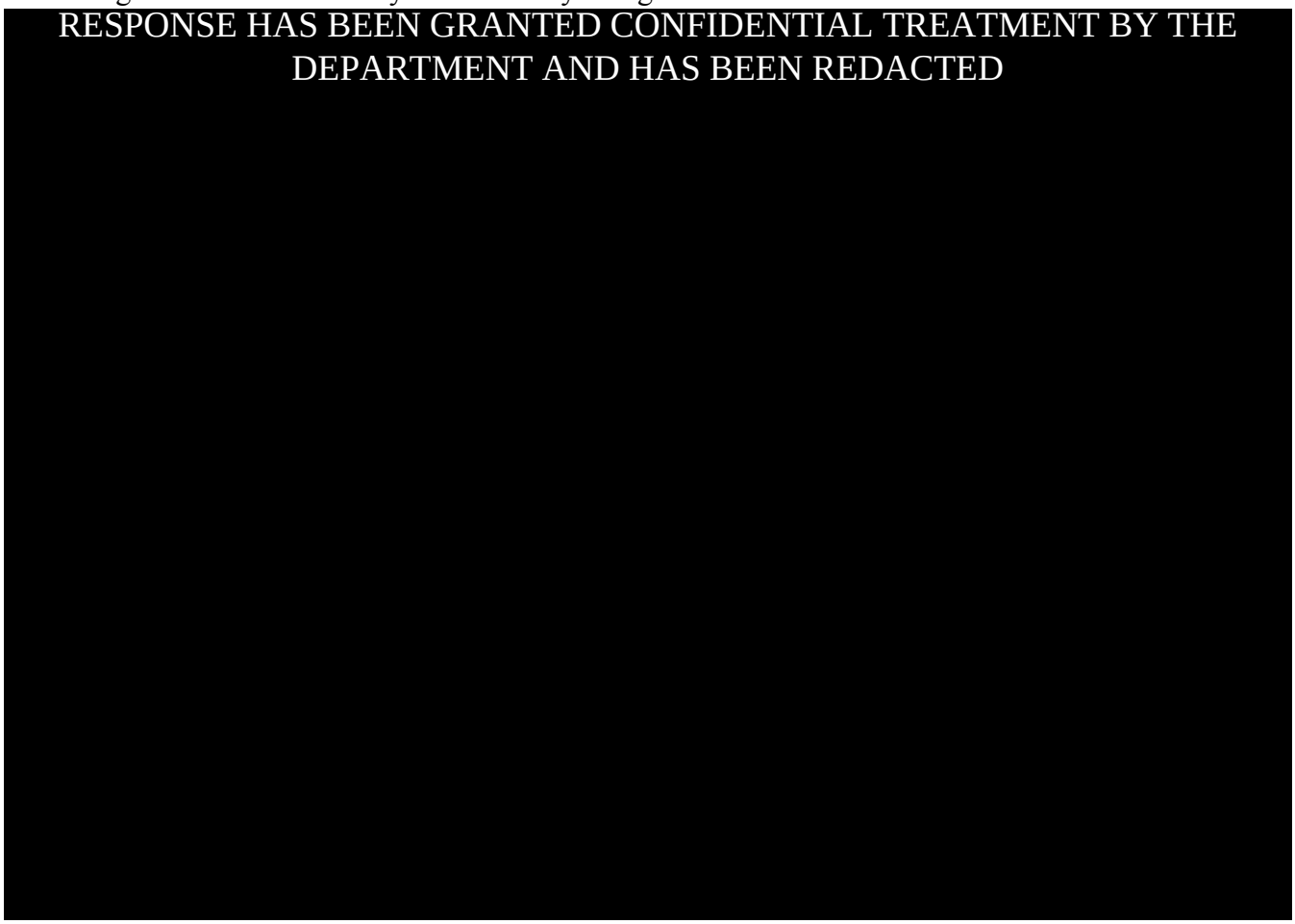

MAPIR is founded on standard object-oriented design and development principles supported by Java and the Spring framework. The code base is deployed as compiled deliverables and source code, which enables Colorado to manage change effectively and carefully.

As a multitier, web-based solution, this Registration and Attestation tool supports multiple concurrent users through access into the Provider Portal and intranet interfaces. The back end uses an Oracle or DB2 database, XML-standard format files, and delimited flat files. These

fundamental components of MAPIR are supported within the Colorado interChange environment. MAPIR also provides increased configurability to support varying needs. A full list of configurable items is available as part of the Attestation and Registration tool deployment guide, including the following examples:

- Directory path characters to align with UNIX-based systems, Windows-based, or other systems
- NLR file names based on the type of CMS communication engine the Department selects

Email capabilities can be configured to be enabled or disabled and can be directed to any server available on the network.

Receive and Provide Data to NLR (Unique ID 1780)

In accordance with CMS interface specifications, MAPIR generates specific output NLR interface files that conform to XML schema definitions (XSDs). The files are transferred to CMS through the Department's secure communication capability. The Multistate Collaborative works to make sure the Attestation and Registration tool complies with the most current facilitates CMS-required interfaces—verifying participating states are supported as interfaces with NLR are upgraded. MAPIR supports the standard NLR interfaces, which includes: B-6, B-7, D-16, D-17, and D-18.

Provider Enrollment Through the Outreach Website (Unique ID 1785)

The MAPIR tool has a detailed set of user manuals that describe the process for provider enrollment. These manuals include relevant validation edits, rules, data sets, and reports, which are updated as modifications to the system are completed. HP includes the public manuals for EHs and EPs besides the Admin Manual. The manual design makes it possible for the Department to incorporate content or configuration preferences specific for the State of Colorado.

HP understands each state has different program requirements, which is why MAPIR affords the Department to address directions, unique to Colorado, to providers through the following features:

- Configuring specific questions to pend or deny an application based on the response
- Displaying or not displaying certain information such as a physician assistant as a provider type based on State-specific policy
- Creating as many as 10 state-specific "yes" or "no" questions to collect basic information from providers before submission of the enrollment application
- Displaying or not displaying MU as an attestation selection for EP or EH

We provide additional discussion on the features found on the Provider Outreach website in the next section.

Payment File Transmission and Returned (SLR) (Unique ID 1786)

As we discussed in the earlier responses, MAPIR transmits a set of files to Colorado interChange to request payment issuance through the MMIS financial system, along with the returned notification and information about the success of those requests. This file exchange process is part of the Attestation and Registration tool batch processing cycle. The tracking of the actual financial transaction is maintained in the Colorado interChange financial system. Initial payments, as well as adjustments, are supported through this file exchange integration.

Validation Edits, Data Sets, Audit Rules, Reports (100 hours/year) and Outreach Page (Unique ID 1787)

Validation Edits

Validation edits are performed on each screen to verify the information is submitted accurately and completely. As an example, when entering client volumes, edits prevent a numerator from being larger than a numerator that results in an invalid client volume percentage. Most validation edits are triggered automatically when a user clicks a button labeled “Save & Continue” to progress to a subsequent screen.

The Department can configure the MAPIR adjudication process to place an application in a pended or denied status based on the answers provided to certain questions or on the outcome of specific business rules. Before submitting the application, the Attestation and Registration tool provides a Check Errors page. This page alerts the provider that errors have been set based on the way a state has configured various questions throughout the application process. If errors are present, the provider can select the Review button adjacent to the error message to be taken back to the error to correct it. If providers do not change any responses, they may still submit their application; however, it will be adjudicated in accordance with the configurations.

The MAPIR Check Errors screen, detailed in the following figure, provides an opportunity to verify information was entered correctly before submitting the application.

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Authorized administrative users also can view an application at any point in the process. As a provider completes the application and saves the information, it is immediately available for viewing.

MAPIR also provides MMIS claim data to be used by state users to validate the provider-submitted data. The information is based on the reporting period submitted by the provider in the Patient Volume tab of the incentive application. Claim data is retrieved from Colorado interChange and displayed with the application. MAPIR will import and display the MMIS summarized claims data in the administrative screens to assist the DHCFP in validating EHR incentive program eligibility. The summarized claims information will be used to test against the provider-submitted volumes and identify discrepancies that require additional research or outreach to the provider.

As a member of the HP MAPIR Multistate Collaborative, the Department will benefit from an open dialogue and shared strategies to address areas of concern with 13 or more Medicaid agencies. As challenges, issues, or areas of concern are identified, they can be discussed among the multistate collaborative to determine the most appropriate way to resolve the issues, such as through operational processes, provider education, or modifications to the MAPIR application.

Examples of validation edits performed in MAPIR include:

- The NLR inbound and outbound transactions are validated against the appropriate XML schema files
- Incoming B-6 transactions that are received from the NLR are validated to verify the current state (in this case, Colorado) was in fact specified by the provider
- Entered provider data is validated against conventional data integrity edits for requirements, such as date validity, numeric length, or valid email structure

The following table lists the disposition edits available in MAPIR. Such edits may be configured to deny an application automatically at time of submission to or to place an application in Pended for Review. Should a disposition edit be configured to deny an application, states will designate an appropriate Reason code, for notification to CMS through a B-7 Ineligible transaction.

MAPIR Disposition Edits

Provider Type	Disposition Edit (Triggered by Validation Rules)	Answer to Trigger Disposition	Resulting Disposition (Configurable)
Hospital	Please confirm that you are choosing the Medicaid incentive program.	No	Pend for Review
Hospital	Do you have any sanctions or pending sanctions with Medicare or Medicaid in Colorado?	Yes	Denied
Hospital	Is your facility currently in compliance with all parts of the HIPAA regulations?	No	Pend for Review
Hospital	Is your facility licensed to operate in all states in which services are rendered?	No	Pend for Review
Hospital	Please confirm that you are either an Acute Care Hospital with an average length of stay of 25 days or fewer, or a Children's Hospital.	No	Pend for Review
Hospital	Please confirm that you are either an Acute Care Hospital with an average length of stay of 25 days or fewer, or a Children's Hospital.	No	Pend for Review
Hospital	(This question does not display. Set the disposition of this question to apply when hospital does not meet patient volume criteria.)	No	Denied

Provider Type	Disposition Edit (Triggered by Validation Rules)	Answer to Trigger Disposition	Resulting Disposition (Configurable)
Hospital	(This question does not display. Set the disposition of this question to apply when hospital does not meet MU criteria.)	No	Denied
Professional	Are you a Hospital-based eligible professional?	Yes	Denied
Professional	I confirm that I waive my right to a Medicare Electronic Health Record Incentive Payment for this payment year and a.m. only accepting Medicaid Electronic Health Record Incentive Payments from Colorado.	No	Pend for Review
Professional	Do you have any current sanctions or pending sanctions with Medicare or Medicaid in any state?	Yes	Denied
Professional	Are you currently in compliance with all parts of the HIPAA regulations?	No	Pend for Review
Professional	Are you licensed in all states in which you practice?	No	Pend for Review
Professional	Based on the information received from the R&A, you requested to assign your incentive payment to the entity above (Payee TIN). Please confirm that you are receiving that payment as the payee indicated above or you are assigning this payment voluntarily to the payee above and that you have a contractual relationship that allows the assigned employer or entity to bill for your services.	No	Pend for Review
Professional	(This question does not display. Set the disposition of this question to apply when professional does not meet patient volume criteria)	No	Denied
Professional	(This question does not display. Set the disposition of this question to apply when professional does not meet MU criteria)	No	Pend for Review

MAPIR is an automated application system that dynamically edits information as it is entered. It processes audit rules internally and allows for reporting from an administrative perspective. On

submission of an application, the tool will allow the provider to review the submission outcome and a report of information that was entered for purpose of attestation.

Audits

Although the formal appeal process for providers is outside the scope of MAPIR, our State Level Repository solution for the Colorado Registration and Attestation Program provides the capability to track appeals and upload supporting documentation related to an application. After an appeal has been filed, an authorized user will change the status of the application to Appeal Initiated, Appeal Approved, or Appeal Denied and include a note for tracking the related activity.

MAPIR provides automated and manual "Start and Stop" capabilities for supporting audits at key points. The MAPIR multistate Collaborative has defined a workflow that will enable the DHCFP to determine at certain points in the process if the application should be denied, pended for review, or approved.

Automated capabilities include a configuration option that disables automatic approval of eligible professional applications. Hospital applications are always placed in a pended status for review. Manual capabilities include the ability for authorized administrators to place an application in a pended status. If MAPIR has been configured by a state to automatically approve eligible professional applications, this ability is only available for hospital applications. In each case, the adjudication process may still result in a pended for review or denied status because of certain edits.

Data Sets

Data sets pertinent to administration of the Colorado Registration and Attestation Program is maintained at rest in the MAPIR database and comprises specific imported Colorado interChange provider data, data representation of R&A interface transactions, incentive attestation and application data, and system-supporting content such as configuration and reference data. In its default configuration, the MAPIR data tier comprises a single dedicated Oracle database instance.

"At-rest" data in the Registration and Attestation tool includes a specific subset of MMIS provider data, a data structure representation of the R&A transaction exchanges, and the data related to submission of incentive payment applications and administration of submitted applications. Additional at-rest data takes the form of configuration settings, audit and system logs, and reference tables.

"In-transit" data comprises text-based file exchanges between MAPIR and Colorado interChange and XML transaction exchanges between MAPIR and the R&A.

MAPIR was architected to facilitate integration with multiple database platforms. This capability is achieved by incorporating an entity model that serves as a layer of abstraction between the MAPIR business tier and the MAPIR data tier.

Reports

The current reports to effectively administer the Colorado Registration and Attestation Program, through the MAPIR tool, are generated in a standard delimited format for ease for ease of analysis in a desktop application or import in an external data repository. Detailed, accurate, and easy to evaluate reporting is inherent within MAPIR and congruent with the CMS vision of continual evaluation and MITA process efficiency across time. Using the MAPIR Report Search option, administrative users also can search for and download various report files to import into reporting tools such as Excel or Access. HP will make available the reports online through the Admin site. The following table lists the available Registration and Attestation tool report titles, purpose, and frequency.

MAPIR Reports

Report	Purpose	Frequency
Provider Activity Report	Daily activity for providers, including the current status of a provider's incentive payment application	Daily
Incentive Payment Report	Details incentive payments for providers from the previous day	Daily
Aging Report	Details provider incentive applications sorted by number of days aged	Daily
Appeal Report	Documents provider applications that are in a MAPIR status of Appeal Initiated	Daily
Provider Mismatch (From R&A)	Lists records received from the R&A that did not successfully match against the State MMIS provider data	Daily
MAPIR Request Status Report (MMIS)	Lists details of requests made by MAPIR to the State MMIS and provides the current application status as of the run date	Weekly
MAPIR Request Status Report (R&A)	Lists details of the requests made by MAPIR to the R&A and will provide the current application status as of the previous run date	Weekly
Dually Eligible Cost Data	Provides monthly R&A D-17 cost data information	Monthly

Data from these reports will help identify common errors and areas where providers may require additional training or documentation.

As shown in the following figure, the MAPIR Report Search simplifies searching for reports.

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The MAPIR Report Search is available for the authorized user to query, select, and download reports generated within a 90-day date range.

Provider Outreach Page

Content on the Provider Outreach Page is secured by the Provider Portal and may consist of content the Department may wish to make available to providers. MAPIR's point of integration with the Provider Portal begins with the Colorado interChange administered Outreach Page. It is from this outreach page that MAPIR is made available using a secure, industry compliant SAML authentication and authorization layer.

The Registration and Attestation tool supports various state-specific configuration options for the Provider Outreach site, including the following:

- Configuring the "look and feel" to align with the Colorado web standards and display the Colorado State logo
- Setting the number of years a hospital payment will be paid across
- Specifying percentage of the overall hospital payment that will be paid out each year in accordance with the final rule
- Displaying Colorado-specific contact information
- Presenting State configurable content pages (identified in MAPIR as "Splash Pages") where states can display Colorado-specific instructions for EPs and EHs.

The following figure depicts the "Get Started" Splash Page before insertion of Colorado-specific content.

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The following Splash Pages are available in MAPIR:

- Public Users
  - Contact Us
- Eligible Hospitals
  - Get Started
  - Core Measures
  - Menu Measures
  - Patient Volumes
  - NLR and Contact Information
  - Eligibility
  - Attestation
  - Submission
  - CQM
- Eligible Professionals
  - Get Started
  - Core Measures
  - Menu Measures
  - NLR and Contact Information
  - Patient Volumes - Individual
  - Patient Volumes – FQHC/RHC
  - Patient Volumes – Group FQHC/RHC
  - Eligibility
  - Attestation
  - Submission
  - CQM
  - Patient Volumes - Group
  - Patient Volumes - Panel
- For Administrators:
  - Administrative Main Menu

Sending Colorado-specific language in each of the multiple MAPIR emails, inserting the Colorado organization name into specific questions, or configuring specific questions to pend or deny an application based on the response are some of the additional capabilities of the tool

demonstrating its flexibility. This Registration and Attestation tool provides the Department the ability to convey federal requirements and processes with the "look and feel" of Colorado-specific information.

Provide Ongoing Support for the Medicaid Incentive Payments for Providers (Unique ID 1788)

The Multistate Collaborative evaluates any new or optional interfaces as they become available to most effectively adjudicate between automated or operational approaches for program needs a identified by member states. For example, CMS recently introduced the ability to withdraw a payment by sending a special adjustment reason code of 07. As specified by the MAPIR Collaborative in a recent enhancement, MAPIR will allow an authorized administrator to reverse the most recent payment with a fully integrated approach that uses existing capabilities.

At state discretion, MAPIR supports operational processes to transmit optional E-7 or E-8 transaction files to CMS for purpose of supporting audit or appeal activities. Such transactions may be further documented in MAPIR through user-generated activity notes or by administrative file upload.

Recently, MAPIR also was enhanced to support revision of EH cost data by providers in future years through a built-in reconciliation process that automatically generates the appropriate adjustments to CMS—saving the states manual time and resources while allowing providers to enter the updated information.