

Claim Administration Audit

SPECIFIC FINDINGS REPORT

**Kansas State Employee Health Plan Medical Plan
Administered by Aetna**

Audit Period: January 1, 2018 through December 31, 2018

Presented to

Kansas State Employee Health Plan

February 28, 2020

Presented by



**CLAIM TECHNOLOGIES
INCORPORATED**

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INTRODUCTION

This report contains findings and recommendations from CTI’s audit of Aetna’s (Aetna) claim administration of the Kansas State Employee Health Plan (the State).

CTI conducted the audit according to current, accepted standards and procedures for claim audits in the health insurance industry. We base our audit findings on the data and information provided by the State and Aetna. Their validity is reliant upon the accuracy and completeness of that information. 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.

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.

OBJECTIVES AND SCOPE

The audit objectives of Aetna’s claims administration were to determine whether:

- Aetna followed the terms of the services agreement;
- 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, 2018 through December 31, 2018. The population of claims and amount paid during that period were:

Total Paid Amount	\$11,483,486
Total Number of Claims Paid/Denied/Adjusted	46,101

The audit included the following components:

- Random Sample Audit of 180 claims
- 100% Electronic Screening with 50 Targeted Sample Analysis (ESAS®)
- Plan Documentation Analysis
- Operational Review
- 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.

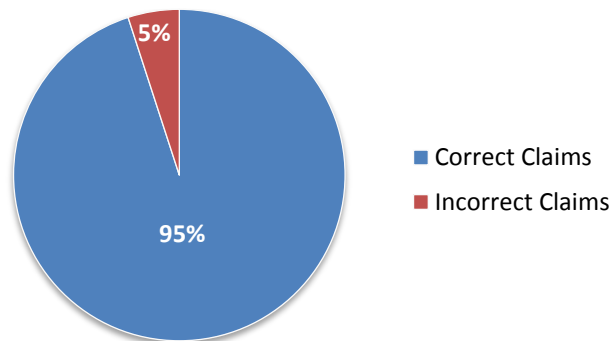
The following table illustrates Aetna’s performance was below the median in CTI’s Financial Accuracy, Accurate Payment, and Accurate Processing benchmarked performance indicators.

Key Performance Indicators	Administrator’s Performance by Quartile				
	Quartile 1	Quartile 2	MEDIAN	Quartile 3	Quartile 4
	Lowest \leftarrow \rightarrow Highest				
Financial Accuracy: Compares total dollars associated with correct claim payments to total dollars of correct claim payments that should have been made.		97.14%	98.77%		
Accurate Payment: Compares number of correctly paid claims to total number of claims paid.		95.56%	96.67%		
Accurate Processing: Compares number of claims processed without any type of error (financial or non-financial) to total number of claims processed.		95.00%	96.17%		

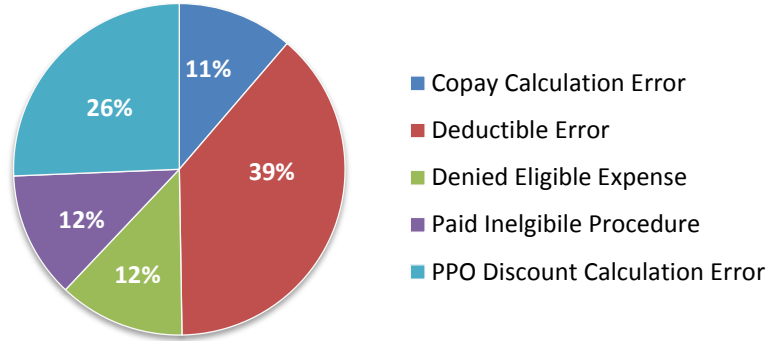
Prioritization of Process Improvement Opportunities

The following charts can help to prioritize improvement and/or recovery opportunities based on savings and service impact and also to pinpoint problem causes.

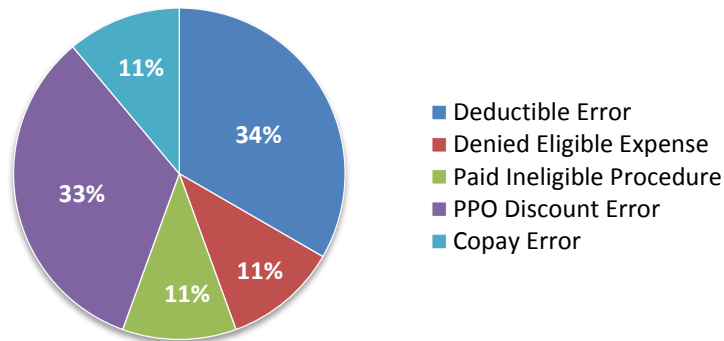
Overall Accurate Processing



Financial Accuracy and Accurate Processing by Error Type



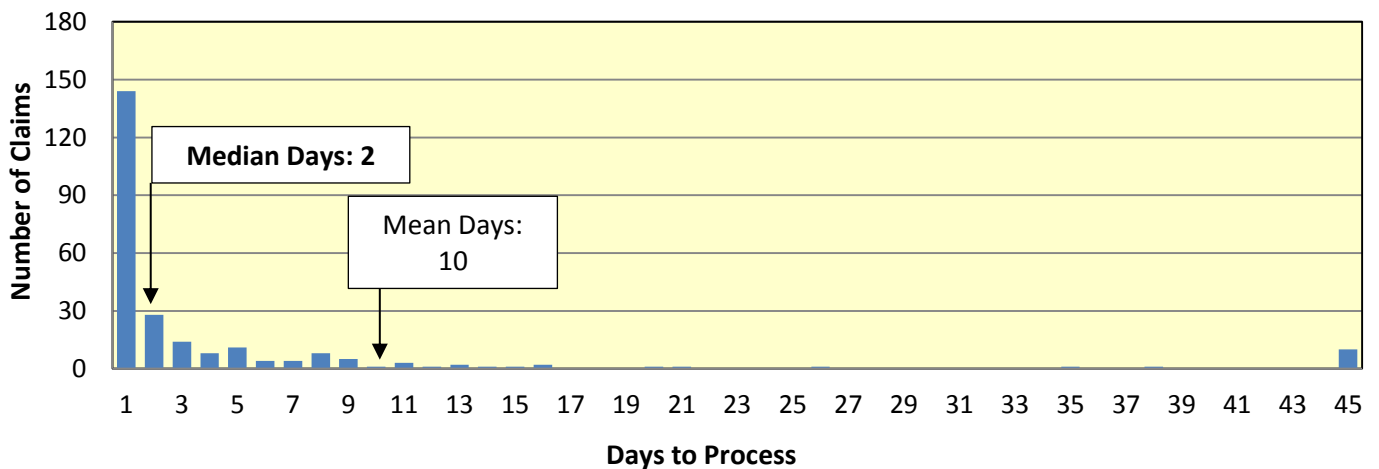
Policy Provision Errors by Type



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 2 days from the date it received a complete claim to the date the claim was paid or denied.

Median and Mean Claim Turnaround



Random Sample Recommendations

CTI and the State met with Aetna to discuss the audit findings and to focus specifically on steps necessary to improve Financial Accuracy, Accurate Payment Frequency, and Accurate Processing Frequency. We reviewed each of the financial errors identified in our random sample audit. Where appropriate, Aetna conducted impact analyses and reported its findings to the State.

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 and opportunities for system and process improvement. We screened 100% of claims paid or denied during the audit period, and our Technical Lead Auditor selected a targeted sample of 50 electronically screened claims to validate findings and test Aetna’s claim administration systems.

The following table 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/Savings
Excluded Services	\$10,247
• Inappropriate Use of 26 and TC Modifiers	\$10,247
Plan Limitations	\$12,297
• Timely Filing	\$12,297
Employee Eligibility Screening – Claims Paid	\$17,715
TOTAL	\$40,259

100% Electronic Screening with Targeted Samples Recommendations

The State and CTI met with Aetna about conducting a focused analysis of the errors identified through ESAS to verify they were administered according to plan documentation and determine if overpayment recovery and/or system improvements are needed to reduce or eliminate similar situations going forward. For the issues identified, CTI provided claims detail to Aetna. Aetna analyzed the claim detail and provided the State with responses to each item and identified any needed follow-up.

The State asked Aetna to review the results of the eligibility screening to validate data provided for this analysis was complete and didn’t generate false positives. Aetna is reviewing the eligibility report detail to perform causal analysis to determine if any needed workflow or system improvements to prevent payment of claims for ineligible claimants and will report its findings to the State.

Operational Review Findings

Aetna completed our Operational Review Questionnaire that 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 Operational 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/E & O: \$ 10,000,000 limit, no annual aggregate
 - Cyber Liability Aggregate limits of at least \$10 million.
 - Fidelity Bonds All employees are bonded
- Aetna and the State have a performance agreement in place with measures during the audit period with specific guarantees for the following categories:
 - Account Management
 - Customer Service
 - Data Management
 - Service Performance Standards
 - Claim Performance Measures
- In 2018, Aetna did not meet 15 performance standards. As a result, it issued the State a check for \$37,500 on February 25, 2019. Aetna indicated that its performance results are typically reported on a unit level basis but where available, Aetna provides State-specific performance goals.
- Aetna reported 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 its own description of its system, which the service auditor validates. CTI has a copy of the audit report and we 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 reported appropriate levels of security and control within its check issuance procedures to protect the State's interest and ensure all transactions were performed by authorized personnel only.
- Aetna provided documentation of claim system security controls that included secure log-on passwords and system authorization, authorized check signatures, separation of duties, and limited ability to override system edits and limitations.
- Aetna had adequately documented training, workflow, procedures, and systems.
- Aetna provided a report showing COB savings of \$103,120, or .7%, for claims incurred in calendar years 2017 and 2018.
- Aetna pursues overpayment recovery for amounts over \$15.00 and has the ability to auto-recoup overpayments from the next payment. Aetna also subcontracts with Optum and a variety of national third-party vendors to assist with overpayment recovery. Aetna electronically sends claim data to the vendors. Each vendor retains a contingency fee.
- A 2018 overpayment recovery report provided by Aetna showed 310 overpayments logged, representing \$123,228, of which 110,575.32 was recovered. After adjustments and recoveries prior to the quarter, the remaining balance was \$6,775,29.
- The report also showed the top five reasons for overpayments. Those were:

- Retroactive Terminations within 60 Days \$23,072.00
 - Duplicate – based on process \$16,147.00
 - Incorrect Allowed Amount \$15,700.73
 - Incorrect Submitted Amount \$9,548.00
 - Revised Bill \$7,031.00
- Aetna provided a report showing there were 14 member appeals in 2018, 11 of which were upheld and 3 of which were overturned. Thirteen of the appeals were reported as in compliance with response timeframes.
 - Aetna indicated that for calendar year 2018, 98.6% of the State’s claims were paid as in-network.
 - Aetna indicated that it does not receive rebates for processing specialty drugs under medical coverage.
 - Aetna reported it did not have any data breaches impacting the State’s members during the audit period.

Operational Review Recommendations

The State, Aetna, and CTI discussed the following recommendations:

- Aetna confirmed missed performance goals and payment of the \$37,500 check issued to the State in February 2019.
- Confirm the coordination of benefits savings Aetna reported of \$103,120, or .7%, for claims incurred in calendar years 2017 and 2018 and continue to monitor plan savings generated by employees’ other coverages and potential liability should those coverages end.
- Regularly review outstanding overpayment reports and discuss root causes of overpayments with Aetna to determine if system or process improvements to reduce the volume and cost of recovering overpayments.
- The State should continue to monitor appeals activity to identify current and emerging trends, potential process improvements, and member communication opportunities.

Plan Documentation Analysis Findings and Recommendations

Plan Documentation

Our Plan Documentation Analysis indicated the State plan document is silent on the topic of marriage counseling. The State may want to consider updating the benefit information for this service to reflect if it’s a covered or non-covered benefit.

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.

Total of All Claims				
Claim Type	Eligible Charge	Provider Discount		Paid
Ancillary	\$848,805	\$441,982	52.1%	\$270,552
Non-Facility	\$8,081,157	\$3,937,369	48.7%	\$2,691,398
Facility Inpatient	\$5,642,645	\$2,844,727	50.4%	\$2,415,062
Facility Outpatient	\$14,047,750	\$8,322,201	59.2%	\$4,330,558
Total	\$28,620,357	\$15,546,280	54.3%	\$9,707,570

The State’s members had high network utilization with 99.0% of all allowed charges and 92.1% of all claims. The average discount off allowed charges from network and secondary network providers was at expected levels.

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

CTI’s analysis found that 91.23% of the procedure codes identified as preventive services were paid by Aetna at 100% when provided in-network. CTI provided a detailed list of the other 8.77% to Aetna which it is reviewing and will share its findings with the State.

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.

In 1997, Aetna introduced the Automatic Claim Adjudication System (ACAS). The system is based upon Dun and Bradstreet’s ClaimFacts system but has been customized to supports its business. In addition, Aetna indicated that it uses a customized version of ClaimsXten to detect unbundled, upcoded, and fragmented billings. Aetna incorporates many edits recommended by NCCI.

Our claim system code editing analysis identified claims for services submitted to the State and paid by Aetna that Medicare and Medicaid would have denied. 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	\$21,472	\$46,784
Non-Facility	\$4,399	\$23,720
Ancillary	N/A	\$1,764
TOTALS	\$25,871	\$72,268

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 Medicare would have been denied using the defined CMS global surgery fees. Payment of post-surgery E/M 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 <i>E/M Procedure Codes with Modifier 24, 25 or 57</i>		CMS Would Deny <i>E/M Procedure Codes without Modifier 24, 25 or 57</i>	
Total Count (0/10/90 days)	Allowed Charge	Total Count (0/10/90 days)	Allowed Charge
429	\$40,455	18	\$1,706

Data Analytics Recommendation

- The State, CTI, and Aetna discussed the Data Analytics findings and the potential for additional plan cost savings. CTI found \$99,845 in claims that would have been denied by CMS. Aetna reported it is unaware of any current plans to incorporate all of the CMS edits into their claims processing system, Automatic Claim Adjudication System (ACAS), but noted edits are enhanced regularly and they could be added at some point.

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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