CHP+

Child Health Plan *Plus*

State Managed Care Network Claims Audit Report

June 2020

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, 2019, through December 31, 2019
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HSAG HEALTH SERVICES ADVISORY GROUP

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, 2019, and December 31, 2019, in accordance with the Department of Health Care Policy and Financing (Department) contract executed on June 28, 2019, 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, 2019, and December 31, 2019, 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 interviews; and follow-up discussions.

The second section of this SMCN claims audit report encompasses the review of pharmacy claims processed between July 1, 2019, and December 31, 2019, 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 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 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 2019–2020, 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 2019, the Department executed a new contract with Colorado Access to provide administrative services for the CHP+ program from July 1, 2019, through June 30, 2020.

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 2019–2020 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 2019–2020 audit was on claims processed between July 1, 2019 and December 31, 2019, 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, 2019, and December 31, 2019; a web 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 2018–2019 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 2019 to December 2019 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 2019–2020 desk review component, Colorado Access received a score of 100 percent with 12 elements scored as *Met*. Based on performance reporting and web 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 did identify opportunities to improve Colorado Access' contractual oversight practices 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 2019–2020 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 2019–2020 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 23, 2020. Appendix C contains the claims data files and supplemental documentation that Colorado Access was required to submit on January 24, 2020. 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 23, 2020. 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 review. The agenda for the web 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—Enrollment Processing 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 2019 through December 2019. The *SMCN Overall TAT Data—Revised* report indicates the overall rate for the "All Claims Finalized Within 14 Days" claims processing turnaround was 90.42 percent for the third quarter (July through September) and 90.01 percent for the fourth quarter (October through December), which met the 90 percent performance standard. Although the rates fell below 90 percent in the months of July, October, and November, the rates are evaluated by the Department quarterly and annually and met the processing threshold. The *SMCN Claims TAT Performance Target Report* displays results indicating that Colorado Access met the requirements for paper claims processed within 45 days and electronic claims processed within 30 calendar days.

Table 2—SMCN Claims Processing Turnaround

Performance Standard	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019
≥90% All Claims Finalized Within 14 Days	88.42%	90.38%	93.05%	88.60%	89.82%	91.71%
≥98% Paper Claims Processed Within 45 Days	99.88%	100.00%	99.65%	99.86%	99.81%	99.86%
≥98% Electronic Claims Processed Within 30 Days	99.68%	99.77%	99.34%	99.73%	99.83%	99.15%

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 2019 through December 2019. 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 2019	August 2019	September 2019	October 2019	November 2019	December 2019
≥90% Finalized Within 14 Days	99.46%	99.43%	99.64%	99.20%	99.06%	99.59%
≥98% Finalized Within 30 Days	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
≥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 2019 through December 2019 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 October 2019), the *Colorado Access Audit Guide* (2019), 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 2019	August 2019	September 2019	October 2019	November 2019	December 2019
≥99% Financial Accuracy	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

- **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 2019 through December 2019 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 October 2019) and the *Colorado Access Audit Guide* (2019), 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 2019	August 2019	September 2019	October 2019	November 2019	December 2019
≥98% Processing Accuracy	100.00%	100.00%	99.02%	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 2019 through December 2019 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* (2019) 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 2019	August 2019	September 2019	October 2019	November 2019	December 2019
≥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 2019 through December 2019 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* (2019); Colorado Access' policy titled *CLM ADP 02 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 2019	August 2019	September 2019	October 2019	November 2019	December 2019
≥99% Entered Within 5 Days	100.00%	100.00%	100.00%	100.00%	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 2019 through December 2019 confirmed that Cognizant met the configuration turnaround requirement all months, as noted in Table 8.

Table 8—Cognizant Configuration Turnaround Time

Performance Standard	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019
≥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 2019 through December 2019 confirmed that Cognizant met the configuration accuracy requirement all months, as noted in Table 9.

Table 9—Cognizant Configuration Accuracy

Performance Standard	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019
≥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 relatively unchanged from the FY 2018–2019 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 claims audit occurred on April 8, 2020.

The web discussion concluded that claims processes and monitoring control activities were consistent with policies and procedures. Colorado Access confirmed that, for 2019, its claims staff members reviewed 100 percent of claims requiring payments over $10,000 before the claims were paid. The Colorado Access claims audit team documented these reviews in both the QNXT claims system and the auditor reports.

The web 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 18 individual claims and scenarios selected from the 2019 audit submission. In one of the example scenarios, Colorado Access displayed a claim paid through the Enhanced Ambulatory Patient Group (EAPG) pricer, demonstrated in QNXT that the claim had been reversed, and showed it was reprocessed with a different amount due to a fee schedule update. In follow-up to the meeting, HSAG reviewed 10 additional claims scenarios and was able to resolve any questions about managing retro-enrollment processing, claim reprocessing for appeals, and handling corrected claim submissions from providers.

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 (FWA). Colorado Access' 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 discussions with Colorado Access and Navitus confirmed that the organizations oversee audit activities focused on detecting and preventing FWA.

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

Enrollment Processing and Reconciliation Systems

The 2019 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 2019 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 discussed the implementation of Edifecs in September 2018, which was used throughout 2019 as an encounter management tool and to create the 837 files monthly. Colorado Access demonstrated the system and processes in use 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, providing monthly security awareness training to employees, utilizing an artificial intelligence tool for intrusion detection, deploying Symantec products for prevention and protection of sensitive information, and rolling out multifactor authentication.

During the web review, Colorado Access indicated having completed the combined business continuity and disaster recovery (BCDR) testing with Cognizant on June 12, 2019. 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. In the web review discussions, Colorado Access confirmed annual BCDR testing with Navitus, and Navitus confirmed that the testing was performed on August 6, 2019. Organizations indicated that the coronavirus disease 2019 (COVID-19) situation has allowed them to execute their BCDR plans, deploy the remote workforce, and identify any improvements. The updates will be incorporated into their business continuity policies.

Analyses of QNXT Claims Extracts

HSAG received an extract file, FY20_CHPSMCN_Medical_Claims_Extract, in January 2020. The claims extract included all SMCN claims processed in the QNXT claims system from July 1, 2019, through December 31, 2019. 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 23,336 unique claims were processed. Of the 23,336 unique claims, 92 percent (21,419) 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 8 percent (1,878) of unique claims processed were denied, with zero paid claims reported with a warn status, as noted in Table 10.

During the web review on April 8, 2020, 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 EAPG pricing. This process helps ensure that Colorado Access is meeting the Department's requirement to use EAPG pricing.

Table 10—2019 Claim Counts by Month and by Claim Status

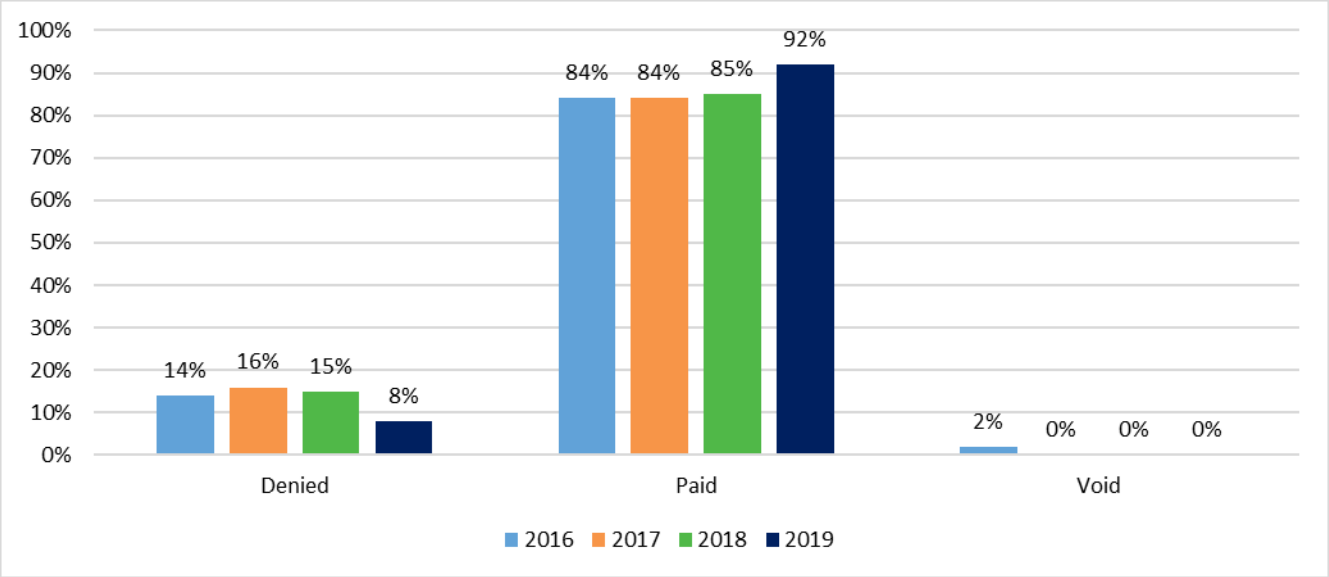
Status	July 2019 Through December 2019 [A]	Percentage
Final Claim Lines (eligible by header status)		
Denied	1,878	8%
Paid	21,419	92%
Warn (included in paid)*	0	N/A
Void (Reversed)	39	0%
Total	**23,336**	**100%**
Total Claim Line Status (eligible by status code)		
Denied	12,681	22%
Paid	46,000	78%
Warn (included in paid)*	7,960	N/A
Void (Reversed)	5	0%
Total	**58,686**	**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.

* Totals exclude claims with a Warn status; claims with a Warn status are included in the percentage of paid claims. Therefore, percentage is N/A, not applicable.

Reversed claims are equivalent to the prior year's "void" designation. Audits conducted during or prior to 2017 analyzed medical claims for January through June. Beginning in 2018, claims analyses were aligned with new contract dates (i.e., June through December); therefore, interpret final claims status trends with caution, due to the differing time periods between the 2016–2017 results and 2018–2019 results. However, the final claims status percentages are illustrated in Figure 1.

Figure 1—Final Claim Header Status Percentages for Unique Claims

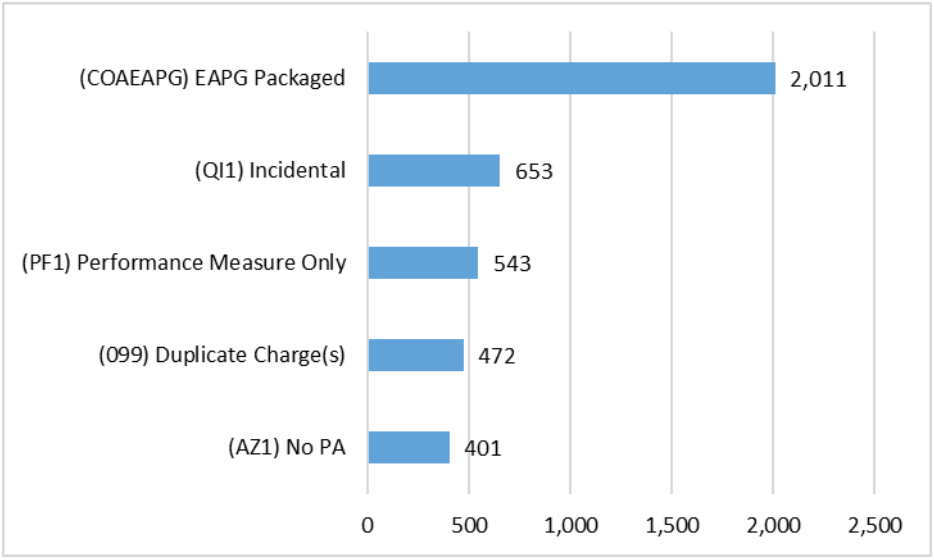


Analysis of Denied Claims. When a claim or service within a claim is denied, the provider is sent an Explanation of Payment (EOP) letter including the applicable denial reason. Providers may appeal claim denials in accordance with the federal managed Medicaid regulations. Table 11 and Figure 2 provide counts of the highest frequency denials by reason code for claims processed July 2019 through December 2019.

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.	2,011
QI1	Code denied as incidental to more complex procedure.	653
PF1	Performance/quality measure codes not payable.	543
099	Duplicate charge(s) previously processed.	472
AZ1	Service denied. No PA obtained.	401

Figure 2—Frequency of Denied Claims by Denial Reason



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

COAEAPG: EAPG packaged or non-priced service—2,011 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 97 percent of claims denied under COAEAPG originated from on-campus outpatient hospitals and hospital emergency rooms.

QI1: Code denied as incidental to more complex procedure—653 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 94 percent of claims denied under QI1 originated from a healthcare provider's office.

PF1: Claim line submitted as performance measure only, no payment required—543 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. Approximately 99 percent of claims denied under PF1 originated from a healthcare provider's office.

099: Duplicate charge(s), previously processed—472 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. Among claims denied under 099, over 38 percent originated from a healthcare provider's office and an additional 24 percent originated from an on-campus outpatient hospital.

AZ1: Service denied. No PA obtained—401 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. Among claims denied under AZ1, 57 percent originated from a healthcare provider's office and an additional 34 percent originated from an on-campus outpatient hospital and inpatient hospital.

[1] Denials usually occur at the claim line level, so it is not unusual to have individual claim lines deny as a bundled/packaged service because the services 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. Eighty-two deduplicated claims (0.35 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 (24) met this criterion; therefore, HSAG requested to review six claims during the live web demonstration and asked Colorado Access to display these claims to validate eligibility at time of service. Colorado Access provided system verification of the claims, eligibility at the time of service, and HSAG extract details. It was determined that it was a data artifact, rather than an actual processing issue for most situations.

HSAG examined the paid claims by service month to determine if any significant increases occurred during specific months in 2019. Following are the counts of claims paid with dates of service outside the member's eligibility dates: July (2), August (5), September (11), October (4), and November (2). In December, there are zero claims paid with dates of service outside the member's eligibility dates. This analysis was based on the eligibility information that HSAG received.

Pharmacy Claims Audit Findings

HSAG received the pharmacy claims data file, FY20_CHPSMCN_Pharmacy_Claims_Extract, in January 2020. This SMCN claims audit report for 2019 examined pharmacy claims processed between July 1, 2019, and December 31, 2019. 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 11,418 unique pharmacy claim records: 5,604 paid and 5,814 rejected (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 2019 Through December 2019

Pharmacy Claims	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019	Total
Paid	818 (50%)	1,028 (51%)	1,013 (53%)	911 (46%)	741 (45%)	1,093 (48%)	5,604 (49%)
Rejected	810 (50%)	971 (49%)	904 (47%)	1,052 (54%)	900 (55%)	1,177 (52%)	5,814 (51%)
Total	1,628	1,999	1,917	1,963	1,641	2,270	11,418

In reviewing the trends in rejected pharmacy claims by month, pharmacy claim rejections ranged from 47 percent to 55 percent. The top five rejection reasons for pharmacy claims are listed in Table 13.

Table 13—Top Five Pharmacy Rejection Reasons

Rejection Code Description	Count of Rejected Claims	Percentage of Rejections*
Patient is not covered	2,614	45.0%
Product/service not covered, plan/benefit exclusion	1,663	28.6%
Days' supply exceeds plan limitation	568	9.8%
Fill too soon	296	5.1%
Missing/invalid dispense as written (DAW)/product selection code	187	3.2%

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

HSAG's analysis indicated that 45.0 percent of pharmacy claim rejections occurred because the member was not eligible at the time of service.

The FY 2019–2020 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 utilization management and 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.

During the live demonstration of the system, HSAG reviewed sample pharmacy claims selected from the 2019 audit submission. Colorado Access and Navitus provided system verification of the scenarios and walked through each of the claim lines with an explanation for each step or edit. Colorado Access and Navitus satisfactorily addressed the reviewer's questions with the display of the source data and systems. In follow-up to the meeting, HSAG reviewed three additional claim scenarios, along with an analysis performed by Colorado Access on the rejections and trends during the audit period.

Colorado Access Follow-Up Regarding FY 2018–2019 Audit Recommendations

The following information provides an overview of the status of Colorado Access efforts to address the recommendation from the FY 2018–2019 claims audit.

- **Recommendation 1:** 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.

- **Response:** In order to avoid duplicate claim payments due to duplicate member enrollment spans, Colorado Access has developed a weekly report to catch any enrollment spans that have undergone a change triggered by 834 enrollment file changes. The report identifies claims that need to be reversed and/or reprocessed in order to avoid double payment. This process ensures there are no duplicate or incorrect payments related to an outdated enrollment span. This report is worked internally by the claims auditing team each week. A sweep identifying historical claims that have been affected by this issue has been completed by Colorado Access to address claims paid July 1, 2018, to current.

  During the web review, Colorado Access discussed the improvements made to the process and provided a sample copy of the *Void Span Report*. Colorado Access explained that the report is generated weekly and submitted to the claims manager. The claims manager performs analysis on the report to ensure it captured all necessary claims for reprocessing, and the report is then sent to the internal claims team. The *Void Span Report* identifies the claims and instances to be reprocessed, and the internal claims team reruns the claims so that QNXT selects the correct eligibility spans.

FY 2019–2020 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, 2020, 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 FY 2019–2020 audit. The Department will provide further instructions and time frames for submitting the remediation plan. The following recommendations are based on the current audit findings, contractual requirements, regulations, and industry trends.

- Colorado Access should monitor the Claims Turnaround Time performance metrics at monthly intervals and implement improvements to ensure meeting the requirement that 90 percent or greater of overall clean claims, paper and electronic, are processed within 14 calendar days of receipt.

Appendix A. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Claims Audit Desk Review Evaluation Tool
for Colorado Access (CHP+ SMCN)

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: 834_RAE processing_DH	☒ Met ☐ Partially Met ☐ Not Met
Findings: Colorado Access provided documentation that 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 Medicaid Management Information System (MMIS) [iChange] 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 was 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 via 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. We send a report monthly to HCPF with any enrollments received in the previous month that had a mid-month begin date not equal to the DOB	☒ Met ☐ Partially Met ☐ Not Met
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 sent by the Department on the enrollment file as the effective date of enrollment in the SMCN network. Additional documentation was provided after the web review as evidence of this procedure and included a sample of the monthly report to show how a mid-month begin date is processed.		
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 MMIS [iChange] and/or the CBMS to verify the CHP+ eligibility and Enrollment in the CHP+ SMCN plan for its Members. Contract: Exhibit C - Section 20.4	Files: • 834_RAE processing_DH • EE DP54 -Desktop Process Reading 834 EDI Files Details: All enrollment files received are loaded to our transaction system (QNXT). See 834 RAE Processing 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 web conference discussions with Colorado Access confirmed use of available reports and information from the Colorado Benefits Management System (CBMS) 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	=	3.00
	Partially Met	=	0	X	.00	=	0.00
	Not Met	=	0	X	.00	=	0.00
Total Applicable		=	3	**Total Score**		=	3.00
				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 BRD Manual Version 10_14_19 • ATA_Audit the Auditor DLP • High Dollar Claims DLP • BPO Audit DLP • CMP211 • Professional Provider Contract -Section C. 6 – hold harmless clause • Claims Audit for SMCN from Daily 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, tracking reports, and a provider participation agreement related to monitoring claims outliers and conducting quality assurance. The 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. Colorado Access provided explanation during the web conference of the claims appeal process and procedures followed by providers as assurance in accepting liability for claims processor negligence, and not holding members liable for nonpayment to providers.		
Recommendations: HSAG identified no recommendations applicable to this requirement.		
2. The Contractor's claims processing system and encounter tracking system contains the necessary elements to accurately adjudicate and report claims payments including the following data elements:	Files: Please refer to claims extract files that were submitted.	☒ Met ☐ Partially Met ☐ Not Met

Standard II—Claims Processing, Operations, and Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 Diseases (ICD-10) diagnosis codes • 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 diagnosis codes • Treating provider • Major diagnosis category • Diagnosis Related Group (DRG) Pharmacy Claims and Encounters in National Council for Prescription Drug Program (NCPDP) version D.0 format: • Subscriber identification number	(HSAG Crosswalk to file layouts submitted 1/31/20) (Updated File Layouts submitted 3/4/20)	

Standard II—Claims Processing, Operations, and Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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 SMCN claims audit file layouts and data extract files confirmed compliance with the required elements for accurately adjudicating and reporting claims payments. Colorado Access provided documentation of the claims file layout and HSAG received the layout files on January 23, 2020. After a phone conference held with Colorado Access, the most current version of file layouts for pharmacy, eligibility, and medical claims were uploaded to the SAFE site and received on March 4, 2020.		
Required Actions: 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 FY19_20 • SMCN Claims TAT Performance Target Q2 FY19_20 COA Report Card 2019 12 AMS BMS	☒ Met ☐ Partially Met ☐ Not Met

Standard II—Claims Processing, Operations, and Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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	(Updated SMCN Overall TAT Data Report submitted 4/29/20)	
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. The *SMCN Overall TAT Data—Revised* report indicated that the overall processing of clean claims within the 14-day requirement was 90.42 percent for third quarter 2019 and 90.01 percent for fourth quarter 2019.		
Required Actions: HSAG identified no recommendations applicable to this requirement.		
4. The Contractor pays 99 percent or greater of the claims accurately (financial accuracy). "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 – F	Files: • COA Report Card 2019 12 AMS BMS • COA Monthly Review July 19 Final • COA Monthly Review August 19 • COA Monthly Review September 19 Final • COA Monthly Review October 19	☒ Met ☐ Partially Met ☐ Not Met
Findings: The documents submitted verify compliance that Colorado Access 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 financial accuracy audits, the errors are reported annually and upon request by Contractor to the Department. Errors are reported under the following circumstances:	Files: • Cognizant-Colorado Access Health Audit Guide Final • ATA_Audit the Auditor DLP	☒ Met ☐ Partially Met ☐ Not Met

Standard II—Claims Processing, Operations, and Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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 D – F	• BMS Weekly Error Report SMCN • CHP+SMCN Errors Sep to Jan. Cognizant provides COA with an Error Log that does categorize the type of Financial Error. They assign a Category and Sub Category. These closely align to the State's categories listed in the contract. There were no financial errors reported during this audit period	
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	=	5.00
	Partially Met	=	0	X	.00	=	0.00
	Not Met	=	0	X	.00	=	0.00
Total Applicable		=	5	**Total Score**		=	5.00
				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 • High dollar claim/reinsurance reports, as available Contract: Exhibit D – O	Files: • Monthly File Drops for the Actuary_Screenshot (CHP Actuary Screenshot) • 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 IBNR calculations for the claims processed by Colorado Access and Navitus. During the Web conference review, Colorado Access provided additional explanation on the processes in place for the claims and encounter reporting requirements, and submitted a flow chart outlining the Optumas vendor process.		
Required Actions: 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_ABC_CHP • 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. During the web review, Colorado Access provided additional details regarding the file submission process, use of the NORC portal, and receipt of confirmation from the parties.		
Required Actions: HSAG identified no recommendations applicable to this requirement.		
3. The contractor maintains a business continuity and recovery plan to manage unexpected events that may negatively and significantly impact its ability to serve 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 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 • IT DP22 Commvault Restore Procedure • ITDP23 Electronic Data Backup Policy • ITDP24 NetBackup Restore Procedure (Storage and Backup) 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	☒ 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 IT DP22, ITDP23, ITDP24 (Storage and Backup) documents cover the IT department's steps for recovering and restoring the entire company's critical technical applications and systems.	
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. Additional policies and procedures supported the backup and restore requirement and included details on testing procedures. The annual disaster recovery testing was performed in 2019.		
Required Actions: 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 Protection of Member Individually Identifiable Health Information and PHI • PRI204 Security of EPHI 2_15_19	☒ 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 Trizetto-COA 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 TriZetto (now Cognizant) also met the federal and State data privacy and security requirements.		
Required Actions: HSAG identified no recommendations applicable to this requirement.		

Results for Standard III—Claims Operations, Infrastructure, and Reporting							
Total	Met	=	4	X	1.00	=	4.00
	Partially Met	=	0	X	.00	=	0.00
	Not Met	=	0	X	.00	=	0.00
Total Applicable		=	4	**Total Score**		=	4.00
				Total Score ÷ Total Applicable		=	100%

Appendix B. FY 2019–2020 SMCN Claims Processing Audit: Desk Review Instructions

November 20, 2019

Ms. Michelle Tomsche
Director of Claims Operations and Research
Colorado Access
11100 East Bethany Drive
Aurora, CO 80014

RE: 2019-2020 SMCN Claims Audit

Dear Michelle:

Health Services Advisory Group, Inc. (HSAG), the external quality review organization (EQRO) for the Colorado Department of Health Care Policy & Financing (the Department) is conducting the SMCN Claims Audit for the claims processed in 2019.

This letter describes the activities related to the Fiscal Year (FY) 2019-2020 CHP+ SMCN claims audit. The claims audit will be conducted in four phases, each building upon the information addressed during the preceding phase. The four claims processing audit phases—i.e., desk review, detailed claims analysis, on-site audit, and reporting —are described in more detail on the following pages.

The following table shows the critical dates of the SMCN Claims Audit.

SMCN Claims Audit Timeline

Task and Sub-task Description	Start Date	End Date	Responsibility
Audit Planning			
Web-conference to review data requests and deliverable timeline.	11/18/19	11/22/19	Department/ Colorado Access/HSAG
Submit requested claims extract data file layouts and other data sources to HSAG.	**11/18/19**	**11/26/19**	**Colorado Access**
Incorporate feedback and submit final methodology to the Department and Colorado Access.	11/18/19	11/26/19	HSAG
Audit Execution			
Prepare document request for desk review and submit to Colorado Access.	11/25/19	12/3/19	HSAG
Colorado Access submits requested documents and data extracts to HSAG.	**1/13/20**	**1/24/20**	**Colorado Access**
Conduct desk review and send requests, if any, for additional documentation to Colorado Access.	1/13/20	1/24/20	HSAG

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Task and Sub-task Description	Start Date	End Date	Responsibility
Finalize on-site review dates.	2/3/20	2/7/20	Department/ Colorado Access/HSAG
Receive additional requested documents from Colorado Access.	2/18/20	2/28/20	HSAG
Conduct claims analysis. Communicate with Colorado Access to clarify any potential issues identified from the analysis.	2/3/20	3/20/20	HSAG
Forward on-site agenda to Colorado Access and the Department.	3/9/20	3/13/20	HSAG
Receive additional requested documents from Colorado Access.	3/30/20	4/7/20	HSAG
Continue with claims analysis activities; finalize and validate results.	3/30/20	5/1/20	HSAG
Conduct on-site review with Colorado Access and the Department.	**4/8/20**	**4/8/20**	**Department/ Colorado Access/HSAG**
Send post-review follow-up documents (if any) to HSAG.	**4/20/20**	**4/24/20**	**Colorado Access**
Resolve all outstanding items with Colorado Access and the Department.	4/27/20	5/15/20	HSAG
Report Generation			
Draft audit findings report and send draft report (D1) to the Department and Colorado Access for review.	4/20/20	5/29/20	HSAG
Review report and provide feedback/comments to HSAG.	**6/1/20**	**6/15/20**	**Department/ Colorado Access**
Incorporate feedback and update report; send final report (F1) to the Department.	6/16/20	6/30/20	HSAG

Phase One – Desk Review

During Phase One, HSAG will evaluate Colorado Access's (COA) contracts, policies and procedures, and reports related to claims processing. HSAG will request that COA submit documents that support the enrollment and claims processing operations and systems requirements. Examples of documents are: medical and pharmacy processed claim files, claims payment data, member eligibility and enrollment data, claims systems edits, claims denial reason codes, fee schedules, benefit configuration change control logs, claims issues logs, subcontractor key performance metrics, internal audit results, and member and provider claims appeals.

To prepare for and initiate the claims processing audit, HSAG is requesting that COA submits the ***Desk Review Evaluation Tool*** (Attached) and all supporting documentation on or before **January 24, 2020** to HSAG. The

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Desk Review Evaluation Tool will be used by HSAG to evaluate COA's contracts, policies and procedures, and reports related to claims processing. Please complete the column labeled, *Information Submitted as Evidence by the Health Plan,* and include the documents submitted as evidence of compliance. Please list any policies, procedures, reports, monitoring tools, copies of emails, or other documentation that provide evidence that COA complied with the contractual, technical, and regulatory requirements for Medicaid managed care in 2019. Please include page numbers, and/or highlight in the documents where the evidence can be found. Do not enter, delete, or change any of the information in the other columns on the desk review tool.

The submitted documentation should be limited to specific and targeted evidence of compliance for each requirement. Once all applicable documentation is listed in the tool for each element, please post copies of the documentation via HSAG's Secure Access File Exchange (SAFE) site. Organize the documents in subfolders labeled according to the corresponding standard. The completed ***Desk Review Evaluation Tool*** and all corresponding documentation must be posted to HSAG's SAFE site, in COA's folder/subfolders on or before **January 24, 2020**.

Phase Two – Analysis of Processed Claims

The second phase involves the analysis of processed claims using the claims and payment file extracts provided by COA. These claims extracts should include the SMCN professional, institutional, and pharmacy claims processed with paid dates between July 1, 2019, and December 31, 2019. HSAG is requesting that COA submits the ***data file documents and data extracts*** to the secure FTP site on or before **January 24, 2020**. Because protected health information (PHI) will be included in these files, HSAG requests that these files be password protected or encrypted. Once these files have been uploaded, please contact me and Crystal Brown, whose information is provided below, to share the password/encryption information. Ms. Brown will move the files from the SAFE site to a restricted area within HSAG's firewall.

Phase Three – Web-conference Review

Upon completion of the preliminary analysis, HSAG will conduct an on-site visit to review COA's systems and conduct interviews with key personnel. HSAG will conduct limited validation activities and require COA to display claims details on items identified with potential anomalies.

Phase Four – Reporting

Upon completion of the on-site review, HSAG will discuss preliminary findings with COA. Upon confirmation of findings, HSAG will submit a draft to the Department for review. After receipt of the Department's feedback, HSAG will finalize the report and distribute to COA and the Department.

In January, please contact Crystal Brown, using the information listed below, if you need to obtain a secure login to HSAG's SAFE site. Please notify Ms. Brown when all documentation has been posted. Please contact Ms. Brown with any questions regarding posting the information or your SAFE site login.

Crystal Brown, Administrative Assistant II
Health Services Advisory Group
Phone: 720-697-7907
E-mail: cbrown@hsag.com

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Thank you in advance for your assistance with the SMCN Claims Audit. Please feel free to contact me at kvanderslice@hsag.com or 602.801.6967 with any questions.

Sincerely,

Kari Vanderslice, MBA
Project Manager, State and Corporate Services

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Appendix C. FY 2019–2020 SMCN Claims Processing Audit: Data Request

The Colorado Department of Health Care Policy & Financing (the Department) contracted with Health Services Advisory Group, Inc. (HSAG), for Fiscal Year (FY) 2019–2020, to assess Colorado Access' (the Department's contracted Administrative Services Organization) ability to process claims for the State Managed Care Network (SMCN) providers. The FY 2019–2020 audit will include a desk review, detailed claims analysis, and on-site visit 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 24, 2020**. 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 in December 2019 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 (i.e., 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.

Colorado Access

SMCN Claims Audit

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 folder within HSAG's Secure Access File Exchange (SAFE) site:

   Health Plans\Colorado Access\ SMCN Claims Audit

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

Data Files and Supplemental Documentation Requirements

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 QNXT system.
3. Quarterly performance reports submitted to the Department for calendar year 2019.
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, 2019 through January 31, 2019.
5. Methodology and/or reporting logic for Cognizant's claim processing turnaround.
6. Results of the 2019 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, 2019, and December 31, 2019. Requested file names are presented in Table 1.

Table 1: Required SMCN claim files

Claim Types	Requested File Name
Medical and Behavioral Health (professional and institutional) claims	FY20_CHPSMCN_Medical_Claims_Extract
Pharmacy claims (include co-pay information)	FY20_CHPSMCN_Pharmacy_Claims_Extract
Vision claims *(if not included in professional claim files)*	FY20_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 2018–2019 audit data file layout.
10. An extract of the QNXT provider file for the period of July 1, 2019, and December 31, 2019.
    - The requested file name is: FY20_CHPSMCN_Provider_Extract
11. Monthly enrollment and eligibility files for January 2019 through January 2020.
    - The requested file name is: FY20_CHPSMCN_Eligibility_Extract
12. Copies of the claim turnaround time reports from May 2019 through January 2020.
13. Narrative and evidence of updates made to documents, policies and/or manuals regarding the following 2018–2019 SMCN Network Claims Processing and Audit Improvement Opportunity:

- 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.

Instructions for Data Files and Supplemental Documentation Submission

1. Colorado Access should submit the requested data file documents and extracts to HSAG on or before **January 24, 2020.**
2. For the claims data files, HSAG requires that Colorado Access secure the data files with passwords prior to uploading the file(s) to the HSAG SAFE site. After uploading the claims files to the SAFE site, please notify Crystal Brown at (720) 697-7907, cbrown@hsag.com, or Kari Vanderslice at (602) 801-6967, kvanderslice@hsag.com and provide the file password(s).

   Please upload all requested documents to the SMCN Claims Audit folder in HSAG's SAFE site: **Health Plans\Colorado Access\ SMCN Claims Audit**
   Contact Crystal Brown at cbrown@hsag.com with questions regarding the SAFE site.
3. 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 2019–2020 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, 2019, federal and state regulations, and HSAG's *FY 2019–2020 SMCN Claims Processing Audit Data File Request.*

Signature of CEO, CEO, or delegated authority	Print Name	Date
Phil M	Phil Reed	1.22.2020

Indicate if the submitted files are a:

☒ **First-time submission**

☐ **Resubmission/Replacement**

Submitter Name:	Submitter ID:
Michelle Tomsche	Colorado Access
Complete Street Address: 11100 E Bethard Dr. Aurora CO 80014	Telephone Number (include area code): (720 744-5299

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

File Name	Record Count
FY20_SMCN_Medical_Claims_Extract	174419
FY20_SMCN_pharmacy_Claims_Extract	82384
FY20_SMCN_Provider_Extract	104798
FY20_SMCN_Eligibility_Extract	107502

Appendix D. SMCN Claims Processing Audit Agenda

Colorado Department of Health Care Policy & Financing
Colorado Access Web Review Agenda
State Managed Care Network (SMCN) Claims Processing Audit

Wednesday, April 8, 2020

Web Conference Information: Join Microsoft Teams Meeting

Call-in Number: 1 720-580-2748 (Denver) / Conference ID: 429 604 325#

Reviewer: Kari Vanderslice, MBA

SMCN Claims Processing Audit - April 8, 2020	
Sessions and Activities	
8:30 a.m. MT	**Opening Session** • Introductions • Overview of SMCN Claims Processing Audit • Review objectives
8:40 – 9:30 a.m.	**Hosted Systems Infrastructure – Cognizant** • Ensuring Data Privacy and Security • Business Continuity and Disaster Recovery (BCDR) • Eligibility and Enrollment Processing *For this session, Colorado Access will be asked to provide an overview of Cognizant's systems infrastructure that supports the COA claims 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. HSAG will ask to review the findings from Colorado Access' recent BCDR testing.* *Additionally, Colorado Access will be required to walk through its processes for managing member enrollment, retro-enrollment, and retro-disenrollment in the relevant systems, and process improvements in QNXT related to the recommendation in last year's audit report.*
9:30 – 9:40 a.m.	Break

SMCN Claims Processing Audit - April 8, 2020	
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).* **Claims Review** *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 processes for monitoring for fraud, waste, and abuse*
12:00 – 1:00 p.m.	Lunch *Note: The web conference will be placed on hold during this time*
1:00 – 3:00 p.m.	**Review Pharmacy Benefit Management (PBM) Oversight and Claims** *Colorado Access will be asked to provide an overview of the policies and procedures for oversight of the PBM. Colorado Access will 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 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 the Review** *Note: The web conference will be placed on hold during this time*
4:00 – 4:30 p.m.	**Review of Audit and/or Desk Review Submissions Requiring Clarification**
4:30 – 4:40 p.m.	Break
4:40 – 4:55 p.m.	**Colorado Access SMCN Claims Processing Audit Closing Conference** • 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 web review agenda; and scheduled the web audit. • HSAG submitted all materials to the Department for review and approval.
Activity 2:	**Perform Preliminary Review**
	• On November 20, 2019, 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 November 20, 2019, 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 23, 2020, Colorado Access provided documentation for the desk review, as requested. • On November 20, 2019, 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, 2019, and December 31, 2019. On January 23, 2020, Colorado Access provided data files and supplemental documentation as requested. • On March 17, 2020, HSAG sent Colorado Access the agenda for the April 8, 2020 web 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.

HSAG completed the following activities:	
Activity 3:	**Conduct Web Claims Audit**
	• During the web 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 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 2019–2020 SMCN claims audit report template to compile findings and incorporate information from the desk review and web 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 2019–2020 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.