STATE MANAGED CARE NETWORK CLAIMS AUDIT REPORT

June 2016

This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy & Financing.

Audit Scope:	To assess the State Managed Care Network (SMCN) claim processing capability of Colorado Access' contracted claim processing vendor and to evaluate Colorado Access' monitoring efforts on this vendor (Colorado Access is the current Administrative Service Organization [ASO] contracted by the Department for SMCN)
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Audit Timeline:	January 2015 through June 2015
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Background and Scope

Child Health Plan *Plus* (CHP+) is Colorado's low-cost health insurance program for uninsured children and pregnant women whose families do not qualify for Medicaid but cannot afford private insurance. The Colorado Department of Health Care Policy & Financing (the Department) administers the CHP+ program. Health maintenance organizations (HMOs) contract with the Department to provide medical services to CHP+ members. The Department also contracts directly (utilizing Colorado Access' provider services department) with healthcare providers to offer CHP+ services during a pre-HMO enrollment period. This network of providers is referred to as the State Managed Care Network (SMCN). Since July 2008, the Department has been contracting with Colorado Access as the Administrative Services Organization (ASO) for SMCN. On behalf of the Department, Colorado Access is contracted to fulfill the following responsibilities:

- Benefit management and customer service for eligible members
- Provider relations, network development, maintenance, and training
- Claims administration
- Pharmacy benefit management
- Utilization review and case management
- Customer service

Since 2011, the Department has contracted with Health Services Advisory Group, Inc. (HSAG), to assess the ability of its ASO to process claims for members enrolled in CHP+ SMCN. Colorado Access has utilized TriZetto as its claim processing vendor for CHP+ SMCN claims since November 2014. The vendor agreement with TriZetto included access to the QNXT application and utilization of TriZetto's Business Management Services (BMS) to administer provider maintenance, paper claim entry (manual and optical character resolution) and claim adjudication. As part of the Department's monitoring efforts to ensure that Colorado Access is meeting its claim processing standards, the fiscal year (FY) 2015–2016 claim processing audit focused on evaluating the capability of the QNXT application and TriZetto's BMS, to process claims for the SMCN providers. Specifically, the audit assessed timeliness and payment accuracy of the claims processed in the following areas:

- Colorado Access' risk mitigation plan provided the ability to continue day-to-day operations (specifically claim processing), despite an occurrence of a catastrophic nature or emergency, that may have resulted in a prolonged period of downtime utilizing a documented business continuity and disaster recovery plan.
- TriZetto's systems and processes for receiving, processing, and storing CHP+ SMCN claims.
- Assessment of the data flow processes between Colorado Access and TriZetto (claims and eligibility).
- Colorado Access' monitoring plan to ensure TriZetto's performance was meeting Department and contractual requirements.

◆ Colorado Access' overall ability to process SMCN claims accurately and in a timely manner utilizing TriZetto's QNXT application and BMS claim staff members.

◆ Colorado Access' ability to maintain a history of changes, adjustments, and audit trails for changes implemented through its claim processing vendor.

Methodology

HSAG used the following audit techniques to accomplish the scope of this audit.

Desk Review of Contracts, Policies and Procedures, and Reports Related to Claim Processing

HSAG requested Colorado Access to submit documents related to claim processing. Examples of documents requested were:

◆ Contracts, data flows, list of system edits specific to claim processing and claim payment, alignment of eligibility and benefits with claim processing, fee schedule updates, policies and procedures, and performance metrics developed by TriZetto to provide reports to Colorado Access.

◆ Data flows, policies and procedures, internal audit reports for procedural and payment accuracy, and audit reports for quality and monitoring developed by Colorado Access and TriZetto.

Appendix A lists the document categories for which Colorado Access was required to submit documentation for the desk review.

HSAG received the requested materials from Colorado Access on January 29, 2016. HSAG conducted a desk review of these documents to evaluate the claim processing system (QNXT) used by TriZetto. HSAG assessed the control mechanisms used by both TriZetto and Colorado Access for ensuring that claim processing timeliness and accuracy met the Department's performance standards. HSAG shared some preliminary desk review findings with Colorado Access and the Department on February 12, 2016 (Appendix C), which included a request for additional documentation and topics that required further clarification. Twelve of the 15 requested follow-up documents were provided by Colorado Access on February 22, 2016. The remaining documents requested were received on February 26, 2016, and/or discussed during the on-site review conducted March 9–10, 2016. During the desk review process, Colorado Access staff members were available for follow-up phone calls to discuss claim file/data questions and general questions related to the documents.

Analyses of Claim Extracts Processed in the QNXT System

HSAG received claim extracts from Colorado Access for detailed analyses focusing on payment timeliness and accuracy. The claim extracts consisted of all SMCN claims processed in the QNXT system from January 1, 2015, through June 30, 2015. To supplement this information, member eligibility and provider data files were received concurrently with the claim extracts, for the same review period. Analyses were focused on the following areas:

◆ Evaluation of whether claims were paid/denied appropriately following timely filing requirements

◆ Evaluation of whether claims were adjudicated within Colorado Access' policy for processing standards

◆ Evaluation of claims processed, ensuring appropriate eligibility coverage under the CHP+/SMCN program

Colorado Access submitted six separate claim and eligibility extract files containing claims processed and paid for members eligible during the audit review period of January 1, 2015, through June 30, 2015. HSAG performed a targeted claim review on these files. The data revealed that 18,438 unique claims and 45,470 claim lines were processed (226 claims were excluded due to the absence of an original claim line). Of the 18,438 claims, 85 percent (15,656) were paid either through an auto-adjudication process or utilizing the pend functionality in QNXT to be handled manually by a TriZetto BMS claim examiner. Approximately 13 percent (2,484) of the claims processed were denied, with the remaining 2 percent of claims being voided for various reasons. The breakdown by claims processed is reflected in Figure 1.

Figure 1—FY 15–16 Claim Activity Total Claims Analyzed
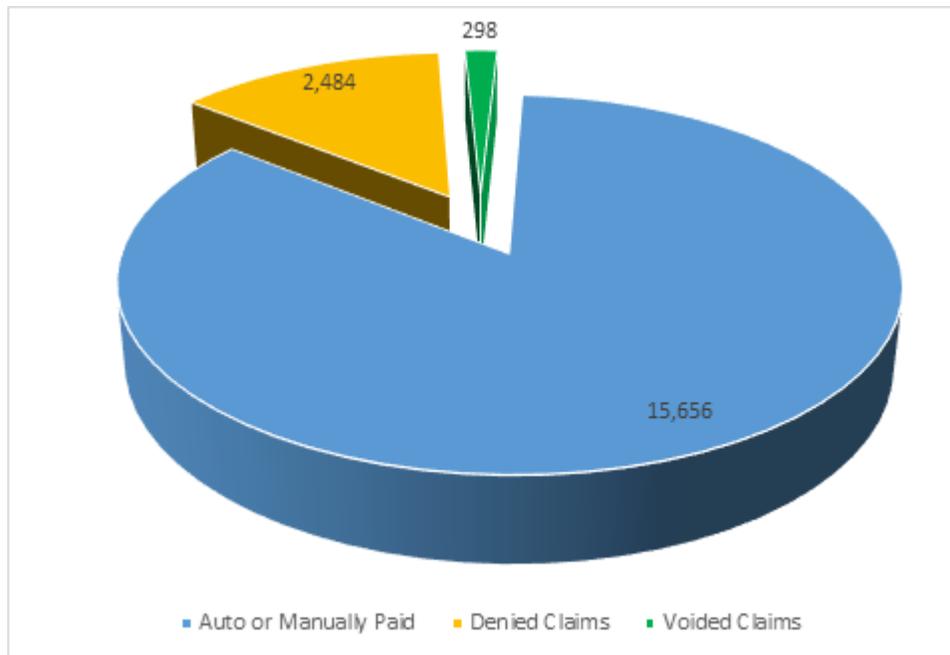
The claim data analyzed during the desk review also reflected:

◆ Of the clean claims submitted, 87.9 percent were processed within 14 days, which was below the 90 percent requirement as set by the Department.

  ▪ One reason for these lower-than-expected results was explained using the January–March 2015 SMCN Quarterly Report, which indicated that during first quarter 2015 (following the QNXT system implementation), a small number of aged claims were still being held for provider contract set-up corrections required for claims to pay accurately.

  ▪ Another reason was that the clean claim date field was inadvertently excluded from the original data extract request to Colorado Access.

    • After several discussions with Colorado Access staff members, it was determined that using the Julian date (contained in the claim number), plus three days for the normal claim handling process, would provide a close approximation of the clean claim date.

◆ The results from the desktop analysis for electronic clean claims processed within 30 days (92.9 percent) and paper claims processed within 45 days (93.7 percent) also fell short of the Department requirements of 98 percent.

  ▪ The claim analysis results were confirmed using the Quarterly State Managed Care Network reports for Quarter 3 (January–March 2015) and Quarter 4 (April–June 2015).

    • These reports reflected that electronic claims finalized within 30 days and paper claims finalized within 45 days were not met for either quarter.

  ▪ These results were further supported by the initial CHP+ SMCN Claims Turnaround Time (TAT) Performance Target reports for January through March 2015 and April through June 2015, which reflected that Colorado Access missed the required service level agreement requirements.

◆ Colorado Access later submitted revised CHP+ SMCN Claims TAT Performance Target reports for January through March 2015 and April through June 2015.

  ▪ The revised reports showed Colorado Access and TriZetto had actually met the mandated service level agreement requirements for the January through June 2015 time frame.

  ▪ The revised reports revealed the 14-day turnaround times of 89.5 percent (January–March 2015) and 94.9 percent (April–June 2015) met the requirements when rounded up.

  ▪ The 30-day turnaround times of 98.5 percent and 99.1 percent and 45-day turnaround times of 99.5 and 99.9 percent, respectively, all met or exceeded the Department's requirements.

Based on the revised information and further discussion with staff members during the on-site review, the HSAG auditor was comfortable with the revised documents, the trend toward continuous improvement, and that the service levels were met. Analyses findings also included the following:

Claims were paid or denied appropriately following the timely filing requirements.

Of the 18,438 claims submitted, 17 claims for 13 members were identified during the desk review as claims potentially paid after the 180-day window (i.e., date of service to claim received date) was exceeded. The HSAG auditor requested a demonstration of the processing logic that was followed for seven of those claims. The Colorado Access and TriZetto BMS staff members sufficiently demonstrated during the second day of the on-site review that these claims were all processed and paid correctly. Two of the seven claims involved appeals, four were retroactive eligibility adjustments (two of which went back over one year), and the seventh claim was correctly denied for missing the filing deadline. A detailed review of each claim can be found in Appendix D.

All paid claims appeared to be appropriately paid based on denials for noncovered services.

All claims were analyzed in relation to a list of noncovered services provided by Colorado Access. The end result of the analysis revealed that no claims were paid which included a dollar amount payment for noncovered services.

Denials due to previously submitted/processed claims with duplicate charges and no prior authorization appeared to be properly applied.

The majority of 2,484 claims with denial codes fell into two categories: duplicate charges (840 claims) and no prior authorization obtained (665 claims). This was consistent with the results from the FY 13–14 audit.

Member copayments were applied correctly.

On April 6, 2016, HSAG submitted a sample of 12 claims with member copayments that were randomly pulled from the claim extracts. Upon initial review, the copayments for nine of the 12 appeared to have been applied/calculated incorrectly by QNXT. HSAG initially compared the Member Copayment Crosswalk document received from Colorado Access to what was reflected in the claim extracts as well as the enrollment/eligibility extracts in relation to the SMCN Benefit Package that was assigned to each member. The analysis took into consideration the type of service location and services provided. If the Member Copayment Crosswalk document indicated a different member copayment amount than was reflected in the claim extract, the claim and the member were flagged for additional input from Colorado Access. Claims were also submitted to Colorado Access if they showed a member copayment in the claim extract, but an eligibility segment for the date of service could not be found in the eligibility extract. On April 7, 2016, Colorado Access provided documentation to support that all nine of the member copayments were calculated and applied correctly based on the Member's SMCN Benefit Package and eligibility span. Three of the claims had multiple dates of service listed that accounted for a member copayment being applied for each date of service. Five of the members had multiple spans of coverage within the eligibility extracts that resulted in the claims being flagged initially. One of the claims reflected a $2.75 member copayment based on a lab test that allowed for no greater than a $2.75 copayment. The follow-up conversations with Colorado Access along with the additional documentation demonstrated that member copayments were calculated and applied correctly.

HSAG's ability to assess Colorado Access' and QNXT's ability to process claims accurately was impacted by data quality issues regarding CHP+ enrollment files received by Colorado Access.

Eligibility issues were revealed during most of the on-site review discussions. Despite the challenges faced by the Department, Colorado Access, and TriZetto, there was a substantial reduction in the number of claims processed and paid incorrectly due to eligibility issues as a result of the ongoing efforts of all parties involved. Claim processing accuracy was dependent on applying an accurate eligibility span for member benefits. During the review period, less than 0.3 percent of all claims paid (63 of the 18,438 unique claims) were paid outside of the eligibility spans for members. This is a substantial improvement over the FY 13–14 result of 4 percent (790 of 18,818 claims, a total of 1,638 claims lines). The 63 claims impacted 35 members. Of the 35 members, 14 did not have an eligibility record, 12 members were newborns with effective dates starting the day after birth, seven members were not eligible for coverage on the date of service but had coverage spans for time periods before the dates of service, and two members were non-newborns who had coverage effective dates that spanned for periods after the dates of service in question. The claim information for the 35 members was shared with Colorado Access for investigation on April 7, 2016. Colorado Access provided the following summary information:

◆ All 14 members with missing eligibility spans were processed and paid correctly. All 14 had retroactive eligibility changes (four of the 14 were retroactively terminated and claim dollars paid were "taken back" from the providers).

◆ Nine of the 12 newborn members with effective dates that occurred after the day of birth were impacted by retroactive eligibility changes.

  ▪ However, three of the members were listed in the eligibility files that were sent to HSAG and misinterpreted during the claim analysis phase.

  ▪ Claims for all 12 members were processed and paid correctly.

◆ The seven members who showed as enrolled in the CHP+ SMCN program but did not appear to be enrolled on the date of service for the claim were also clarified through Colorado Access' response.

  ▪ Two members (claim #26A1 and #27) were showing as CHP+ SMCN-eligible when the claim was processed. The eligibility span for April was deleted in May when the member moved to CHP HMO. The claim dollars paid will be transferred from CHP+ SMCN to CHP HMO in April 2016 when the annual reconciliation process is completed. The HSAG auditor agrees with the explanation.

  ▪ Through its investigation, Colorado Access determined that one member (claim #28) had other healthcare coverage on the date of service. The claim payment to the provider was "taken back," and the eligibility span was removed. However, these activities were not represented as such in the eligibility extract sent to HSAG for that month, which can be explained due to the timing of when the eligibility extracts were generated in late January 2016 and when the change was made in QNXT.

  ▪ Claim #29: Based on manual enrollment information received from Maximus on June 1, 2015, the member was enrolled for the entire month of June 2015 but never appeared in the Medicaid Management Information System (MMIS) file.

■ The remaining three members in this category were all reflected on Colorado Access' capitation (monthly fee) listing for the dates of service in question. All were processed and paid appropriately.

◆ Colorado Access adequately explained the two members who were not newborns and had coverage effective dates that spanned after the dates of service as follows:

■ Colorado Access received capitation through both the CHP HMO contract and the CHP+ SMCN contract for one member (claim #30). The duplicate capitation will be reconciled during the next annual reconciliation with the Department.

■ The last member in this category (claim #31) represented another manual enrollment received from Maximus on April 9, 2015. The member was made eligible for CHP+ SMCN coverage back to February 1, 2015. Unfortunately, the member was never reflected in a future MMIS file. Any outstanding capitation due to Colorado Access will be reconciled as part of the annual process with the Department.

Retroactive eligibility changes impacted all areas of review during the HSAG claim analyses.

HSAG was informed on-site that Colorado Access was still working through enrollment/eligibility issues with the MMIS, the Department, and Maximus (beginning July 1, 2015, the enrollment vendor was Denver Health Group). Colorado Access staff members indicated that while the quality of the files improved (especially since October 2015), it was still common for enrollment files received during the audit period to have significant issues with mass terminations and incorrect member data. Since these files were used to process claims, these issues impacted claim processing accuracy. Colorado Access staff members notified the Department when radical changes in enrollment data are identified and then follow the Department's guidance in changing enrollment dates as appropriate.

Based on the explanation provided by Colorado Access, "out-of-span" claims such as those identified above appeared to reflect a snapshot of ongoing enrollment data issues rather than any data processing issues within the QNXT system. Colorado Access researched and followed up with an explanation for all claims after the on-site visit. Colorado Access stated that in most instances the eligibility had been updated after the claim extract was pulled for analysis.

On-site Visit Included Staff Member Interviews, System Demonstrations, and Claim Testing

HSAG conducted an on-site visit on March 9 and 10, 2016, at the Colorado Access office. Representatives from TriZetto also attended the on-site either in person or via conference call. Appendix B presents the on-site agenda showing the various areas that were reviewed and discussed during the on-site visit. HSAG utilized a combination of demonstrations and interviews with both Colorado Access operations staff members and claim processing staff members from TriZetto BMS. The goal was to understand the systems and various processes related to the receipt, editing, processing, and payment of the SMCN claims. A demonstration of the QNXT system was provided during the on-site visit that focused on processing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), durable medical equipment (DME), and vision claims randomly selected by

Colorado Access. The demonstration confirmed that the systems, policies, and procedures were aligned, operational, and designed to support Colorado Access' ASO claim processing obligations to the Department. On the second day of the on-site audit, HSAG conducted claim testing and reviewed selected claims based on its offsite claim extract analyses. Additional documents were requested and reviewed to address other outstanding questions or concerns brought up during the on-site visit. Claim analysis continued after the on-site visit, with requests for additional claim data clarification on March 9, 18, 25, and 29, and the first week in April.

Colorado Access' staff members were very helpful and responsive in answering questions from the HSAG auditor and in providing relevant documents to support the audit. All outstanding issues were resolved prior to April 27, 2016. The remainder of the report discusses the major audit findings, divided into two sections: (1) system and process evaluation, and (2) claim testing and targeted claim review results.

System and Process Evaluation Findings

General Observations on Vendor Management and Auditing

Results from the desk review, on-site demonstrations, and interviews indicated Colorado Access continually monitored and evaluated the performance of its contracted claim processing vendor, TriZetto. During the on-site visit, Colorado Access affirmed the rigorous auditing processes and procedures in place for both electronic data interchange (EDI) and paper claims. Colorado Access demonstrated adequate processes, procedures, and oversight activities associated with the TriZetto contract. The governance structure provided appropriate monitoring of day-to-day claim processing activities. This included an in-depth explanation/overview of reports and scheduled meetings used to monitor TriZetto performance. The following is a summary of the reports, audit processes, and scheduled meetings focused on claim processing that were discussed for the review period:

◆ The COA Daily Inventory Report—when paper claim submissions did not agree with the manual count, TriZetto BMS would notify the Colorado Access mailroom about the issue. The mailroom would investigate and then notify the appropriate department leads within Colorado Access about the situation and the resolution plan.

◆ A number of other daily claim processing reports were generated and reviewed by both TriZetto and Colorado Access staff members. These included:
  ▪ Pended Claim Report—included all lines of business in aggregate.
  ▪ Weekly report on claim aging.
  ▪ High Dollar Claim report.
  ▪ Monthly COA Quality Report and Discussion document (which highlighted all aspects of the claim process) was also worked by both Colorado Access and TriZetto staff members.
  ▪ ATA Weekly Audit Sheet report containing randomly pulled, auto-adjudicated claims for audit.
  ▪ Large Claim and Pay Deny Audit report.

◆ The Claim Anomaly Report was produced by OPTUMAS (the Department's actuarial vendor) based on monthly encounter data submitted by Colorado Access to OPTUMAS through the QNXT Connect (Q-Connect) encounter transfer application. The report originally was distributed to Colorado Access monthly. Colorado Access was given 45 days to provide explanations for all anomalies identified. The report then shifted to a quarterly distribution. During the review period, distribution of the report from OPTUMAS became so sporadic that Colorado Access seldom received or worked the report, which has continued to be the case.

◆ TriZetto BMS and Colorado Access staff members met twice a week to address claim-related issues that included developing action plans and system tickets to resolve the issues.

◆ Colorado Access implemented a comprehensive audit strategy for monitoring TriZetto BMS activity in relation to service level agreements between TriZetto and Colorado Access as well as Colorado Access and the Department. The Colorado Access Audit Team (Audit Team):

- Reviewed the Daily Audit Report (based on claim auto adjudication data) from TriZetto BMS to identify specific claims to audit.

- Reviewed the Paid/Denied Report from BMS daily to identify and audit claims that were pended and manually processed by a BMS claim examiner. The report was generated at 5:30 a.m. each day, which gave the Audit Team the opportunity to address pended claim issues from the prior day within 24 hours. Data were separated by line of business. CHP+ SMCN had a separate report tab.

- Generated ad hoc reports to check for prior claims that may have required adjustment after notification from the Colorado Access Provider Data Integrity Team that new provider contracts were added or deleted in QNXT.

- Generated other miscellaneous ad hoc reports to monitor BMS claim processing and QNXT system enhancements depending on the issue identified during the course of the Audit Team's routine daily review.

- Conducted audits of the BMS auditors' work. Initially, Colorado Access re-audited 7 percent of all TriZetto BMS adjudicated claims. However, the error rate was so low that the re-audited claim rate was dropped to 3 percent. Staff members attributed this to the BMS auditors implementing the same audit guidelines as Colorado Access.

- Reviewed every claim of $20,000 or more identified through the High Dollar Claim report after the BMS claim examiner pended and sent the claim to the TriZetto auditor. This dollar threshold for mandatory review was later dropped to $10,000 or more because the volume of claims in the $10,000 to $19,999 category warranted more attention/review. Member eligibility for the dates of service in question was the first element audited to make certain members were covered during the time span.

- Notified the Colorado Access Provider Data Integrity unit of any provider contract issues identified in QNXT.

- Met with the TriZetto BMS team every other week to discuss processing issues that were identified during the BMS claim audits. Staff members discovered that many of the issues resulted from Colorado Access not providing usable claim and member notes to TriZetto. Colorado Access established an initiative to focus on note quality and completeness. This

gave TriZetto BMS the opportunity to place clearer, more concise claim notes into QNXT, which resulted in a reduction of ongoing claim processing issues.

- Reviewed the Less-Of Report daily to monitor claims paid to providers who received the fee schedule rate for a service when the provider's billed charges were less than the fee schedule amount. These claims are presented to TriZetto BMS management to further train the claim examiners and to incorporate appropriate claim edits in QNXT to catch these situations.

- Daily monitored the No Authorization Claims Report that identified claims denied due to QNXT's lack of a prior authorization (PA). Comparison of the PA system to QNXT checked to determine if a PA existed for the date of service. If it did, the Audit Team opened a ticket with TriZetto to determine why the discrepancy occurred.

- Audited 40 randomly selected "paper" claims monthly to determine when a paper claim was scanned by Colorado Access mailroom staff members for batch delivery to QNXT (to undergo the optical character recognition [OCR] process) in relation to when a claim number was assigned. If more than seven days passed between the scan date and the claim number being assigned, the issue was sent to both the mailroom and TriZetto BMS requesting an explanation. TriZetto's SLA for converting the scanned (batched) paper claims to OCR (837 format) was five business days. Once a determination was made as to whether the issue was a mailroom or TriZetto issue, a corrective action plan was implemented.

- Presented all audit-related issues to the executive director of the Colorado Access CHP program. Any potential fraudulent provider issues were sent to the appropriate provider relations representative for further investigation. Depending on the findings of the investigation, Colorado Access' Legal Department may have been asked to draft a letter to the provider. This may have resulted in a settlement with the provider that could have included termination from the network and possibly referring the provider to the appropriate State or federal authorities. The Department was always informed of the situation before any discussion with the provider was initiated. The Department would approve all settlements before they were presented to the provider.

In addition to the comprehensive reporting, meeting, and auditing processes, both organizations designated business leads within each of the operational and claim processing-related areas. These individuals/teams were responsible for initiating system updates (when needed), testing, and implementing changes to QNXT or an existing process.

Adequate training was in place for new Colorado Access staff members, and ongoing retraining for existing staff members on the QNXT system was available when needed. Colorado Access used multiple training programs to ensure all staff members were adequately trained to utilize the different aspects/modules of QNXT. As Colorado Access staff members continued to become proficient with the QNXT application, there was less reliance on TriZetto for training. At the time of the on-site visit, HSAG auditors confirmed that TriZetto continued to provide some training support to Colorado Access when needed. It was also apparent that the good working relationship between Colorado Access and TriZetto had enabled Colorado Access the opportunity to achieve training goals and overall systems and operational support objectives.

Appropriate Change Management and Risk Mitigation Strategies

Colorado Access and TriZetto had processes in place to manage change requests to the QNXT system and the ongoing, day-to-day claim processing operations during normal work hours. Both organizations also had a framework in place to continue operations in the event of a catastrophic or prolonged interruption in normal business operations. Policies and procedures for initiating and tracking QNXT issues through a ticket process were updated periodically to ensure Colorado Access staff members had access to the appropriate contacts at TriZetto to identify, prioritize, authorize, approve, and monitor any change requests and progress.

To minimize the risk of potential data loss and to assure accuracy of data reconciliation and reporting needs, Colorado Access implemented indirect interfaces with QNXT. While there were no direct interfaces between the two organizations, data from the data warehouse were subject to a "real-time replication" with QNXT. The replication tool ran 24 hours a day, seven days a week. There were no automated reports in place to show if the number of records received by QNXT was actually what was passed. However, Colorado Access used a manual process for checking the number of records sent daily. During the on-site visit, Colorado Access and TriZetto indicated they were in the process of automating the flow of information from QNXT to Colorado Access (data warehouses). They have targeted to have this automation in place by third quarter 2016.

The data and presentations reflected minimal issues with how members received services or how providers submitted claims and received reimbursement. CHP+ SMCN members did not receive an explanation of benefits. The member handbook provided detailed information on how to find a provider; how to determine whether a service was covered or not; how to schedule an appointment; how to contact Colorado Access Customer Service in the event of a question, issue or concern; and how to file a grievance.

Network providers had access to the Colorado Access provider manual, which outlined all aspects of the CHP+ SMCN program (as well as all other Colorado Access lines of business). The information included how, where, and when (the appropriate timing) to submit claims. The provider manual also outlined key claim policies and procedures as well as data validation requirements used to administer the CHP+ SMCN program. Key aspects of the provider manual were stressed in training sessions provided to all physicians and facilities in the network. This training, coupled with a dedicated provider services representative assigned to each provider, assisted in maintaining a stable network. Provider questions and comments were handled by representatives from the Colorado Access Customer Service or Provider Relations departments.

Network providers were under contract with the State of Colorado through the SMCN Provider Agreement. Colorado Access administered the provider network on behalf of the Department. At the time of the audit, there were approximately 8,000 network providers. Loading provider contracts in QNXT was a joint effort between Colorado Access and TriZetto. TriZetto was responsible for configuring the contracts in QNXT, while Colorado Access loaded the contracts. A provider contract included the agreed-upon fee schedule assigned to each provider as well as the benefit packages in which the provider participated. Colorado Access provided the direction and oversight for the process, and TriZetto BMS conducted the end-to-end testing. TriZetto BMS verified that provider contracts were correctly and timely placed into production. Quarterly end-to-end testing was conducted by TriZetto BMS on all new provider contract files. BMS ran five to 10 claims

through the testing process to make certain the provider contracts worked correctly for all new entries.

The provider data integrity supervisor and the director of eligibility, configuration, and credentialing managed the loading of provider additions and terminations into QNXT as well as provider credentialing. Provider forms were loaded into a SharePoint file. A compliance analyst was assigned to each provider. The compliance analyst verified several pieces of background information about the provider via Office of Inspector General (OIG) searches, determining if a provider could not receive federal funds, checking for any sanctions against the provider, and finally, determining whether the provider was affiliated with any provider groups with which Colorado Access may have experienced problems/issues in the past. Claims received from providers who were not in the network were pended. A shell provider contract was created to establish a provider's record, and the provider was affiliated as "non-par" (i.e., nonparticipating) for claim payment. The provider was designated as "participating" on the date credentialing was completed and approved by the Colorado Access Credentialing Committee. During the on-site visit, staff members indicated that credentialing was delegated to six large provider group entities: UPI, Centura Health, Denver Health, NCIPA, Boulder Valley, and Rose Medical Group. These entities credentialed over 47 percent of the CHP+ SMCN network providers. It is not unusual for health plans to delegate some or all of their credentialing to an external entity due to the seasonal variability in the number of providers who need to be credentialed or recredentialed throughout the year. Because providers were credentialed based on an organizational level, they were loaded at the "pay to provider" level in QNXT rather than the individual provider level. If a provider could not be matched by QNXT during claim processing, TriZetto BMS used an "ignore functionality" in QNXT to pend the claim for review and manual processing.

The provider data integrity supervisor was also responsible for the set-up and maintenance of provider fee schedules in QNXT. Fee schedules were based on CMS Medicare Resource-Based Relative Value Scale (RBRVS) schedules. Professional, DME and anesthesia claims were paid at 90 percent of RBRVS. Behavioral health (BH) fees were derived from internal Colorado Access data. Institutional claims were paid on an All Patients Refined Diagnosis Related Groups (APR DRG) basis. All fee schedules required approval from the Department before implementation. Colorado Access monitored the CMS website for fee schedule updates that occurred at different time frames (i.e., quarterly, annually, or ad hoc). All fee schedule updates were sent to TriZetto using the established ticket system. After the fee schedules were updated in QNXT, Colorado Access and TriZetto conducted quality checks to ensure updates were accurately loaded and appropriate codes were used when verifying fee schedule loads/updates.

Colorado Access' Approach to Handling Claim-Related Data for QNXT Processing to Assure Contractual Requirements and Industry Standards Were Met

Since the last audit, no changes were made in Colorado Access' processes for receiving, validating, loading, and monitoring the completeness for all claim-related data (e.g., eligibility data, claim data [electronic and paper], provider data, and fee schedules). All followed industry standards. Colorado Access performed all eligibility updates and reconciliations before they were loaded into the QNXT system. Colorado Access received daily files from the State via the MMIS system on a secure file transfer protocol (FTP) site and uploaded to a repository nightly. The electronic load process was

completely automated with failed load alerts, and results were automatically sent to applicable Colorado Access staff members via email. System-generated reports were available that monitored the progress and success of each step. A similar process was followed for the monthly files for new members. A hierarchy of processes for loading files was followed. Error reports were generated for member records that failed a criteria set for the standard process. All resolutions for exception processing occurred at Colorado Access prior to forwarding data to TriZetto.

Colorado Access continued to work with the Department and its enrollment vendor (Maximus) during the review period to resolve data issues involving the State's Colorado Benefits Management System (CBMS) and MMIS data transfer process.[1] While improvement in data transmission was realized, the State continued to experience multiple issues with enrollment data. During 2015, Colorado Access indicated that approximately 2 percent of CHP+ SMCN enrollment was received via a manual input/process. This was a substantial improvement from the 5 percent level seen during the FY 13–14 audit. However, the 2 percent still equated to more than 150 manual enrollment entries each month during the review period. The CHP+ SMCN enrollment ranged from 8,572 (January 31, 2015) to 7,663 (June 30, 2015) members during the review period. Colorado Access received daily Microsoft Excel spreadsheets from the State. The list contained members who called Maximus or Colorado Access for services because the provider could not confirm eligibility. Colorado Access manually loaded these members' information into its eligibility data system. Colorado Access had processes in place to monitor the updated files received for these manually entered members to establish an audit trail for accuracy and completion. Effective July 1, 2015, Denver Health Group replaced Maximus as the enrollment broker/vendor. Colorado Access and the enrollment vendor conduct an annual "look-back" or reconciliation to identify members who were not on the official Colorado Access member listing but had claims paid. The purpose of the reconciliation is to make corrections to the fees paid to Colorado Access during the past year.

The 2013–2014 CHP+ SMCN audit identified and the 2016 on-site visit confirmed that CHP+ SMCN enrollment data accuracy continued to be an issue. Colorado Access staff members worked closely with the Department and Maximus during the review period to address problems. In some cases, Colorado Access staff members indicated that there where large-scale terminations (as many as several thousand in a month). In these instances, Colorado Access staff members notified the Department immediately and obtained approval to hold the termination files until data could be verified. This process helped to address many potential front-end eligibility data issues before the data were loaded into the QNXT system for claim processing.

Colorado Access' processes for handling EDI claims submitted by providers or clearinghouses and paper claims submitted directly from providers were consistent with industry practices. Paper claims processed during the review period accounted for approximately 20 percent of all claims. Paper claims were received on-site in the Colorado Access mailroom. Two staff members opened the mail and date stamped each piece of correspondence with the clean claim date. TriZetto was instrumental in establishing the process Colorado Access followed for paper claim handling. This aided greatly in the success of the remaining downstream process. Claim documents were assigned a tracking/identification (DCN) number. Claims were not assigned a claim number until loaded into

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[1] CBMS determines benefit eligibility for residents in Colorado. It is a database that processes applications for public assistance such as Medicaid, food stamps, and Temporary Assistance for Needy Families. CHP+ enrollment spans are generated by CBMS and sent to MMIS for loading.

QNXT. All paper claims were scanned into a file that was posted to the TriZetto FTP site. The claim files were renamed in folders using TriZetto's naming convention. TriZetto retrieved the scanned image (claim) files electronically at two different times each day. There were control mechanisms in place to validate the volume, format, and accuracy of the claims. TriZetto BMS staff members downloaded the files containing scanned claims and initiated an OCR process to convert the claims into an 837 format to be loaded into QNXT. The scanned paper claim files were subject to the same EDI (i.e., member eligibility, provider [par or non-par], and product) and Health Insurance Portability and Accountability Act of 1996 (HIPAA) edits as electronic claims.

Paper claims that failed the OCR process were not rejected but were "keyed" into the system by BMS staff members. Colorado Access staff members indicated that approximately 5 to 7 percent of the claims fell into this category. Generally, the claims lacked national provider identifier (NPI) information. All manually entered claims (100 percent) were subject to audit by BMS auditors. However, 1 percent of the 5 to 7 percent of the claims that "fell-out" were audited by BMS staff members. The Colorado Access Provider Relations team received details through claim and claim audit reports on the top errors/issues by the providers who submitted paper claims. These providers were then targeted to receive additional education regarding claim submission, including the use of EDI. Attachments such as explanation of benefits (EOBs) from other carriers or medical records attached to paper claims were scanned separately and associated to the claim document through the DCN tracking number—which was loaded into the Colorado Access DMS (data warehouse) system. TriZetto used rigorous auditing processes for both EDI and paper claims, which included reviewing and working the Colorado Access Daily Inventory Report. When comparative reports on the paper claims did not align, TriZetto BMS notified the Colorado Access mailroom about the issue/discrepancy. The mailroom would then notify the appropriate department leads within Colorado Access. TriZetto and Colorado Access continue to meet twice weekly to address claim-related issues during the review period.

Only electronic claims submitted in an 837 standard format (utilizing HIPAA-compliant ASC X12N) or National Council for Prescription Drug Programs (NCPDP) (for certain pharmacy transactions) were accepted. Colorado Access had approximately 30 trading partners consisting of clearinghouses and some providers who submitted directly. All files were received on the Colorado Access secure SharePoint site. For electronic files submitted via Emdeon, a large national claim clearinghouse, Colorado Access obtained files from the Emdeon site and placed them on the TriZetto EDI site to be loaded into QNXT. Colorado Access received EDI-generated claims from their trading partners twice a day, at 11:00 a.m. and 3:00 p.m. The claim files were electronically pulled from the FTP site and were subject to further validation before being placed on the TriZetto FTP site through the EDI Sweep process. The claims were also loaded into the Colorado Access MedData database, which helped to verify which claims were sent to QNXT by each unique trading partner. All claim files were subject to HIPAA validation, which consisted of three levels of HIPAA edits, as documented in policy. TriZetto generated a 999 file confirming receipt as well as 277 files that identified accepted and rejected records. These files were posted to TriZetto's FTP site for Colorado Access to collect, review, analyze, and send to the appropriate trading partners. If validation reports did not align, the Colorado Access EDI analyst initiated a ticket with TriZetto identifying any issues and requested a timeline for investigation and resolution. All trading partners had a business associate agreement in place with Colorado Access.

TriZetto's claim processing BMS team oversaw all management functions associated with claim processing, utilizing multiple geographic locations. Standard 837 file edits and reporting were followed. The QNXT application processed edits such as provider matching, national provider identifier (NPI), member eligibility, and covered benefits that triggered claims to be pended for manual review. Colorado Access had effective processes in place for monitoring data transmission. Additionally, Colorado Access converted each electronic claim to a claim form image via a document management system where Colorado Access staff members accessed claim data to review or conduct validation.

On-site system demonstrations showed that the claim processes and decision making practiced by Colorado Access, TriZetto BMS, and the QNXT application accurately reflected information that was documented in policies and procedures as well as in business rule manuals. HSAG observed the following related to the system demonstrations:

◆ An educational discussion/demonstration of the process flow of receipt, adjudication, and processing of claims as described by Colorado Access and TriZetto BMS staff members.

◆ That systematic and manual processes and procedures had been established and were operating efficiently to address eligibility issues (at date of service) during processing.

◆ Demonstration of how system-generated reports were integrated into the Colorado Access auditing and vendor management/monitoring processes.

◆ Examples of logic for handling claims with dates of service greater than 180 days prior to claim receipt that worked as expected.

◆ Example of duplicate claims being denied accurately.

◆ Demonstrations of functionality within the QNXT application (including soft/warning edits and general claim review process) which reflected that Colorado Access had adequate knowledge of QNXT and that TriZetto BMS staff members had adequate knowledge of CHP+ SMCN benefits.

Colorado Access' Oversight of TriZetto That Ensured a High Level of Claim Processing Efficiency

A key component of vendor management related to Colorado Access' ability to monitor TriZetto's performance is effectively using claim reports and audits to assure timely payment and financial and procedural accuracy. TriZetto was contractually required to conduct daily audits on claims processed in the QNXT system. TriZetto performed post-adjudication and pre-payment audits on a minimum of 5 percent of manually adjudicated claims and a minimum of 2.5 percent of auto-adjudicated claims. The June 2015 claims audit report (*COA Monthly Review June '15*) was pre-selected to verify TriZetto's contract compliance. During that month, 813 claims were manually adjudicated, with 83 claims audited (10.21 percent). The audit reflected 100 percent financial and 100 percent processing accuracy, which also met the contractual requirements of 99 percent and 96 percent, respectively. Auto-adjudicated claims for that month totaled 2,297 claims, with 83 audited (3.61 percent). As with the manually adjudicated claims, the audit revealed 100 percent financial and 97.59 percent processing accuracy, which also met the contractual requirements of 99 percent

and 96 percent, respectively. These results were also verified during discussion with staff members during the on-site visit.

Audit reports were sent to Colorado Access weekly and daily for review. A few months after implementation of QNXT, TriZetto BMS began to follow the same audit protocols as Colorado Access. This resulted in the Colorado Access audit results seldom, if ever, contradicting the TriZetto audit results. Therefore, Colorado Access began to rely on the TriZetto audit results, yet the Colorado Access Audit Department continued to scrutinize all audit reports from TriZetto. In addition, appropriate processes were in place that encouraged the audit teams from both organizations to communicate daily, if needed.

The *COA Monthly Review June '15* claim audit report also reflected TriZetto BMS' ability to meet its contractual, Department-required claim turnaround times. The report showed the turnaround times for all Colorado Access lines of business; however, it still verified contractual compliance, with 99.46 percent of all EDI claims (including SMCN) processed within 30 days and 99.40 percent of all paper claims (including SMCN) processed within 30 days. The report also broke out the total SMCN claims processed within 14 calendar days (97.95 percent), 30 calendar days (99.97 percent), and 60 calendar days (100 percent). (Note: the SLA requirement/standard with the Department was 45 calendar days.) All SLA percentages met or exceeded the contractual requirements of 90 percent (within 14 calendar days) and 98 percent (within 30 and 45 days) for EDI and paper claims, respectively.

In addition to re-auditing TriZetto's audit performance, Colorado Access also performed a variety of audits as previously discussed in the General Observations on Vendor Management and Auditing section of this report. These activities provided continual monitoring for Colorado Access of its vendor's performance.

Claim Testing and Targeted Claim Review Results

General Claim Processing Protocols

Discussion during the course of the first day of the on-site visit confirmed that the originally submitted claim turnaround time (i.e., Report Card) reports were incorrect. Colorado Access had submitted the corrected reports prior to the on-site visit, which reflected that claim financial accuracy for January 2015 was the only measured monthly service level that was not attained during the review period. The second day of the on-site visit consisted of a discussion, demonstration, and review of claims identified by the HSAG auditor for additional clarification on how they were originally processed and paid. The session consisted of testing claims for processing and verifying that appropriate policies and procedures were in place to support that the claim adjudication process met the Department's requirements. The claim review consisted of 22 claims that were flagged due to timely filing concerns, eligibility issues, missing paid dates, and claims that appeared to have "unusual" processing results. Overall, the claim test, demonstration, and processing session were successful, with the following specific observations:

◆ Timely filing concerns were dispelled following discussion/presentations by the Colorado Access team. Claims were paid or denied appropriately following the timely filing requirements discussed earlier in this report. A detailed review of each claim can be found in Appendix D.

◆ During the desk review, the HSAG auditor identified five claims that had unusual claim processing handling. Colorado Access' review of one of these claims (claim #8) revealed that QNXT initiated a "systematic reversal" on the claim and placed the claim in a "RevSynch" (pended) status for approximately three months. Colorado Access worked with TriZetto to implement a process for claim staff members to check this claim status category daily. The remaining claims were impacted by either member retroactive eligibility changes or retroactively adding a network provider. A detailed review of each claim can be found in Appendix E.

◆ During the claim analysis that followed the on-site review, the HSAG auditor identified 134 unique claims that were missing a paid date in the claim files. Of those claims, 92 had a Julian date of either June 22, 2015, or June 24, 2015. This led to the assumption that claims may have been impacted by the timing between when the claims were processed and checks/drafts were ultimately generated within the system each specific month. The other variable that may have impacted the data was the timing of when the claim extract files were pulled by Colorado Access, which was January 22, 2016. As indicated, retroactive eligibility changes were not uncommon with the CHP+ SMCN program. Many of these claims may have been paid after January 22, 2016. Twenty-three of the claims had Julian dates outside the review period but well within the timely filing requirements. Nineteen claims were processed that reflected a Julian date that fell outside the timely filing requirement of 180 days. Of the 19 claims, 17 were denied appropriately due to timely filing (TF1). Thirteen were submitted to Colorado Access for further review and an explanation. The director of Systems Operations and Vendor Management confirmed that the primary issue related to the paid dates issue was the date when the claim extract files were generated—January 22, 2016. The extract did not pick up any paid dates after this date. Most of the claims sent to Colorado Access reflected a paid date in QNXT that occurred after January 22, 2016. Several claims reviewed were voided (i.e., had a VOID status). QNXT only allowed nonfinalized claims to be voided. If a claim had a paid date (whether paid or denied), it could not be voided—it needed to be reversed. In those situations, providers submitted corrected claims. QNXT functionality identified the original claim and if the claim was not finalized, QNXT voided the original claim and processed the claim submission under the corrected claim number. Based on the information provided by Colorado Access, all the claims were processed and paid correctly (Appendix F).

◆ During the desk review, claim #32 was flagged from the A_Pend_Edit_03032015 Report for further discussion. The report indicated that University of Colorado Hospital had 365 days to submit a claim (the CHP+ SMCN requirement was 180 days). When asked for clarification, Colorado Access provided documentation which indicated that the claim originally went through the CHP+ SMCN appeals process in error. The Delayed Notice of Eligibility process was discussed and proved to be helpful in understanding the overall claim process for this type of claim. Staff members confirmed the claim was misrouted to be paid by CHP+ HMO. University of Colorado Hospital was held to the 180-day timely filing requirement/SLA for all CHP+ SMCN claims during the review period.

Colorado Access successfully demonstrated the edits that would flag a claim for timely filing issues. The QNXT system appeared to be appropriately set up to ensure that claims which fall outside timely filing guidelines were denied.

The HSAG auditor was provided with information on-site which demonstrated that Colorado Access used the claim reports to identify and evaluate claim trends. These reports were used in preparing strategies related to claim processing.

Conclusions and Recommendations

The audit was conducted approximately one and a half years following the QNXT system becoming operational and was based on claims processed three to nine months after implementation. HSAG examined the critical aspects of claim processing functions performed by TriZetto on behalf of Colorado Access. Major system configurations and processes were appropriate and followed industry standards. The collaborative efforts between Colorado Access and TriZetto resulted in policies, procedures, and operational protocols that produced an efficient claim operation. The demonstration and interviews revealed that all processes were executed appropriately and that Colorado Access closely monitored TriZetto and its BMS staff members. HSAG's conclusions and recommendations are as follows:

◆ Colorado Access and TriZetto should complete the combined business continuity and disaster recovery (BCDR) strategy discussed during the on-site review and update the BCDR plan. Colorado Access should complete a desk review of the BCDR during third or fourth quarter 2016 and ultimately execute a full end-to-end test of the BCDR before year-end 2017.

◆ During the on-site visit, HSAG and Colorado Access discovered that QNXT could systematically reverse a claim or a claim line and pend it to a RevSynch classification, even if a claim examiner had manually reversed the same claim or claim line. The RevSynch folder should be worked daily or at least weekly to assure reimbursement to impacted providers is correct. Colorado Access and TriZetto should implement processes and procedures to assure the TriZetto BMS claim examiners are frequently checking this specific file folder for claims.

◆ On the first day of the on-site visit, Colorado Access provided a detailed system demonstration that highlighted the processing of EPSDT, DME, and vision claims. In addition, the second day of the on-site visit was devoted to reviewing claims identified by the HSAG auditor during the desk review as requiring additional information or clarification on how they were processed. For all of the claims discussed on the first day and many of those discussed on the second day, Colorado Access and TriZetto staff members allowed the Audit Team to view the "expanded edit steps" screens in QNXT. This functionality, expanded from earlier versions of QNXT, provided detailed, step-by-step claim logic that was followed for each of the claims. This level of detail coupled with the claim notes expedited the review process by offering an in-depth overview of claim processing. This QNXT functionality proved very beneficial in demonstrating that claims were processed correctly.

◆ Follow-up was completed during the desk review and the on-site visit to verify Colorado Access had taken appropriate action on the recommendations provided during the last CHP+ SMCN audit for FY 13–14. Colorado Access demonstrated compliance with the recommendations through:

- An updated claim manual and audit processes and procedures, as well as a demonstration of comprehensive audit protocols being in place and functioning properly for claim processing and SMCN program administration. In addition, policies were recently updated to reflect changes/improvements to reporting and auditing processes.

- Addressing the "General Claim Check Error" issue. The issue, which was revealed by submission of the key claim edits that were based on business rules in place for claim processing, allowed claims to be pended for manual review and processing even though the claims were auto-adjudicated correctly. Colorado Access also provided documentation and walked the Audit Team through TriZetto's "ticket" process, which was used to address system fixes for similar situations.

- Documentation that was approved by the Department, validating the calculation used in determining the total billed amount on any claim equaled the total of the respective claim lines for that specific claim in the Colorado Access data warehouse.

- Submission of documentation that substantiated changes were made to QNXT to accurately apply age and gender edits to all claims. The primary issue was the processing of claims for newborns. The information provided included a write-up of the McKesson Claim Check System used in processing all claims and a letter from Medicaid to the Department that validated the process utilized.

◆ The CHP+ SMCN enrollment data receipt, update, and reconciliation processes presented an ongoing challenge for Colorado Access in its efforts to effectively manage member services and provider reimbursement. The HSAG auditor confirmed that appropriate processes, procedures, and personnel resources were allocated to investigate and resolve eligibility issues by Colorado Access. Colorado Access demonstrated the measures taken to address this problem through a series of reports and audit steps that identified eligibility issues on files from the State before they were passed to TriZetto to be loaded into QNXT. New eligibility files were reconciled to the existing eligibility database. Once pre-defined thresholds of member terminations were hit, eligibility files were prevented from being posted to the TriZetto FTP site. Claims for these members were manually reviewed for possible adjustments and any provider take-backs as a result of the change/update in member eligibility. Colorado Access followed a Claims for Ineligible Members (CIM) process that looks back at claims paid on members who were determined to no longer be eligible for coverage. HSAG recommends continued focus in this area until such time that the contract between the Department and Colorado Access is completely transitioned.

The FY 15–16 audit was conducted during the period following notification from the Department that Colorado Access would be losing the CHP+ SMCN contract. Despite that fact, Colorado Access met all requested timelines for submitting information. The Colorado Access team continued to be more than accommodating in responding to follow-up data and document requests and questions following the on-site audit. That noted, the CHP+ SMCN contract will transition to a new vendor beginning on November 1, 2016. Colorado Access will only administer claims impacted by retroactive eligibility. HSAG recommends the Department conduct an audit of Colorado Access beginning in January 2017 to verify that transition plans implemented between the Department, Colorado Access and the new vendor were followed and that Colorado Access maintained the service levels required during the transition of administration of the CHP+ SMCN program.

1. Contract requirements/guidelines (provider requirements for submitting claims—provider manual) regarding the collection and processing of claims/encounters for SMCN providers as well as guidelines/instructions and/or sample reports related to assistance given to providers related to submitting claims/encounters appropriately. Documentation related to corrective action plans for offending providers.

2. Contract requirements with TriZetto, including performance standards established for claim processing.

3. Documentation describing secure transmission of data among SMCN providers, TriZetto, and Colorado Access. This includes data security and privacy policy and procedures. Documentation should also be provided regarding corrective actions planned in the event of a possible breach in data integrity.

4. Documentation demonstrating that TriZetto and Colorado Access have disaster recovery plans to ensure business continuity in the event of a catastrophic incident. This documentation should include a copy of the disaster recovery and business continuity plans and an inventory of the core systems specifically used to process and support SMCN claim processing.

5. Documentation describing the data structure and data flow in the QNXT system for processing, validating, and accepting claims and encounters.

6. Documentation describing the maintenance of fee schedule and rates for capitated and/or fee-for-service providers in the QNXT system.

7. System edits and business rules in the QNXT system used to check submitted claims/encounters for format and value accuracy.

8. Documentation demonstrating that the claim system check claim payment logic in the QNXT system to identify erroneous billing from providers as well as pricing applied to claims before payments. Documentation should include a description of system edits as well as a list of reports (including the claim anomaly reports already submitted) used to identify claim processing trends and anomalies. If Colorado Access or TriZetto uses additional vendors to perform claim verification, documentation should be provided of the contract with the external vendor as well as oversight policies and procedures and any related performance standards.

9. Documentation demonstrating adjudication rate reports. Documentation about the claim processing policy that details turnaround time frames and steps for managing pended claims. Additionally, reports demonstrating claim processing statistics such as average number of daily/monthly claims processed, pended, and denied; paper claims; etc.

10. Performance standards related to the submission, accuracy, and timeliness of claim and encounter data (standards established by the Department or internally developed by Colorado Access).

11. Quarterly performance reports submitted to the Department for calendar year 2015.

12. Communication documents (Explanation of Payment—EOP—to providers) sent to providers related to data validation results (e.g., policies and procedures, rejection reports).

   ◆ Explanation of how/why Colorado Access paid the claim.

13. Internal policies and procedures, studies, and reports for monitoring claim volume, patterns, or trends of claim errors (including the claim anomaly reports already submitted).

14. Colorado Access' internal claim processing audit methodology and any associated audit results and reports.

15. Reports submitted to the Department that reflect encounter data submission activities to the Department (e.g., submission statistics).

16. Process documentation outlining the approaches used to address issues identified in the Department's anomaly reports including prepared responses.

17. Claim extract of all professional and institutional SMCN claims processed in the QNXT system and submitted to the Department by Colorado Access during 2015 with dates of service between January 1, 2015, and June 30, 2015.

18. Data file layout (record layout) used by Colorado Access for submitting to the Department the SMCN claims/encounters processed in the QNXT system.

19. Data file layout by which Colorado Access receives and ultimately determines member eligibility.

20. An extract of the QNXT provider file for the period of January 1, 2015, through June 30, 2015.

21. Documentation supporting the QNXT "fix" to address a "General Claim Check Error" that was being generated on claims appropriately auto-adjudicating but being pended for manual review and processing (as relayed to the HSAG auditors during the 2013–2014 claim processing audit).

22. Copies of the April 2015, May 2015, and June 2015 Current Timely Processing reports.

    ◆ Turnaround time for processing.

23. Documentation demonstrating Colorado Access' data warehouse calculation for Total Billed on any claim and the respective claim lines corrected for reporting purposes (as relayed to the HSAG auditors during the 2013–2014 claim processing audit).

24. Documentation verifying when the QNXT system was modified to accurately apply age and gender edits to all claims (as relayed to the HSAG auditors during the 2013–2014 claim processing audit).

25. Documentation reflecting changes in claim staff member training, monitoring, and the ongoing audit process established to develop claim memoranda.

26. Documentation supporting the development and successful implementation of a manual process to identify claims paid incorrectly due to CHP+ enrollment data receipt, updating, and reconciliation processes identified during the 2013–2014 claim processing audit.

Colorado Department of Health Care Policy & Financing—SMCN Claim Processing Audit

Dates: March 9–10, 2016
Location: Colorado Access—11100 East Bethany Drive, Aurora, CO 80014
Audit Team: Matt Sobczyk, MBA, and Barbara McConnell, MBA, OTR

Day 1—Wednesday, March 9th, 2016	
Time	**Sessions and Activities**
9:00–9:30 a.m.	**Introductions and Opening Remarks** ◆ Introductions ◆ HSAG overview and process ◆ On-site visit objectives
9:30–11:45 a.m.	**Overview of Data Flow Between The Department, Colorado Access (COA), and TriZetto** ◆ Eligibility ◆ Electronic and paper claims process ◆ Monitoring process for data transmission ◆ Reporting process related to anomalies or issues pertaining to data flow
11:45 a.m.–1:00 p.m.—Lunch	
1:00 p.m.–3:30 p.m.	**Claim Processing in QNXT—Overview** ◆ Claim system demonstration ◆ Day in the life of a claim ◆ Fee schedules set up and updates ◆ Pended claims ◆ TriZetto staff supporting COA ◆ COA staff training on QNXT ◆ COA system interface(s) with QNXT ◆ Provider file processing ◆ Coordination of benefits process ◆ Claim Backlog—strategy to address ◆ Internal auditing process
3:30–3:45 p.m.—Break	
3:45–4:30 p.m.	**Quality and Vendor Management** ◆ Roles and responsibilities ◆ Audit process ◆ Monitoring process ◆ System/Application modification process ◆ Optumas report process ◆ SLA report card

Day 2—Thursday, March 10th, 2016	
Time	**Sessions and Activities**
9:00–10:45 a.m.	**Claim Testing and Reviews (Based on Claim Analyses)**
10:45–11:15 a.m.—Break *(Audit Team to Prepare for Closing Conference With COA and The Department)*	
11:15–11:45 a.m.	**Closing Conference** ◆ Overview of preliminary findings ◆ Next steps

Note: Some materials may appear multiple times in different requirement folders as each requirement was reviewed independently.

Requirement Folder Number	HSAG Requirements	Colorado Access Comments/Responses
1	Contract requirements/guidelines regarding the collection and processing of claims/encounters for SMCN providers as well as guidelines/instructions and/or sample reports related to assistance given to providers related to submitting claims/encounters appropriately. Documentation related to corrective action plans for offending providers.	COA's physician's training slides. Slides may address both CHP HMO and SMCN as the processes for both are the same. 2015 Provider Bulletins. SMCN Web Link. SMCN Provider Manual. Most current SMCN Contract Amendment and complete original contract.
2	Contract requirements with TriZetto, including performance standards established for claim processing.	Due to privacy concerns for TriZetto's processes a "snapshot" pertaining specifically to this requirement was taken from the contract requirements document. Examples of 2 SLA report cards
3	Documentation describing secure transmission of data among SMCN providers, TriZetto, and Colorado Access. This includes data security and privacy policy and procedures. Documentation should also be provided regarding corrective actions planned in the event of a possible breach in data integrity.	Claims processes and flow charts, privacy practices and COA policies
4	Documentation demonstrating that TriZetto and Colorado Access have disaster recovery plans to ensure business continuity in the event of a catastrophic incident. This documentation should include a copy of the disaster recovery and business continuity plans and an inventory of the core systems specifically used to process and support SMCN claim processing.	The complete COA Disaster Recovery Plan. Note: the revised date on this document is 2014, after TriZetto implementation. Therefore this document is current and all aspects of the DRP are still in place today.
5	Documentation describing the data structure and data flow in the QNXT system for processing, validating, and accepting claims and encounters.	Claim process and TriZetto business program summary and IT data flow processes
6	Documentation describing the maintenance of fee schedule and rates for capitated and/or fee-for-service providers in the QNXT system.	Configuration process, COA business rules and provider manual
7	System edits and business rules in the QNXT system used to check submitted claims/encounters for format and value accuracy.	Claim Check process, procedures and rules

Requirement Folder Number	HSAG Requirements	Colorado Access Comments/Responses
8	Documentation demonstrating that the claim system check claim payment logic in the QNXT system to identify erroneous billing from providers as well as pricing applied to claims before payments. Documentation should include a description of system edits as well as a list of reports (including the claim anomaly reports already submitted) used to identify claim processing trends and anomalies. If Colorado Access or TriZetto uses additional vendors to perform claim verification, documentation should be provided of the contract with the external vendor as well as oversight policies and procedures and any related performance standards.	Copies of the anomaly reports, auditing processes, workflows and rules.
9	Documentation demonstrating adjudication rate reports. Documentation about the claim processing policy that details turnaround time frames and steps for managing pended claims. Additionally, reports demonstrating claim processing statistics such as average number of daily/monthly claims processed, pended, and denied; paper claims; etc.).	Claims policy, inventory reports, TAT performance, business rules
10	Performance standards related to the submission, accuracy, and timeliness of claims and encounter data (standards established by the Department or internally developed by Colorado Access).	Copy of a claims accuracy report from the Q1 quarterly report (this information is in all quarterly reports), Inventory report, business rules
11	Quarterly performance reports submitted to the Department for calendar year 2015.	Included in Folder 11 are the four SFY 14–15 reports that have been completed and submitted to the Dept.
12	Communication documents sent to providers related to data validation results (e.g., policies and procedures, rejection reports).	Copies of explanation of payment (EOP) vouchers for a different claim payment scenarios
13	Internal policies and procedures, studies, and reports for monitoring claim volume, patterns, or trends of claim errors (including the claim anomaly reports already submitted).	Audit report, compliance monitoring, inventory reports
14	Colorado Access' internal claim processing audit methodology and any associated audit results and reports.	Auditing procedures, copies of audit reports, copy of audit processes.
15	Reports submitted to the Department that reflect encounter data submission activities to the Department (e.g., submission statistics).	Monthly COA auto generates CHP SMCN extract data and submits to Optumas. Attached is a screen shot of 3 extract generations in 2015 as well as the Optumas file specifications.
16	Process documentation outlining the approaches used to address issues identified in the Department's anomaly reports including prepared responses.	Anomaly workflow process

Requirement Folder Number	HSAG Requirements	Colorado Access Comments/Responses
17	Claim extract of all professional and institutional SMCN claims processed in the QNXT system and submitted to the Department by Colorado Access during 2015 with dates of service between January 1, 2015, and June 30, 2015.	All extract data was uploaded to HSAG FTP site on Tuesday January 26th. Folder 17 will be empty.
18	Data file layout used by Colorado Access for submitting to the Department the SMCN claims/encounters processed in the QNXT system.	CHP SMCN file specs document
19	Data file layout by which Colorado Access receives and ultimately determines member eligibility.	State's Interface File Guide. The date on this document is 2011 but is still the current process. No updated guide has been provided by the State.
20	An extract of the QNXT provider file for the period of January 1, 2015, through June 30, 2015.	The provider file extract was uploaded to the HSAG FTP site on Tuesday January 26th. Folder 20 will be empty.
21	Results of the special audit report project that Colorado Access indicated it would conduct following the implementation of the QNXT application (as relayed to the HSAG auditors during the 2013–2014 claim processing audit).	Materials used to evaluate the successful implementation of claims adjudication. Audit Manual, monthly reviews, report cards. This process is still in place today.
22	Documentation supporting the QNXT "fix" to address a "General Claim Check Error" that was being generated on claims appropriately auto-adjudicating but being pended for manual review and processing (as relayed to the HSAG auditors during the 2013–2014 claim processing audit).	Business Rules Edits document
23	Copies of the April 2015, May 2015, and June 2015 Current Timely Filing reports.	Claim turnaround time reports attached
24	Documentation demonstrating Colorado Access' data warehouse calculation for Total Billed on any claim and the respective claim lines corrected for reporting purposes (as relayed to the HSAG auditors during the 2013–2014 claim processing audit).	Explanation attached to the folder
25	Documentation verifying when the QNXT system was modified to accurately apply age and gender edits to all claims (as relayed to the HSAG auditors during the 2013–2014 claim processing audit).	Related to the 2013–2014 auditor's belief that the newborn process was being processed incorrectly: documents attached include a write up of the McKesson Claim Check System as well as an email approval from Medicaid to Teresa Craig indicating that our process was correct.

Requirement Folder Number	HSAG Requirements	Colorado Access Comments/Responses
26	Documentation reflecting changes in claim staff member training, monitoring, and the ongoing audit process established to develop claim memoranda.	Example of a monthly quality report between COA and TriZetto, Claims notes desktop
27	Documentation supporting the development and successful implementation of a manual process to identify claims paid incorrectly due to CHP+ enrollment data receipt, updating, and reconciliation processes identified during the 2013–2014 claim processing audit.	Copy of Claims for Ineligible Member (CIM) process, system data pull specs copy

- Claim #1—as the discussion of the 180-day claims began, a new claim was identified to discuss whether it was denied correctly. Colorado Access staff members were able to demonstrate that all the appropriate edits in QNXT fired correctly and that the claim was appropriately denied through the auto-adjudication process based on timely filing. The claim allowed the staff members to further demonstrate the sophistication built into the QNXT system that flagged/pended any claim denied that had an attachment to an examiner review status.

- Claim #2—service end date of January 2015—claim was received on August 3, 2015—place of Service of 22—Line 1 COA paid $508.95 and Line 2 paid at $53.01. Colorado Access indicated this was a claim appeal (Appeal Log XXX48). The Colorado Access Audit Team determined the provider submitted the claim originally to State Medicaid and it was denied. Medicaid received the claim approximately 180 days from the date of service and denied it on day 187. It was logged and handled as a formal provider appeal and paid correctly.

- Claim #3A1—service end date of January 2015—claim was received on August 4, 2015—place of service 11—Claim paid January 19, 2016. Colorado Access showed this claim was adjusted and reprocessed under the CHP+ SMCN group plan. The member's eligibility was retroactively adjusted to cover the date of service (retroactively adjusted backed more than a year). Eligibility was updated on January 8, 2016, for the date span of January 1, 2015, through January 31, 2015. Colorado Access overrode timely filing based on the retroactive eligibility update. If a member called Customer Service with this type of issue, it was forwarded to the Grievance Unit at Colorado Access who worked with the Provider Services unit to address the issue with the provider. The claim was paid correctly.

- Claim #4A1—same member and same dates of service as the claim above. The claim was paid correctly.

- Claim#5A1—service end date of January 2015—claim was received on August 9, 2015—place of service 22—Claim paid on September 30, 2015. Colorado Access demonstrated that this claim was adjusted and reprocessed due to retroactive eligibility adjustments to both CHP HMO and CHP SMCN eligibility files. Colorado Access worked with Colorado Medical Assistance Program (CMAP) (State eligibility unit/system) to resolve the issue. The claim was paid correctly.

- 1Claim #6A1—service end date of January 2015—claim was received August 12, 2015—place of service 11—claim paid on December 16, 2015. Colorado Access showed this claim was an appeal (Appeal Log XXX15). Dispute from the provider was received on October 2, 2015. The State eligibility area was emailed about the issue, and the eligibility record was corrected. The claim was paid correctly.

- Claim #7A1—service end date of January 2015—claim received September 29, 2015—place of service 11—claim paid December 22, 2015. Staff members could demonstrate through QNXT edits and notes that the claim originally denied due to no eligibility (no eligibility takes precedence over timely filing). Eligibility was updated retroactively during the week of December 7 2015–December 11, 2015. Customer Service received an email on the issue on December 12, 2015. The claim was adjusted due to retroactive eligibility and paid.

◆ Claim #8—Colorado Access/TriZetto received a corrected claim that was processed under a different claim number (manually entered claim #8A—which was paid on June 24, 2015). However, the bigger issue is that QNXT initiated a "systematic reversal" on this claim. Colorado Access was unaware of that functionality in QNXT and required additional investigation.

- Paid $162.90 as an SMCN paper claim submission.
- Originally paid as one claim.
- Provider later resubmitted as two claims.
- Both QNXT and the BMS claim examiner reversed the claim.
  - However, only the BMS manual reversal was applied.
  - The QNXT reversal went into a RevSynch status (a type of pend).
  - This resulted in the entire claim being placed in a RevSynch status.
- The provider was ultimately paid correctly and in a timely manner.
- TriZetto BMS (Sue) will revise the corrected claim process for the BMS claim examiners.
  - If the examiner identifies any item on a claim that does not make sense from a claim processing perspective, the examiner will take the claim to the BMS senior claim examiner for review.
  - BMS staff members will closely monitor the RevSynch bucket/file to make certain claims that QNXT drops into this bucket are addressed in a timely manner.
- The claim was ultimately processed and paid correctly.

◆ Claim #9A1—A good example of the eligibility/enrollment challenges that Colorado Access/TriZetto experience with the program. Originally flagged and discussed with Colorado Access because it was missing the original claim lines and HSAG was seeking guidance on whether to classify this claim as a voided claim. While the Department worked closely with Colorado Access to address the long-standing eligibility challenges, they still persist. In this situation, the claim was originally paid as a Colorado Access CHP HMO member. However, Colorado Access later learned the member should have been under CHP+ SMCN on the date of service. Colorado Access walked through how this claim was processed—specifically, all of the reversals and adjustments.

- The member was a premature baby.
- Stayed in a neonatal intensive-care unit (NICU) for over a year—at which time the baby was assigned its own CHP HMO.
  - Note: The process of moving a newborn to a CHP HMO health plan usually takes place within 30 days of delivery. However, that was not feasible due to the condition of the baby.
- The reason there were so many claim reversals and adjustments was because after every 30 days the member was in the hospital, the State's eligibility system would move the baby into coverage with a CHP HMO. These changes would need to be manually changed back each month so that the member could remain under CHP+ SMCN, which impacted claim payments.

- The CIM Report showed coverage for the member/baby repeatedly moving to and from CHP+ SMCN/CHP HMO.
  - The CIM Report is only generated every 10 months.
- Note: Colorado Access Case Management closely managed the case while the member was enrolled in the program.
- The claim was processed and paid correctly.

◆ Claim #10A1—claim was reviewed with the provider data integrity supervisor on March 9, 2016. The paid amount of $485 as a CHP+ SMCN member was to a "nonparticipating" provider. The claim was later reversed and adjusted to pay at the "in-network" level after the provider became a participating provider. This was because the provider's effective date was retroactively backdated to the original date of service, January 5, 2015.

- The provider was originally paid at an out-of-network fee amount, which was later changed to 90 percent of RBRVS when the provider was added to the CHP+ SMCN provider network.
- The claim was handled correctly.

◆ Claim #11A1—Another retroactive eligibility claim issue for which the original claim paid, then denied, then reversed, etc.

- Colorado Access demonstrated how the eligibility and claim transactions were communicated to the provider.
- Originally denied under CHP+ SMCN due to no eligibility based on a date of service of April 13, 2015.
- The claim was received on April 20, 2015.
- The member's eligibility was made retroactive May 20, 2015, which was during the dates of service.
- The claim was adjusted on May 29, 2015, and paid on June 2, 2015.
- Note: Colorado Access' Customer Service unit was contacted by the hospital to alert them that the child was CHP+ SMCN eligible.
- The Colorado Access Audit Team authorized the adjustment.
- The Colorado Access director of eligibility, configuration, and credentialing indicated that approximately 300 similar-type claims were tracked each month.
- The claim was handled and processed correctly.

◆ Claim #12—due to the claim extract record layout requested, this claim appeared to be unusual and warranted further review. The claim was a professional claim form for services performed in the home (speech therapy) that spanned two months with respect to dates of service. HSAG understood the potential for providers to submit Health Care Finance Administration (HCFA) claims for services that extend beyond one month on a claim.

- Due to the time period requested, the first two claim lines on the claim were in 2014 and therefore were not included in the extract.
- The claim was ultimately denied correctly due to a missing NPI for the provider.

- Claim #13 had a service end date of March 2015, and the Julian date indicated the claim number was created on January 19, 2016—$0 were paid. This claim had a paid date of February 9, 2016, in QNXT. It was denied as the member was not eligible. Timely filing of the claim was not reflected in the EOP messages since "no eligibility" takes precedence over "timely filing." The auditor agreed with the response, and the claim was handled correctly.

- Claim #14 had a service end date of June 2015, and the Julian date indicated the claim number was created on January 18, 2016—$142.83 was paid. This claim had a paid date in QNXT of January 26, 2016. The member appealed the claim, and Colorado Access reversed the claim and overrode the timely filing edit to pay the claim due to eligibility issues. The auditor agreed with the decision.

- Claim #15 had a service end date of April 2015, and the claim number reflected a Julian date of January 19, 2016 (the claim was denied correctly for timely filing—TF1). The auditor agreed with the processing of the claim.

- Claim #16 had a service end date of April 2015, and the claim number reflected a Julian date of December 23, 2015 ($0 were paid, but there was no indication of a denial for timely filing). The claim paid in QNXT on February 3, 2016. The claim did deny, but it denied due to eligibility reasons. The member had other primary commercial coverage confirmed. The auditor agreed with the handling of the claim.

- Claim #17 had a service end date of May 2015, and the claim number reflected a Julian date of August 10, 2015 (the claim record reflected a paid amount in QNXT of $125.51, but the claim did not show a paid date). This claim was voided which is why there was no paid date. There is a corrected claim in QNXT for this same service. See claim #17A. This claim was loaded August 24, 2015, and has a paid date of September 1, 2015. The auditor agreed with the response.

Some of the claims did not have a paid date in the record/file even though the Julian date within the claim number reflected a date that fell within the review period. For example:

- Claim #18 had a service end date of April 2015, and the Julian date reflected that the claim received a claim number on June 24, 2015.This claim was voided on June 26, 2015, which is why there was no paid date. There was a corrected claim in QNXT for this same service. See claim #18A. This claim loaded on June 26, 2015, and paid on June 30, 2015. The auditor agreed with the response.

- Claim #19 had a service end date of April 2015, and the Julian date indicated the claim number was created on April 27, 2015—it was showing up as both a void and an AZ1 denial (no PA obtained). This claim was voided. QNXT will not allow a paid or denied claim to be voided. A claim must have a status other than nonfinalized in order for the system to allow a void. The provider sent in a corrected claim, which is why the system voided the original (since it had not yet paid or denied) and created the adjusted (A1) claim. This A1 claim did deny for no prior authorization. The auditor agreed with the response.

◆ Claim #20A1 had a service end date of May 2015, and the Julian date indicated the claim number was created on June 2, 2015—$0 were paid, and the auditor could not find a reference to a void or denial. This claim had a paid date of February 16, 2016. The claim was reversed and then denied due to a retroactive eligibility update. The auditor agreed with the response.

◆ Claim #21A1 had a service end date of June 2015, and the Julian date indicated the claim number was created on June 16, 2015—$0 were paid, and the auditor could not find a reference to a void or denial. This claim had a paid date of February 16, 2016. The member was a newborn, and duplicate member records were discovered. The member records were consolidated, and this claim was reprocessed under the correct member record after the consolidation. The auditor agreed with the response.

◆ Claim #22A1 had a service end date of February 2015, and the Julian date indicated the claim number was created on April 3, 2015—$107.20 was paid, and the auditor could not find a reference to a void or denial. This claim had a paid date of January 26, 2016. The claim was reprocessed due to a retroactive provider update. The auditor agreed with the response.

◆ Claim #23A1 had a service end date of February 2015, and the Julian date indicated the claim number was created on March 31, 2015—$107.20 was paid. This claim had a paid date of January 26, 2016, and had the same provider as claim #23A1, which is why it was also reprocessed due to the retroactive provider update. The auditor agreed with the response.

◆ Claim #24A1 had a service end date of March 2015, and the Julian date indicated the claim number was created on March 11, 2015—$0 were paid. The claim was denied due to D34—could not find the code on the list provided. The auditor questioned whether it was a duplicate claim. This claim had a paid date of January 26, 2016. An appeal was received, and the provider requested that Colorado Access take back the payment as it was submitted to the plan in error. The auditor agreed with the response.

◆ Claim #25A1 had a service end date of March 2015, and the Julian date indicated the claim number was created on March 12, 2015—$96.67 was paid. This claim had a paid date of January 26, 2016. It was reprocessed due to a retroactive eligibility update request. The auditor agreed with the response.