



**Medical Administration Audit
of Aetna**

Final Report

September 12, 2025

**Prepared for
The State Employee Health Plan
State of Kansas**

Submitted by:

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Executive Summary

Sagebrush Analytic Solutions LLC (Sagebrush) was engaged by The State Employee Health Plan (SEHP), State of Kansas (SOK), to review and evaluate the medical claims processing services provided on behalf of the SEHP employee benefit plan by Aetna for calendar year 2024.

The State Employee Health Plan (SEHP) currently offers four self-insured medical plan designs, Plan A, Plan C, Plan J, and Plan N, administered by Aetna and Blue Cross Blue Shield of Kansas (BCBSKS). The plans cover more than 81,000 active participants, early retirees, and their dependents.

The purpose of the audit is to verify that Aetna is administering the benefit provisions as intended. The audit is designed to evaluate overall claims processing accuracy and efficiency and identify opportunities for improved administration.

In addition to conducting a statistical audit to verify administrative accuracy, SEHP engaged Sagebrush to:

- o Electronically compare claims to eligibility data to identify any payment for ineligible participants; and
- o Interrogate 100% of the claims data electronically for potential errors, such as duplicate payments and clinical edits.
- o Interrogate 100% of the claims data electronically to verify that plan provisions were administered properly. Tests would include deductible, copayments, and plan limitations and exclusions.

The findings were reviewed by Sagebrush during the remote review and up to 50 findings were provided to Aetna for review.

Sagebrush conducted the review of claims remotely the week of April 28, 2025. During this review, the audit team tested a statistical sample of 250 medical claims for financial and processing accuracy. The claims were tested for eligibility, timeliness, payment accuracy and adherence to plan benefits and administration procedures. The sample was selected from the population of 86,377 SEHP medical claims, with a total paid amount of \$27,000,477.72, processed between January 1, 2024 and December 31, 2024.

Based on Sagebrush’s review of the claims data, contracts, and other documents and information provided for audit, Aetna administered the medical benefits within the scope of the contract with SEHP during the 2024 calendar year. However, there is room for improvement.

The following summary provides an overview of the audit findings, including both statistical and focused electronic testing. The detailed audit results are discussed in the body of the report.

Exhibit 1: Summary of Audit Findings

Finding	Description	Impact												
Performance Guarantees – Claims adjudication	Aetna did not meet the performance guarantees for Q3 turnaround time per self-measured quarterly analyses	Aetna reported 2024 penalties due to SEHP for all guarantees as follows: <ul style="list-style-type: none"> Quarter 3 \$2,500, and 												
Performance Guarantees – Customer Service	Aetna did not meet performance guarantees for First Call Resolution, Open Inquiries Resolutions Customer Service Quality, Written Inquiry Response within 5 days, Written Inquiry Response within 10 days and E-mail Response	Aetna reported 2024 penalties due to SEHP for all guarantees as follows: <ul style="list-style-type: none"> Quarter 1 \$5,000, Quarter 2 \$2,500, Quarter 3 \$2,500, and Quarter 4 \$10,000 												
Statistical Audit	The statistical sample revealed a net underpayment of \$53,836.88 <ul style="list-style-type: none"> Four overpayments, totaling \$3,891.90 Seven underpayments, totaling \$57,728.78 	Based on the errors identified in the sample, the following table shows Aetna’s measured performance for 2024 compared to guarantees: <table border="1" data-bbox="727 919 1115 1058"> <thead> <tr> <th>Accuracy Measure</th> <th>Measured Statistic</th> <th>CY2024 Guarantee</th> </tr> </thead> <tbody> <tr> <td>Financial</td> <td>98.40%</td> <td>95%</td> </tr> <tr> <td>Payment</td> <td>96.12%</td> <td>95%</td> </tr> <tr> <td>Procedural</td> <td>100.00%</td> <td>97%</td> </tr> </tbody> </table>	Accuracy Measure	Measured Statistic	CY2024 Guarantee	Financial	98.40%	95%	Payment	96.12%	95%	Procedural	100.00%	97%
Accuracy Measure	Measured Statistic	CY2024 Guarantee												
Financial	98.40%	95%												
Payment	96.12%	95%												
Procedural	100.00%	97%												
Focused Electronic Testing	The electronic testing identified \$72,255.83* in potential overpayments. *This figure could differ from the impact column based on Aetna’s system review to the finding. Details are in the body of the report.	<ul style="list-style-type: none"> Aetna is in process of recovering the \$4,331.38 in overpayments that will be paid to SEHP via check. Aetna agreed to one underpayment of \$1,659.00 Aetna disagreed with \$64,583.45 stating the claims were paid correctly at the time of payment. 												
TOTAL IMPACT		<ul style="list-style-type: none"> Total fees and overpayments paid / to be paid to SEHP: \$30,723.28 Less total Performance Guarantees Fees previously paid to SEHP: \$22,500.00 Equals total remaining fees and overpayments to be recovered and paid to SEHP: \$8,223.28 												

Summary of Statistical Sample Review Results

The statistical sample review identified eleven (11) payment errors, resulting in a net underpayment of (\$53,836.88). Aetna agreed with ten (10) of the errors and disagreed with one (1). All of these claims were manually processed.

Commented [MM1]: Was this resolved

Considering the eleven (11) payment errors identified in the sample, the overall financial accuracy of the claims administered by Aetna in 2024 is 98.40%. The performance guarantee for financial accuracy is 95%. The calculated payment or dollar accuracy from the audit is 96.12%, compared to the Aetna performance guarantee of 95%. The calculated procedural accuracy is 100.00%, compared to the Aetna performance guarantee of 97%.

The following exhibits summarizes the eleven (11) errors identified in the 250-claim statistical sample by root cause and error amount.

Exhibit 2: Summary of Statistical Sample Errors by Net Value

Root Cause Type	Description	# of Errors	Net Amount of Error Corrected/To Be Corrected
Incorrect Fee Allowed	The allowed fees were calculated incorrectly.	5	(\$245.88)
Incorrect application of benefit copayment	Copayment was applied in error. Service was preventive.	4	(\$2,306.18)
Incorrect Inpatient Pricing allowable	The incorrect inpatient pricing allowable was calculated.	2	(\$51,284.82)
Total		11	(\$53,836.88)

Exhibit 3: Number of Statistical Errors by Root Cause Type

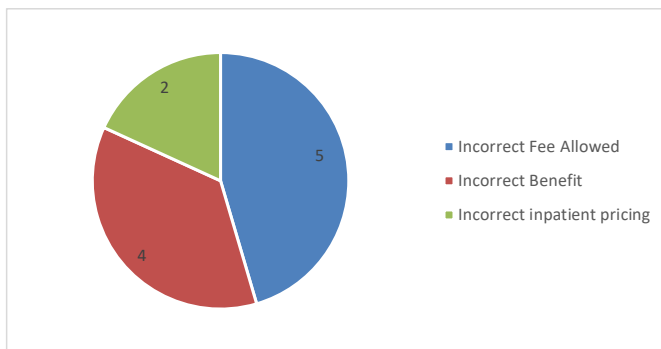
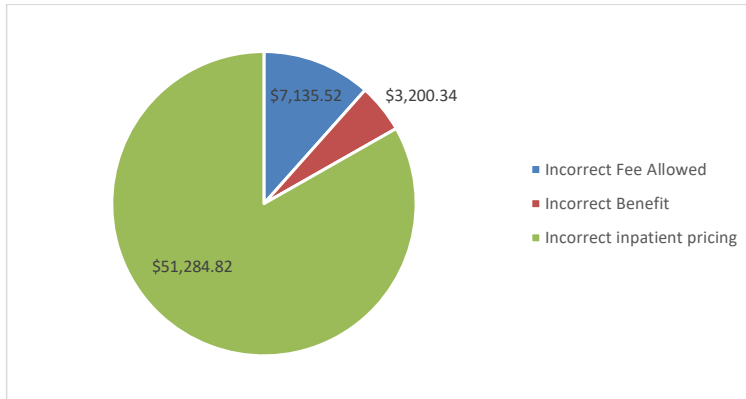


Exhibit 4: Absolute Value of Statistical Errors by Root Cause Type



Summary of Focused Electronic Testing Results

In addition to the statistical claim review, Sagebrush electronically tested 100% of the claims data to identify potential duplicate claim payments, analyzed medical claim payments utilizing clinical editing software, identified participants with claim payments after coverage terminated, and tested specific benefit provisions and exclusions. The chart below is a summary of the testing that was completed.

Exhibit 5: Electronic Testing Summary

Test	Description	Findings	Net Amount of Error Corrected/To Be Corrected
Clinical Edits			
Multiple Procedures, Incidental, and Mutually Exclusive Procedures	Electronically apply clinical edits to claims data to identify claims where unbundling edits have not been applied	●	\$0.00
Assistant Surgeon Not Allowed	Identify claims where payment was made on a procedure that the American Medical Association states an assistant at surgery is not necessary or recommended	●	\$0.00
Visits in the Global Surgical Period	Identify instances where a provider billed an evaluation and management service during the global post-operative period. When the diagnosis submitted on these claims is the same or related to the diagnosis submitted for the operative procedure, the services are considered post-op visits and should be included in the fee that was paid for the surgery and not separately reimbursed.	●	\$0.00
Benefit Provisions			
Deductible – Coinsurance test	Identify the participants that appear to have incorrect deductible and coinsurance amounts applied	●	\$0.00
Benefit Limitations/Exclusions			
Cosmetic Procedures	Identify claims for surgical procedures that could be considered cosmetic and not medically necessary, such as Mammoplasty	●	\$0.00
Bariatric Services	Identify claims for Bariatric services that do not meet the criteria outlined by the plan.	●	\$0.00
TMJ	Medical, surgical or dental treatment or services related to the treatment of temporomandibular joint (jaw hinge) disease (TMJ) is not covered.	●	\$0.00
Routine Foot Care	Is not a covered service unless Medically Necessary for the treatment of a person who, due to a demonstrated medical condition, is unable to perform such activity, and except as specifically provided for a diabetic Participant	●	\$0.00
Hearing Aids	Eligible services are subject to deductible and coinsurance up to a maximum benefit for all covered services of \$5,000 per a three (3) year period	●	\$4,064.09
Acupuncture	Those acupuncture services and associated expenses that include, but are not limited to, the treatment of certain painful conditions or for anesthesia purposes are not covered.	●	\$0.00
Dental Services	Treatment of teeth or supporting structures is not covered, except as specified in the Dental Services and the Transplant within the Covered Service Section provided under the terms of the Plan.	●	\$0.00
Other			

Summary of Findings

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Test	Description	Findings	Net Amount of Error Corrected/To Be Corrected
Claims Paid for Ineligibles	Electronically compare claims data to eligibility data to identify claims payments on behalf of ineligible participants. <i>All errors are retro terminations; Aetna notified of termination after process date. Variations noted between SEHP date termination was reported and date Aetna received the termination date.</i>	●	\$90.45
Duplicate Payments	Electronically test claims data for duplicate payments for the same service for the same participant	●	\$176.84
TOTAL			\$4,331.38

Exhibit 2 Key:

- Aetna has adequate system edits/controls in place for this test.
- Opportunities for improvement exist for System edits and/or processes for this test.
- Less than satisfactory, needs immediate action

Summary of Turnaround Time Testing Results

The following exhibit presents the findings of turnaround time, or time taken to process each claim, for the entire population of medical claims processed by Aetna in 2024.

Exhibit 6: Turnaround Time

Business Days	# of Claims	% of Claim Population	Cumulative # of Claims	Cumulative % of Population
0 - 12 days	83,938	97.01%	83,938	97.01%
13 - 14 days	173	0.20%	84,111	97.21%
15 - 30 days	367	0.43%	84,478	97.64%
> 30 days	2,045	2.36%	86,523	100.00%
	86,523	100.00%		

The findings are that Aetna processed 97.01% of all claims within twelve (12) business days of receipt and 97.64% of claims within thirty (30) days. The performance guarantees for these measures are 92.00% and 98.00%, for time to process all claims within twelve (12) and thirty (30) business days, respectively, as stated in the documents provided by SEHP for the audit.

The total number of claims used to determine the turn-around-time will differ from the total number of claims in the claims population used to select the claim sample. Claims with a negative paid amount that do not have a related positive payment are removed from the claims count prior to the sample selection. For example, a claim that was originally processed and paid in the prior calendar

year that was reversed in the current calendar year is included in turnaround time but excluded from sample selection.

The Calendar year performance guarantee report provided by Aetna shows that the turnaround time of 98% of claims within 30 days was not met for Quarters 3 in calendar year 2024. A penalty of \$2,500.00 was included in a check for \$5,000.00 processed on 11/26/2024, and SEHP confirmed receipt of on 12/26/2024.

Statistical Sample Findings

The statistical sample review identified eleven (11) payment errors, resulting in a net underpayment amount of \$53,836.88. Aetna agreed with ten (10) of the errors and disagreed with one (1).

The stratified random sampling method permits projection of the audited financial accuracy rate to the entire population. The auditor’s ability to statistically project the audit findings in this manner depends on the sampling technique used.

- The tested gross financial error in the statistical sample is \$61,620.68. Based on the distribution of the eleven (11) financial errors identified in the statistical sample, Sagebrush’s best estimate of the total absolute financial (dollar) error in the population is \$432,269.07 in the paid claim population of \$27,000,477.72. The projected gross financial (dollar) accuracy within the medical claim population is 98.40%. The standard commonly found in the industry for financial accuracy is 99.00%. The performance guarantee between Aetna and SEHP for financial accuracy is 99%.

Aetna does not guarantee the financial accuracy of 99% as group specific, but for the overall book of business.

- Based on the distribution of the eleven (11) payment errors identified in the statistical sample, the projected payment accuracy or dollar accuracy of the medical claim population is 96.12%. Payment accuracy refers to the incidence of correct claim payments. The common industry standard for this measure is 95.00% - 97.00%. The performance guarantee between Aetna and SEHP for payment accuracy is 95%.

Aetna does not guarantee the payment accuracy of 95% as group specific, but for the overall book of business.

- There were no procedural (non-payment) errors identified in the sample. Based on this result, the projected procedural accuracy of the claim population is 100.00%. The common industry standard for this measure is 95.00%. The performance guarantee between Aetna and SEHP for processing accuracy is 97%.

Financial Accuracy

The tested gross financial error in the medical claim population processed in 2024 is \$61,620.68. Based on the distribution of the eleven (11) financial errors identified in the statistical sample, Sagebrush’s best estimate of the total absolute financial (dollar) error in the population is \$432,269.07 in the paid claim population of \$27,000,477.72. The projected gross financial (dollar) accuracy within the medical claim population is 98.40%. The standard commonly found in the industry for financial accuracy is 99.00%. The performance guarantee between Aetna and SEHP for financial accuracy is 95%.

Classification of Errors

The following exhibits provide a breakdown of the errors identified in the audited samples.

Exhibit 11: Classification of Errors

Error Classification	# of Errors	\$ Error
Overpayments	4	\$3,891.90
Underpayments	7	(\$57,728.78)
Non-Payment	0	
Total/Net Error	11	(\$53,836.88)

Exhibit 12: Root Cause Error Type

Error Type	# of Errors	% of Total	Absolute \$ Error	% of Total \$
Incorrect Fee Allowed	5	45.46%	\$7,135.52	11.58%
Incorrect Application of Benefits	4	36.36%	\$3,200.34	5.19%
Incorrect Inpatient Pricing	2	18.18%	\$51,284.82	83.23%
Total	11	100.00%	\$61,620.68	100.00%

The statistical sample review identified eleven (11) errors with a net underpayment of \$53,836.88. Aetna agreed with ten (10) of the errors and disagreed with one (1).

Incorrect Fee Allowed

There were five (5) claims with an incorrect fee schedule allowable amount. This resulted in a net underpayment of \$245.88.

- **Sample #32**– The correct allowable for the provider is \$138.66. the actual allowed was \$205.80. Claim is overpaid \$67.14. Aetna agreed to this error.

Aetna Response: Agree - This claim was billed by Medicaid. Per Aetna policy, the allowed amount should be calculated based on the servicing provider. The error occurred when the processor incorrectly priced the claim at a higher allowed amount. The claim was reprocessed, on 08/04/2025, and overpayment recovery has been initiated.

- **Sample #130** – Claim should price an emergency room case rate of \$7,998 + high-cost drugs (revenue code 636) are allowed at 41.02% of billed charges. Examiner forgot to price high-cost drugs (revenue code 636, HCPCS code S0028) for an allowed of \$941.54. Claim is underpaid \$351.28. Aetna agreed to this error.

Aetna Response: Agree - When the claim was originally processed, and reviewed during the audit, Aetna agreed to a processor error for not pricing Revenue code 636 at the provider’s contracted carve-out rate. The claim was reprocessed on 05/20/2025 and additional benefits were issued; however, upon post payment review it was determined a provider billing error was made. The service rendered was not a high cost drug, and it should not have been billed with Revenue code 636. The charge would have been included in the case rate. The claim was reprocessed again on 06/10/2025 and overpayment recovery has been initiated.

- **Sample #153** – Three of the charges on this claim were entered incorrectly, resulting in an overpayment of \$3,377.68. Aetna agreed to this error.

Aetna Response: Agree – The error occurred when the processor incorrectly keyed the submitted charges. The claim was reprocessed on 05/20/2025 and overpayment recovery has been initiated.

- **Sample #169** – Injectable drug price (HCPCS code J2405) increased between 1/3/24 to 1/17/24, resulting in an underpayment of \$0.75. Aetna agreed to this error.

Aetna Response: Agree -The error occurred when the processor committed a mathematical error when pricing the claim. The claim was reprocessed on 05/27/2025 and additional benefits were issued.

- **Sample #247** - The pricing for injectable drugs (HCPCS codes J2469 and J2506) increased between 4/3/24 and 4/25/24, resulting in an underpayment of \$3,338.67. Aetna agreed to this error.

Aetna Response: Agree -The error occurred when the processor committed a mathematical error when pricing the claim. The claim was reprocessed on 05/19/2025 and additional benefits were issued.

Incorrect Application of Benefits

The plan benefits, such as deductible, copayment or coinsurance, were incorrectly applied on four (4) claims. These four claims resulted in a net underpayment of \$2,306.18.

- **Sample #18** – Medicaid reclamation claim. In-network deductible had been satisfied but out-of-pocket was not met. Should have paid provider 80% coinsurance. Claim is underpaid \$90.53. Aetna agreed to this error.

Aetna Response: Agree – This claim was billed by Medicaid. Per Aetna policy, the allowed amount should be calculated based on the servicing provider. The error occurred when the processor failed to elevate the claim to In-network benefit level based on rendering provider, and the charges were applied to the out-of-network deductible. The claim was reprocessed on 04/29/2025 and additional benefits have been issued.

- **Sample #73** – This claim was billed as a diagnostic colonoscopy and biopsy. There was no screening or preventive diagnosis on the claim. Aetna processed the claim at 100% of the allowable under the plan’s preventive benefit stating that the first colonoscopy of the year is payable as preventive regardless of the diagnosis in conflict with plan benefits. This resulted in an overpayment of \$361.40.

Per the information obtained from SEHP, only the diagnosis codes Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, K63.5 & R19.5 are considered preventive or HCPCS codes G0105 & G0121. None of these codes were billed on the claim in question. Aetna disagrees with this error.

Aetna Response: Disagree – Per the member’s plan, Colorectal Cancer Screening is covered at 100% no deductible, no copay for the first colonoscopy regardless of the diagnosis. This claim was the member’s first colonoscopy of the year, and is allowable at 100%.

Sagebrush Comment: Based on confirmation from SEHP that the colonoscopy of the year is payable under the preventive benefit at 100%, Sagebrush agrees with Aetna’s assessment of this claim.

Sagebrush Comment: Based on confirmation from SEHP, Sagebrush agrees with Aetna that the colonoscopy claim paid correctly at 100% of the allowed amount.

- **Sample #133** – Emergency room visit split in 3 segments to pay. Claim is underpaid \$2,662.73. Segment 1 adjusted \$3,310.33 in error. Claim applied \$300 copayment in error. Aetna agrees to the error.

Aetna Response: Agree – The error occurred when the processor committed a mathematical error when pricing the claim. The claim was reprocessed on 05/19/2025 and additional benefits were issued

- **Sample #179** - Claim priced correctly per provider contract, however per the accumulator screens in Aetna’s systems, \$950.54 in coinsurance should have been applied to meet the \$4,500 out-of-pocket maximum. The out-of-pocket maximum was not reached until 4/27/2024, this claim processed 4/4/2024. This claim is overpaid \$85.68. Aetna agrees with this error.

Aetna Response: Agree – The error occurred when the claim was allowed with an incorrect coinsurance amount taken. The member has now met the \$4,500.00 out-of-pocket maximum; therefore, the claim was not reprocessed.

Incorrect Inpatient Pricing

Two (2) claims were processed with the incorrect inpatient pricing allowable resulting in a net underpayment of \$51,284.82.

- **Sample #213** - Claim should price DRG 231 base \$17,825.00 x weight 8.4739 = \$151,047.26 less \$189.71 coinsurance = \$150,857.56 payable. Claim was underpaid \$51,280.79 at the time of processing. However, the claim was adjusted on 2/25/25 to pay the remaining balance (outside audit period but prior to the audit). Aetna agrees to this error.

Aetna Response: Agree - This is a multi-segmented hospital claim in which the processor committed a mathematical error when pricing the claim. The claim was reprocessed on 02/25/2025 and additional benefits have been issued.

- **Sample #230** - Provider contract shows stoploss applies and pays 36.7% of billed charges. The authorization on file denied 7 days 8-13-24 to 8-19-24 due to late notification, therefore claim prices as follows - \$256,019.14 less \$111,205.14 denied = \$144,813.40 x 36.7% = \$53,146.52 allowed less \$4,156.70 coinsurance = \$48,989.82 payable. Claim is underpaid \$4.03. Aetna agrees with this error.

Aetna Response: Agree - This is a multi-segmented hospital claim in which the processor committed a mathematical error when pricing the claim. The claim was reprocessed on 05/21/2025 and additional benefits have been issued.

Focused Electronic Testing Results

Sagebrush reviewed the electronic results and provided Aetna with a file of up to 50 potentially erroneous claims from the menu of tests above. Aetna reviewed the claims and provided a response with additional documentation to support each position.

Clinical Edits

- Based on the clinical edit review, Sagebrush included two (2) claims in the focused review sample for multiple surgery. Aetna states that the multiple surgery reductions were generally being applied correctly and mutually exclusive or incidental procedures were denied accordingly.
- Sagebrush also tested for claims with office visits that would not normally be reimbursed separately from the related surgery and claims for assistant at surgery where an assistant is not medically necessary or required. No issues were found in these categories.

Aetna states that the visits billed during the post operative period had a different primary diagnosis than the surgical claim or the inpatient visit is allowed as the surgical CPT code was billed with modifier 22, also known as the "Increased Procedural Services" modifier.

Specific Benefit Provisions and Exclusion

- Cosmetic procedures – Sagebrush tested the claims data for procedures and related services performed to reshape structures of the body in order to alter the individual's appearance, to alter the aging process or when performed primarily for psychological purposes and determined not to be Medically Necessary.

Sagebrush identified five (5) members with claims for Mammoplasty, totaling \$42,639.22 however, there was a medical necessity review on file and prior authorization in place for these claims to be paid.

- Sagebrush tested the deductible and coinsurance amounts in the claims data to determine whether the Aetna systems were accurately calculating the participant's deductible and out-of-pocket maximum. It appears that accumulators are working properly in the ACAS claim system.
- Bariatric procedures – Per the Bariatric rider in the summary of plan description, in order for Bariatric services to be eligible for benefits, the services must be prior authorized and the participant must be an adult age 18 or over, a non-tobacco user and have a documented medical history of two years or more of a Body Mass Index (BMI):
 - Equal to 35 and less than 40 with two or more co-morbid conditions
 - 40 or over with one or more co-morbid conditions

Sagebrush identified one (1) member with claims for bariatric services totaling \$17,089.83 The member met the BMI of 40.0 or over, but there were no co-morbidities on the claim.

Aetna states services were found to be medically necessary and authorized under authorization #2403-2506-4482.

- Sagebrush also tested 100% of the claims data looking for claims paid for excluded services. Sagebrush did not find any issues or exceptions for routine foot care, massage therapy, dental or acupuncture services.

There were three (3) claims identified for TMJ services, however, Aetna states two (2) of the claims were for a visit or consultation and not for the treatment to alter bite or operation of the jaw and therefore allowed under the plan. The other claim was for chiropractic services, which Aetna considers as medically necessary. If no improvement within two weeks, the chiropractic services are no longer considered medically necessary.

- Hearing aid services including hearing devices, and covered services from both Network and Non Network apply toward a maximum benefit for all services of \$5,000 per a three (3) year period. Sagebrush identified thirteen (13) claims for these services that may have exceeded the three (3) year maximum allowed benefit. Aetna reviewed these claims and agreed that three (3) claims exceeded the maximum benefit, resulting in a total overpaid amount of \$4,064.09.

Aetna also agreed to one (1) underpayment of \$1,659.00 stating the claim should have paid up to the \$5,000.00 maximum benefit, but only allowed \$3,341.00.

Aetna Response: Aetna agreed to 3 overpayment errors totaling \$4,063.89 and 1 underpayment

FC-14 - \$1,699.20 – This was reprocessed on 07/22/2025 and overpayment recovery has been initiated.

FC-15 - \$1,684.69 This was reprocessed on 06/09/2025. The overpayment was recovered and funded to State of Kansas on 07/29/2025.

FC-16 - \$680.00 - This was reprocessed on 06/09/2025 and overpayment was recovery has been initiated.

FC-17 - (\$1,659.00) – This was reprocessed on 06/09/2025 and additional benefits have been issued.

Other Electronic Testing

- Duplicate payments - Sagebrush’s review of the potential duplicate payments identified seven (7) possible errors resulting in an overpaid amount of \$4,569.43.
 - Aetna agreed with three (3) of the errors, resulting in an overpaid amount totaling \$176.84.
 - Aetna agreed with one (3) stating claim EYY2FVT8K00 is the provider claim. Claim E8Y197DWZ00 is the Medicaid claim in which Aetna paid \$260.00. The provider is entitled to receive up to their contracted rate for the services rendered.

The contracted rate is \$2429.47 less \$485.89 coinsurance = \$1943.58 less \$260.00 previously paid to Medicaid = \$1735.58. On claim EYY2FVT8K00, Aetna previously paid \$1334.26. \$1735.58 less \$1334.26 = \$401.32 underpayment to the provider.

- The remaining three (3) claims were not duplicate payments, but corrected claims that included charges not paid on the original submission.

Aetna Response: Agree – Three (2) claims were paid as duplicates in error. One (1) claim was correcting an underpayment to the provider.

FC-4 - \$91.47 - This was reprocessed on 05/23/2025 and overpayment recovery has been initiated.

FC-5 - \$37.65 – This was reprocessed on 05/23/2025 and overpayment recovery has been initiated.

FC-6 - \$47.72 – This was reprocessed on 05/23/2025 and overpayment recovery has been initiated.

FC-10 - (\$401.32) - This was reprocessed on 05/23/2025 and additional benefits have been issued.

- Ineligible Participants – Sagebrush compared the eligibility file that was received from the State of Kansas against the paid claims data provided by Aetna to identify claims paid for participants that were no longer eligible for coverage. Sagebrush included 11 participants with paid claims totaling \$1,102.62 in the focused claims sent to Aetna for review.

Aetna agreed with two (2) participants with claims totaling \$36.62. The claims will be adjusted and the \$36.62 will be included in the reimbursement check at the conclusion of the audit.

Aetna disagreed with six (6) of the participants with claims totaling \$833.33 stating the participants still had active coverage on the date of service.

One (1) participant was not listed on the eligibility file for calendar year 2023 or calendar year 2024. There was one claim for date of service 1/23/2024, totaling \$53.83 that was paid by Aetna. Aetna did not issue a response regarding the eligibility of this participant on the date of service in question.

For the other two (2) participants, FC-32 & FC-33, Aetna states that the claims totaling \$178.84 were paid correctly. The eligibility file from SEHP shows that these participants terminated on 8/31/2024 prior to the dates of service in September. However, Aetna states that the participants were covered until 9/30/2024. Per confirmation from SEHP an effective date of 8/31/2024 was processed on 9/5/2024 and 9/10/2024, respectfully, and sent over to Aetna. Coverage was still in effect.

Aetna Response: Aetna agrees FC-30 and FC-35 are overpaid; however, Aetna did not receive notification of termination until after the below claims were processed. These claims were allowed correctly at the time they were processed

FC-30 - \$16.04 - The member terminated effective 05/01/2024; however, Aetna did not receive notification of the termination until 06/23/2024. This claim was reprocessed on 05/23/2025, and the overpayment was recovered and funded to SEHP on 07/16/2025.

FC-35 - \$10.29 - The member terminated effective 05/01/2024; however, Aetna did not receive notification of the termination until 06/23/2024. These claims were reprocessed on 05/23/2025; however, the amount is under the threshold for recovery.

FC-36 - \$53.83 - The coverage for this member terminated on 01/31/2024. The date of service on this claim is 01/23/2024 and is prior to the termination date.

- Sagebrush also tested the paper provider contracts against fifteen (15) of the randomly selected claim samples to ensure the contracts are accurately loaded in the Aetna claim system.

Sagebrush’s review shows that the contracts appear to be loaded into the Aetna system correctly.

Claim Administrator Questionnaire

Customer Service

Aetna has a service unit separate from claims processing to handle participant service phone calls. Calls are routed through a system called Aetna Voice Advantage. The average call wait time was 36.8 seconds for calendar year 2024. The average speed to answer performance guarantee between Aetna and SEHP is 30 seconds. The average on line time with a customer service representative is 750.7 seconds.

All claims office personnel, including the customer service representatives have access to claim processing, inquiry and maintenance functions. Accordingly, all medical and dental claim history and financial history are immediately updated and available on-line as soon as the claim is accepted by a processor.

Aetna provided the performance guarantee report for calendar year 2024. The chart below shows the missed Customer Service performance guarantees and the total penalties assessed. We are waiting for Aetna to provide the check number and date of payment for each quarter.

Exhibit 14: Customer Service CY2024 Reported Penalties

Quarter	Performance Guarantee	Target Goal	Aetna Reported	Penalty Assessed	Penalty Paid
1 st					
	First Call Resolution	95%	94.42%	\$2,500.00	check was processed on 05/30/2024, and SOK confirmed receipt of check on 06/11/2024
	Customer Service Quality	98%	97.28%	\$2,500.00	check was processed on 05/30/2024, and SOK confirmed receipt of check on 06/11/2024
2 nd					
	First Call Resolution	95%	94.42%	\$2,500.00	check was processed on 08/27/2024, and SOK confirmed receipt of check on 09/11/2024
3 rd					
	First Call Resolution	95%	94.34%	\$2,500.00	check was processed on 11/26/2024, and SOK confirmed receipt of check on 12/26/2024
4 th					
	First Call Resolution	95%	94.08%	\$2,500.00	check was processed on 02/20/2025, and SOK confirmed receipt of check on 03/06/2025
	Written Correspondence (5 day TAT)	98%	81.82%	\$2,500.00	check was processed on 02/20/2025, and SOK confirmed receipt of check on 03/06/2025
	Written Correspondence (10 day TAT)	100%	90.91%	\$5,000.00	check was processed on 02/20/2025, and SOK confirmed receipt of check on 03/06/2025
TOTAL				\$20,000.00	

Overall Findings, Recommendations, Actions and Observations

Findings and Recommendations

The statistical and electronic testing results indicate that Aetna’s performance relative to claims accuracy meets the expectations in 2024.

Sagebrush’s observations during the claim reviews and the analysis of the administrative questionnaire are that Aetna appears to have adequate system edits and controls in place or, with regards to processing eligibility updates, have been enhanced to provide adequate controls. The claims operation effectively utilizes technological solutions as evidenced by the largely paperless environment and efficient claims processing system.

The following information provides a summary of Sagebrush’s general observations and recommendations relative to the claims and operational review and electronic testing.

- **Financial Accuracy:** The performance guarantee between Aetna and SEHP for financial accuracy is 95%. This guarantee has an at-risk amount of \$2,500 per calendar quarter.

Finding: Based on the calculated financial accuracy from the audit, 98.40%, Aetna met the contractual performance guarantee of 95%.

Action: No further action is required.

The financial accuracy calculated for this audit is based on SEHP claims processed in calendar year 2024. However, the internal quality results reported by Aetna and used to determine performance guarantee penalties for the State of Kansas, are calculated on a quarterly basis.

- **Payment/ Dollar Accuracy (total claim (overall) accuracy):** The performance guarantee between Aetna and SEHP for payment or dollar accuracy is 95% with a total at risk amount of \$2,500.00 per calendar quarter

Finding: Based on the calculated payment or dollar accuracy from the audit, 96.12%, Aetna met the contractual performance guarantee between SEHP and Aetna of 95%. Aetna’s reported payment accuracy for calendar year 2024 was 99.29%, which meets the contracted guarantee of 95%.

Action: No further action is required.

- **Incorrect Fee Schedule Allowable -** There were five (5) claims identified with the incorrect fee schedule allowable calculated. This resulted in a net underpayment of \$245.88.

Action: Aetna agreed with all five (5) errors. These claims will need to be adjusted to issue the additional payment to the provider of service.

- **Incorrect Benefit Applied** - There were four (4) claims that incorrectly applied the plan benefits, such as deductible, copayment or coinsurance. These claims resulted in a net underpayment of \$2,306.18.

Action: Aetna agreed to three (3) of the errors. Aetna will need to adjust the claims and issue the additional \$2,667.58 to the providers of service.

Aetna disagreed to a claim with an overpaid amount of \$361.40 stating the claim paid correctly under the preventive benefit per the plan.

- **Incorrect Inpatient Pricing** – Sagebrush identified two (2) claims for inpatient stays where the incorrect allowable was calculated. These claims resulted in a total net underpayment of \$51,284.82. Aetna agreed with these errors.

Action: One (1) claim with an underpayment of \$4.03 will need to be adjusted to pay the additional \$4.03 to the provider of service.

The other claim with a total underpayment of \$51,280.79 was identified by Aetna and the claim was adjusted to issue the additional payment on 2-25-2025. No further action is required for this claim.

- **Duplicate payments** - Sagebrush's review of the potential duplicate payments identified 7 possible errors resulting in an overpaid amount of \$4,569.43. Aetna agreed with 3 of the errors with an overpaid amount totaling \$176.84. Aetna also agreed to 1 claim citing an underpayment of \$401.32.

Action: Aetna is working to recover the \$176.84 and will issue payment to SEHP by check. The underpaid claim will be adjusted to pay the additional \$401.32 to the provider of service.

- **Hearing Aids and Related Services** – The plan covers hearing aid services, which includes hearing devices, and covered services from both Network and Non Network providers. These services apply toward a maximum benefit for all services of \$5,000 per a three (3) year period.
Aetna agreed to 3 claims with a total overpaid amount of \$4,064.09. These claims exceeded the \$5,000 maximum benefit in a 3 year period.

Action: Aetna is working to recover the \$4,064.09 and will issue payment to SEHP by check.

- **Ineligible Participants** – Sagebrush compared the eligibility file that was received from the State of Kansas against the paid claims data provided by Aetna to identify claims paid for participants that were no longer eligible for coverage. Sagebrush included 11 participants with paid claims totaling \$1,102.62 in the electronic testing sample sent to Aetna.

Aetna agreed with two (2) participants with claims totaling \$36.62. The claims will need to be adjusted and the \$36.62 will be included in the reimbursement check at the conclusion of the audit.

One (1) participant that was not found on the eligibility file, had a claim totaling \$53.83. Aetna did not respond to this participant to prove that there was active coverage in place on the date of service.

Aetna disagreed with eight (8) of the participants with claims totaling \$1,012.17 stating the participants still had active coverage on the date of service.

Action: Aetna is working to recover the \$36.62 and will issue payment to SEHP by check.

Overall Conclusions

Sagebrush’s review of the Aetna systems encompassed the remote on-line testing of each claim in the statistical sample. The on-line testing consisted of “re-adjudicating” each of the claims sampled, just as an Aetna examiner would have paid the claim using the Aetna system. The auditors’ review did not include the application of Aetna systems to functions beyond the scope of claims processing, such as participant services, utilization management or general financial functions.

Based on the responses provided in the questionnaire, Sagebrush’s understanding of Aetna operations, and the testing of claims in the statistical claim audit, Sagebrush concludes that Aetna has appropriate and adequate system, controls, guidelines, and processes. All of the identified errors were due to manually intervention at the time of processing.

The statistical sample revealed four (4) overpayments totaling \$3,891.90. Aetna agreed with these errors. The claims will be adjusted and the \$3,891.90 will be included in a reimbursement check to SEHP at the conclusion of the audit.

The electronic testing identified \$4,331.38 in overpayments. Aetna is in process of adjusting the claims for \$4,277.55 and will include the payment in the reimbursement check at the conclusion of the audit. The other \$53.83, Aetna did not issue a response to this eligibility issue.

Based on the statements above, the total amount due from the overpayments identified in the statistical sample and the additional focused review, is \$10,723.28. Aetna will need to issue a check in the amount of \$8,223.28 to SEHP.