COLORADO
Department of Health Care Policy & Financing

State Managed Care Network Claims Audit Report

June 2018

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

HSAG HEALTH SERVICES ADVISORY GROUP

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General Audit Information

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:	July 1, 2017, through December 31, 2017
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State Managed Care Network Claims Audit Report

Executive Summary

Audit Purpose

The purpose of this audit was to determine to what degree Colorado Access and its delegated entities, Cognizant and Navitus Health Solutions, LLC (Navitus), managed the State Managed Care Network (SMCN) Child Health Plan *Plus* (CHP+) claims processing between July 1, 2017, and December 31, 2017, in accordance with the Department of Health Care Policy and Financing (Department) contract executed on June 27, 2017, and with federal and State requirements related to timeliness and accuracy of claims processing.

Introduction

The audit report is divided into two sections. The first section addresses the review of medical claims processed between July 1, 2017, and December 31, 2017, to determine whether or not Colorado Access and its delegated claims processing vendor, Cognizant, met the contractual performance standards outlined in Section 27.2 of Exhibit C—Program-Specific Statement of Work, the eligibility and claims processing standards detailed in Exhibit D—Performance Standards and Reporting Requirements, and the contractual and regulatory requirements regarding data privacy and security. HSAG auditors reviewed Colorado Access' system of controls and conducted claim analyses to determine whether medical claims were processed timely and accurately. The scope of the medical claims audit included a desk review of enrollment and eligibility and claims policies, procedures, and systems diagrams; analysis of eligibility, provider, and claims data files; on-site interviews; and follow-up discussions via Web conferences.

The second section of this SMCN claims audit report encompasses the review of pharmacy claims processed between July 1, 2017, and December 31, 2017, to assess whether Colorado Access and its delegated pharmacy benefit manager (PBM) vendor, Navitus, met the contractual and regulatory requirements for timely and accurate pharmacy benefit fulfillment and claims processing. HSAG auditors reviewed Colorado Access' system of controls and conducted pharmacy claim analyses to determine whether medical claims were processed timely and accurately. The scope of the pharmacy claims audit included a desk review of enrollment and eligibility and claims policies, procedures, and systems diagrams; analysis of eligibility, formulary, and claims data files; on-site interviews; and follow-up discussions via Web conferences.

Appendix A contains the completed desk review tool and the findings for the standards. Appendices B and C contain the audit-related communications to Colorado Access with instructions related to document and data file submission requirements. Appendix D contains the SMCN claims processing audit on-site agenda. Appendix E contains a detailed description of HSAG's SMCN claims processing audit methodology.

Background and Scope

Child Health Plan *Plus* is Colorado's low-cost health insurance program for uninsured children and pregnant women whose families do not qualify for Medicaid and cannot afford private insurance. 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 (using Colorado Access' provider services department) with healthcare providers to offer CHP+ services during the pre-HMO enrollment period. This network of providers is referred to as the SMCN. Since July 2008, the Department has been contracting with Colorado Access as the Administrative Services Organization (ASO) managing the health plan-related services for SMCN. In June 2017, the Department executed a new contract with Colorado Access to provide administrative services for the CHP+ program from July 1, 2017, through June 30, 2018.

On behalf of the Department, Colorado Access is contracted to fulfill the following responsibilities:

- Management of eligibility and enrollment information
- Behavioral health benefit management provider network contract management, credentialing and recredentialing, provider relations and training
- Management and reporting of grievances and appeals
- Claims administration and payment
- Pharmacy benefit management
- Utilization review
- Member and provider communications
- Customer service
- Encounter data submission
- Quality assessment and performance improvement program implementation

Health Services Advisory Group, Inc. (HSAG), has conducted the SMCN CHP+ claims audit since 2011. Colorado Access has subcontracted with Cognizant (formerly TriZetto Healthcare Administration Solutions) since November 2013 for Cognizant's systems and back-office support. Colorado Access staff use the QNXT platform for managing eligibility and enrollment information, provider maintenance, paper claim entry (manual and optical character resolution), along with claims adjudication and payment. HSAG's 2018 claims audit encompassed a comprehensive review of eligibility; enrollment; claims processing; and claims auditing policies, procedures, systems, and data for Colorado Access, Cognizant, and COA's PBM, Navitus.

In late June 2017, the Department executed a one-year contract (18-101936) with Colorado Access to complete the responsibilities highlighted preceding. This new contract included eligibility and enrollment provisions stating that, upon implementation of the Hewlett Packard Enterprise (HPE) interChange (interChange) system (the Department's Medicaid Management Information System [MMIS]), the 834 transaction files would not provide effective begin and end dates for either eligibility or enrollment as would be provided prior to the transition to the interChange system. HSAG requested, but did not receive, clarification from the Department regarding the date Colorado Access received the

contract that would have informed them about the 834 file limitations. The Department indicated that it would provide advance notification (at least ten business days) before providing a post-implementation system update that would enable passing the actual effective and end dates in the 834 transaction files. Site visit discussions with Colorado Access revealed that the interChange system implementation occurred in March 2017 and that Colorado Access did not receive the 834 files for the CHP+ members from the Department until December 27, 2017.

After the site visit, HSAG requested clarification of Colorado Access processes for maintaining accurate eligibility and enrollment information for the CHP+ members during the time that the 834 transaction files were not available. Initially, Colorado Access addressed issues with eligibility and enrollment information case by case, typically when the member called in with a complaint. Colorado Access stated that in April 2017 the Department was able to provide an enrollment report of all CHP+ members from the Colorado Benefits Management System (CBMS); however, the report did not distinguish which members were assigned to SMCN versus being assigned to the other health plans. Colorado Access took mitigation steps to load all member records identified as prenatal or presumptive eligibility (PE), and the remaining member records had to be manually researched on the State Web portal to verify eligibility. Colorado Access used temporary staffing to assist with member eligibility verification during this time. In August 2017, a report from the business intelligence and data management (BIDM) system was created to identify all CHP+ members and their corresponding health plan assignments, which Colorado Access began using to manage eligibility and enrollment. On December 28, 2017, Colorado Access received its first 834 file and began using that for managing eligibility and enrollment. HSAG's subsequent inquiries suggested that Colorado Access had not performed any reconciliation of enrollment files and special audits regarding any member claims that could have been impacted by the eligibility and enrollment systems issues described preceding.

HSAG's focus for the fiscal year (FY) 2017–2018 audit was on claims processed between July 1, 2017, and December 31, 2017, to align with the contractual period of performance. The audit included a desk review of documentation submitted by Colorado Access; detailed claims analysis of claims processed between July 1, 2017, and December 31, 2017; an on-site review of systems and claims operations with key personnel from Colorado Access, Cognizant, and Navitus; and follow-up communications and Web conferences. HSAG had recently completed Regional Accountable Entity (RAE) readiness reviews for Colorado Access; therefore, HSAG was able to leverage information gathered during the RAE systems testing to learn about Colorado Access' foundational policies, procedures, and systems for managing claims processing. To assess Colorado Access' compliance with the timeliness, quality, and effectiveness standards for the CHP+ medical, behavioral health, and pharmacy claims, HSAG's audit focused on the following areas:

- Policies and procedures from Colorado Access, Cognizant, and Navitus
- Department-mandated accuracy and timeliness requirements
- Eligibility at time of service
- Claims services, adjustments, and final statuses for claims processed during the audit period
- Colorado Access' remediation activities related to the FY 2016–2017 audit findings
- Information security plans and business continuity and disaster recovery plans

Conclusion

Based on the analyses of medical and pharmacy claims for the period of July 2017 to December 2017 as well as on interviews with Colorado Access, Cognizant, and Navitus key personnel, HSAG determined that Colorado Access met the contractual requirements for timely and accurate claims processing. For the FY 2017–2018 desk review component, Colorado Access received a score of 96 percent as one of 12 elements was scored as *Partially Met*. Based upon performance reporting and on-site discussions, the HSAG auditors determined that Colorado Access, Cognizant, and Navitus staff members worked effectively as a team in managing claims volume and resolving any issues. Inherent complexities related to eligibility and enrollment with this member population, most particularly during the period of March 2017 through December 2017, required Colorado Access staff to be diligent in monitoring enrollment transactions and taking appropriate action (e.g., validating enrollment on the Department's system and reprocessing denied claims for retro-enrollment). HSAG identified several opportunities to improve Colorado Access' contractual oversight practices and provide further assurance that claims will be paid accurately and timely.

Desk Review

HSAG requested Colorado Access to submit evidence related to 12 desk review elements developed for the FY 2017–2018 claims audit using the new contract requirements. The desk review elements examine Colorado Access' operations and systems related to enrollment and eligibility, claims processing, and claims payment. Examples of documents requested included:

- Contracts and performance metrics
- Data flow diagrams for eligibility, enrollment, and claims processing
- Lists of system edits for claims processing, claims payment, and claims processing system business rules
- Claims processing policies and procedures and operational reports
- Audit policies and procedures and audit reports for procedural and payment accuracy

Appendix A contains the completed FY 2017–2018 desk review tool. The desk review summary scores are detailed in Table 1.

Appendix B contains the desk review instructions letter sent to Colorado Access. HSAG received the requested materials for the desk review from Colorado Access on January 26, 2018. Appendix C contains the claims data files and supplemental documentation that Colorado Access was required to submit on February 15, 2018. HSAG reviewed this information to validate Colorado Access' and Cognizant's claims processing operations and systems.

HSAG allotted extra time for Colorado Access to create the claims data files for submission because the audit period end date was December 31, 2017. HSAG received the requested data files and supplemental documentation from Colorado Access on February 15, 2018, although additional follow-up was required

to obtain the pharmacy claim data as requested (e.g., paid, denied, pended, adjusted, and voided). The documents received included, but were not limited to, copies of executed written agreements for the delegation of administrative services to Cognizant and Navitus, including performance standards established for claims processing. Refer to Appendix C for additional information about the information submitted by Colorado Access.

HSAG used the desk review materials and supplemental documentation to guide the discussions and interviews with key personnel for the on-site review. The agenda for the on-site review is provided in Appendix D.

Summary of Desk Review Results

Based on conclusions drawn from the review activities, HSAG assigned each applicable requirement in the desk review tool a score of *Met*, *Partially Met*, or *Not Met.* For any requirement within the desk review tool receiving a score of *Partially Met* or *Not Met*, HSAG assigned required action(s).

Table 1 presents the scores for Colorado Access for each standard. Details of the findings for each requirement receiving a score of *Met*, *Partially Met* or *Not Met* follow in Appendix A—Desk Review Tool.

Table 1—Summary of SMCN Scores for the Standards

Standard	# of Elements	# of Elements Scored *Met*	# of Elements Scored *Partially Met*	# of Elements Scored *Not Met*	Total Percentage Score
Standard I—Eligibility and Enrollment Systems	3	3	0	0	100%
Standard II—Claims Processing Operations and Systems	5	4	1	0	90%
Standard III—Claims Operations, Infrastructure, and Reporting	4	4	0	0	100%
Totals	**12**	**11**	**1**	**0**	**96%***

* *Met* elements are assigned 1 point each, *Partially Met* elements are assigned 0.5 points each, and *Not Met* elements are assigned zero points each. The overall score is calculated by adding the total score and dividing by the total number of elements.

Following are key claims audit findings grouped into two major categories: medical claims and pharmacy claims.

Medical Claims Audit Findings

Claims Processing Performance Standards: Colorado Access provided information on Cognizant's contractual obligations regarding the business services warranty and service levels and performance outcomes for the audit period. HSAG also reviewed the Department's contract with Colorado Access related to Exhibit D—Performance Standards and Reporting Requirements, to verify the minimum performance standard requirements. The key service metrics required by the Department in Exhibit D and/or reported by Cognizant to Colorado Access in the report, *Colorado Access BMS Report Card*, are:

- **Claims Processing Turnaround—**Of clean claims, 90 percent or more will be finalized within 14 calendar days and 98 percent or more will be finalized and sent for payment within 30 calendar days of receipt by Cognizant; 99 percent or more of all claims will be finalized and sent for payment within 60 calendar days of receipt by Cognizant.

  Table 2 presents the results reported in the *Colorado Access BMS Report Card* for Cognizant for the review period of July 2017 through December 2017. The *Colorado Access BMS Report Card* displays results suggesting that Cognizant met the requirements for all claims finalized and sent for payment within 14, 30, and 60 calendar days.

Table 2—Cognizant Claims Processing Turnaround

Performance Standard	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017
≥90% Finalized Within 14 Days	98.86%	97.88%	98.60%	99.53%	98.83%	99.51%
≥98% Finalized Within 30 Days	100%	100%	99.82%	100%	100%	100%
≥99% Finalized Within 60 Days	100%	100%	99.82%	100%	100%	100%

However, for external validation, HSAG auditors performed calculations for the claims processing turnaround times and reported some variations in outcomes. Additional discussions with Colorado Access revealed some key differences in calculation logic. HSAG agrees with Cognizant reporting logic that excludes adjusted claims and identifies the reporting month based upon paid date. Modifications to HSAG's reporting logic will be incorporated in future claims audits. Table 3 displays HSAG's results which illustrate the minor discrepancies due to reporting logic. These minor variances were not a concern for the objectives of this claims audit.

Table 3—HSAG Claims Processing Turnaround

Performance Standard	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017
≥90% Finalized Within 14 Days	89.95%	87.92%	97.71%	91.56%	90.85%	97.59%
≥98% Finalized Within 30 Days	99.75%	99.18%	99.78%	99.77%	99.54%	98.93%
≥99% Finalized Within 60 Days	100%	100%	100%	100%	100%	99.51%

- **Financial Claims Processing Accuracy**—The Department's contract with Colorado Access states that at least 99 percent of claims will exhibit financial accuracy. "Claims financial accuracy" is defined by the Department as total dollars that should have been paid, less the sum of the absolute value of dollars overpaid, plus dollars underpaid, divided by the total claims dollars which should have been paid correctly of audited claims. Financially *accurate* as defined by Cognizant means that the amount paid is correct according to the company's rules.

  Cognizant reports financial processing accuracy monthly as a percentage. The numerator is the number of financially accurate finalized claims processed during the month. The denominator is the total number of finalized claims processed during the month. Claims submitted for adjustments and claims that require a change in configuration to pay accurately will not be included in this calculation until such adjustment or change is made. Claims paid inaccurately because the then current configuration was inaccurate will be treated as accurate for the purposes of this service level. The report is calculated based upon the number of financial errors and the number of samples audited.

  The *Colorado Access BMS Report Card* for July 2017 through December 2017 confirmed that Cognizant met the financial claims processing accuracy requirement all months as noted in Table 4. HSAG reviewed Cognizant's *COA Claims Business Rules Manual* (updated September 2017), the *Colorado Access Audit Guide* (2017), and a series of Cognizant's claims audit files and concluded that the financial claims processing accuracy reporting was consistent with Cognizant's methodology. HSAG recommends, however, that Colorado Access re-evaluate Cognizant's caveat that *"claims that were paid inaccurately because the then current configuration was inaccurate will be treated as accurate for the purposes of this service level"* because the approved methodology does not account for claims payment systems configuration issues that would cause inaccurate financial claims outcomes. Inaccurate financial claims processing should be identified and reported irrespective of cause.

Table 4—Cognizant Financial Claims Processing Accuracy

Performance Standard	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017
≥99% Financial Accuracy	100%	100%	100%	100%	100%	100%

- **Claims Processing Procedural Accuracy—**The Department's contract with Colorado Access references this performance metric as claims transaction accuracy and defines it as the total number of audited claims processed, less the total number of audited claims processed with errors, divided by the total number of claims audited. Errors include nonmonetary errors such as spelling and coding errors as well as monetary errors and apply to clean and non-clean claims. Per Exhibit D of this contract, at least 96 percent of claims should be finalized accurately. Per Colorado Access' contract with Cognizant, at least 98 percent of claims will be finalized accurately. *Finalized accurately* is defined by Cognizant as "if the processing is correct according to the Procedure." Cognizant reports claims processing procedural accuracy monthly as a percentage. The numerator is the number of procedurally accurate finalized claims processed during the month. The denominator is the total number of finalized claims processed during the month. Claims submitted for adjustments and claims that require a change in configuration to pay accurately will not be included in this calculation until such adjustments or changes are made. Claims paid inaccurately because the then current configuration was inaccurate will be treated as accurate for purposes of this service level. The report is calculated based upon the number of processing errors and the number of samples audited.

  The *Colorado Access BMS Report Card* for July 2017 through December 2017 confirmed that Cognizant met the claims processing procedural accuracy requirement all six months as noted in Table 5. HSAG reviewed Cognizant's *COA Claims Business Rules Manual* (updated September 2017) and the *Colorado Access Audit Guide* (2017), Cognizant's claims audit files as well as joint meeting notes for Colorado Access and Cognizant and concluded that the claims processing procedural accuracy reporting was consistent with Cognizant's methodology. HSAG recommends, however, that Colorado Access re-evaluate Cognizant's caveat that *"Claims that were paid inaccurately because the then current configuration was inaccurate will be treated as accurate for purposes of this service level"* because the approved methodology does not account for claims procedural systems configuration issues that would cause inaccurate claims processing outcomes. Inaccurate claims processing procedures should be identified and reported irrespective of cause.

Table 5—Cognizant Claims Processing Procedural Accuracy

Performance Standard	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017
≥98% Procedural Accuracy	100%	100%	100%	100%	100%	100%

- **Claims Adjustment Turnaround—**At least 99 percent of clean claims adjustments will be finalized within 60 calendar days of the claims' receipt by Cognizant. This minimum performance standard is not part of Exhibit D of the Department's contract with Colorado Access.

  The *Colorado Access BMS Report Card* for July 2017 through December 2017 confirmed that Cognizant met the claims adjustment turnaround requirement all months as noted in Table 6. HSAG reviewed Cognizant's *Colorado Access Audit Guide* (2017) as well as Colorado Access' claims adjustment policies and procedures and adjusted claims data and determined that the claims adjustment turnaround time frames reported were accurate.

Table 6—Cognizant Claims Adjustment Turnaround

Performance Standard	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017
≥99% Finalized Within 60 Days	100%	100%	100%	100%	100%	100%

- **Paper Claims Entry Into the System—**At least 99 percent of clean paper claims submitted to Cognizant will be entered in the system within five business days of receipt of the claim by Cognizant. Entry of claims includes scanning of hard copy claims properly provided to Cognizant and data entry corrections to those scanned claims. This minimum performance standard is not part of Exhibit D of the Department's contract with Colorado Access.

  The *Colorado Access BMS Report Card* for July 2017 through December 2017 confirmed that Cognizant met the paper claim entry turnaround requirement all months as noted in Table 7. HSAG reviewed Cognizant's *Colorado Access Audit Guide* (2017); Colorado Access' policy titled *BPO Audit DLP*, that included steps for auditing paper claims processing; and paper and scanned claims data and determined that the paper claims entry turnaround time frames reported were accurate. HSAG noted that the *BPO Audit DLP* document defines the turnaround time as three to seven days, instead of the five day turnaround time reporting metric below. Additionally, the *BPO Audit DLP* document does not include basic information that effectuates the policy or process. HSAG recommends that Colorado Access align turnaround time expectations and add a title, policy number, and effective date for this document to ensure its validity.

Table 7—Cognizant Paper Claims Entry Into the System

Performance Standard	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017
≥99% Entered Within 5 Days	100%	100%	100%	100%	100%	100%

- **Configuration Turnaround Time—**The 2016 audit information defined the following regarding configuration turnaround times. For each business rule configuration (BRC) request ticket that is not a BRC incident, Cognizant will meet the estimated time to complete (ETC) at least 98 percent of the time, excluding time waiting for company or time waiting on software or system updates required to finalize the configuration. This minimum performance standard is not part of Exhibit D of the Department's contract with Colorado Access.

  The *Colorado Access BMS Report Card* for July 2017 through December 2017 confirmed that Cognizant met the configuration turnaround requirement all months, as noted in Table 8.

Table 8—Cognizant Configuration Turnaround Time

Performance Standard	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017
≥98% Configuration Requests Meet ETC	100%	100%	100%	100%	100%	100%

- **Configuration Accuracy—**The 2016 audit information defined the following regarding configuration accuracy. At least 98 percent of provider and benefit maintenance transactions completed by Cognizant will be accurate. Configuration accuracy is defined as "if it correctly reflects the information in the form submitted to Cognizant." This minimum performance standard is not part of Exhibit D of the Department's contract with Colorado Access. The *Colorado Access BMS Report Card* for July 2017 through December 2017 confirmed that Cognizant met the configuration accuracy requirement all months, as noted in Table 9.

Table 9—Cognizant Configuration Accuracy

Performance Standard	July 2017*	August 2017	September 2017	October 2017	November 2017	December 2017
≥98% Configuration Accuracy	-	100%	100%	100%	100%	100%

*Note: No transactions occurred in July.

Claims Processing Operations and Monitoring Controls

The claims processing operations documentation submitted for the desk review remained largely unchanged from the FY 2016–2017 audit. The operational claims processing policies and procedures align with industry best practices and contractual requirements. The on-site audit objectives included interviews to ensure that Colorado Access staff followed the claims processing policies and procedures. The one day on-site claims audit occurred on April 20, 2018. In March 2018, HSAG completed the RAE readiness reviews that included a review of Colorado Access' foundational policies, procedures, and systems for managing claims processing. With this background information established, HSAG was able to condense the on-site claims audit agenda to one day.

The on-site discussions concluded that claims processes and monitoring controls activities were consistent with policies and procedures. Colorado Access confirmed that for 2017, their claims staff members reviewed 100 percent of claims requiring payments of over $10,000 before the claims are paid. The Colorado Access reviewers documented these reviews in both the QNXT claims system and the auditor reports. Additionally, during the on-site review, Colorado Access discussed the 3M licensed Core Grouping Software (CGS) tool, purchased recently to improve claims processing efficacy, resulting in cleaner data.

On March 1, 2017, the Department launched a new claims payment system, interChange, to replace their legacy MMIS. In conjunction with the Department's implementation of the interChange system in March 2017, the Department also implemented a revised the payment methodology for reimbursing hospitals for outpatient services. The Enhanced Ambulatory Patient Groupings (EAPG) methodology was operationalized by the Department on October 31, 2017. The Department selected a 3M licensed CGS tool to classify and process outpatient hospital services (bill type 013X) by incorporating the pre-defined weight tables and hospital-specific base rates.

The Department did not require managed care organizations to use the same EAPG software or payment methodology; however, Colorado Access indicated the Department required Colorado Access to implement EAPG software for the SMCN outpatient hospital reimbursement methodology. Colorado Access purchased the same 3M CGS tool to replace previous Medicaid cost-to-charge ratio hospital outpatient service methodology. At time of purchase, the tool was configured with the Department's weights and Medicaid pricing logic, including what is packaged or bundled, discounted, and separately payable. On October 1, 2017, Colorado Access operationalized the new software. The outpatient hospital service contracts were not integrated in QNXT, the Colorado Access claims adjudication system. Steps were taken to configure QNXT to pend bill type 013X claims with a custom edit (6500) which indicates that EAPG pricing is necessary.

Nightly, claims with edit 6500 are exported to the 3M CGS tool for pricing. Cognizant, host of the 3M CGS pricing tool, created a custom process that batches these claims. Once the tool completes pricing the batch, the original edit is removed and edit 6501 is added, indicating that the claim went through the EAPG tool; then the batched claims are directed back to QNXT. Once back in QNXT, the claims run through the standard re-pricing edits. As described previously, the EAPG pricing is an activity separate from the actual adjudication. Colorado Access explained that processing EAPG claims is primarily automated and requires no action by a claims processor.

Colorado Access also incorporated two additional custom edits, 6502 and 6503, to pend EAPG claims. These two "warn" edits resulted in requiring examiner review for five specific scenarios. Once the necessary action was taken by a Colorado Access examiner, the EAPG claim exported in the nightly batch for pricing through the 3M CGS tool as explained previously.

Colorado Access and Cognizant conducted interdepartmental meetings each month for a year prior to implementation of the EAPG payment methodology. From the time that go-live occurred, Cognizant has generated daily reports for Colorado Access to review, track, and trend pricing detail edit and error reports. In addition, EAPG claims are incorporated into the standard "audit the auditor" process. Based

on identified reporting and audit trends, the Colorado Access claims processing team created trainings and/or provider education as needed. Colorado Access' decision to implement the same software has afforded leverage of the same provider education and lessons learned as experienced by the Department.

In addition to the specialized claims interventions regarding EAPG, the on-site claims analysis included a discussion on Colorado Access' processes for reviewing pended and denied claims. Claims denied for eligibility, prior authorization (PA), or provider validation requirements were also pended for manual review prior to being finalized. Given the new requirement for providers to register with the Department and the unique circumstances with the enrollment and eligibility files, these review activities helped to mitigate the downstream impact to claims payment after implementation of the Department's new requirements and systems in 2017.

42 Code of Federal Regulations (CFR) §438.608 required states to implement contractual mechanisms beginning in July 2017 to ensure that managed care organizations implement and maintain arrangements or procedures designed to detect and prevent fraud, waste, and abuse. Colorado Access' Fraud, Waste, and Abuse (FWA) policy—effectuated on March 1, 2017—addresses the federal requirements for FWA training, reporting, non-retaliation, investigation, notification to the Department, and enforcement which meets those federal requirements. HSAG's on-site discussions confirmed that Colorado Access' compliance department oversees audit activities focused on detecting and preventing fraud, waste, and abuse.

Overall, based on the desk review documentation and on-site discussions, Colorado Access demonstrated that the Cognizant BMS team and Colorado Access' claims operations staff ensured that claims monitoring and audit activities identify and resolve procedural and system-related issues as they occur.

Enrollment Processing and Reconciliation Systems

The 2016 audit findings confirmed that Colorado Access performed ongoing oversight and worked closely with the Department to resolve eligibility and enrollment discrepancies. The processes in place are generally appropriate for managing day-to-day eligibility and enrollment discrepancies. For the 2017 audit, the Department's MMIS interChange system implementation in March resulted in the 834 files for CHP+ members not being available until December 27, 2017. Beginning March 1, 2017, Colorado Access addressed issues with eligibility and enrollment information case by case. By April 2017, the Department provided an enrollment report of all CHP+ members from the CBMS. The CBMS report did not distinguish which members were assigned to the SMCN network versus being assigned to other health plans; therefore, Colorado Access decided to load all member records identified as prenatal or PE, and member records were manually researched on the State Web portal to verify eligibility. In August 2017, Colorado Access began using the BIDM report that identified the SMCN network CHP+ members to manage eligibility and enrollment in its systems. On December 28, 2017, Colorado Access received the initial 834 files for managing eligibility and enrollment. Other than reconciliation activities performed for actuarial purposes, Colorado Access indicated that no reconciliation of enrollment files or special audits for member claims with dates of service had occurred during the time of enrollment;

therefore, eligibility information was inherently more cumbersome to manage timely and accurately (due to the manual interventions required).

Technical Infrastructure and Standards

The desk review and information from the RAE readiness reviews conducted in March 2018 confirmed that Colorado Access and Cognizant have the appropriate technical infrastructure, policies and procedures, training, and business associate agreements (BAAs) to meet the Department's and federal regulations for data privacy and security.

During the on-site audit, Colorado Access indicated having not completed the combined business continuity and disaster recovery (BCDR) testing with Cognizant, although testing was reported to have been planned to occur in the near future. HSAG contacted Colorado Access on May 18, 2018, to inquire about the status of the combined BCDR testing. At the time of the *2018 State Managed Care Network Claims Audit Report*, HSAG was unable to ascertain whether Colorado Access and Cognizant have been testing the BCDR plans to ensure that Colorado Access and Cognizant will be able to continue claims processing operations in the event of unplanned systems down time.

Analyses of QNXT Claims Extracts

HSAG received an updated file titled Medical_Standard_Claims_Extract_CHPSMCN in April 2018. The claims extract included all SMCN claims processed in the QNXT claims system from July 1, 2017, through December 31, 2017. Supplementing this information, member eligibility and provider data files for the same review period were received concurrently with the extracts. Analyses focused on the following areas:

- Evaluation of whether claims were paid or denied appropriately following timely filing requirements.
- Validation that claims were adjudicated in accordance with Colorado Access' claims processing policies and standards.
- Evaluation of claims processed, ensuring appropriate eligibility coverage under the CHP+/SMCN program.

HSAG's preliminary review of claim files revealed that 20,846 unique claims and 54,217 claim lines were processed. Of the 20,846 unique claims, 79 percent (16,551) were paid either through an auto-adjudication process or using the "pend" functionality in QNXT—to be handled manually by a Cognizant BMS claims examiner. Approximately 16 percent (3,324) of unique claims processed were denied, with the remaining 5 percent (970) of claims reported with a warn status, as noted in Table 10.

During the on-site review on April 20, 2018, HSAG reviewers inquired about the increase in final claims with "warn" statuses. Colorado Access indicated that the increase in claims with "warn" statuses appeared unattributable to any specific reason and that a "warn" status typically would not be the final disposition on a claim. Upon further analysis after the on-site audit, HSAG noted that of the 3,414 claim lines with "warn" statuses, 3,299 reflected a bill type of 131 (Hospital-Outpatient-Admit-Discharge). This bill type is associated with the Department's requirements around EAPG beginning on March 1,

2018. Colorado Access indicated that the increase in warn statuses was because the claims system is set to flag all outpatient hospital claims to identify that the claim went through EAPG pricing. This process helps ensure that Colorado Access is meeting the Department's requirement to utilize EAPG pricing.

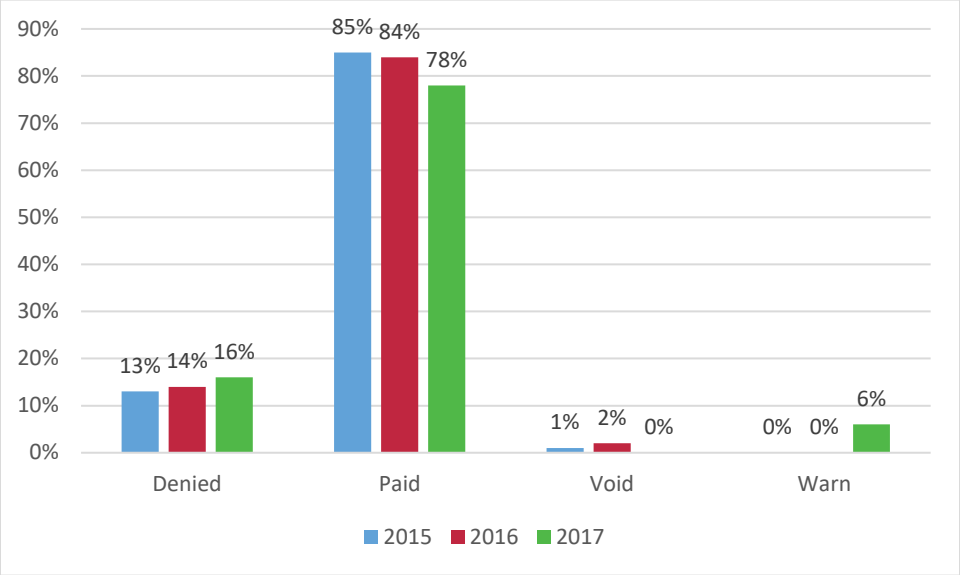
Table 10—2017 Claim Counts by Month and by Claim Status

Status	July 2017 through December 2017 [A]	Percentage
Unique Claims		
Denied	3,324	16%
Paid	16,551	79%
Void	1	0%
Warn	970	5%
Total	**20,846**	**100%**
Total Claim Lines		
Denied	8,446	16%
Paid	42,322	78%
Void	35	0%
Warn	3,414	6%
Total	**54,217**	**100%**

[A] Claim counts will not equal the sum of individual months because a claim may be present in one or more monthly file(s) but counted only once in the aggregate, six-month count.

Audits conducted in earlier years analyzed medical claims for January through June. The claims analysis for this audit was changed to align with new contract dates of June through December; therefore, interpretation regarding the final claims status trends should not be performed. However, the final claims status percentages are illustrated following in Figure 1.

Figure 1—Final Claim Status Percentages for Unique Claims



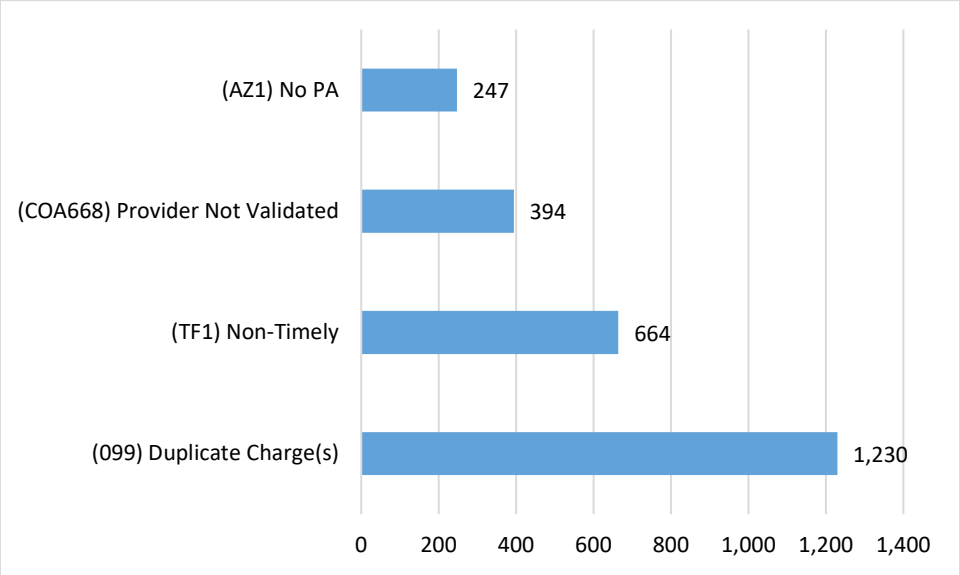
Objectives of the claims analyses included examination of key indicators previously reviewed during the FY 2015–2016 audit, along with comprehensive review of top reasons for claims denials.

Analysis of Denied Claims. When a claim or service within a claim is denied, the provider is sent a remittance advice letter including the applicable denial reason. Providers may appeal claim denials in accordance with the federal managed Medicaid regulations. Table 11 and Figure 2 provide counts of highest frequency denials by reason code for claims processed July 2017 through December 2017.

Table 11—Denied Claims Listed by Denial Reason

Payment Denial Explanation Code	Denial Code Description	Count of Denials[1]
099	Duplicate charge(s) previously processed.	1,230
TF1	Claim not filed within timely filing guidelines.	664
COA668	Payment denied. Provider not validated with State of Colorado.	394
AZ1	Service denied. No prior authorization obtained.	247

Figure 2—Frequency of Denied Claims by Denial Reason



[1] Denial count methodologies differentiated between denials denied at a claims level (e.g., TF1, OR1) and denials wherein only one claim line within the claim was denied (e.g., QI1, QW1).

HSAG performed a high-level review of claims denied for all denial reasons along with a targeted review related to the following denial reasons:

099: Duplicate charge(s), previously processed—1,230 unique claims denied.

Duplicate charge denials were examined by claim format (electronic versus scanned), place of service, and date of service, then grouped by provider name and provider type to identify potential trends with this type of denial. Some key observations noted:

- Eighty-six percent (1,062 duplicate claims) were electronic submissions.
- The top five providers with highest frequency of claims submitted 212 duplicate claims (17 percent of the total 1,230 claims denied).
- Forty-one percent of claims (507) were submitted by providers rendering care in offices (POS 11); 30 percent (364 duplicate claims) were for services provided at inpatient hospital facilities (POS 21); and 16 percent (197 duplicate claims) were submitted for services rendered at on-campus outpatient hospital facilities (POS 22).
- Of the 1,230 duplicate claims for the top five providers, 53 percent (112 claims) were submitted by contracted hospitals.
- Of the 542 providers that submitted duplicate charges, 62 percent (334 providers) submitted only one duplicate claim during the review period.

TF1: Claim not filed within timely filing guidelines—664 unique claims denied.

- Colorado Access is required to accept original claims submissions up to 180 calendar days after services are rendered or eligibility is loaded, whichever occurs last. Colorado Access is further required to accept a provider claim appeal within 90 days after processing the claim.
- Colorado Access has a process for contacting the Department to receive special approval to override timely filing. As a result of the eligibility and enrollment file workarounds and information corrections after the interChange implementation, some instances existed wherein Colorado Access necessarily overrode the timely filing requirements.

COA668: Payment Denied. Provider not validated with State of Colorado—394 unique claims denied.

All Colorado Medicaid providers were required to complete the enrollment or revalidation process prior to the implementation of the interChange system (the Department's MMIS) on March, 1, 2017. Colorado Access was not authorized to pay claims until enrollment or revalidation was complete:

- The Department's provider enrollment and revalidation requirements resulted in the 394 claims denied for providers that did not register by the implementation date.
- Thirty-seven percent of claims (145) were submitted by Metro Community Provider Network. All were submitted with bill type 771, to indicate services rendered by a Federally Qualified Health Center (FQHC) provider.

- Review of the Colorado Access website confirmed that providers were informed about this change and of the consequences for not completing the enrollment or revalidation process with the Department. In addition, Colorado Access' provider relations department identified high-volume providers and worked with them closely to complete providers' revalidations timely.
- During the on-site review, Colorado Access described the following actions related to provider revalidation after the March 1, 2017, effective date:
  - Upon completing the revalidation process, a provider may submit a back-dated form to the Department for consideration.
  - Due to the revalidation process taking up to 30 days, a provider could contact the Department to request that the process be expedited.
  - Upon confirmation of a revalidated provider, Colorado Access loaded the provider data in QNXT with the effective date designated by the Department. Colorado Access proactively generated reports to identify claims with the COA668 denial code and reprocessed them via batching from the provider's effective date.

AZ1: Service denied. No PA obtained—247 unique claims denied.

To conduct analysis of claims denied for no prior authorization, HSAG compared the service codes in these denied claims with the list of services requiring PA and available on the Colorado Access website at: http://www.coaccess.com/documents/MasterAuthorizationList.pdf. These claims were also examined by claim form type, place of service, type of service, and provider to identify potential trends with this type of denial. Some key observations noted:

- When 151 denied claims (61 percent) were compared to the service codes identified in the master authorization list from Colorado Access, 28 claims (19 percent) were denied due to being for services that required PA.
- A review of the claims denied by form type illustrated that 78 percent were submitted on HCFA 1500 (professional) claim forms while 22 percent were submitted on UB-04 (institutional) claim forms.
- A review of the claims denied related to place of service (POS) illustrated that 158 claims (64 percent) were for services rendered in offices (POS 11).
- While the claims data file had no clear mechanism to identify a provider's contract status, a separate file containing both in- and out-of-network providers and provided by Colorado Access was cross-walked to identify the providers' statuses. Of the top five providers with the highest frequencies of AZ1 denials, 40 claims (74 percent) were submitted by providers who were in network.
- Of the top five providers with the highest frequency, only one of the four contracted providers, Solace Healthcare, Inc., required a prior authorization for home health speech-language pathology (0441 Revenue Code).
- The sampling of the denied claims illustrated that 99213, the Evaluation and Management CPT code, totaled 80 claims (32 percent). Of the 80 claims denied, 29 (36 percent) were from two providers. Both providers were certified nurse midwives (CNMs) rendering care with Metro Community Provider Network. One CNM rendered care for dates of service prior to her February 22, 2018,

effective date; the other CNM was a contracted (par) provider between January 1, 2012, and January 9, 2018, during which time services were rendered to Colorado Access members.

Review of Claims With Coordination of Benefits Payments

The claims analysis involved a review of processed claims that included coordination of benefit (COB) payments to ensure that any SMCN network payments did not exceed the allowed amount minus any COB payment. No claims were identified as having been paid incorrectly. In fact, in most cases the Medicaid allowed amount was less than the COB payment; therefore, no payment was made. No concerns were identified from this analysis.

Evaluation of Claims Paid for Dates of Services Outside of Eligibility Dates

The claims analysis included a review of claims that appeared to have been paid for members with dates of service that occurred when the member was reportedly not enrolled. Meeting this criterion were 58 unique claims. This was a relatively low number; therefore, HSAG did not ask Colorado Access to research these claims to validate eligibility or enrollment at time of service.

HSAG examined the paid claims by service month to determine if any significant increases occurred during months in which the 834 files were unavailable. Following are the counts of claims paid with dates of service outside the member's eligibility dates: March (1), April (0), May (3), June (9), July (12), August (14), September (12), and October (7). This analysis was based upon the eligibility and enrollment information that HSAG received. If Colorado Access were to perform a complete reconciliation of SMCN network member data for the time during which the 834 file was unavailable, the number of claims paid for services provided to ineligible members might be different. The Department should determine whether or not a comprehensive reconciliation and review of paid claims from March 2017 through December 2017 would be beneficial.

Evaluation of Claims Paid 180 Days or More After Claim Received Date

The claims analysis included a review of claims paid outside the 180-day submission requirement. Colorado Access works with the Department to pay a claim when circumstances warrant making an exception. These paid claims were examined for outliers; while some claims dated back to 2015 and 2016, most were related to claims adjustments. The common trends in these 286 unique claims follow.

- Thirty-two of the 286 unique claims were not related to claims adjustments.
- Twenty-seven of the 32 unique claims were less than thirty days past the filing deadline.
- Of the 155 inpatient unique claims (non-adjusted and adjusted), 100 had dates of service in 2017 and 55 had dates of service in 2016.
- Of the 131 professional unique claims (non-adjusted and adjusted), nine had dates of service from 2015, 39 had dates of service from 2016, and 83 had dates of service from 2017.

No concerns were identified from this analysis.

Pharmacy Claims Audit Findings

HSAG received the initial pharmacy claims data file on February 15, 2018. Upon preliminary review of the information, HSAG determined that the rejected pharmacy claims were not included in the file. HSAG requested a second pharmacy claims file that included the rejected claims. This second pharmacy claims submission, received on March 19, 2018, included claims with a rejected status; however, the second claims submission did not include information that HSAG could use to analyze the trends in pharmacy claims denials. The third pharmacy claims submission file, received on April 4, 2018, was deemed sufficient to complete the analyses of pharmacy claims.

This SMCN claims audit report for 2018 examined pharmacy claims processed between July 1, 2017, and December 31, 2017. Due to the nature of pharmacy claims being processed at point of sale, HSAG excluded pharmacy claims with a void or reversal status in the analysis.

The analyses focused on all of the following areas:

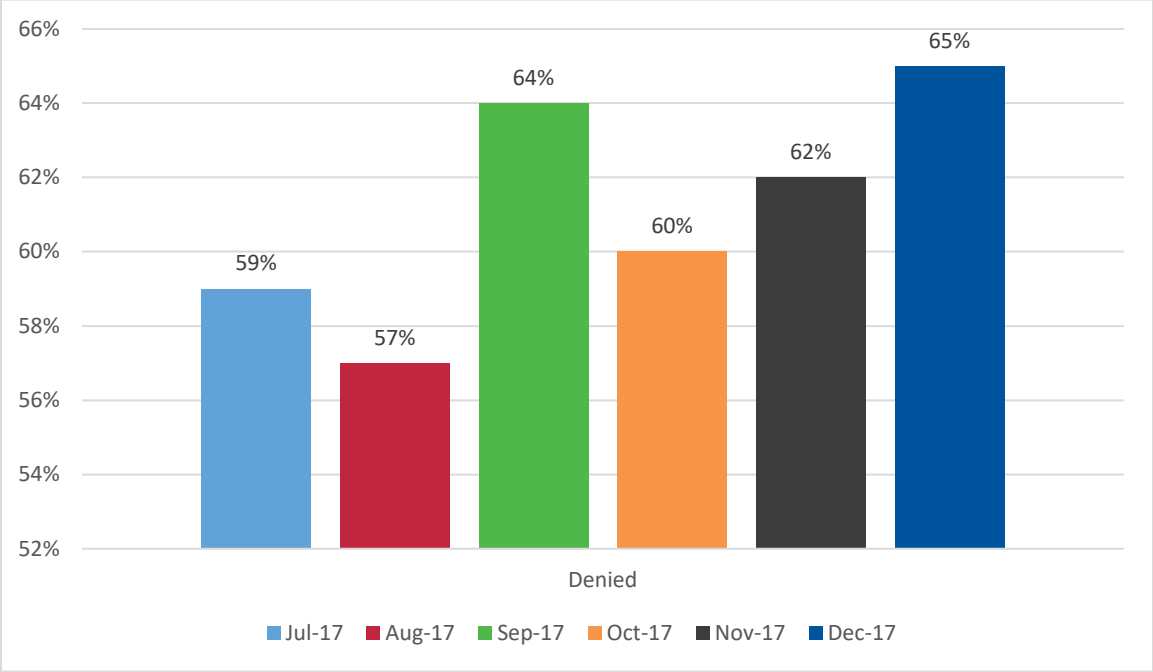
- Evaluation of the trends in pharmacy claims paid and rejected each month.
- Evaluation of pharmacy claims rejections.
- Examination of pharmacy claims with rejection status of "Patient is Not Covered." However, the enrollment and eligibility files that HSAG received indicated that these members were eligible at the time of the pharmacy claim date.

HSAG's preliminary review of claim files revealed 10,569 unique pharmacy claim records: 4,074 paid and 6,495 denied. Voided and reversed pharmacy claims were excluded from this scope of analysis given the commonality with point-of-sale pharmacy transactions. With the exclusion of the voided and reversed claims, the total paid and rejected claims were calculated for each month as shown in Table 12 following.

Table 12—Pharmacy Claims Processed July 2017 Through December 2017

Pharmacy Claims Volume	July 2017	August 2017	September 2017	October 2017	November 2017	December 2017	Total
Paid	460	746	616	758	771	723	**4,074**
Denied	674	1,008	1,083	1,121	1,277	1,332	**6,495**
Total	1,134	1,754	1,699	1,879	2,048	2,055	**10,569**

Figure 3—Trends in Denied Claims July 2017 Through December 2017



In reviewing the trends in denied pharmacy claims by month, pharmacy claim denials ranged from 57 percent to 65 percent. An analysis of pharmacy claims data was not performed in prior claims audits; therefore, HSAG was unable to determine whether the lack of the 834 enrollment and eligibility files during this audit time frame impacted the frequency of pharmacy denials each month. The top five denial reasons for pharmacy claims are listed in Table 13.

Table 13—Top Five Pharmacy Denial Reasons

Denial Code Description	Count of Denials	Percentage of Denials
Person not covered	3,974	61%
Product/service not a covered benefit	1,279	20%
Days' supply exceeds maximum allowable	475	7%
Refill too soon	264	4%
Missing/invalid—dispense as written	150	2%

HSAG's analysis indicated that 61 percent of pharmacy claim denials occurred because the member was not eligible at the time of service. Enrollment and eligibility file issues existed in 2017; therefore, HSAG, using the enrollment and eligibility files on file, conducted an analysis of these 3,974 denied claims. On April 26, 2018, a list of 2,523 claims denied were sent to Colorado Access for more information. Colorado Access collaborated with Navitus, the PBM, to de-duplicate claims denied for

members not being eligible to perform a detailed review of each claim. Navitus' research determined that many of these members did receive their medications, although that occurred under different programs or payors. In other instances, it was confirmed that members were not eligible at the time of service.

On-site discussions included a review of the subcontractor agreement between Colorado Access and Navitus (effective June 15, 2017), the Navitus business continuity and disaster recovery plan, and PBM policies and procedures. Additionally, Navitus shared copies of the performance dashboard reports available to Colorado Access. Regular review of these dashboard reports helps to ensure that Colorado Access maintains proper oversight of this delegated subcontractor performance.

The on-site discussions included the processes for supporting member access to prescription medications when eligibility and enrollment discrepancies occur. After the on-site meeting, HSAG reviewed the Navitus contract in detail to ascertain the off-hours availability of Navitus customer service staff to address prescription requests for members with discrepancies in eligibility and enrollment information. While Section 2.05 of the contract indicates that "Navitus maintains call centers accessible through a toll-free telephone line, responsible for responding to inquiries from participating pharmacies, other providers, and eligible persons regarding the services provided by Navitus," the contract states that the toll-free help line is available to Colorado Access, all participating pharmacies, and providers from 8 a.m. to 5 p.m. Mountain Standard Time. The contract also states that the Navitus customer service will be available twenty-four hours a day, seven days a week. Furthermore, Navitus states reserving the right to change such hours of operation and that Navitus shall notify Colorado Access and the participating pharmacies 72 hours prior to any changes. The on-site discussions regarding this suggested that Colorado Access and Navitus understanding of the PBM off-hours coverage for eligibility questions were not aligned. Colorado Access has subsequently clarified that the pharmacies are authorized to provide a 3-day emergency fill when the member has an emergent need for the medication and the member's eligibility status requires research.

Based on the on-site discussions and this review of the contract between Colorado Access and Navitus, enhancing the contractual requirements regarding off-hours customer service support would help to ensure members' timely access to covered prescription medicines.

This initial round of pharmacy claims analysis was limited to establish a baseline evaluation of contractual performance. In future claim audits, HSAG suggests exploring with the Department whether or not additional analysis of the formulary, provider prescribing patterns, and member utilization would provide additional insights into the timeliness and accuracy of pharmacy claims processing.

Colorado Access Follow-Up Regarding 2017 Audit Recommendations

The following information provides an overview of the status of Colorado Access efforts to address the recommendations from the 2016–2017 claims audit recommendations.

- **Recommendation 1:** The scope of audit services provided by HSAG would benefit from analysis beyond the current scope of processed and paid claims.

  Response: HSAG expanded the analysis to include identification of trends in pended claims, examination of claims that incurred manual overrides, and review of pharmacy claims.

- **Recommendation 2**: While Colorado Access and Cognizant have well-established claim-by-claim processes for monitoring and managing pended and denied claims, Colorado Access' claims processing oversight activities should include policies, procedures, and reports for analyzing claims in aggregate to identify and mitigate trends with pended and denied claims.

  Response: On-site discussions and review of claims outcomes confirmed that Colorado Access and Cognizant performed additional oversight of pended and denied claims.

- **Recommendation 3:** Colorado Access should have written policies and procedures to retrospectively review claims paid or denied for any member with a retroactive change in eligibility or enrollment status.

  Response: Colorado access provided some policies and desk-level procedures regarding review of pended and denied claims.

- **Recommendation 4:** The analysis of claims denied due to no prior authorization revealed that many were submitted by out-of-network providers. Colorado Access should develop policies, procedures, and reports for analyzing out-of-network provider claims to understand the members' reasons for using out-of-network providers and/or the providers' lack of knowledge about prior authorization requirements.

  Response: Colorado Access provided their Member Grievance Workflow and examples of prior authorization overrides for a better understanding of members' reasons for using out-of-network providers.

- **Recommendation 5:** While the BAA between Colorado Access and Cognizant provides appropriate provisions to hold the business associate (Cognizant) and its subcontractors accountable for data privacy and security, Colorado Access should validate that Cognizant is in compliance with the BAA terms.

  Response: Review of the BAA and discussions with Colorado Access confirmed that Cognizant is in compliance with federal and State data privacy and security standards.

- **Recommendation 6:** Colorado Access' claims procedure documents should be updated to reflect current processes (e.g., auditing 100 percent of all claims paid exceeding $10,000) and to ensure that

procedure documents identified as "Colorado Access SMCN Processes" include effective dates, process owners, and approval status tracking.

Response: HSAG's review of Colorado Access' policies and procedures indicated that while some improvements have been made, additional work is needed to ensure that these policies and desk-level procedures are consistently maintained.

2017–2018 SMCN Network Claims Processing and Audit Improvement Opportunities

HSAG has been evaluating the Department's ASO CHP+ SMCN claims processing since 2011. The audit methodologies have been adapted each year to maintain alignment with regulatory and contractual requirements and to re-assess claims administration capabilities after Colorado Access transitioned the delegated claims processing to Cognizant in 2013. Should the Department extend the contract with Colorado Access beyond June 30, 2018, the opportunity exists to refine some organizational processes to optimize claims processing resources and outcomes. The Department is requiring Colorado Access provide a remediation plan for the recommendations below. The Department will provide further instructions and timeframes for submitting the remediation plan. The following recommendations are based upon the current audit findings, contractual requirements, regulations, and industry trends.

- Colorado Access' policies and desk-level procedures should be properly labeled with the organization name, effective dates, policy owner, and update history.
- Colorado Access should work with Cognizant to refine the *Claims Business Rules Manual* and audit guides to remove performance measure caveats that may result in adverse claims outcomes being inaccurately reported—for example, *"claims that were paid inaccurately because the then current configuration was inaccurate will be treated as accurate for the purposes of this service level."*
- As previously noted, the *BPO Audit DLP* document defines the turnaround time as three to seven days instead of the five-day turnaround time reporting metric reported for the paper claim entry turnaround requirement. Additionally, the *BPO Audit DLP* document does not include basic information that effectuates the policy or process. HSAG recommends that Colorado Access align turnaround time expectations and add a title, policy number, and effective date for this document to ensure its validity.
- The policies, titled *ATA Audit the Auditor DLP*, *High Dollar Claims DLP*, and *BPO Audit DLP* should be updated to clearly identify which entity the desk-level procedure applies to and to ensure consistency in completing the template fields (i.e., policy number, effective date, policy name, and last revision date in the footer). These updates will help substantiate that these desk-level procedures are being used consistently by the appropriate staff to ensure compliance with the policies and procedures approved by the Department.

Standard I—Enrollment Processing Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor accepts the CHP+ eligibility data submitted in text format, electronically on a daily and monthly basis transmitted by CHP+ or its designee. Contractor reads, loads, manages, and tracks all data elements provided in the file format. Contract: Exhibit C - Section 20.3	Files: • Attachment A – Eligibility Load Process • IT Process 534 – SMCN Manual File Download Details: When the State transitioned to the new MMIS interchange system, they were unable to create SMCN enrollment files. There were workaround files put in place until the 834 files could be created. These workaround files originally pulled from the CBMS system and then in August 2017 were pulled from the interchange system using BIDM. Colorado Access received these files daily and created a load process to input these files into our normal processing cycle, similar to the 834s. See Attachment A process flow. IT Process 534 also has the steps to download the BIDM files for daily processing. Colorado Access started receiving 834 enrollment files for SMCN on 12/28/2017.	☒ Met ☐ Partially Met ☐ Not Met
Findings: Colorado Access (COA) provided documentation that substantiated the various eligibility and enrollment file processes that the organization had to follow until the Department's MMIS systems vendor was able to provide the 834 files. Site visit discussions with Colorado Access revealed that the interChange system implementation occurred in March 2017 and that COA did not receive the 834 files for the CHP+ members from the Department until December 27, 2017. Without the daily and monthly 834 files, Colorado Access had to rely upon workarounds, including manual verification of eligibility and enrollment during that time. Initially, Colorado Access addressed		

Standard I—Enrollment Processing Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
issues with eligibility and enrollment information case by case. In April 2017, the Department began providing an enrollment report of all CHP+ members from the CBMS; however, the report did not distinguish which members were assigned to SMCN versus being assigned to the other health plans. Colorado Access took mitigation steps to load all member records identified as prenatal or PE and necessarily manually researched the remaining member records on the State Web portal to verify eligibility. Colorado Access used temporary staffing to assist with member eligibility verification during this time. In August 2017, a report from the BIDM system was created to identify all CHP+ members along with the health plan assignment. This BIDM report enabled COA to manage eligibility and enrollment more seamlessly and timely. On December 28, 2017, Colorado Access received its first 834 file and began using that for managing eligibility and enrollment.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		
2. When the Contractor is notified of Member Enrollment status using reports and information from the Colorado interchange (CiC) and/or the Colorado Benefits Management Systems (CBMS) or the PHP interface files or the HIPAA compliant x12n transactions, the effective date of enrollment is the first (1st) day of the month in which the member's application is completed. (Note: If the Contractor has not been notified of a member's enrollment status on the PHP interface files or the HIPAA compliant X12N transactions, the Contractor is not responsible for coverage of the member, except as otherwise agreed by the contractor in writing or electronic mail.) Contract: Exhibit C - Section 20.3.1	No Files Details: Colorado Access uses the begin date HCPF sends on the enrollment files to load the member in our system. The date the application was completed is not provided to COA on the CBMS, BIDM or 834 enrollment files.	☒ Met ☐ Partially Met ☐ Not Met
Findings: Colorado Access indicated in the "Evidence as Submitted by the Health Plan" field preceding that the application date is not included in any of the three eligibility and enrollment files that COA received between March 2017 and December 2017. Instead, Colorado Access used the "begin date" populated in these files as the effective date of enrollment in the SMCN network.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		

Standard I—Enrollment Processing Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor uses reports and information from the CIC and /or the CMBS to verify the CHP+ eligibility and Enrollment in the CHP+ SMCN plan. Contract: Exhibit C - Section 20.4	Files: • Attachment A – Eligibility Load Process • EE DP54 -Desktop Process Reading 834 EDI Files Details: All enrollment files received are loaded to our transaction system (QNXT). See Attachment A process flow for this process. All files received are also loaded to an oracle table where a front end view was built for researching the raw data files. See section 4 in EE DP54 on how to use the 834 viewer.	☒ Met ☐ Partially Met ☐ Not Met
Findings: The desk review information and on-site and Web conference discussions with Colorado Access confirmed use of available reports and information from CMBS to verify CHP+ eligibility and enrollment in the CHP+ SMCN plan.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		

Results for Standard I—Enrollment Processing Systems							
Total	Met	=	3	X	1.00	=	3
	Partially Met	=	0	X	.50	=	0
	Not Met	=	0	X	.00	=	0
Total Applicable		=	3	**Total Score**		=	3
				Total Score ÷ Total Applicable		=	100%

Standard II—Claims Processing Operations and Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor administers all claims payment activities for SMCN providers and subcontractors with policies and procedures approved by the Department. These activities include, but are not limited to: • Monitoring outliers and unusual claim submissions • Conducting periodic claims processor quality assurance reviews • Accepting liability for claims processor negligence or fraud • Holding the member harmless for improper provider procedures and noncompliance issues, such as ineligible charges or nonparticipating referral Contract: Exhibit C - Section 23.1	Files: • Trizetto-COA Claims Business Rules Manual • ATA_Audit the Auditor DLP • High Dollar Claims DLP • BPO Audit DLP • CMP211 Fraud, Waste and Abuse • Professional Provider Contract -Section C. 6 – hold harmless clause • Trizetto(Cognizant)_Weekly Inventory Tracking • Trizetto(Cognizant)_Monthly Quality Tracking Details: The Cognizant/Trizetto Delegation Agreement will be available for review during the on-site visit.	☐ Met ☒ Partially Met ☐ Not Met
Findings: Colorado Access submitted policies, procedures, business rules, and tracking reports related to monitoring claims outliers, conducting quality assurance reviews, accepting liability for claims processor negligence, and not holding members liable for nonpayment to providers. The TriZetto-related business rules and tracking reports were acceptable evidence for demonstrating that Colorado Access and Cognizant are performing the claims management responsibilities in accordance with the Department's requirements. Three policies, however, require updating to be compliant from an auditing perspective.		
Recommendations: The policies, titled *ATA Audit the Auditor DLP*, *High Dollar Claims DLP*, and *BPO Audit DLP* should be updated to clearly identify which entity the desk-level procedure applies to and to ensure consistency in completing the template fields (i.e., policy number, effective date, policy name, and last revision date in the footer). These updates will help substantiate that these desk-level		

procedures are being used consistently by the appropriate staff to ensure compliance with the policies and procedures approved by the Department.		
2. The Contractor's claims processing systems and encounter tracking system contains the necessary elements to accurately adjudicate and report claims payments including the following data elements: Medical and Behavioral Health Claims and Encounters: • Subscriber identification number • Patient identification number • Place of treatment • Patient date of birth • Patient gender • Date of service(s) • Five-digit Current Procedural Terminology (CPT-4) codes with modifiers • Five-digit International Classification of Diagnosis Codes (ICD-10) • Treating provider Hospital Claims and Encounters: • Subscriber identification number • Patient identification number • Place of treatment • Patient date of birth • Patient gender • Date of service(s) • Five-digit ICD-10 codes • Treating provider • Major diagnosis category • Diagnosis related group (DRG)	Files: Now- • HSAG_SMCN Claims Audit File Layouts -submitted in Dec, 2017 Later- • Please refer to claims extract files that will be submitted by Feb 16, 2018	☒ Met ☐ Partially Met ☐ Not Met

Pharmacy Claims and Encounters in National Council on Prescription Drug Programs (NCPDP) format: • Subscriber identification number • Patient identification number • Patient date of birth • Patient gender • National Provider Identified (NPI) of Service Provider (Pharmacy) • Prescriber's NPI • Date of Prescription • Fill date • Fill number • Days supply • Dispense as written code • Prior authorization number (if applicable) • Quantity dispensed • National drug code (NDC) Contract: Exhibit C - 23.2.1 – 23.2.2		
Findings: The HSAG_SMCN Claims Audit File Layouts and data extract files confirmed compliance with the required elements for accurately adjudicating and reporting claims payments.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		
3. The Contractor pays clean claims for both in-network and out-of-network claims in accordance with the following timeliness requirements: • 90 percent or greater of clean claims are finalized within 14 calendar days. • 98 percent or greater of clean paper claims are processed within 45 days of receipt.	Files: • SMCN Claims TAT Performance Target Q1 • SMCN Claims TAT Performance Target Q2 • COA Report Card 2017 12 AMS BMS	☒ Met ☐ Partially Met ☐ Not Met

• 98 percent or greater of clean electronic claims are processed within 30 days of receipt. Inpatient PE Prenatal claims held for the 45-day eligibility review period are not be included in this standard. These claims will be reported separately to the Department. Contract: Exhibit D – D – E.		
Findings: The documents submitted verify compliance that COA pays clean claims following the timeliness requirements for both in-network and out-of-network claims. While HSAG's calculations, for two of the six months reviewed indicated that COA did not meet the "90 percent or greater of clean claims are finalized within 14 calendar days" requirement, additional discussions with Colorado Access revealed some differences in the calculation logic. HSAG agrees with Cognizant reporting logic that excludes adjusted claims and identifies the reporting month based upon paid date. Modifications to HSAG's reporting logic will be incorporated in future claims audits.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		
4. The Contractor pays 99 percent or greater of the claims accurately. 'Claim financial accuracy' is defined as total dollars that should have been paid, less the sum of the absolute value of dollars overpaid plus dollars underpaid divided by the total claims dollars which should have been paid correctly of audited claims. Round to two decimal places. Contract: Exhibit D – G	Files: • COA Report Card 2017 12 AMS BMS • QNXT Quarterly Summary_2017 • Cognizant-COA Monthly Review-Sep 2017	☒ Met ☐ Partially Met ☐ Not Met
Findings: The documents submitted verify compliance that COA accurately pays 99 percent or greater of claims.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		
5. For financial errors identified during the claims accuracy audits, the errors are classified and tracked in the following categories: • Processor error • System error • Incorrect application of CHP+ benefit plan provisions • Incorrect application of discounts	Files: • Cognizant-COA Audit Guide • ATA_Audit the Auditor_Desktop Process	☒ Met ☐ Partially Met ☐ Not Met

• Failure to pursue coordination of benefits or subrogation opportunities • Incorrect programming of Department's plan benefits in the claim processing system • Incorrect application of eligibility data • Duplicate payments • Scanning/imaging errors Contract: Exhibit D – G		
Findings: The documents submitted do not verify compliance with this requirement. The documents provided do not show that all categories of errors for this element are tracked and trended. After the on-site review, COA reviewed the error categories provided by Cognizant and sent a document, *SMCN Financial Errors Log*, including a new column (Column G) which assigns the error to one of the State's categories.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		

Results for Standard II—Claims Processing Operations and Systems							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	1	X	.50	=	.50
	Not Met	=	0	X	.00	=	0
Total Applicable		=	5	**Total Score**		=	4.50
				Total Score ÷ Total Applicable		=	90%

Standard III—Claims Operations Infrastructure and Reporting		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides the Department reports to calculate the Incurred But Not Reported (IBNR) calculation. • Quarterly claims data • Monthly claims open inventory • High dollar claim/reinsurance reports, as available	Files: • Monthly File Drops for the Actuary_Screenshot • COA Daily inventory reports from Cognizant (3) • Emails to HCPF Contract Manager with weekly spends attachments include (3): -Bi-weekly pharmacy report -SMCN weekly check run	☒ Met ☐ Partially Met ☐ Not Met
Findings: The documents submitted demonstrate that Colorado Access is able to provide the Department the information required to calculate the incurred but not reported (IBNR) calculations for the claims processed by Colorado Access and Navitus.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		
2. The Contractor prepares the required files for submission of medical and pharmacy claims and eligibility and provider data to the All Payer Claims Database. Contract: Exhibit C—2.LL C.R.S. §25.5-1-204.	Files: • APCD FRD_All LOB_2017 • Email -CO APCD Portal –Submission Validation Details: -APCD FRD is the IT process document for the APCD claim file production -Email demonstrates Confirmation of receipt of APCD file submission	☒ Met ☐ Partially Met ☐ Not Met
Findings: The documents submitted demonstrate that Colorado Access has the business processes in place to submit medical and pharmacy claims and eligibility and provider data to the Department's all-payer claims database.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		

Standard III—Claims Operations Infrastructure and Reporting		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The contractor maintains a business continuity and recovery plan to manage unexpected events that may negative and significantly impact its ability to service Members. The Contractor's plan, at a minimum, includes processes and training for: • Health facility closure or loss of clinics, hospitals or other major providers; • Electronic or telephonic failure at Contractor's main place of business; • Complete loss of use of the Contractor's main site; • Loss of primary computer system/records; • Contractor's strategies to communicate with the Department in the event of a business disruption; • Periodic testing; and • Process for reviewing/updating the business continuity and recovery plan annually. Contract: Exhibit C —29	Files: • Business Continuity Plan CHP • Business Continuity Plan–Customer Service • DRP Storage and Backup • CCS306- Delivering Continuity of Care and Transition of Care for Members Details: Each department has a separate business continuity plan. -The Business Continuity Plan-CHP covers how the business functions of the CHP department would continue if we were unable to work on-site due to an emergency event. This plan also includes methods for informing HCPF of the issue and its impact on the company's ability to fulfill contractually required functions and deliverables. -The Business Continuity Plan-Customer Service covers alternate working sites and set-ups if the building was impacted. If the phone system was impacted and the call system was down, we have a communication plan to keep HCPF informed of the issue. -The DRP Storage and Backup document covers the IT department's steps for recovering and restoring the entire company's critical technical applications and systems.	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Claims Operations Infrastructure and Reporting		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	-CCS306, section 3 (page 3-4) covers transition of care plans for members when there is a network transition or disruption.	
Findings: The documents submitted demonstrate that COA maintains a BCDR plan to manage unexpected events that may negatively and significantly impact ability to service members. As of May 18, 2018, HSAG was awaiting an update from Colorado Access regarding the status of the 2018 BCDR testing results.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		
4. The Contractor and its delegated claims vendors have processes to monitor and report the four primary risk areas: • Unauthorized systems access • Compromised data • Loss of data integrity • Inability to transmit or process data Contract: Exhibit C—32	Files: • ADM202 Systems Access • IT201 IT Management of Systems Access • IT202 IT Processes for Maintaining Security of ePHI • SFTP Login Audit Procedures • HIP201 Protection of Member Individually Identifiable Health Information and PHI • HIP204 Security of ePHI • PRI DP02 Breach for Contracts with State • Trizetto-COA BAA Details: -Access: Two factor authentication required to access the Network remotely -Access: Termed employees account access is removed immediately following termination	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Claims Operations Infrastructure and Reporting		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	-Access: Weekly audit review is performed to identify users that have not connected to the domain. -Access: Logins to the Oracle DB, Linux servers, and sFTP sites are monitored and reported -Access: ADM202, page 4 Staff are allowed the minimum necessary access to systems that include member PHI -Transmissions: The Production Control department monitors all production jobs. Job failures and transmission errors generate e-mail notifications are resolved by the team. -Compromised Data/Integrity: Addressed by HIP201, HIP204, IT202, Trizetto-COA BAA (pg 3, II), PRI DP 202 -Compromised Data: DLP (Data Loss Prevention) rules are applied per standard Microsoft Sensitive data rules	
Findings: The documents submitted verify compliance with this requirement. COA has a comprehensive set of data privacy and security policies and processes to monitor and report the four primary risk areas. COA ensures that the BAA with Cognizant also meets the federal and State data privacy and security requirements.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		

Results for Standard III—Claims Operations Infrastructure and Reporting							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.50	=	0

	Not Met	=	0	X	.00	=	0
Total Applicable		=	4	**Total Score**		=	4
			Total Score ÷ Total Applicable			=	100%

Results Summary for All Standards							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	1	X	.50	=	.50
	Not Met	=	0	X	.00	=	0
Total Applicable		=	12	**Total Score**		=	11.50
			Total Score ÷ Total Applicable			=	96%

Appendix B. FY 2017–2018 SMCN Claims Processing Audit: Desk Review Instructions

Instructions for Document Submission

Colorado Access must submit the desk review documents and the completed *Claims Audit Desk Review Tool* to HSAG on or before January 26, 2018. After the initial review of the document submissions HSAG will determine if it requires any additional documentation to prepare for the on-site visit. HSAG will send the detailed data request to Colorado Access by January 15, 2018. Colorado Access must submit the requested data file documents and extracts to HSAG on or before February 16, 2018.

1. Submit the completed *Claims Audit Desk Review Tool* with the column titled "Evidence as Submitted by the Health Plan" completed for each requirement.

   The *Claims Audit Desk Review Tool* is provided in a pre-formatted Microsoft Word document. Please do not change the format. **Contact HSAG if you have any difficulties with the document formatting.**

   For each requirement, review and then determine what information and documentation provide evidence of compliance with that requirement. Enter the information in the column labeled, "Evidence as Submitted by the Health Plan." Enter information in that column only—please do not type in or alter any other cell in the tool. Information provided should include:

   - A list of documents that support and provide evidence of compliance with the requirement (e.g., written policies and procedures, forms, templates, completed logs, or reports produced by the health plan or delegate).
   - Information that identifies the exact portion of the document that provides the evidence of compliance (e.g., section, page number).
   - A brief description of how the section of the document provides evidence of compliance with the requirement or what the document demonstrates (why or how you believe it demonstrates compliance).

2. Submit all documents referenced in the completed *Claims Audit Desk Review Tool*.
   - Do not submit portions or sections of documents. All documents should be submitted in entirety with specific sections that relate to the requirement highlighted.
   - Only submit documents that relate specifically to the requirements.

3. Submit the following additional documents:
   - Copies of executed written agreements for the delegation of administrative services related to each standard reviewed.

- HSAG recommends arranging documents into a single, compressed (e.g., WinZip) folder and then uploading the single file to the FTP site. Document names should describe the content of the document (e.g., "Enrollment Processing P&P" not "Standard III_1a"). Note: If any documents contain protected health information (PHI), please secure the file or the WinZip file with a password.

 Colorado Access (Before posting to FTP site, compress this folder using WinZip or similar.)

 *Claims Audit Desk Review Tool*

 *Miscellaneous* (e.g., documents that contribute to the general overview and/or that apply to multiple standards and elements)

TriZetto contract
Pharmacy Benefit Manager (PBM) contract

 *Standard I*

Document
Document

 *Standard II*

Document
Document

 *Standard III*

Document
Document

Tips:

1. Please submit only the policies and procedures and other documents that apply to SMCN claims processing conducted by Colorado Access and TriZetto. All policies and procedures and other documents submitted should be current and relevant for the desk review.
2. Please provide names of all files/documents you will be submitting. Next to the file/document name, provide in parentheses relevant page numbers/sections of the file or document applicable to the processing of SMCN claims. For each document, please clearly highlight the specific text that satisfies the requirement listed in the *Claims Audit Desk Review Tool.*
3. Please upload all requested documents to the SMCN_Claims Audit FY2017–2018 folder under HSAG's secure FTP site:

   Colorado\Child Health Plan Plus\Administrative Service Organization (ASO)\Colorado Access\ SMCN_Claims Audit FY2017-2018.

Should you have questions about obtaining access to this FTP folder, please contact Crystal Brown at cbrown@hsag.com.

Appendix C. FY 2017–2018 SMCN Claims Processing Audit: Data File Request

As communicated on December 15, 2017, Colorado Access is required to submit the desk review documents and the completed *Claims Audit Desk Review Tool* to HSAG on or before **January 26, 2018**.

Additionally, Colorado Access must submit the following data file and documents on or before **February 16, 2018**. After the initial review of the data file submissions, HSAG will confirm that it has all the information needed to conduct the review of the claims data files.

This document outlines the specific requirements related to the February 16 data submission, along with detailed instructions for submitting documents and data files to HSAG.

List of Data Files and Supplemental Documentation

1. Copies of executed written agreements for the delegation of administrative services to TriZetto and the pharmacy benefit manager (PBM), including performance standards established for claims processing.
2. Documentation describing the maintenance of fee schedule and rates for capitated and/or fee-for-service providers in the QNXT system.
3. Quarterly performance reports submitted to the Department for calendar year 2017.
4. Reports submitted to the Department that reflect encounter data submission activities to the Department (e.g., submission statistics) for processed claims (paid, denied, pended, adjusted, and voided) from July 1, 2017, through January 31, 2018.
5. Claims extract of all professional, institutional, pharmacy, and vision CHP+ SMCN claims processed (paid, denied, pended, adjusted, and voided) with paid dates between July 1, 2017, and December 31, 2017. Requested file names are presented in Table C-1.

Table C-1—Required SMCN Claim Files

Claim Types	Requested File Name
Medical and behavioral health (professional and institutional) claims	FY18_CHPSMCN_Medical_Claims_Extract
Pharmacy claims (include co-pay information)	FY18_CHPSMCN_Pharmacy_Claims_Extract
Vision claims *(if not included in professional claim files)*	FY18_CHPSMCN_Vision_Claims_Extract

6. Data file layout by which Colorado Access receives and ultimately determines member eligibility. Identify and describe any changes from the FY 2016–2017 audit data file layout.
7. An extract of the QNXT provider file for the period of July 1, 2017, through December 31, 2017.
   - The requested file name is: FY18_CHPSMCN_Provider_Extract
8. Monthly enrollment and eligibility files for May 2017 through February 2018.
   - The requested file name is: FY18_CHPSMCN_Eligibility_Extract
9. Copies of the claim turnaround time reports from May 2017 through January 2018.
10. Update on any items addressed regarding recommendations from the FY 2016–2017 audit findings:
    - Description of processes and reports implemented to validate that billed services were provided. If processes existed during the July 2017 through December 2017 time frame, provide examples of the services that were provided.
    - List of paid or denied claims from QNXT (claim numbers only) that required manual overrides to complete claims processing between July 2017 and December 2017.
    - List and examples of the policies, procedures, and reports that were in effect from July 2017 through December 2017 to analyze claims in aggregate to identify and mitigate trends with pended and denied claims, if applicable.
    - Description and examples of any written policies and procedures in effect from July 2017 through December 2017 to retrospectively review claims paid or denied for any member with a retroactive change in eligibility or enrollment status.
    - Description and examples of any written policies, procedures, and reports in effect from July 2017 through December 2017 for analyzing out-of-network provider claims to understand the members' reasons for using out-of-network providers and/or the providers' lack of knowledge about prior authorization requirements.
    - The business associate agreement with TriZetto and the PBM, along with TriZetto's data privacy and security training materials for the staff and delegated entities that support the COA claims processing.
    - Description and examples of Colorado Access' claims procedure documents that were updated to include effective dates, process owners, and approval status tracking.
    - The health plan's provider manual effective as of July 1, 2017.
    - The health plan's member handbook effective as of July 1, 2017.

Instructions for Data and Related Document Submissions

1. Colorado Access should submit the requested data file documents and extracts to HSAG on or before **February 16, 2018**.
2. For the claims data files, HSAG requires that the data files be secured with passwords prior to uploading the file(s) to the HSAG FTP site. Once the claims files have been uploaded to the secure

FTP site, please notify Ms. Amrit Kerr at (602) 801-6858 or akerr@hsag.com to provide her with the file password(s).

3. Please upload all requested documents to the SMCN_Claims Audit FY2017–2018 folder under HSAG's secure FTP site:

   Colorado\Child Health Plan Plus\Administrative Service Organization (ASO)\Colorado Access\ SMCN_Claims Audit FY2017-2018.

   Contact Crystal Brown at cbrown@hsag.com with questions regarding the FTP site.

4. Please submit a letter of certification, signed by the chief executive officer (CEO) or the chief financial officer (CFO), that confirms that data submitted to HSAG for the audit were extracted from Colorado Access' data systems (or delegated entity's system) and follow HSAG's data submission requirements. Provide one letter of certification for all submitted file(s) per submission. However, a separate certification letter will be required for any subsequent submissions. A copy of the standard letter is included at the end of this document. The following information should be included in the letter.

   - A list of data file(s) in the submission
   - Record counts (i.e., total number of rows) for each transmitted data file

Colorado Access CHP+ SMCN Claims Data Letter of Certification
for the FY 2017–2018 SMCN Claims Processing Audit

I, the undersigned, do hereby attest, based on my knowledge, information, and belief, that the data contained in the file submission is accurate, truthful, and complete. I attest that the records contained within the data file were extracted from our adjudicated claims system and align with our data submission files. I further attest that these records comply with the payment reporting requirements and general data submission requirements specified in the Department of Health Care Policy and Financing contract with Colorado Access effective July 1, 2017, federal and state regulations, and HSAG's *FY 2017–2018 SMCN Claims Processing Audit Data File Request.*

Signature of CEO, CFO, or delegated authority	Print Name	Date
Phil Reed	Phil Reed	2-9-18

Indicate if the submitted files are a:

☑ **First-time submission**

☐ **Resubmission/Replacement**

Submitter Name: **Colorado Access (Janet Milliman, MPH)**	**Submitter ID:**
Complete Street Address: 11100 E. Bethany Dr. Aurora, CO 80014	Telephone Number (include area code): (720-744-5306)

Please indicate the name and record count of each file that is submitted along with this certification letter.

File Name	Record Count
1. Navitus_COA PBM Service Agreement	1
1. Trizetto Revised Delegation Agreement	1
2. PBC DP14 SMCN Fee Schedule	1
2. PBC DP15 FQHC Rates Updates	1
3. N/A – No Files	0
4. N/A – No Files	0
5. Medical Standard_Claims_Extract_CHPSMCN	63,998
5. Pharmacy_Extract_CHPSMCN	39,450
6. Inbound_834_Src2Tgt_Mapping	61
6. Attachment A- Eligibility Load Process	1
6. EE DP54- Desktop Process Reading 834 EDI File	1
7. Provider_Extract_CHPSMCN	79,746
8. Eligibility Extract_CHP SMCN	108,312
9. COA Report Card 2017 12 AMS BMS	24
9. SMCN Claims TAT Performance Target Q1	15
9. SMCN Claims TAT Performance Target Q2	15
10a. Memo Validation of Services Provided	1
10a. CMP DP08 Compliance Operations Manual	1
10a. CMP204 Compliance Educ & Training	1
10a. CMP211 Fraud, Waste & Abuse	1
10a. CMP212 False Claims Act	1
10a. CMP213 Internal Compliance Reviews	1
10a. COA Compliance Plan	1
10a. Code of Conduct	1
10a. QM302 Quality Review of Medical Records	1

File Name	Record Count
10b. Pended Claims with Manual Intervention (list)	2799
10c. EAPG Monitoring Prod Claims Oct 17	812
10c. CLM DP04 Manually Pended Claims	1
10c. CLM DP05 Retro Eligibility Spreadsheet	1
10c. COA Analytical Report Dec 17	1
10c. Cognizant COA Audit Guide	1
10c. COA BMS Action Tracker	20
10c. COA Overall Review	8
10d. EE DP15 Running Claims for Ineligibles	1
10d. EE DP56 Running Claims Recycle Report	1
10d. CLM DP05 Retro Eligibility Spreadsheet	1
10d. 20171013 Provider Takeback Summary	15
10d. 20171013 Takeback COB	11
10d. 20171013 Takeback Not Elig	10
10d. 20171026 Claims Recycle	275
10e. CS DP26 Member Grievance Workflow	1
10e. RE CAMC Prenatal Prior Auth Override	1
10e. RE CAMC Timely Filing Override	1
10f. Navitus BAA	1
10f. Trizetto BAA	1
10g. COA Process to Update Claims BRD	1
10g. Rpt Request ### EAPG	1
10g. RE BMS Talking Point EAPG	1
10h. Provider Manual	1
10i. Member Handbook	1

Appendix D. SMCN Claims Processing Audit Agenda

Colorado Department of Health Care Policy and Financing
Colorado Access On-Site Review Agenda
State Managed Care Network (SMCN) Claims Processing Audit

April 20, 2018
Location: Colorado Access – 11100 E. Bethany Dr., Aurora, CO 80014
WebEx Conference Information:

https://hsagonline.webex.com/hsagonline/j.php?MTID=m80ffece198074a7d1c45eae8f02cfda4
Meeting number (access code): 803 471 214 Meeting password: ZWmNTpHB
1-844-740-1234

On-Site Audit Team: Amrit Kerr, MBA and Erika Bowman, BA, CPC
Remote Auditor: Holly Dolgaard, MBA, CHC, CHPC

SMCN Claims Processing Audit—April 20, 2018	
Sessions and Activities	
8:30 a.m.	Opening Session: • Introductions • Overview of SMCN Claims Processing Audit • On-site visit objectives
8:35–9:30 a.m.	**Hosted Systems Infrastructure – Cognizant** • Data Privacy and Security • Business Continuity and Disaster Recovery (BCDR) *Colorado Access completed a Systems Infrastructure overview of its internal network on March 7, 2018. For this session, Colorado Access is required to provide an overview of Cognizant's systems infrastructure that supports the COA claims processing. The discussions will include questions about Cognizant's network infrastructure, data warehouse, information security plans, data privacy and security training materials, and business continuity and disaster recovery plans. HSAG would also like to review the findings from Colorado Access' recent BCDR testing.* *Additionally, Colorado Access will be required to walk through its processes for managing member retro-enrollment/retro-disenrollment, and issues related to eligibility and enrollment data.*

SMCN Claims Processing Audit—April 20, 2018	
Sessions and Activities	
9:40–12:00 p.m.	**Claims Review** *HSAG will require Colorado Access to display a series of claims identified for in-depth review. Colorado Access will be expected to share information associated with the claim (e.g. eligibility history, provider contract, fee schedules, benefits configuration, remittance advice).* *HSAG's review and discussions will include, but may not be limited to the following items:* • ***Internal auditing processes and supporting documents*** • ***Processes and resources for managing claims backlog*** • ***Coordination of benefits and third-party liability procedures*** • ***Review of provider claims appeals*** • ***Review of processes for monitoring for fraud, waste, and abuse***
12:00–1:00 p.m.	Lunch *Note: Colorado Access staff members to provide HSAG a private conference room to work privately during this lunch.*
1:00–3:00 p.m.	**Review Pharmacy Benefit Management (PBM) Oversight and Claims** *Colorado Access will be required to provide an overview of the policies and procedures for oversight of the PBM. Colorado Access may be asked to provide copies of the reports that the PBM provides regarding coverage determinations and exceptions, denials, enrollment counts for the audit period, and information about the PBM's fraud, waste, and abuse (FWA) compliance program.* *HSAG will require Colorado Access to display a series of pharmacy claims identified for in-depth review.*
3:00–4:00 p.m.	**HSAG review of information provided during on-site review** *Note: Colorado Access staff members to provide HSAG a private conference room to work privately during this session.*
4:00–4:30 p.m.	**Review of Audit and/or Desk Review Submissions Requiring Clarification**
4:30–4:40 p.m.	Break (Audit team to prepare closing conference with Colorado Access and the Department)
4:40–4:55 p.m.	• Overview of preliminary findings • Next steps

Appendix E. SMCN Claims Processing Audit Review Activities

The following table describes the activities performed throughout the SMCN claims processing audit.

Table E-1— SMCN Claims Processing Audit Activities Performed

	HSAG completed the following activities:
Activity 1:	**Develop Methodology**
	Before developing the desk review tools and claims audit methodology, HSAG completed the following: • HSAG reviewed the Department's contract with Colorado Access and applicable managed Medicaid regulations. • HSAG and the Department discussed the timing and scope of the claims audit. • HSAG collaborated with the Department to develop the desk review tool, report templates, and on-site agenda; and scheduled the on-site audit. • HSAG submitted all materials to the Department for review and approval.
Activity 2:	**Perform Preliminary Review**
	• On November 30, 2017, HSAG notified Colorado Access in writing of the request for desk review documents (SMCN claims audit timeline and desk review tool) to be delivered via email. • On December 15, 2017, HSAG sent Colorado Access the desk review instructions letter, which included instructions for organizing and preparing the documents related to review of the three standards. On January 26, 2018, Colorado Access provided documentation for the desk review, as requested. • On January 15, 2018, HSAG sent Colorado Access the data file request letter, which included the list of data files and supplemental documents related to the analysis of professional, institutional, pharmacy, and vision CHP+ SMCN claims processed (paid, denied, pended, adjusted, and voided) with paid dates between July 1, 2017, and December 31, 2017. On February 16, 2018, Colorado Access provided data files and supplemental documentation as requested. • On March 16, 2018, HSAG sent Colorado Access the on-site agenda for the April 20, 2018 on-site review. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and sent via email several requests for further documentation to aid with the claims analyses and claims to be reviewed during the on-site visit.

	HSAG completed the following activities:
Activity 3:	**Conduct On-Site Claims Audit**
	• During the on-site portion of the review, HSAG met with Colorado Access, Cognizant, and Navitus key staff members to obtain a complete picture of Colorado Access' compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of Colorado Access' performance. • HSAG requested clarification on preliminary findings from the review of medical and pharmacy claims. • While on-site, HSAG collected and reviewed additional documents as needed. • At the close of the on-site portion of the site review, HSAG met with Colorado Access staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2017–2018 SMCN claims audit report template to compile findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings and identified opportunities for improvement for the Department and Colorado Access.
Activity 5:	**Report Results to the Department**
	• HSAG developed the report content and supporting tables and figures. • HSAG submitted the draft FY 2017–2018 SMCN Claims Audit Report to the Department on May 25, 2018, for review and comment. • Upon Department's approval, HSAG to submit draft report to Colorado Access for review and comment. • HSAG to incorporate Colorado Access' and Department's comments, as applicable, then finalize the report. • HSAG to distribute the final report to Colorado Access and the Department.