Comprehensive Claim Administration Audit

SPECIFIC FINDINGS REPORT

Kansas State Employee Health Plan

Administered by Aetna

Audit Period: January 1, 2019 through December 31, 2019

Presented to

Kansas State Employee Health Plan

September 4, 2020

CLAIM TECHNOLOGIES INCORPORATED

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INTRODUCTION

This ***Specific Findings Report*** contains CTI's findings and recommendations from our audit of Aetna's (Aetna) administration of the Kansas State Employee Health Plan (the State) plan.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by the State and Aetna. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between Aetna and the State as well as all approved plan documents and communications.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Aetna used to pay the State's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

OBJECTIVES AND SCOPE

The objectives of CTI's audit of Aetna's claim administration were to determine whether:

- Aetna followed the terms of its contract with the State;
- Aetna paid claims according to the provisions of the plan documents and if those provisions were clear and consistent;
- Members were eligible and covered by the State's plan at the time a service paid by Aetna was incurred; and
- Any claim administration or eligibility maintenance systems or processes need improvement.

CTI audited Aetna's claim administration of the State medical plan for the period of January 1, 2019 through December 31, 2019. The population of claims and amount paid during that period were:

Total Paid Amount	$13,632,344
Total Number of Claims Paid/Denied/Adjusted	52,304

The audit included the following components which are described in greater detail on the following pages:

- Operational Review and Questionnaire
- Plan Documentation Analysis
- 100% Electronic Screening with 50 Targeted Samples
- Random Sample Audit of 180 Claims
- Data Analytics

AUDIT FINDINGS AND RECOMMENDATIONS

Random Sample Findings

CTI validated claim processing accuracy based on a sample of 180 medical claims paid or denied by Aetna during the audit period. We selected the random sample (stratified by the claim billed amount and the date processed) to provide a statistical confidence level of 95% +/- 3% margin of error.

CTI's Random Sample Audit categorizes errors into key performance indicators. We use this systematic labeling of errors and calculation of performance as the basis for the benchmarks generated using results from our most recent 100 medical claim audits.

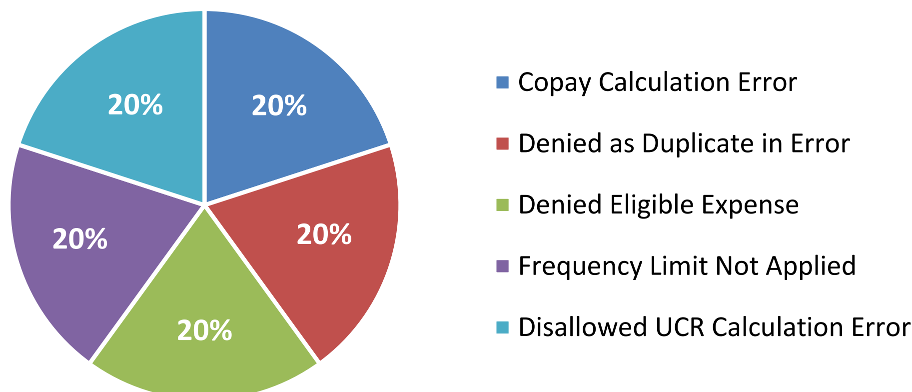
The following table illustrates Aetna's performance was above the median in two and below the median in one of CTI's benchmarked performance indicators.

Key Performance Indicators	Administrator's Performance by Quartile				
	Quartile 1	Quartile 2	MEDIAN	Quartile 3	Quartile 4
	Lowest →				*Highest*
Financial Accuracy: Compares total dollars associated with correct claim payments to total dollars of correct claim payments that should have been made.		97.79%	98.58%		
Accurate Payment: Compares number of correctly paid claims to total number of claims paid.			96.53%	97.22%	
Accurate Processing: Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.			96.03%	97.22%	

Prioritization of Process Improvement Opportunities

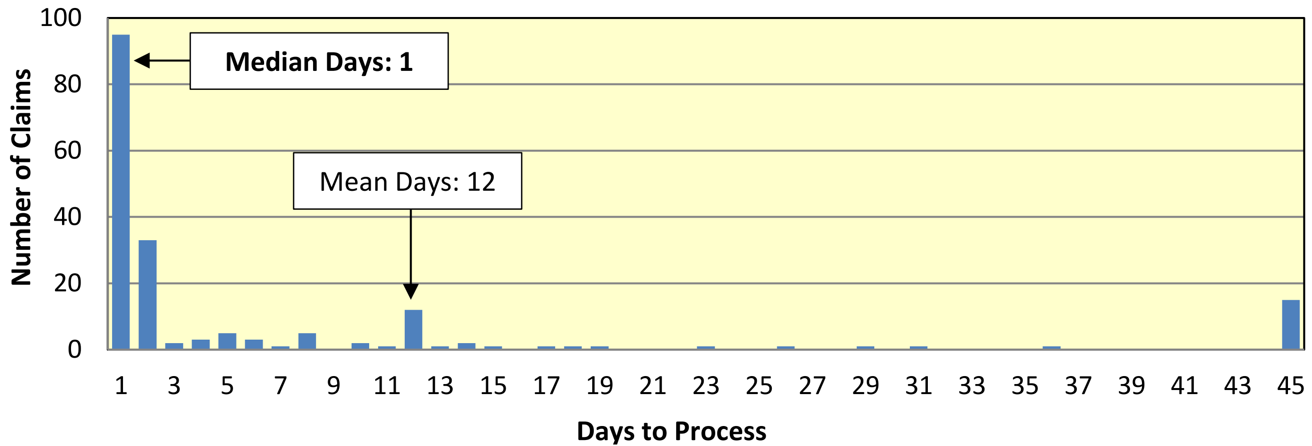
The following chart can help to prioritize improvement and/or recovery opportunities based on savings and service impact and to pinpoint problem causes. Of the 180-claim random sample, CTI identified five claims processed incorrectly.

Financial Accuracy, Accurate Payment and Accurate Processing by Error Type



Claim Turnaround Time

A final measure of claim administration performance is claim turnaround time. Through the audit sample, Aetna demonstrated its median turnaround time on a complete claim submission was one day from the date it received a complete claim to the date the claim was paid or denied.



Random Sample Recommendations

CTI suggests that the State meet with Aetna to discuss the audit findings and focus specifically on steps necessary to improve Financial Accuracy, Accurate Payment Frequency, and Accurate Processing Frequency. Of the five errors cited, Aetna agreed to four.

The four concerned denial of an eligible procedure, denial as a duplicate in error, frequency limits applied in error and an incorrect usual, customary and reasonable calculation. We recommend confirming the claims have been reprocessed by Aetna. The error Aetna disagreed with concerned non-application of a copayment to an office consultation. Aetna is covering CPT code 99242 (level 2 office consult) at 100% with no patient cost share which the State's plan documents don't support. Should Aetna's handling of this procedure code not meet the State's intent, Aetna will need to correct its claim system and conduct impact analysis of all affected claims.

The State, CTI and Aetna discussed the random sample results. Aetna confirmed three of the claims cited as errors were reprocessed. Aetna is performing research on the fourth claim concerning CPT code 99242 and will report its findings to the State upon completion.

100% Electronic Screening with Targeted Samples Findings

We used our proprietary Electronic Screening and Analysis System (ESAS) software to further analyze claim payment and eligibility maintenance accuracy as well as and opportunities for system and process improvement. Using the data file provided by Aetna, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of 50 claims to provide insight into Aetna's claim administration as well as operational policies and procedures.

The table on the following page shows the medical services identified as potentially overpaid. It is important to note that the amount shown represents potential payment errors; additional testing would be required to substantiate the findings and provide the basis for remedial action planning or recovery.

ESAS Candidates for Additional Testing	Potential Recovery
Duplicate Payments	**$1,691**
Excluded Services	**$27,731**
Inappropriate Use of 26 and TC Modifiers	$10,735
PA, Nurse Practitioner, Nurse Surgery Asst.	$11,481
Liposuction (Cosmetic)	$5,515
Plan Limitations	**$24,645**
Durable Medical Equipment	$15,706
Cardiac Rehabilitation	$14,522
Timely Filing	$4,417
Employee Eligibility Screening – Claims Paid*	**$28,409**

**CTI notes that .002% of the State's total medical spend processed by Aetna was identified as paid for members who may not have been eligible for coverage. These results are below the 1 – 2% CTI generally reports.*

100% Electronic Screening with Targeted Samples Recommendations

The State should talk to Aetna about conducting a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. Specifically, we recommend the State talk to Aetna about:

- Three targeted samples identified duplicate payments to which Aetna agreed were overpaid. We recommend root cause analysis of these duplicate payments and identification of needed system or workflow enhancements to prevent similar errors going forward.
- Agreement on a process to handle exceptions to the plan's timely filing deadline of 90 days after the date of service that involves the State's review.
- Review of Aetna's plan documentation for services that require prior authorization and prior approval to ensure it mirrors the State's language in its plan documents. A claim for durable medical equipment was paid without prior authorization which the plan booklet requires and a claim for cardiac rehabilitation was paid without the required submission and approval of a pre-treatment plan.
- Review of the claimants flagged in the eligibility screening and causal analysis to identify any improvements that could reduce or eliminate paying claims for ineligible claimants.

The State, CTI and Aetna discussed the ESAS results to determine if overpayment recovery and/or system improvements were possible and to reduce or eliminate similar errors going forward. Where any research or impact analyses were requested by the State, Aetna agreed to share its findings upon completion.

The State asked Aetna to review a sample of high dollar claimants who were flagged in the eligibility screening to determine if they were eligible on their dates of service. Aetna shared their research with CTI and the screening was updated.

Operational Review Findings

Aetna completed our Operational Review Questionnaire and provided information on its:

- Systems, staffing, and workflow;
- Claim administration and eligibility maintenance procedures; and

- Internal control risk mechanisms, e.g., HIPAA protections; internal audit policies and practices; and fraud, waste, and abuse detection and prevention.

Highlights of our review include:

- Aetna did not provide copies of its errors and omissions policy declaration page and its certificate of liability for fidelity bond and cyber liability. However, it indicated it has professional liability insurance with coverage with at a least $10 million aggregate. It also indicated that all employees are bonded through a $10 million fidelity bond. Finally, Aetna reported having privacy and network liability insurance with an aggregate limit of $15 million.
- Aetna and the State have a performance agreement in place with measure categories for Implementation, Account Management, Claims Administration, Network Management, and Member Services. Aetna provided penalty letters from the State showing 10 missed performance guarantees, incurring penalties in the amount of $23,500. Aetna indicated that results are reported at the "unit" level, meaning that other clients' results are included.
- Aetna indicated that it had been audited for compliance with the standards of the American Institute of Certified Public Accountants (AICPA) through the issuance of a Statement on Standards for Attestation Engagements (SSAE) No. 18, reporting on controls at a service organization. Under SSAE 18, the administrator is required to provide a description of its system, which the service auditor validates. We have a copy of the report and can confirm that Aetna's external auditor did not note any deviations in the installation and maintenance of customer benefits, enrollment information, and healthcare provider agreements control, or in the claim adjudication and claim payment and customer funding controls.
- Aetna provided overviews of its Business Continuity Management Program and Disaster Backup and Recovery (DBAR). The mission and purpose are to improve resiliency against service disruption; ensure the ability to provide service, provide a framework to identify critical operations, risks, impacts, and recovery strategies; and validate strategies and capabilities through exercises and maintenance. Aetna has two hardened computer data centers for information back-up, where infrastructure and application production data are secured and stored daily.
- Aetna handles claim checking account reconciliation and refunds for the State. Customer Service Representatives void returned checks and reissue them if necessary.
- Aetna described its large claim pre-payment review process. All claims equal to or greater than $10,000 are routed to its pre-payment review area to check for accuracy.
- Aetna described its claim system security controls including secure log-on passwords and system authorization, authorized check signatures, separation of duties, and limited ability to override system edits and limitations.
- Aetna tracks coordination of benefits (COB) on a pursue and pay and basis using 100% Allowable methodology. Aetna screens and investigates all claims using information obtained from a variety of sources. Aetna calculates COB savings as the amount it would have paid without applying COB provisions minus the amount actually paid after applying the COB provisions, based on fully adjudicated claims only.
- Aetna reported COB savings of $584,818 in 2019 and that it uses benefit reserve or credit banking.

- Aetna indicated 85.62% of the State's claims auto-adjudicated during the audit period.
- Aetna pursues overpayment recovery for amounts over $15.00 (providers) and $25.00 (members) and can auto-recoup overpayments from the next payment. Aetna also subcontracts with Optum and a variety of other national third-party vendors to assist with overpayment recovery. Aetna electronically sends claim data to the vendors. Each vendor retains a contingency fee. Recoveries are reported to Aetna's Cost/Containment/Operational Accounting areas by PRS which then creates a credit to the State.
- Aetna screens claims of all amounts for potential work-related injuries or conditions on a pursue and pay basis. Aetna provided a report of Workers' Compensation savings prepared by its vendor, The Rawlings Group, showing $67,460 saved in 2019.
- Aetna provided appeal reports for 2019. There were nine member appeals, six of which were upheld (67%), two of which were overturned (22%), and one of which was partially overturned (11%). 100% were reported as in compliance with response timeframes.
- Aetna indicated that in 2019 the percent of claims paid in-network was 97.9%. Aetna provided a National Advantage Plan savings report for 2019 showing gross savings of $107,366 with a $42,944 fee (40%) for net savings of $64,422.
- Aetna reimburses out-of-network facilities at 250% of Medicare and out-of-network professional and ancillary fees at 125% of Medicare RBRVS (resource-based relative value scale).
- Aetna indicated it receives rebates for processing specialty drugs under medical coverage but does not pass any of those rebates on to the State.
- Aetna did not report any data breaches during the audit period.

Operational Review Recommendations

- Aetna indicated performance guarantees in the State's contract are reported at the unit level and included other clients' results. We recommend discussion with Aetna about performance guarantees based solely on the State's account which the State confirmed took place as recently as this past spring. Should Aetna make this option available, the State will pursue it.
- Aetna subcontracts with Optum and other national third-party vendors to assist with overpayment recovery. If not already provided, we recommend review of periodic overpayment reports to see the volume of overpayments made on the State's behalf, the causes, the amounts recovered and associated fees to ensure the State isn't paying recovery fees for overpayments caused by Aetna's administration.
- Aetna reported it receives rebates for processing specialty drugs under the medical coverage and doesn't pass the rebates on to the State. We recommend the State ask Aetna to quantify the rebates received during the audit period and initiate discussions about sharing rebates going forward.

The State, CTI and Aetna discussed the operational review recommendations. Aetna agreed to provide quarterly overpayment reports to the State and is researching specialty medications processed under the medical plan and will update the State on its findings.

The State asked Aetna to research a sample of high dollar claimants who were flagged in the eligibility screening to determine if they were eligible on their dates of service. Aetna shared their research with CTI and the screening was updated.

Plan Documentation Analysis Findings and Recommendations

Our Plan Documentation Analysis indicated the State plan documents were silent on whether marriage counseling is a covered benefit. We recommend the State consider updating its plan documents to include this as a covered benefit or to list it as a plan exclusion.

Data Analytics Findings

CTI used electronic claim data provided by Aetna to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

Network Provider Utilization and Discount Savings

CTI compared submitted charges to allowable charges for all claims paid for the plan during the audit period. The analysis relied on data provided by Aetna and we made no assumptions when necessary data fields were not provided. The following table shows the results of CTI's analysis of the value of discounts given by network providers as a percentage of all claims processed during the audit period. Paid claims totals do not include claims paid for members 65 and older.

Total of All Claims				
Claim Type	**Eligible Charge**	**Provider Discount**		**Paid**
Ancillary	$1,803,321	$1,280,962	71.0%	$385,547
Non-Facility	$9,982,720	$5,105,847	51.1%	$3,051,884
Facility Inpatient	$8,845,630	$4,567,493	51.6%	$3,862,202
Facility Outpatient	$17,362,408	$10,644,691	61.3%	$5,022,397
Total	**$37,994,079**	**$21,598,993**	**56.8%**	**$12,322,029**

The State's members had network utilization with 98.6% of all allowed charges and 94.4% of all claims.

Sanctioned Provider Identification

CTI screened 100% of non-facility provider claims from Aetna against the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). No claims were paid to sanctioned providers during the audit period.

PPACA Preventive Services Coverage Compliance

Federal healthcare reform (PPACA) mandates that all health plans (unless grandfathered) cover certain preventive services at 100% without cost-share if the service is performed by a network provider. CTI's analysis found 90.63% of the procedure codes were identified as preventive services from in-network providers. CTI can provide a detailed list of the other 9.37% upon request.

NCCI Editing Capability

CTI analyzed Aetna's claim system code editing capability to determine the degree to which it conformed to the Centers for Medicare & Medicaid Services' (CMS) NCCI guidelines used for Medicare Part B and Medicaid claims.

While not mandatory for non-Medicare/Medicaid plans, it is important to understand the benefit and potential value of these initiatives. The two CMS initiatives offering the greatest return to self-funded benefit plans are Procedure-to-Procedure Edits and Medically Unlikely Edits.

Our claim system code editing analysis identified claims for services submitted to the State and paid by Aetna that CMS would have denied using the NCCI edits. Since Aetna paid the billed charges, the payments represent a potential savings opportunity to the State.

Claim System Code Editing Capability Analysis by CMS NCCI Initiative		
	Procedure-to-Procedure Edits	**Medically Unlikely Edits**
Facility	$7,298	$31,046
Non-Facility	$20,199	$10,536
Ancillary	N/A	$828

Global Surgery Prohibited Fee Period Analysis

CTI's claim system code editing analysis identified evaluation and management (E/M) procedure codes that were submitted and paid by Aetna that CMS would have denied using its defined global surgery fees. Payment of post-surgery E/M (office visits) services that should have been submitted as part of the physician's surgery charge is an example of unbundling, a provider billing practice that drives up cost. Since Aetna paid allowed charges, those payments represent a potential savings opportunity to the State.

E/M Services Using Same Provider ID as Surgeon Within Prohibited Global Fee Period			
CMS Would Deny Without Documentation *E/M Procedure Codes with Modifier 24, 25 or 57*		**CMS Would Deny** *E/M Procedure Codes without Modifier 24, 25 or 57*	
Total Count (0/10/90 days)	**Allowed Charge**	**Total Count (0/10/90 days)**	**Allowed Charge**
519	$48,380	38	$3,790

Data Analytics Recommendations

The State, CTI and Aetna discussed the Data Analytics findings and the potential for additional cost savings to the plan. While Aetna has several of the CMS edits in place and correctly denied claims billed inappropriately, CTI found $73,697 in claims that would have been denied by CMS. Aetna reported there are no current plans to incorporate more CMS edits but they could be added at a later date. If more CMS edits are incorporated, the State will be notified.

CONCLUSION

We understand you will need to review these findings and recommendations to determine your priorities for action. Should the State desire additional assistance with this, our contract offers eight hours of post-audit time to help you create an implementation plan.

CTI also suggests that the State perform a follow-up audit to verify that Aetna has made the recommended improvements, that performance results against benchmarks are improving, and that no new processing issues have arisen.

We consider it a privilege to have worked for, and with, your staff and we welcome any opportunity to assist you in the future. Thank you again for choosing CTI.

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