State Managed Care Network Claims Audit Report

June 2019

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

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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, 2018, through December 31, 2018
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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, 2018, and December 31, 2018, in accordance with the Department of Health Care Policy and Financing (Department) contract executed on June 28, 2018, 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, 2018, and December 31, 2018, 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; Web conference interviews; and follow-up discussions.

The second section of this SMCN claims audit report encompasses the review of pharmacy claims processed between July 1, 2018, and December 31, 2018, 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; Web conference 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 Web conference 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. During FY 2018–2019, five managed care organizations (MCOs) contracted with the Department to provide medical services to CHP+ members. The Department also contracted directly (using Colorado Access' provider services department) with healthcare providers to offer CHP+ services during the pre-MCO 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 2018, the Department executed a new contract with Colorado Access to provide administrative services for the CHP+ program from July 1, 2018, through June 30, 2019.

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

- Management of eligibility and enrollment information
- Physical and behavioral health benefit management
- Provider network management
- 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 annual 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, Electronic Data Interchange (EDI) and paper claim entry (manual and optical character resolution), along with claims adjudication and payment. HSAG's FY 2018–2019 claims audit encompassed a comprehensive review of eligibility; enrollment; claims processing; and claims auditing policies, procedures, systems, and data for Colorado Access, Cognizant, and Colorado Access' PBM, Navitus.

HSAG's focus for the FY 2018–2019 audit was on claims processed between July 1, 2018 and December 31, 2018, 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, 2018, and December 31, 2018; a Web conference review of systems and claims operations with key personnel from Colorado Access, Cognizant, and Navitus; and follow-up communications and Web conferences as needed. 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 2017–2018 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 2018 to December 2018 as well as 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 2018–2019 desk review component, Colorado Access received a score of 100 percent with all 12 elements scored as *Met*. Based on performance reporting and Web conference 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. HSAG identified opportunities to improve Colorado Access' contractual oversight practices and to provide further assurance that claims will be paid accurately and on time.

Desk Review

HSAG requested Colorado Access to submit evidence related to 12 desk review elements developed for the FY 2018–2019 claims audit using the 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 2018–2019 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 25, 2019. Appendix C contains the claims data files and supplemental documentation that Colorado Access was required to submit on January 25, 2019. HSAG reviewed this information to validate Colorado Access' and Cognizant's claims processing operations and systems.

HSAG received the requested data files and supplemental documentation from Colorado Access on January 25, 2019. 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 documentation submitted by Colorado Access.

HSAG used the desk review materials and supplemental documentation to guide the discussions and interviews with key personnel for the Web conference review. The agenda for the Web conference 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	5	0	0	100%
Standard III—Claims Operations, Infrastructure, and Reporting	4	4	0	0	100%
Totals	**12**	**12**	**0**	**0**	**100%**

* *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 Colorado Access in the *SMCN Claims Turnaround Time (TAT) Performance Target Report* are:

- **Claims Processing Turnaround**—Of clean claims, 90 percent or more will be finalized within 14 calendar days. For paper claims, 98 percent or more of clean claims will be processed within 45 days of receipt; for electronic claims, 98 percent will be processed within 30 days.

  Table 2 presents the results reported by Colorado Access for the review period of July 2018 through December 2018. The *SMCN Claims TAT Performance Target Report* displays results indicating that Colorado Access met the requirements for paper and electronic claims processed within 14, 45, and 30 calendar days.

Table 2—SMCN Claims Processing Turnaround

Performance Standard	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018
≥90% All Claims Finalized Within 14 Days	97.56%	90.92%	93.92%	92.39%	95.26%	92.94%
≥98% Paper Claims Processed Within 45 Days	99.07%	99.73%	99.01%	99.82%	99.72%	99.71%
≥98% Electronic Claims Processed Within 30 Days	99.51%	99.74%	99.81%	99.79%	99.74%	99.75%

The key service metrics reported by Cognizant to Colorado Access in the report, *Colorado Access BMS [Business Management Services] Report Card,* are:

- **Claims Processing Turnaround**—Of clean claims, 90 percent or more will be finalized within 14 calendar days; 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 3 presents the results reported in the *Colorado Access BMS Report Card* for Cognizant for the review period of July 2018 through December 2018. 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 3—Cognizant Claims Processing Turnaround

Performance Standard	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018
≥90% Finalized Within 14 Days	99.75%	99.78%	99.76%	99.36%	99.77%	99.75%
≥98% Finalized Within 30 Days	99.94%	100.00%	100.00%	100.00%	100.00%	99.98%
≥99% Finalized Within 60 Days	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- **Claims Financial 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 claims financial 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 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 2018 through December 2018 confirmed that Cognizant met the claims financial 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* (2018), and a series of Cognizant's claims audit files and concluded that the financial claims processing accuracy reporting was consistent with Cognizant's methodology.

Table 4—Cognizant Claims Financial Accuracy

Performance Standard	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018
≥99% Financial Accuracy	99.98%	99.62%	100.00%	99.62%	100.00%	99.55%

- **Claims Processing 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 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 2018 through December 2018 confirmed that Cognizant met the claims processing accuracy requirement all six months as noted in Table 5. HSAG reviewed Cognizant's *COA Claims Business Rules Manual* (updated September 2018) and the *Colorado Access Audit Guide* (2018), Cognizant's claims audit files as well as joint meeting notes for Colorado Access and Cognizant and concluded that the claims processing accuracy reporting was consistent with Cognizant's methodology.

Table 5—Cognizant Claims Processing Accuracy

Performance Standard	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018
≥98% Processing Accuracy	98.11%	98.04%	100.00%	100.00%	100.00%	100.00%

- **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 2018 through December 2018 confirmed that Cognizant met the claims adjustment turnaround within 60 calendar days requirement all months as noted in Table 6. HSAG reviewed Cognizant's *Colorado Access Audit Guide* (2018) 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 Within 60 Calendar Days

Performance Standard	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018
≥99% Finalized Within 60 Days	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- **Paper Claims Entry Into the System**—At least 99 percent of clean paper claims submitted to Cognizant will be entered in the system within three days and processed 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 2018 through December 2018 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* (2018); Colorado Access' policy titled *CLM DP23 BPO [Business Process Outsourcing] Audit*, 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.

Table 7—Cognizant Paper Claims Entry Into the System

Performance Standard	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018
≥99% Entered Within 5 Days	100.00%	99.98%	100.00%	99.99%	100.00%	100.00%

- **Configuration Turnaround Time**—The HSAG FY 2016–2017 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 2018 through December 2018 confirmed that Cognizant met the configuration turnaround requirement all months, as noted in Table 8.

Table 8—Cognizant Configuration Turnaround Time

Performance Standard	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018
≥98% Configuration Requests Meet ETC	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- **Configuration Accuracy**—The HSAG FY 2016–2017 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 2018 through December 2018 confirmed that Cognizant met the configuration accuracy requirement all months, as noted in Table 9.

Table 9—Cognizant Configuration Accuracy

Performance Standard	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018
≥98% Configuration Accuracy	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Claims Processing Operations and Monitoring Controls

The claims processing operations documentation submitted for the desk review remained largely unchanged from the FY 2017–2018 audit. Colorado Access submitted policies, procedures, business rules, tracking reports, and a provider participation agreement 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 Cognizant-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. The operational claims processing policies and procedures aligned with industry best practices and contractual requirements. The audit objectives included interviews to ensure that Colorado Access staff

followed the claims processing policies and procedures. The Web conference claims audit occurred on April 15, 2019.

The Web conference discussions concluded that claims processes and monitoring controls activities were consistent with policies and procedures. Colorado Access confirmed that for 2018, its claims staff members reviewed 100 percent of claims requiring payments over $10,000 before the claims were paid. The Colorado Access reviewers documented these reviews in both the QNXT claims system and the auditor reports.

The Web conference 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. During the live demonstration of the claims system, HSAG reviewed individual claims and scenarios selected from the 2018 audit submission. In one of the example scenarios, Colorado Access was asked to display a potential duplicate claim with the same member, same date of service, and same service billed, but paid on different dates. Colorado Access explained that currently in QNXT, when a previous eligibility span is voided (e.g., a member's federal poverty level [FPL] changes), the new span will be recorded with a new enrollee ID, even if the eligibility dates are the same. The current claim-matching logic uses the enrollee ID when evaluating an exact duplicate. Colorado Access described the manual process in place and the reporting process staff used to review voided and reloaded eligibility spans to check for duplicates by enrollee ID. Colorado Access demonstrated in QNXT that the claim had been reprocessed to allow the second claim to deny as a duplicate. HSAG reviewed screen shots of both the claim page and the pay screen; both screen shots showed a payment reversal to validate that the claim was not a duplicate payment. HSAG recommended that Colorado Access work with Cognizant to clarify the procedure when a member change impacts an eligibility span to ensure that duplicate claims are not paid. Colorado Access provided follow-up details to HSAG that described active efforts with Cognizant to address strengthening the process and system procedure.

42 Code of Federal Regulations (CFR) §438.608 requires states to implement contractual mechanisms beginning in July 2018 for Children's Health Insurance Program (CHIP) health plans to ensure that MCOs 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 and meets the federal requirements for FWA training, reporting, nonretaliation, investigation, notification to the Department, and enforcement. HSAG's Web conference 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 Web conference 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 2018 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 were appropriate for managing day-to-day eligibility and enrollment discrepancies. For the 2018 audit, Colorado Access continued to use the business intelligence and data management (BIDM) report that identified the SMCN network CHP+ members to manage eligibility and enrollment in its systems. Colorado Access received 834 files for managing eligibility and enrollment and performed weekly reconciliation of enrollment files or special audits. During the Web review, Colorado Access mentioned the implementation of Edifecs in 2018 as an encounter management tool and demonstrated the system used to manage the end-to-end encounter submission.

Technical Infrastructure and Standards

The desk review confirmed that Colorado Access and Cognizant have the appropriate technical infrastructure, policies and procedures, training, and business associate agreements (BAAs) to meet both Department and federal regulations for data privacy and security. Additionally, during the Web review, Colorado Access discussed methods to ensure data privacy and security; for example, development of several staff training programs and implementation of new technology tools.

During the Web conference review, Colorado Access indicated having completed the combined business continuity and disaster recovery (BCDR) testing with Cognizant on June 4, 2018. Colorado Access and Cognizant have been testing the BCDR plans to ensure that claims processing operations can continue during unplanned systems downtime. Colorado Access confirmed an annual testing schedule with Cognizant.

Analyses of QNXT Claims Extracts

HSAG received an extract file, FY19_CHPSMCN_Claims_Extract, in January 2019. The claims extract included all SMCN claims processed in the QNXT claims system from July 1, 2018, through December 31, 2018. 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 28,489 unique claims were processed. Of the 28,489 unique claims, 83 percent (23,716) 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 17 percent (4,771) of unique claims processed were denied, with nearly 16 percent (4,593) of paid claims reported with a warn status, as noted in Table 10.

During the Web conference review on April 15, 2019, Colorado Access explained the scenario around classifying claims by assigning them "warn" statuses. Colorado Access indicated that assigning a "warn" status to a claim typically would not be the claim's final disposition. Within the claims system, a warn status is used to flag all outpatient hospital claims to indicate that the claims went through Enhanced Ambulatory Patient Groups (EAPG) pricing. This process helps ensure that Colorado Access is meeting the Department's requirement to use EAPG pricing.

Table 10—2018 Claim Counts by Month and by Claim Status

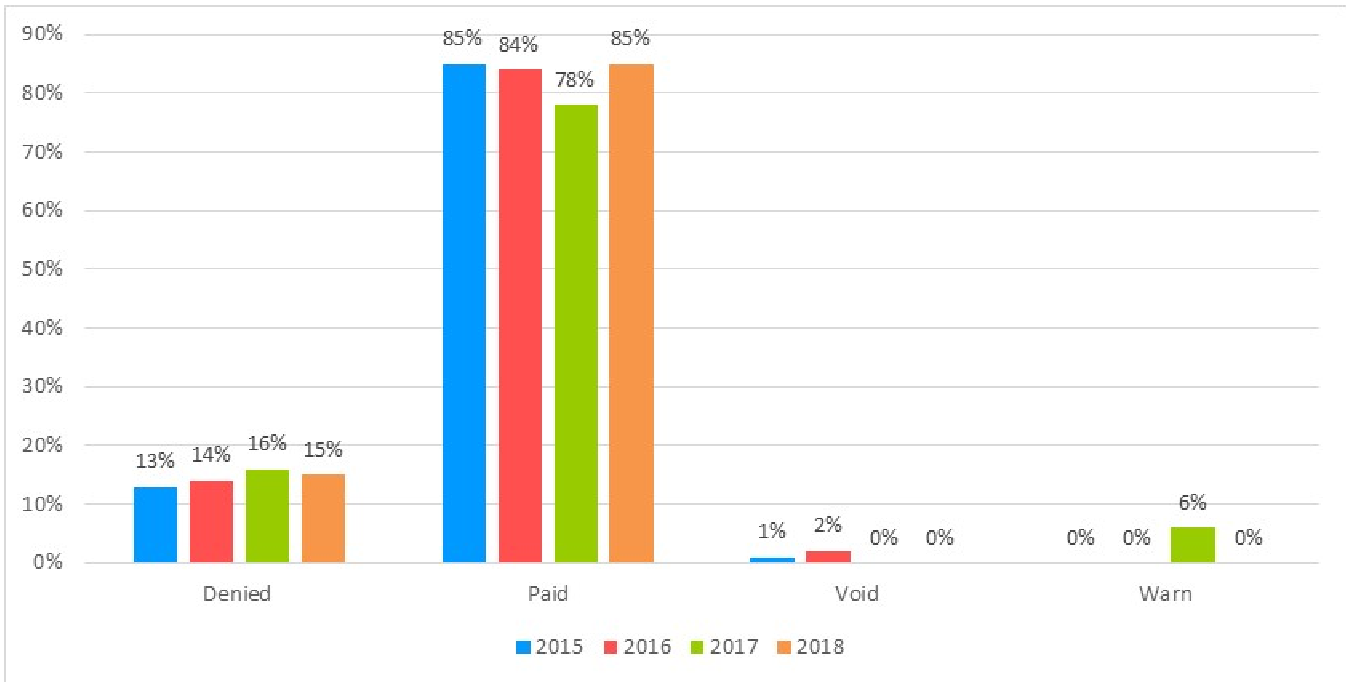
Status	July 2018 Through December 2018 [A]	Percentage*
Final Claim Line Status (eligible by status code)		
Denied	4,771	17%
Paid	23,716	83%
Void (Reversed)	3	0%
Warn (included in paid)	4,593	16%
Total	**28,489**	**116%**
Total Claim Lines (eligible by header status)		
Denied	4,807	15%
Paid	27,900	85%
Void (Reversed)	2	0%
Warn	0	0%
Total	**32,709**	**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.

*Percentage in excess of 100 percent is due to overlap in status codes.

Reversed claims are equivalent to the prior year's "void" designation. Audits conducted in earlier years (2016 and 2017) analyzed medical claims for January through June. The claims analyses for the 2018 and 2019 audits were changed to align with new contract dates of June through December; therefore, final claims status trends should not be interpreted as they are not from comparable time periods. However, the final claims status percentages are illustrated in Figure 1.

Figure 1—Final Claim Header Status Percentages for Unique Claims

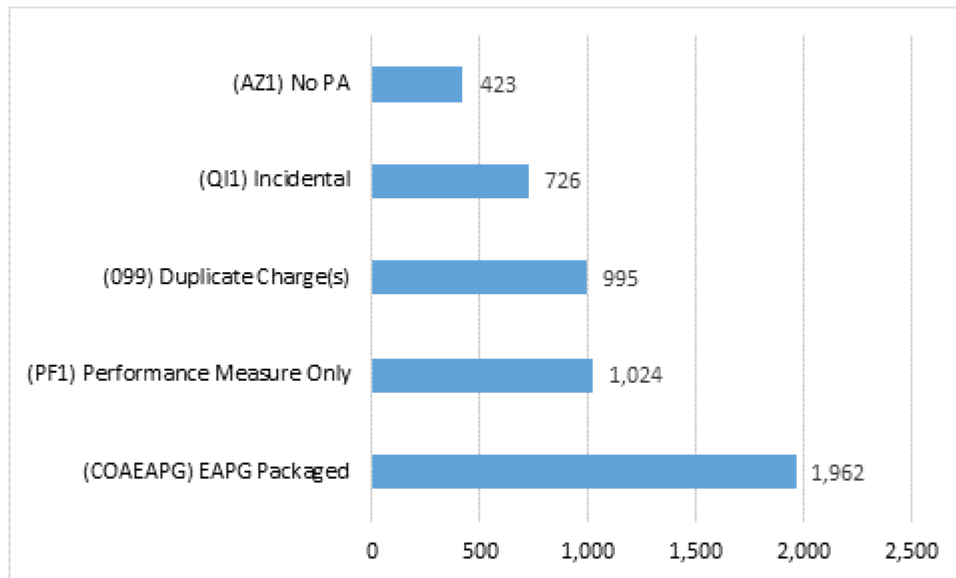


Analysis of Denied Claims. When a claim or service within a claim is denied, the provider is sent an Explanation of Payment (EOP) letter including the applicable denial reason. Providers may appeal claim denials in accordance with the federal managed Medicaid regulations. Table 11 and Figure 2 provide counts of highest frequency denials by reason code for claims processed July 2018 through December 2018.

Table 11—Denied Claims Listed by Denial Reason

Payment Denial Explanation Code	Denial Code Description	Count of Denials
COAEAPG	EAPG packaged or non-priced service.	1,962
PF1	Claim line submitted as performance measure only, no payment required.	1,024
099	Duplicate charge(s), previously processed.	995
QI1	Code denied as incidental to more complex procedure.	726
AZ1	Service denied. No prior authorization obtained.	423

Figure 2—Frequency of Denied Claims by Denial Reason



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

COAEAPG: EAPG packaged or non-priced service—1,962 unique claims denied.[1]

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. Over 95 percent of claims denied under COAEAPG originated from on-campus outpatient hospitals and hospital emergency rooms.

PF1: Claim line submitted as performance measure only, no payment required—1,024 unique claims denied.

Performance measures are reported by providers via claims by adding a specific, identifiable measure code to a claim line. These claim lines are denied since codes are used for reporting only and do not represent services provided. Over 92 percent of claims denied under PF1 originated from a healthcare provider's office.

099: Duplicate charge(s), previously processed—995 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. Over 43 percent of claims denied under 099 originated from a healthcare provider's office.

QI1: Code denied as incidental to more complex procedure—726 unique claims denied.

Claims submitted with services considered to be incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance are not eligible for separate reimbursement. As a result, claim lines processed with the incidental code (or codes) are denied. Over 91 percent of claims denied under QI1 originated from a healthcare provider's office.

AZ1: Service denied. No PA obtained—423 unique claims denied.

To conduct an analysis of claims denied for no PA, HSAG compared the service codes in these denied claims with the list of services requiring PA and available on the Colorado Access website: 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. Over 58 percent of claims denied under AZ1 originated from a healthcare provider's office.

[1] Denials are usually at the claim line level, so it is common to have some lines deny as a bundled/packaged service because they are included in the lines that generate an EAPG payment.

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. Thirty-four deduplicated claims (0.14 percent) were identified as having been paid incorrectly. In most cases the Medicaid allowed amount was less than the COB payment; therefore, no payment was made.

Evaluation of Claims Paid for Dates of Service 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 eligible. A relatively low number of unique claims (105) met this criterion; therefore, HSAG did not ask Colorado Access to research these claims to validate eligibility at time of service.

HSAG examined the paid claims by service month to determine if any significant increases occurred during specific months in 2018. Following are the counts of claims paid with dates of service outside the member's eligibility dates: July (27), August (19), September (17), October (11), November (23), and December (8). This analysis was based on the eligibility information that HSAG received.

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

The claims analysis included a review of claims with a last date of service between July 1, 2018, and December 31, 2018, and a status of "Paid." No claims were identified as having been paid more than 180 days after the claims received date. No concerns were identified from this analysis.

Pharmacy Claims Audit Findings

HSAG received the initial pharmacy claims data file on January 25, 2019. This SMCN claims audit report for 2019 examined pharmacy claims processed between July 1, 2018, and December 31, 2018. Since pharmacy claims are 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:

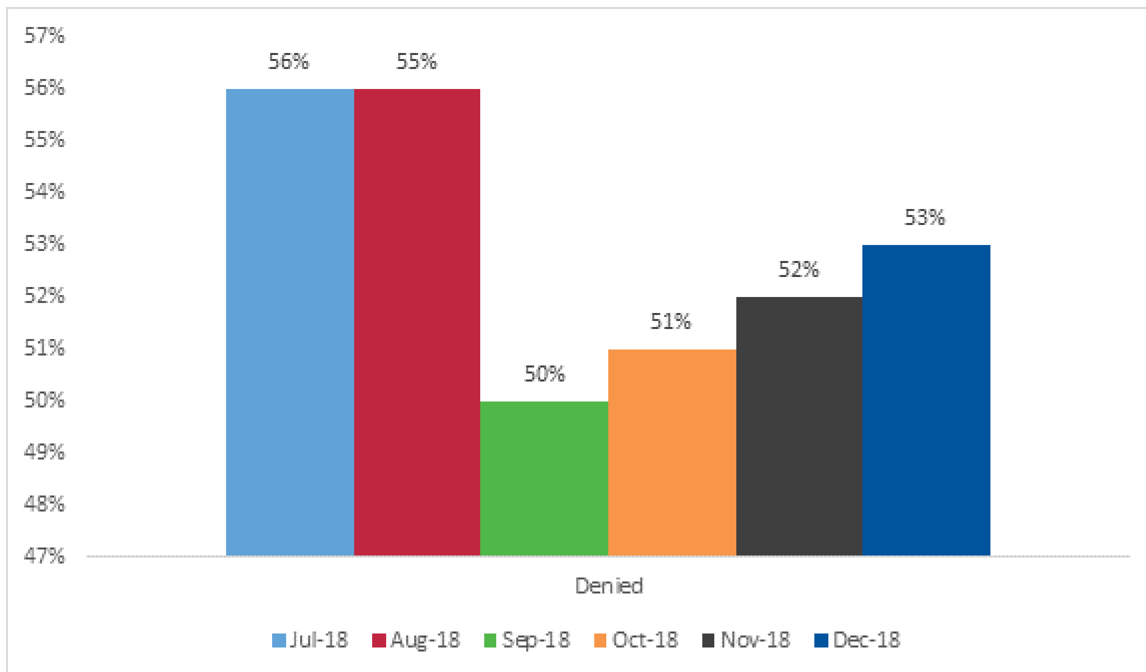
- Evaluation of the trends in pharmacy claims paid and rejected each month.
- Evaluation of pharmacy claims rejections.
- Examination of pharmacy claims with rejection status of "Patient is Not Covered." However, the enrollment and eligibility files that HSAG received indicated that these members were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

HSAG's preliminary review of claim files revealed 12,567 unique pharmacy claim records: 5,927 paid and 6,640 denied. Voided and reversed pharmacy claims were excluded from this scope of analysis given the commonality with point-of-sale pharmacy transactions. Excluding voided and reversed claims, the total paid and rejected claims were calculated for each month as shown in Table 12.

Table 12—Pharmacy Claims Processed From July 2018 Through December 2018

Pharmacy Claims Volume	July 2018	August 2018	September 2018	October 2018	November 2018	December 2018	Total
Paid	821	998	956	1,274	1,015	863	5,927
Rejected	1,032	1,241	963	1,326	1,097	981	6,640
Total	1,853	2,239	1,919	2,600	2,112	1,844	12,567

Figure 3—Trends in Denied Claims—July 2018 Through December 2018



In reviewing the trends in denied pharmacy claims by month, pharmacy claim denials ranged from 50 percent to 56 percent. 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	3,493	52.6%
Product/service not a covered benefit	1,468	22.1%
Days' supply exceeds maximum allowable	653	9.8%
Refill too soon	276	4.2%
Missing/invalid—dispense as written	263	4.0%

*Total does not equal 100 percent because only the top five reasons were included.

HSAG's analysis indicated that 52.6 percent of pharmacy claim denials occurred because the member was not eligible at the time of service.

The FY 2018–2019 audit desk review tool included a review of the subcontractor agreement between Colorado Access and Navitus, 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's performance. The pharmacy claims analysis was limited to establish a baseline evaluation of contractual performance.

Colorado Access Follow-Up Regarding 2018 Audit Recommendations

The following information provides an overview of the status of Colorado Access efforts to address the recommendations from the 2017–2018 claims audit recommendations.

- **Recommendation 1:** Colorado Access' policies and desk-level procedures should be properly labeled with the organization name, effective dates, policy owner, and update history.

  Response: Colorado Access has a process for policy and desk-level procedure updates. The three desk-level procedures that lacked proper labeling were stuck in process due to the departure of a staff member in the Compliance Department. Colorado Access' Chief Compliance Officer personally updated the three desk-level procedures that lacked proper labeling. Colorado Access plans to fill the open position and resume with the established process as soon as possible.

  The ADM201 Policy and Procedure Management document was updated based on the recommendations to label the policies and procedures with the policy organization name, effective dates, policy owner, and update history. HSAG received the updated policy on January 25, 2019, among the uploaded files.

- **Recommendation 2**: 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."

  Response: Colorado Access produces its own statistics for claims accuracy to include inaccuracies that are due to improper QNXT system configurations (i.e., problems that arose on Colorado Access' side of the system). The internal calculations are the numbers that Colorado Access turns into the State, as they reflect true claim processing accuracy and turnaround times. Colorado Access cannot expect Cognizant to process a claim any differently than the system's configuration indicates. Therefore, the caveats listed in the *Business Rules Manual* are acceptable from Colorado Access' perspective. Colorado Access uses the statistics produced by Cognizant for oversight of the vendor only.

- **Recommendation 3:** 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.

  Response: The *BPO Audit DLP* language has been edited to reflect that Colorado Access has three days to enter a paper claim into the QNXT system and seven days to process the claim. Colorado Access was unaware about any five-day turnaround time requirement and requested more information about the origin of that reference.

  The *BPO Audit DLP* document was updated based on the recommendations to define the turnaround time and include a title, policy number, and effective date. The CLM DP23 – BPO Audit document was submitted for the FY 2018–2019 audit and included the title, policy number (CLM DP23), and effective date of November 15, 2018. This policy now states that claims will be logged into QNXT within three days and claims processed within five business days.

- **Recommendation 4**: The policies, *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.

  Response: The above listed desk-level procedures have been updated as requested and uploaded to the HSAG FTP site. Note: HSAG received updated policies on January 25, 2019, within the uploaded files. Documents included were *CLM DP17 ATA Audit the Auditor, CLM DP24 High Dollar Claims,* and *CLM DP23 BPO Audit*.

2018–2019 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, 2019, the opportunity exists to refine some organizational processes to optimize claims processing resources and outcomes. The Department is requiring Colorado Access to provide a remediation plan for the recommendation outlined in the 2018–2019 audit. The Department will provide further instructions and time frames for submitting the remediation plan. The following recommendation is based on the current audit findings, contractual requirements, regulations, and industry trends.

- Colorado Access should continue to work with Cognizant to refine the process in QNXT when a member change occurs affecting the enrollment span to ensure that duplicate payments are not made due to existing claim matching logic.

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 Details: 834s are received from the State daily and are posted to the HCPF SFTP site where we download them and then process them in our system that night. See Attachment A process flow. We also receive manual spreadsheet files from DH CMAP, the States CHP enrollment vendor. These files have urgent enrollments that are not coming over on the 834 files due to HCPF system issues.	☒ Met ☐ Partially Met ☐ Not Met
Findings: Colorado Access provided documentation which substantiated the eligibility and enrollment file process that the organization follows to read, load, manage, and track all data elements provided in the 834 files.		
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.	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

Standard I—Enrollment Processing Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(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		
Findings: Colorado Access indicated in the "Evidence as Submitted by the Health Plan" field that the application date is not included in any of the three eligibility and enrollment files that Colorado Access receives. Instead, Colorado Access uses 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.		
3. The Contractor uses reports and information from the CIC and /or the CMBS to verify the CHIP+ 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

Standard I—Enrollment Processing Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The desk review information and Web conference discussions with Colorado Access confirmed use of available reports and information from Colorado Benefits Management System (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	.00	=	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 • CLM DP17 ATA_Audit the Auditor • CLM DP24 High Dollar Claims • CLM DP26 Error Reporting to BMS • CLM DP23 BPO Audit • CMP211 Fraud, Waste and Abuse • Professional Provider Contract_SMCN -Section C. 6 – hold harmless clause • Trizetto(Cognizant)_Weekly Inventory Tracking • Trizetto(Cognizant)_Monthly Quality Tracking (3)	☒ Met ☐ Partially Met ☐ Not Met
Findings: Colorado Access submitted policies, procedures, business rules, tracking reports, and a provider participation agreement 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 (Cognizant)-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.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		

Standard II—Claims Processing Operations and Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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: • FY19_CHPSMCN_Claims Extracts *See Password Document	☒ Met ☐ Partially Met ☐ Not Met

Standard II—Claims Processing Operations and Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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.		

<table>
<tr><th colspan="3">Standard II—Claims Processing Operations and Systems</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the Health Plan</th><th>Score</th></tr>
<tr><td>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.
• 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 – E</td><td>Files:
• SMCN Claims TAT Performance Target Q1
• SMCN Claims TAT Performance Target Q2
• COA Report Card 2018 10 AMS BMS</td><td>☒ Met
☐ Partially Met
☐ Not Met</td></tr>
<tr><td colspan="3">Findings: The documents submitted verify compliance that Colorado Access pays clean claims following the timeliness requirements for both in-network and out-of-network claims.</td></tr>
<tr><td colspan="3">Recommendations: HSAG identified no recommendations applicable to this requirement.</td></tr>
<tr><td>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 F</td><td>Files:
• COA Report Card 2018 10 AMS BMS
• QNXT Quarterly Summary_2018
• Trizetto(Cognizant)_Monthly Quality Tracking (3)</td><td>☒ Met
☐ Partially Met
☐ Not Met</td></tr>
<tr><td colspan="3">Findings: The documents submitted verify compliance that Colorado Access accurately pays 99 percent or greater of claims.</td></tr>
<tr><td colspan="3">Recommendations: HSAG identified no recommendations applicable to this requirement.</td></tr>
</table>

Standard II—Claims Processing Operations and Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. For financial errors identified during the claims accuracy audits, the errors are reported annually and upon request by Contractor to the Department. Errors are reported under the following circumstances: • Processor error • System error • Incorrect application of CHP+ benefit plan provisions • Incorrect application of discounts • 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 G	Files: • Cognizant Audit Guide • CLM DP17 ATA_Audit the Auditor • CHP+ SMCN Errors Sep'17-Sep'18	☒ Met ☐ Partially Met ☐ Not Met
Findings: The documents submitted verify compliance that Colorado Access' financial errors are reported annually and upon request to the Department and include the Department's error categories.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		

Results for Standard II—Claims Processing Operations and Systems							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
Total Applicable		=	5	**Total Score**		=	5
					Total Score ÷ Total Applicable	=	100%

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: • Optumas File Submission Screen Shot • Weekly Inventory Tracking • Emails to HCPF Contract Manager with weekly spends attachments include: -Bi-weekly Pharmacy Report (3) -Weekly Check Run (3) • Notification of high dollar claims sent on case-by-case basis -High Dollar Claim Paying Over 100K (2)	☒ 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 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.LL3. C.R.S. §25.5-1-204.	Files: • APCD FRD_All LOB • Email -CO APCD Portal Submission Receipt 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

Standard III—Claims Operations Infrastructure and Reporting		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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.		
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 CHPHMO_SMCN • Business Continuity Plan–Customer Service • Business Continuity Plan – Info Technology • 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-CHPHMO_SMCN 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	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Claims Operations Infrastructure and Reporting		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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. -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 Colorado Access maintains a BCDR plan to manage unexpected events that may negatively and significantly impact the ability to service members. HSAG received the disaster recovery test results for 2018 wherein five issues were identified by Cognizant/TriZetto hosting but were successfully corrected by Colorado Access.		
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 • PRI 100 Protecting Member PHI • PRI 102 Non-clinical Staff Use & Disclosure of Member PHI • HIP204 Security of ePHI	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Claims Operations Infrastructure and Reporting		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• PRI DP02 Breach for Contracts with State • Cognizant BAA	
Findings: The documents submitted verify compliance with this requirement. Colorado Access had a comprehensive set of data privacy and security policies and processes to monitor and report the four primary risk areas. Colorado Access ensured that the BAA with Cognizant also met 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	.00	=	0
	Not Met	=	0	X	.00	=	0
Total Applicable		=	4	**Total Score**		=	4
					Total Score ÷ Total Applicable	=	100%

Appendix B. FY 2018–2019 SMCN Claims Processing Audit: Desk Review Instructions

The Colorado Department of Health Care Policy and Financing (the Department) contracted with Health Services Advisory Group, Inc. (HSAG), for Fiscal Year (FY) 2018–2019, to assess Colorado Access' (the Department's contracted Administrative Services Organization) ability to process claims for the State Managed Care Network (SMCN) providers. The focus of the FY 2018–2019 audit will include a desk review, detailed claims analysis, and Web-conference review to assess compliance with the medical, behavioral health, and pharmacy claims timeliness, quality, and effectiveness standards detailed in the contract.

Colorado Access is required to submit data files, desk review documents, and the completed *Claims Audit Desk Review Tool* to HSAG on or before **January 25, 2019**. After the initial review of the data files and desk review documents submission, HSAG will confirm that it has all the information needed to conduct the review of the claims data files and desk review. This document outlines the specific document and data request requirements, with detailed instructions for submitting them to HSAG.

Instructions for Desk Review Documents Submission

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* was provided on November 19, 2018 as a pre-formatted Microsoft Word document. Please do not change the format.

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:

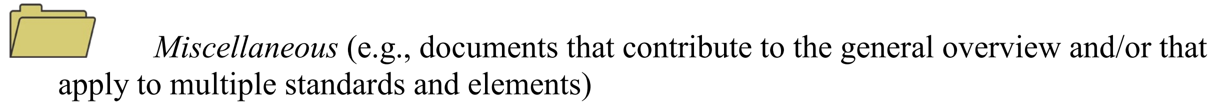
- A list of documents that support and provide evidence of compliance with the requirement (e.g., written policies and procedures, forms, templates, completed logs, or reports produced by the health plan or delegate).
- Information that identifies the exact portion of the document that provides the evidence 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).
- Copies of executed written agreements for the delegation of administrative services related to each standard reviewed.

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.

- 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 with a password.

SMCN_Claims Audit FY2018–2019

Claims Audit Desk Review Tool


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

- Cognizant 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 Cognizant. 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 in yellow 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 FY2018-2019 folder under HSAG's secured FTP site:

   Child Health Plan Plus\Administrative Service Organization (ASO)\Colorado Access\ SMCN_Claims Audit FY2018-2019.

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

Appendix C. FY 2018–2019 SMCN Claims Processing Audit: Data File Request

As communicated on December 15, 2018, Colorado Access is required to submit the desk review documents and the completed *Claims Audit Desk Review Tool* to HSAG on or before **January 25, 2019**.

Additionally, Colorado Access must submit the following data files and documents on or before **January 25, 2019**. 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 January 25 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 Cognizant 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 QXNT system.
3. Quarterly performance reports submitted to the Department for calendar year 2018.
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, 2018, through January 31, 2018.
5. Methodology and/or reporting logic for Cognizant's claim processing turnaround.
6. Results of the 2018 combined business continuity and disaster recovery (BCDR) testing with Cognizant.
7. PBM's BCDR plan and testing results if available.
8. 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, 2018, and December 31, 2018. 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	FY19_CHPSMCN_Medical_Claims_Extract
Pharmacy claims (include co-pay information)	FY19_CHPSMCN_Pharmacy_Claims_Extract
Vision claims *(if not included in professional claim files)*	FY19_CHPSMCN_Vision_Claims_Extract

9. Data file layout by which Colorado Access receives and ultimately determines member eligibility. Identify and describe any changes from the FY 2017–2018 audit data file layout.
10. An extract of the QNXT provider file for the period of July 1, 2018, and December 31, 2018.
    - The requested file name is: FY19_CHPSMCN_Provider_Extract
11. Monthly enrollment and eligibility files for May 2018, through February 2019.
    - The requested file name is: FY19_CHPSMCN_Eligibility_Extract
12. Copies of the claim turnaround time reports from May 2018 – January 2019.
13. Narrative and evidence of updates made to documents, policies and/or manuals regarding the following 2017–2018 SMCN Network Claims Processing and Audit Improvement Opportunities:
    - 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.

Instructions for Data and Related Document Submissions

1. Colorado Access should submit the requested data file documents and extracts to HSAG on or before **January 25, 2019.**
2. For the claims data files, HSAG requires that the data files are 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 Amrit Kerr at (602) 801-6858 or akerr@hsag.com and Ms. Crystal Brown at (720) 697-7907 or cbrown@hsag.com to provide her with the file password(s).
3. Please upload all requested documents to the SMCN_Claims Audit FY2018–2019 folder under HSAG's secure FTP site:
   Child Health Plan Plus\Administrative Service Organization (ASO)\Colorado Access\ SMCN_Claims Audit FY2018-2019.
   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 the data submitted to HSAG for the audit was extracted from Colorado Access' data systems (or delegated entity's system) and follows 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 2018–2019 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, 2018, federal and state regulations, and HSAG's *FY 2018–2019 SMCN Claims Processing Audit Data File Request*.

Signature of CEO, CFO, or delegated authority	Print Name	Date
	Phil Reed	1.24.19

Indicate if the submitted files are a:

- [x] **First-time submission**
- [ ] **Resubmission/Replacement**

Submitter Name:	**Submitter ID:**
Janet Milliman	n/a
Complete Street Address:	Telephone Number (include area code):
11100 E. Bethany Dr. Aurora, CO 80014	(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
Attachment A – Eligibility Load Process	1
EE DP54 – Desktop Process Reading 834 EDI Files	1
CHP+ SMCN Errors Sep' 17-Jan23'19	15

CLM DP17 ATA Audit the Auditor	1
CLM DP24 High Dollar Claims	1
CLM DP26 BMS Error Report	1
CLM DP23 BPO Audit	1
CMP211 Fraud Waste and Abuse	1
COA Report Card 2018 10 AMS BMS	22
Cognizant Audit Guide	1
Professional Provider Contract_SMCN	1
QNXT Quarterly Summary_2018	11
SMCN TAT Performance Target Q1 FY2018-19	12
SMCN TAT Performance Target Q2 FY2018-19	12
Trizetto(Cognizant) Monthly Quality Tracking November '18	1
Trizetto(Cognizant) Monthly Quality Tracking October '18	1
Trizetto(Cognizant) Monthly Quality Tracking September '18	1
Trizetto-Cognizant Business Rules Document	1
Weekly Inventory Tracking	39
sFTP Log-in Audit Procedure	1
PRI DP02 Breach for Contracts with State	1
PRI 102 Non-Clinical Staff Use and Disclosure of Member PHI	1
PRI 100 Protecting Member PHI	1
Optumas File Submission Screen Shot	1
NHS Business Continuity Plan v7.1	1
IT202 IT processes for Maintaining Security of EPHI	1
IT201 IT Management of Systems Access	1
HIP204 Security of EPHI	1

DRP – Storage and Backup V2.1	1
Cognizant Delegation Agreement	1
Cognizant BAA	1
CO APCD Portal Submission Receipt	1
CCS306 Delivering Continuity and Transition of Care for Members	1
Business Continuity Plan – Information Technology	1
Business Continuity Plan – Customer Service	1
Business Continuity Plan- CHP HMO_SMCN	1
APCD FRD All LOB	1
ADM202 – Systems Access	1
Weekly Check Run	3
High Dollar Claim Paying Over 100K	2
Bi-Weekly Pharmacy Report	3
Navitus BAA	1
Navitus Delegation Agreement	1
PBC DP14 SMCN Fee Schedule	1
PBC DP15 FQHC Rates Updates	1
Rx DP24 Immunization Fee Schedule Update	1
SMCN Claims Audit – Quarterly Reports	1
Exceptions Summary SMCN	1
SMCN Encounter 2	1
Cognizant Logic TAT Calculations	1
COA DR Results 2018	1
FY19_CHPSMCN_Medical_ Claims_Extract	111093
FY19_CHPSMCN_Pharmacy_ Claims_Extract	170897

834_x220A1_consolidated	1
CO_EDI_v5010_X12_834_Companion Guide_7.27.18	1
FY19_CHPSMCN_Provider_Extract	98028
FY19_CHPSMCN_Eligibility_Extract	723757
ADM201 Policy and Procedure Management	1
13b. Caveats	1

Appendix D. SMCN Claims Processing Audit Agenda

Colorado Department of Health Care Policy and Financing
Web Conference Review Agenda
SMCN Claims Processing Audit

April 15, 2019
1:00 p.m. – 4:00 p.m. MT

https://hsagonline.webex.com/hsagonline/j.php?MTID=m07e37278195c6a2930d8fb7d275aaba7
Meeting Number (Access Code): 809 245 621 • Meeting Password: Hsag2019!

HSAG Reviewer: Kari Vanderslice, MBA

Agenda	
Sessions and Activities	
1:00 – 1:05 p.m.	**Welcome and Introductions** • Introductions • Overview of SMCN Claims Processing Audit
1:05 – 1:45 p.m.	**Systems Infrastructure** • Ensuring Data Privacy and Security • Data Integration Strategy and Capabilities • Business Continuity and Disaster Recovery • Eligibility and Enrollment Processing *Colorado Access will be asked to provide overview of network infrastructure, data warehouse, information security plans, data privacy and security training materials, and business continuity and disaster recovery plans. Colorado Access will review testing activities and remediation plans for exchanging data with the Department's enrollment broker.* *Colorado Access will be required to display member enrollment and eligibility records in the relevant systems, electronic and paper claims process, and processes related to anomalies or issues pertaining to data flow.*

<table>
<tr><th colspan="2">Agenda</th></tr>
<tr><th colspan="2">Sessions and Activities</th></tr>
<tr><td>1:45 – 3:00 p.m.</td><td>Claims Data Analysis Preliminary Findings and Questions
• Note: may require access to QNXT system

Colorado Access will be asked to review systems for managing prior authorizations. HSAG will require a claims system demonstration and the process followed when a claim is pended for review and when a claim is denied. Colorado Access will demonstrate how fee schedules are set up and updated.

HSAG will also review the following items:
• TriZetto/Cognizant staff supporting COA
• COA staff training on QNXT
• COA system interface(s) with QNXT
• Provider file processing
• Coordination of benefits process
• Claim Backlog – strategy to address
• Internal auditing process

HSAG will require Colorado Access to walk through the steps for creating, validating, and submitting encounter data files to the Department.</td></tr>
<tr><td>3:00 – 3:10 p.m.</td><td>Break</td></tr>
<tr><td>3:10 – 3:55 p.m.</td><td>Desk Review Documents Questions and Clarifications</td></tr>
<tr><td>3:55 – 4:00 p.m.</td><td>Closing and Adjournment
• Next steps</td></tr>
</table>

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 Web conference agenda; and scheduled the Web conference audit. • HSAG submitted all materials to the Department for review and approval.
Activity 2:	**Perform Preliminary Review**
	• On November 19, 2018, 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 5, 2018, 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 25, 2019, Colorado Access provided documentation for the desk review, as requested. • On December 5, 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, 2018, and December 31, 2018. On January 25, 2019, Colorado Access provided data files and supplemental documentation as requested. • On March 15, 2019, HSAG sent Colorado Access the on-site agenda for the April 15, 2019 Web conference review. • The HSAG review team reviewed all documentation submitted prior to the Web conference 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 Web conference.

	HSAG completed the following activities:
Activity 3:	**Conduct On-Site Claims Audit**
	• During the Web conference 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. • HSAG requested and reviewed additional documents as needed. • At the close of the Web conference review, HSAG discussed with Colorado Access staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2018–2019 SMCN claims audit report template to compile findings and incorporate information from the desk review and Web conference 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 2018–2019 SMCN Claims Audit Report to the Department for review and comment, according to the Department-approved timeline. • Upon the Department's approval, HSAG to submit draft report to Colorado Access for review and comment. • HSAG to incorporate Colorado Access' and the Department's comments, as applicable, then finalize the report. • HSAG to distribute the final report to Colorado Access and the Department.