Draft as of October 11, 2022

Claim Administration Audit

HEALTH REIMBURSEMENT ARRANGEMENT

State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement Plan
Administered by Via Benefits from Willis Towers Watson

Audit Period: July 1, 2021 through June 30, 2022
Plan Year 2022

Presented to

State of Nevada Public Employees' Benefits Program

October 7, 2022

CLAIM TECHNOLOGIES INCORPORATED

Proprietary and Confidential

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EXECUTIVE SUMMARY

This Comprehensive Audit Report is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of Via Benefits from Willis Towers Watson's (Via Benefits) administration of the State of Nevada Public Employees' Benefits Program (PEBP) Medicare Exchange Health Reimbursement Arrangement (HRA) plan.

Scope

CTI performed an audit of Via Benefits' administration of the PEBP HRA for the period of July 1, 2021 through June 30, 2022 (plan year 2022). The population of claims and amount paid during the audit period was taken from the paid claim file provided by Via Benefits.

Total Paid Amount	$22,353,547.40
Total Number of Claims Paid/Denied/Adjusted	236,770

The audit included the following components which are described in more detail in the following pages.

- Operational Review
- Random Sample Audit
- Eligibility Verification

Auditor's Opinion

Based on these findings, and in our opinion:

1. Via Benefits provided good service to PEBP's members by exceeding its performance guarantee for all four quarters for the Customer Satisfaction Quarter Review goal. Via Benefits exceeded the goal by more than 8% each quarter during plan year 2022 despite missing the Customer Service Abandonment Rate and Average Speed of Answer performance goals for FY 2022 Q2 and Q3.
2. Although Via Benefits provided good service to PEBP's members, CTI recommends the following areas for improvement:
   - Track the reasons for overpayments to understand why overpayments occur and prevent them going forward.
   - Provide claim processors with coaching on the processing errors identified during the audit.
   - Implement a contingency plan for handling increased call volumes during Q2 and Q3 as Speed to Answer continues to exceed the agreed upon goals for those quarters.

Summary of Via Benefits Guarantee Measurements

Based on CTI's Random Sample Audit results, Via Benefits met all three of its claims processing measurements for the PEBP.

FY 2022 Annual Metrics	Met/Not Met	Penalty
Claim Processing Turnaround Time	Met	NA
Claim Processing Payment Precision	Met	NA
Claim Financial Payment Precision	Met	NA

As a follow up to the FY 2021 audit, CTI confirmed Via Benefits issued an ACH credit to PEBP on 3/7/22 for the following missed metrics:

- Annual Customer Service Abandonment Rate – $7,500 penalty
- FY 2021 Q2 and Q3 Customer Average Speed to Answer – $2,000 penalty
- Annual Claim Processing Payment Precision – $10,000 penalty

OPERATIONAL REVIEW

Objectives

CTI's Operational Review evaluates Via Benefits' claims system, staffing, and procedures related to administration including enrollment, customer service, and overpayment recovery. We also used the Operational Review to verify compliance with contract terms and in support of our Random Sample Audit activities.

Scope

The scope of our review included:

1. Claim administrator information
    - Insurance and bonding
    - Conflicts of interest
    - Performance standards
    - Business continuity planning
    - System software
    - Offsite claim administration
2. Claim funding:
    - Claim funding mechanism
    - Check processing and security
3. Claim adjudication, customer service, and eligibility maintenance procedures:
    - Contributions and rollovers
    - Claim processing
    - Customer service call and inquiry handling
    - Overpayment and adjustments
    - System security
4. Privacy and security compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from Via Benefits. We reviewed Via Benefits' responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the PEBP's HRA plan. This allowed us to conduct the audit more effectively.

Findings

In our review we observed the following:

- Via Benefits provided the following insurance coverage information.

Coverage	Amount
Errors and Omissions	$5,000,000 Aggregate Limit
Crime	$1,000,000
Cyber Liability	$5,000,000
General Liability	$5,000,000

- Willis Towers Watson indicated that it had been audited by KPMG LLP, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. We have asked WTW to forward a copy of the report to PEBP. Any questions regarding the report and impact should be discussed with WTW.
- Compliance with Performance Guarantees

Metric	Guarantee Measurement	Actual	Met/ Not Met
Claim Processing Turnaround Time Annual Review	Processing will average two business days. Additionally, 98% of claims will be processed within five business days.	0.37 days 100% processed within five business days	Met Met
Claim Processing Payment Precision Annual Review	Processing average precision will be at least 98% or better.	98.0%	Met
Claim Financial Payment Precision Annual Review	Financial Accuracy will be 98% or better.	99.14%	Met
Reports Annual Review	Reports provided within 15 days.	Met	Met
HRA Web Services Annual Review	99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.67%	Met
Customer Service Abandon Rate Annual Review	The percentage of incoming calls abandoned by participants be 5% or less.	8.8%	Not Met
Customer Service Speed to Answer Quarter Review	Incoming telephone calls answered in less than or equal to: Ninety seconds in Q1 PY 2022 Five minutes in Q2 PY 2022 Two minutes in Q3 PY 2022 Ninety seconds in Q4 PY 2022	Q1 PY 2022 – 0:48 Q2 PY 2022 – 7:57 Q3 PY 2022 – 4:16 Q4 PY 2022 – 0:18	Met – Q1 PY 2022 Not Met – Q2 PY 2022 Not Met – Q3 PY 2022 Met – Q4 PY 2022
Customer Satisfaction Quarter Review	At least 80% of participants surveyed will be satisfied with services.	Q1 PY 2022 – 94.69% Q2 PY 2022 – 88.15% Q3 PY 2022 – 90.77% Q4 PY 2022 – 94.06%	Met
Disclosure of Subcontractors Per Violation	Additional subcontractors shall not be engaged, unless at least 60 days prior to the engagement is given.	Individual Marketplace Subcontractor list dated April 15, 2021	Met
Unauthorized Transfer of Data Per Violation	All data will be stored, processed, and maintained on designated servers. Any changes must have 60 days notification.	No changes reported	Met

- Via Benefits reported for FY 2021 it made payment on 3/7/22 of $19,500 due to missed performance guarantees for Average Speed of Answer ($2,000), Call Center Abandonment Rate ($7,500), and Claim Processing Payment Precision ($10,000).
- Via Benefits reported using the Acclaim system, an in-house application that was developed for claim adjudication and payment purposes. The system has been used for 21 years.

- The business continuity plan provided by Via Benefits included two approaches to data protection; 1) continuous off-site replication to a second, geographically distant location and, 2) the use of daily backups of files and databases.
- Via Benefits indicated no claim processing functions are outsourced.
- All refunds and return checks are forwarded to PEBP to deposit to their bank account.
- Via Benefits indicated PEBP provided the allocation amount that participants were eligible for. Effective May 31, 2021, PEBP implemented an $8,000 cap on the available balance.
- Via Benefits provided an overpayment report for plan year 2022, that showed:
    - Overpayment Total: $21,085.64
    - Recovered Total: $937.90
    - Unrecovered Total: $20,147.74
- Via Benefits did not provide the reason for overpayments on the report; however, it did indicate lost eligibility was the biggest reason for recovering medical expenses.
- Customer service operations were available via phone Monday through Friday from 5:00 AM to 6:00 PM PST. Effective July 1, 2022, customer service hours changed to 5:00 AM to 4:00 PM PST.
- The member online portal allows claim submission, check claim status, check participant balances, supporting documents submittal, and viewing of historical information.
- Via Benefits communicated with account holders via mail or email. It provided newsletters twice a year, a one-time enrollment guide mailing when a participant aged into Medicare, and a one-time HRA welcome packet mailing upon initial qualification.
- Via Benefits reported it used secure system passwords and system authorization, as well as separation of duties. It also limited access to eligibility maintenance and claim adjudication.
- Via Benefits' internal system control document provided a thorough overview including detail on data entry logic, duplicate logic, and overpayment logic as examples.
- Web-based security and compliance training was provided by Via Benefits annually.
- Via Benefits reported that there were no privacy or security breaches identified during the audit period.

RANDOM SAMPLE AUDIT

Objective

The objective of the Random Sample Audit was to identify any administrative process deficiencies in PEBP's health reimbursement arrangement claims.

Scope

The scope of our Random Sample Audit for the PEBP included a review of 200 random sample HRA claims paid by Via Benefits for the period of July 1, 2021 through June 30, 2022. Performance was measured for the following key performance categories:

- Financial Accuracy
- Payment Accuracy
- Claim Turnaround Time

Methodology

The Random Sample Audit was conducted remotely at CTI's Des Moines, Iowa office. A CTI auditor reviewed each claim to determine if it was paid or processed correctly based on member eligibility or plan provisions as defined in the plan documents or amendments.

CTI cited errors when a sampled claim was determined to have been paid or processed incorrectly. Payment errors were observed based on how the selected claim was paid and the information Via Benefits had at the time the transaction was processed.

Findings

CTI defines financial accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample. The sampled claims were selected from the PEBP HRA claims. Note: procedural accuracy includes both financial and procedural errors. A summary of each finding follows the chart below.

Performance Measure	Claims Sampled		Sampled Claims with Errors		Results
	Claims	Dollars Paid	Claims	Dollars Paid	
Financial Accuracy	200	$20,552.57	1	$6.80	99.97%
Procedural Accuracy	200		3		98.00%
Claim Turnaround Time	Guarantee – 98% of claims reimbursed within 5 business days				100%

Audit Number	CTI's Observation	Via Benefits Response	CTI's Conclusion
Financial Errors			
1122	Letter from member states the renewal premium of $91.18 goes into effect on March 1, 2022. This premium amount was applied towards Jan and Feb premium payments. An adjudication error is cited with an overpayment of $6.80.	Agree.	Error and $6.80 overpayment remain. Paid incorrect premium amount.
1	**Financial Error**		

Audit Number	CTI's Observation	Via Benefits Response	CTI's Conclusion
Procedural Errors			
1062	The claim was submitted online for the spouse and processed for the employee. An adjudication error is cited and overpayment of $133.59.	Agree with procedural error.	Procedural error remains. Claim processed under the incorrect claimant. No financial error assessed.
1071	The claim was submitted online for the spouse and member. All charges were processed under the member. An adjudication error is cited and overpayment of $255.	Agree with procedural error.	Procedural error remains. Claim processed under the incorrect claimant. No financial error assessed.
1119	There were two separate expenses from the pharmacy for $27.40, both filled on 01/13/2022 and were picked up on 1/14/2022. One of the expenses was processed using the fill date of 01/13/2022, both should use the receipt date 01/14/2022. An adjudication error is cited.	Agree.	Procedural error remains. Incorrect date of service was used to process claim.
3	**Procedural Errors**		
4	**TOTAL ERRORS**		

Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
The claim was received on 11/1/2021; however, the claim was not moved to the queue for processing until five days after receipt.	1028, 1039
Via Benefit's protocol is to process claims as one payment for multiple receipts. Best practice is to separate the charges to identify and prevent duplicate payments.	1047
The member submitted the monthly premium request for 2022 as $165.10. The claims were also received from Pass Thru at $170.10, therefore the following (out of sample) months have been overpaid – March, April, May, June, and partial payment for July. Total overpayment $719.92.	1110
The member submitted the monthly premium request for 2021 as $297.00. The claims were also received from Pass Thru at $148.50, therefore the following (out of sample) months have been overpaid – Feb- June in the amount of $742.50. A refund has been requested from the member.	1114

ELIGIBILITY VERIFICATION

Our electronic comparison of dates of service to PEBP's eligibility file revealed some services were paid during the audit period for potentially ineligible claimants. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Description	Claim Lines	Members	*Paid Amount
Member Not on File	602	65	$74,667.07
Incurred After Member Benefit End Date	146	36	$15,555.88
Incurred Prior to Member Benefit Begin Date	666	167	$70,789.08
TOTALS	**1,414**	**268**	**$161,012.03**

**CTI notes that 1.2% of PEBP's total medical spend processed by Via Benefits was identified as paid for members who may not have been eligible for coverage. These results are slightly higher than the less than 1% CTI generally reports.*

Due to the brief change in eligibility vendors to BenefitFocus in January of 2022, PEBP eligibility data was not available for January 2022 through April 2022. Claims processed and incurred during that period were removed from CTI's eligibility analysis. With those claims removed, the total paid claims during the 8-month period were $13,144,193.

In our experience, there are occasionally eligibility data issues that affect screening quality and reliability. CTI has provided LifeWorks with detail reports listing individuals with flagged claims to validate eligibility data provided for this screening was correct and did not generate false positives.

RECOMMENDATIONS

Based on the findings of our annual audit of Via Benefits, CTI recommends the following:

1. The overpayment report provided by Via Benefits should specify the reason for overpayments. If the reasons are not currently captured and tracked, CTI recommends doing so. Tracking the reason for overpayments will allow both the PEBP and Via Benefits to understand why overpayments occur and help determine the steps necessary to prevent them going forward.

2. Via Benefits should coach its claims processors on errors identified during the audit:
   - Overlooked charges in claim file
   - Incorrect amount entered
   - Incorrect date of service entered
   - Grouping claims together for family members or paying under wrong family member

3. Via Benefits should implement a contingency plan for handling increased call volumes during Q2 and Q3 as Speed to Answer continues to exceed the agreed upon goals for those quarters.

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Thank you for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Additional information submitted to CTI from the administrator in response to the draft report is reviewed and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response to the draft report.

September 24, 2022

State of Nevada Public Employees Benefits Program:

On behalf of Willis Towers Watson (WTW) in regards to the draft report of the Audit of the State of Nevada Public Employees' Benefits Program Health Savings Account and Health Reimbursement Arrangement for the period of July 2021-June 2022 please see our response to the report and the auditor's recommendations below:

- Claim Technologies Incorporated noted that of the 200 claims reviewed there were two financial errors after review with the auditors, WTW disagrees to these findings. WTW agrees to one financial error.
  - Claim #1056 for $148.50 was received via the mobile app on 1/24/2022 it was processed and paid on 1/26/2022. Along with the online submission the participant uploaded an incomplete claim form with two lines on it for reimbursement, one line for the Dec 2021 Med Part B at $148.50 and one line for Jan 2022 Med Part B at $170.10. On the same day in a separate request via the mobile app they also submitted another reimbursement request with the same incomplete claim form for the Jan 2022 Med Part B at $170.10 which was also processed and paid on 1/26/2022.
    - It is our opinion that both of these claims were processed and paid correctly and should not result in an error.
- Claim Technologies Incorporated noted that of the 200 claims reviewed there were three procedural errors, after review with the auditors, WTW agrees to these findings.

Recommendation #1:

The overpayment report provided by Via Benefits' should specify the reason for overpayments. If the reasons are not currently captured and tracked, CTI recommends doing so. Tracking the reason for overpayments will allow both the PEBP and Via Benefits to understand why overpayments occur and help determine the steps necessary to prevent them going forward.

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WTW Response:

The Overpayment Report does identify the type of overpayment that was created in two categories as described below.

- "Negative Account Balance" - In many cases these overpayments happen due to a late notification that the participant has passed away so funding is removed from the account and claims paid from those funds are then denied and placed into overpayment. This can also happen if a participant has a retroactive loss of their HRA funding qualification.

- "Claims Overpayment" - These overpayments can be tied a claim that was approved but then later determined to be an ineligible expense, for example a claim that was later identified a duplicate claim.

- Our current overpayment report does not provide more detailed information on why a specific overpayment occurred on an account. Manual research would need to occur on the individual participant to confirm the specific reason for an overpayment.

- We are continuing to work on improving the overpayment process and participants can now resolve their overpayments through the portal. They have the option to pay online or submit a help ticket. The amount of calls we take regarding overpayments has decreased more than half because of this change.

Recommendation #2:
Via Benefits should coach examiners on the claim processing errors identified during the audit:

- Overlooked charges in claim file
- Incorrect amount entered
- Incorrect date of service entered
- Allowed payment under incorrect benefit type

WTW Response:

WTW's Claims Manager has confirmed that claim processors are coached on all identified errors, and we have shared the report broadly with the onshore team.

Recommendation #3:

Via Benefits should implement a contingency plan for handling increased call volumes during Q2 and Q3 as Speed to Answer continues to exceed the agreed upon goals for

those quarters.

WTW Response:

Our plan to manage increased call volume during Q2 and Q3 includes hiring staff earlier in the year for Q2 and Q3 2023, which will allow us to meet our staffing targets earlier in the year. We are seeing better retention with those colleagues. During the hiring process, we better set expectations regarding work hours, explaining colleagues will be scheduled for more than 40 hours during the busiest days/weeks during the Medicare Open Enrollment period. As we on board new colleagues, we are leveraging enhanced scenario-based learning with more in-depth Medicare knowledge, soft skills and guided system activities, enabling associates to continuously be prepared for Open Enrollment. We are currently staffed above forecasted needs and are continuing our work from home model, which allowed us to expand our hiring pool. We have improved rewards for our call center colleagues during peak periods. These actions should help minimize attrition which was a driving factor for the Average Speed to Answer being missed last year.

We at WTW appreciate the partnership with Claim Technologies Incorporated and the State of Nevada Public Employees' Benefits Program and look forward to building on a strong audit.

CLAIM TECHNOLOGIES INCORPORATED

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