COLORADO
Department of Health Care Policy & Financing

Dear Providers,

It has been three months since we launched our new claims payment system, the Colorado interChange on March 1, 2017.

Since March 1st, the Department of Health Care Policy & Financing (the Department) has processed 10,960,628 claims and paid more than $1.5 billion to providers. On a weekly basis, 60 percent of claims pay, on average. The Department's goal is to reach an average paid claims percentage of 85 percent which is similar to the legacy (Xerox) system.

To reach this goal, we will continue working with our new vendor, DXC Technology (DXC)* to implement system updates, provide excellent customer service and assist providers to become more familiar with the Provider Web Portal and policy changes that have been implemented. In previous implementations, DXC has seen an adjustment period of six to nine months from the date of implementation, although this varies from state to state.

In the meantime, we want to ensure that you have the information you need to continue serving the 1.3 million Coloradoans covered by Health First Colorado (Colorado's Medicaid Program) or Child Health Plan *Plus* (CHP+).

Financial assistance available

The Department is aware some providers are experiencing billing difficulties. If you are an enrolled provider experiencing financial distress, you can call the Provider Services Call Center at 1-844-235-2387 and select option 2 to "speak with an agent" and then option 4 to learn about interim payment options. Interim payments are paid at 80 percent of a provider's historic weekly payment over a three month period prior to March 1st.

Interim payments are meant to provide temporary relief to providers until their claims are processed correctly. These payments are not intended to pay outstanding claims billed. Once claims are processing correctly, an accounts receivable will be set up and these payments will be recouped from future payments. We cannot issue interim payments to providers who are not enrolled or who have not yet completed the revalidation process.

Provider Services call center improvements

Since launch, many providers have reported frustrating experiences with the Provider Services Call Center. DXC and the Department have been working closely to resolve the situation. There are now more than 60 call center agents, an average of 50 agents to answer incoming calls every day (since mid-April)

and others to return escalated calls. Because of the increased staffing, we have seen wait times drop dramatically.

If you have called the call center recently, you know we added queues to better route your call and provide relevant help quicker. Since May 1st most queues have a maximum hold time of less than three minutes. Our busiest queues are the claims and EDI queues which had max hold times of 30-40 minutes on three occasions, but averaged less than 11 minutes the rest of the month.

Please note the Provider Services Call Center is the only provider dedicated line. Providers should not attempt calling our member facing lines (including the Member Contact Center or the enrollment broker line). The agents working these call centers are not trained to address provider issues or questions.

Member eligibility

Providers are responsible for checking and confirming member eligibility before providing services-this is not an expectation for members unless they believe their eligibility information is incorrect.

Providers can check eligibility on the new Provider Portal or by calling Provider Services at 1-844-235-2387 (Press 1 for the automated voice response system, then Press 1 again to verify eligibility). If a provider verifies eligibility through the voice response system, they will be given a Guarantee Number which can be submitted with claims for services to that member. The number will guarantee payment for otherwise appropriately submitted claims.

The Department can issue a Proof of Insurance too; this Proof of Insurance is the same as a Guarantee Number and providers should accept this documentation as proof of coverage.

Clarifying information

- Currently the Department is giving providers a grace period to make updates to their affiliations. EOB 1010 (Rendering provider not member of billing provider group) may appear on a claim; however, it is only informational and will not cause the claim to deny.

- Some providers are having issues with the way the Remittance Advice (RA) is downloading and printing, for instructions on formatting the RA, refer to this Quick Guide.

Stay in the know

- Make sure you sign up to receive our emails. Include your provider type and we'll send you specialized updates related to your provider type.
- Be sure to check our Known Issues and Updates web page. Note: This page is updated frequently but is not a complete list.
- You might not be the first one to ask your question-- browse our Web Portal FAQs and Quick Guides!
- As always, please refer to billing manuals and the monthly Provider

Bulletin for policy changes and other important billing guidance.

Thank you,

Health First Colorado (Colorado's Medicaid Program) and Child Health Plan *Plus* (CHP+)

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* Fiscal Agent Name Change: References to the current fiscal agent will now be DXC Technology (DXC), due to the Enterprise Services business of Hewlett Packard Enterprise (HPE) merging with Computer Sciences Corporation (CSC) to form DXC.

Please do not reply to this email; this address is not monitored.