STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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LAURA RICH
Executive Officer

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

MEETING NOTICE AND AGENDA - Amended 5/20/22

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	May 26, 2022 9:00 a.m.
Place of Meeting:	Pursuant to Assembly Bill 253 (2021), this meeting will be held virtually. Participation will be enabled by the use of remote technology using video- and tele-conference. Instructions for both options are below. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://youtu.be/-Q1Jc1v7CVw

Members of the public are encouraged to submit public comment in writing by emailing wlunz@peb.nv.gov at least two business days prior to the meeting.

To listen to and view the PEBP Board Meeting please click on the YouTube Link located in "Place of Meeting" field above.

There are two agenda items designated for public comment. If you wish to provide verbal public comment during those agenda items, please follow the instructions below:

Option #1 **Join the webinar as an attendee** https://us06web.zoom.us/j/89400386208

This link is only for those who want to make public comment. If you are just listening to the webinar, please use the YouTube Link located in the "Place of Meeting" field above.

Option #2 **Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 894 0038 6208 then press #. When prompted for a Participant ID, please enter #.**

Participants that call in will be muted until it is time for public comment. A moderator will then unmute callers one at a time for public comment.

To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7016 or email wlunz@peb.nv.gov

Meeting materials can be accessed here: https://pebp.state.nv.us/meetings-events/board-meetings/

AGENDA

1. Open Meeting; Roll Call

2. Public Comment

   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three-minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. The total time allotted to public comment may be limited to one hour at the discretion of the chairperson. As noted above, members of the public may make public comment by using the call-in number provided above. Persons unable to attend the meeting by telephone and persons whose comments may extend past the three-minute time limit may submit their public comment in writing to PEBP Attn: Wendi Lunz 901 S. Stewart St, Suite 1001 Carson City NV 89701, Fax: (775) 684-7028 or wlunz@peb.nv.gov at least two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Michelle Briggs, Chief Deputy Attorney General) (Information/Discussion)

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.1 Approval of Action Minutes from the March 24, 2022 PEBP Board Meeting

   4.2 Acceptance of Claim Technologies Incorporated quarterly audit findings:

      4.2.1 Audit of HealthSCOPE Benefits for the timeframe of July 1, 2021 – September 30, 2021.

      4.2.2 Audit of HealthSCOPE Benefits for the timeframe of October 1, 2021 – December 31, 2021.

   4.3 Approval of PEBP Master Plan Documents for Plan Year 2023 including Master Plan Documents for the Consumer Driven High Deductible (CHDP) Plan, Low Deductible (LD) Plan and Exclusive Provider Organization (EPO) Plan

5. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)

6. Enrollment and Eligibility System Transition Update (Nik Proper, Operations Officer) (Information/Discussion)

7. Discussion and possible action regarding the framework for development of the Agency Budget Request for the 2023-2024 Biennium (Laura Rich, Executive Officer) **(For Possible Action)**

8. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

    8.1. Contract Overview

    8.2. New Contracts

        8.2.1. Vivo

    8.3. Contract Amendments

        8.3.1. Segal

        8.3.2. Claims Technologies, Inc.

    8.4. Contract Solicitations

    8.5. Status of Current Solicitations

9. Public Comment

    Public comment will be taken during this agenda item. Comments may be limited to three minutes per person at the discretion of the chairperson. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

10. Adjournment

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at www.pebp.state.nv.us/meetings-events/board-/meetings (under the Board Meeting date referenced above). Contact Wendi Lunz at PEBP, 901 S Stewart Street, Suite 1001, Carson City NV 89701 (775) 684-7020 or (800) 326-5496
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 901 South Stewart Street, Suite 1001, Carson City, NV 89701, or call Wendi Lunz at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 901 South Stewart Street, Suite 1001, Carson City, Nevada, 89701 or on the PEBP website at www.pebp.state.nv.us. For additional information, contact Wendi Lunz at (775) 684-7020 or (800) 326-5496.

Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at www.pebp.state.nv.us, at the office of the public body and to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call

2.

2. Public Comment

3.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Michelle Briggs, Chief Deputy Attorney General) (Information/Discussion)

4.

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

Consent Items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

4.1 Approval of Action Minutes from the March 24, 2022 PEBP Board Meeting

4.2 Acceptance of Claim Technologies Incorporated quarterly audit findings:

4.2.1 Audit of HealthSCOPE Benefits for the timeframe of July 1, 2021 – September 30, 2021

4.2.2 Audit of HealthSCOPE Benefits for the timeframe of October 1, 2021 – December 31, 2021

4.3 Approval of PEBP Master Plan Documents for Plan Year 2023 including Master Plan Documents for the Consumer Driven High Deductible (CDHP) Plan, Low Deductible (LD) Plan and Exclusive Provider Organization (EPO) Plan.

4.1

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

   4.1 Approval of Action Minutes from the March 24, 2022 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
March 24, 2022

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Michelle Kelley, Member Mr. Tom Verducci, Member Ms. Betsy Aiello, Member Ms. April Caughron, Member Mr. Jim Barnes, Member Ms. Leslie Bittleston, Member Ms. Janell Woodward, Member Dr. Jennifer McClendon, Member
MEMBERS EXCUSED:	Ms. Linda Fox, Vice Chair
FOR THE BOARD:	Ms. Michelle Briggs, Chief Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Tim Lindley, Quality Control Officer Ms. Nicole Broyles, Education and Information Officer
OTHER PRESENTERS:	Allison Slife – Clifton Larson Allen Chanelle Bergren – AHH Rhonda Huckaby – HSB Nathan Maier – UMR Scott Muir – LSI Paul Sywulych - LifeWorks Colleen Huber – AON Tim Zettinger - AON

1. Open Meeting; Roll Call

    - Board Chair Freed opened the meeting at 9:04 a.m.

2. Public Comment

    - Jeremy Gladstone – PEBP Member
    - Jenny Johnson – State Employee
    - Kent Ervin – Nevada Faculty Alliance
    - Brad
    - Jenny Druger
    - Brooke Maylath
    - Joel Tyning
    - Will Dawson – Nevada Police Union
    - Paige Menicucci – State Employee
    - Kevin Ranft – AFSCME
    - Terri Laird – RPEN
    - Sean Gallagher – NV State Law Enforcement Officer Assoc.
    - Jamie Phillips
    - Mr. Martinez-Boyd – State Employee
    - Carmen Cortez – State Employee

3. PEBP Board disclosures for applicable Board meeting agenda items. (Michelle Briggs, Chief Deputy Attorney General) (Information/Discussion)

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

    4.1 Approval of Action Minutes from the January 27, 2022 PEBP Board Meeting

    4.2 Receipt of quarterly staff reports for the period ending December 31, 2021:

    4.2.1 Budget Report

    4.2.2 Utilization Report

    4.3 Receipt of quarterly vendor reports for the period ending December 31, 2021:

    4.3.1 HealthSCOPE Benefits – Obesity Care Management

    4.3.2 HealthSCOPE Benefits – Diabetes Care Management

4.3.3 American Health Holdings – Utilization and Large Case Management

4.3.4 The Standard Insurance – Basic Life Insurance

4.3.5 Willis Towers Watson's Individual Marketplace Enrollment and Performance Report

4.3.6 AETNA Signature Administrators – PPO Network

4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

4.3.8 Doctor on Demand

4.4 Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by HealthSCOPE Benefits for:

4.4.1 Period October 1, 2020 – December 31, 2020 (FY21.Q2)

4.4.2 Period January 1, 2021 – March 31, 2021 (FY21.Q3)

4.4.3 Period April 1, 2021 – June 30, 2021 (FY21.Q4)

4.4.4 Focus audit for the period February 1, 2020 through September 30, 2021

4.5 Willis Towers Watson (WTW) response to the recommendations from Claim Technologies Incorporated (CTI) to the Audit of the State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement for the period of July 2020 – June 2021

4.6 Clifton Larson Allen Audited Financial Statements of Public Employees' Benefits Program Self-Insurance Trust Fund for FY21

4.7 AON June 30, 2021 IBNP Report

4.8 Proposed summary revisions to the Plan Year 2023 Master Plan Documents for the Consumer Driven High Deductible Plan, Low Deductible Plan and Exclusive Provider Organization Plan

BOARD ACTION ON ITEM 4
MOTION: Motion to accept all of the items on the consent agenda except for 4.6 and 4.8.
BY: Member Leslie Bittleston
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.6 and 4.8

MOTION: Motion to accept 4.6 and 4.8 and include authorization for staff to make technical adjustments on the plan year 2023 MPD's. **Amendment to motion** (Member Kelley) Once amendments are made, MPD's will be brought back to Board for review even if it's just informational.
BY: Member Tom Verducci
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

5. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)

6. COVID-19 Status Update including possible action to eliminate COVID-19 surcharges (Laura Rich, Executive Officer) **(For Possible Action)**

BOARD ACTION ON ITEM 6

MOTION: Motion to eliminate the surcharges that were previously approved by the Board that were supposed to be effective by July 1, 2022.
BY: Member Tom Verducci
SECOND: Member Janell Woodward
VOTE: Unanimous; the motion carried

7. Enrollment and Eligibility System Implementation Update including possible action regarding changes to contract and vendor relationships and vendor payments (Nik Proper, Operations Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 7

MOTION: Motion to not pay the work orders that were presented in the report. Terminate for convenience with LSI and pursue a solicitation waiver with LifeWorks, the previous vendor. Release an RFI and ultimately and RFP for a new E and E vendor, and shorten open enrollment from May 16th through May 31st of 2022.
BY: Member Leslie Bittleston
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

8. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

    8.1 Contract Overview

    8.2 New Contracts

        8.2.1 Segal Actuarial Consulting

        8.2.2 United Healthcare Life Insurance

8.2.3 Vivo Technologies

8.2.4 LifeWorks, LTD

BOARD ACTION ON ITEM 8.2
MOTION: Motion to ratify and approve the evaluation committee's recommendation on 8.2.1, 8.2.2 and then ratify the contract with Vivo, 8.2.3 and then the contract with LifeWorks in 8.2.4.
BY: Member Leslie Bittleston
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

8.3 Contract Amendments

8.3.1 Healthscope Benefits Third Party Administration

8.3.2 UMR, Inc.

BOARD ACTION ON ITEM 8.3
MOTION: Motion to approve the HealthScope Benefits and UMR Contract amendments per staff recommendation.
BY: Member Betsy Aiello
SECOND: Chair Laura Freed
VOTE: Unanimous; the motion carried

8.4 Contract Solicitations

8.4.1 Eligibility and Enrollment System

BOARD ACTION ON ITEM 8.4
MOTION: Motion to authorize staff to do an RFI and then an RFP for an Enrollment and Eligibility System vendor.
BY: Chair Laura Freed
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

8.5 Status of Current Solicitations

9. Presentation on PEBP claims experience and trend (Collen Huber, Aon) (Information/Discussion)

10. Discussion and possible action to include approving Plan Year 23 (July 1, 2022 – June 30, 2023) rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible (LD) Plan, Exclusive Provider Organization (EPO) Plan, and Health Maintenance Organization (HMO) Plan (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 10
MOTION: Motion to accept the plan year '23 rates that are being presented.
BY: Member April Caughron
SECOND: Member Leslie Bittleston
VOTE: Yes – 8
No – 1 (Member Janell Woodward)
Motion carried

11. Public Comment
    - Kent Ervin – Nevada Faculty Alliance

12. Adjournment
    - Board Chair Freed adjourned the meeting at 2:10 p.m.

4.2

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

   4.1 Approval of Action Minutes from the March 24, 2022 PEBP Board Meeting.

   4.2 Acceptance of Claim Technologies Incorporated quarterly audit findings.

4.2.1

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.2 Acceptance of Claim Technologies Incorporated quarterly audit findings:

        4.2.1 Audit of HealthSCOPE Benefits for the timeframe of July 1, 2021 – September 30, 2021

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees Benefit Program Plans

Administered by HealthSCOPE Benefits

Audit Period: July 1, 2021 through September 30, 2021
Audit Number 1.FY22.Q1

Presented to

State of Nevada Public Employees Benefit Program

Revised May 4, 2022

CLAIM TECHNOLOGIES INCORPORATED

Proprietary and Confidential

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

AUDIT OBJECTIVES 4

OPERATIONAL REVIEW PERFORMANCE GUARANTEES 5

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS 6

RANDOM SAMPLE AUDIT 10

DATA ANALYTICS 13

CONCLUSION 21

APPENDIX – Administrator's Response to Draft Report 22

EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees Benefit Program's (PEBP) medical, dental, and health reimbursement arrangement (HRA) plan.

Scope

CTI performed an audit of HealthSCOPE's administration of the PEBP's medical, dental and HRA for the period of July 1, 2021 through September 30, 2021 (quarter 1 (Q1) for Fiscal Year (FY) 2022). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Medical and Dental	
Total Paid Amount	$62,465,813
Total Number of Claims Paid/Denied/Adjusted	211,811
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$1,642,330
Total Number of Claims Paid/Denied/Adjusted	16,827

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

- Operational Review – Performance Guarantees Only
- 100% Electronic Screening with Targeted Samples
- Random Sample Audit
- Data Analytics

Auditor's Opinion

Based on these findings, and in our opinion:

1. HealthSCOPE met both its Financial and Payment Accuracy measures in Q1 FY2022.
2. HealthSCOPE should:
   - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings in Paid Greater than Charged, Spinal Region Upcoding, and Duplicate Claims Payments.
   - Review the Random Sample Audit results and focus on providing coaching and feedback to examiners to prevent similar manual errors going forward.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both of CTI's claims processing measurements for the PEBP in Q1 FY2022.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.29%	None.
Payment Accuracy	98%	Met – 99.00%	None.

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees Benefit Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and HealthSCOPE, the claim administrator. A copy of HealthSCOPE's response to these findings can be found in the Appendix of this report.

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 PEBP and HealthSCOPE. 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 HealthSCOPE and PEBP.

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 HealthSCOPE used to pay PEBP'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.

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

- HealthSCOPE followed the terms of its contract with PEBP;
- HealthSCOPE paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by HealthSCOPE was incurred.

OPERATIONAL REVIEW PERFORMANCE GUARANTEES

Performance Guarantees

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with HealthSCOPE. The results for Q1 FY2022 follow.

Metric	Guarantee Measurement	Actual	Met/ Not Met
Financial Accuracy	99% or greater of the dollars paid for the audited medical/dental claims to be paid accurately.	99.29%	Met
Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately.	99.00%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.88%	Met
Customer Service	• Telephone Response Time less than 30 seconds for inbound calls. • Telephone Abandonment Rate less than 3% • First call Resolution greater or equal to 95%	9 Seconds Less than .01% 97.67%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	No exceptions noted NA – Annual Report	Met NA
Disclosure of Subcontractors	• Report access of PEBP data within 30 calendar days • Removal of PEBP member PHI within 3 business days after knowledge	No exceptions noted No exceptions noted	Met Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS) software identified and quantified potential claim administration payment errors. PEBP and HealthSCOPE should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by HealthSCOPE during the audit period for both medical and dental claims. The accuracy and completeness of HealthSCOPE's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by HealthSCOPE, 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 claims to provide insight into HealthSCOPE's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note than using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched HealthSCOPE's administration.
- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The following detail report shows, by category, the number of line items or claimants with process improvement opportunities remaining after our analysis and removal of verified false positives. A CTI auditor reviewed the responses and supporting documentation. The administrator responses are copied directly from HealthSCOPE's reply to audit findings.

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q1 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,215	448	$80,326	$42,848

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended. For each potential error, we sent an ESAS Questionnaire (QID) to HealthSCOPE for written response. After review of the response and additional information provided, CTI confirmed the potential for process improvement. Note that all recommendations for HealthSCOPE process improvements will also be included in the Q4 FY2022 report.

Manually adjudicated claims were processed by an individual claims processor. Auto-adjudicated claims were paid by the system with no manual intervention.

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
27	Spinal Region Upcoding	$55.00	Disagree. Claim was paid according to the plan benefits.	Procedural deficiency and overpayment remain. The description for CPT codes for chiropractic care includes the number of regions of the spine or extraspinal regions treated and should be supported by the diagnosis. The provider billed five or more spinal regions treated; however, the diagnosis billed supported treatment of only two spinal regions. These procedures are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☐ M ☒ S
28		$136.00			☒ M ☐ S

Categories for Potential Amount at Risk

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where, in our opinion, process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from HealthSCOPE's reply to audit findings.

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q1 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payment				
Providers and/or Employees	304	63	$113,369	$38,669
Exclusions				
Dental, General Anesthesia	458	238	$108,572	$91,253
Dental, Orthodontia	2	2	$809	$731
Dental, Other Services	116	92	$40,277	$22,686
Dental, Other Surgical Procedures	184	158	$125,931	$88,334
Dental, TMJ	4	3	$2,555	$1,916
Orthopedic Shoes	3	3	$668	$409

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended.

Duplicate Payments Detail Report				
QID	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
18	$500.00	Agree. The refund has not been received.	Procedural deficiency and overpayment remain. HealthSCOPE paid duplicate charges.	☒ M ☐ S
19	$147.48			☒ M ☐ S
22	$458.10			☒ M ☐ S
23	$201.72			☒ M ☐ S
24	$1,371.60			☒ M ☐ S
25	$690.00			☒ M ☐ S

Exclusion Detail Report				
QID	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
43	$189.60	Agree. Claim would suspend for analyst review. Analyst should have denied to request medical records.	Procedural deficiency and overpayment remain. HealthSCOPE should have denied charges and requested medical records.	☒ M ☐ S

There were also nine errors found under the dental benefit plan for excluded services paid. CTI's review indicated five "Other Dental Surgical Procedures" paid for a total of $2,631.00 including:

- two Sinus Augmentation claims;
- two Bone Replacement Graft for Ridge Preservation; and
- one Osseous, Osteoperiosteal, or Cartilage of the Mandible or Facial Bones.

The remaining four dental claims paid for excluded services include:

- one TMJ for $1,174.20;
- one Other Services for $692.61;
- one Orthodontia for $337.60;
- one General Anesthesia for $142.66.

In CTI's experience the PEBP's dental plan document is vague and/or silent on a number of dental services. We recommend that the language be updated to indicate specifically which services are covered and which are excluded. This will eliminate the option for medical necessity which means any claim currently submitted is being paid.

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's statistically valid Random Sample Audit included a stratified random sample of 200 paid or denied claims. HealthSCOPE's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

In addition, CTI sampled 50 health reimbursement arrangement (HRA) claims to ensure payment and processing accuracy.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information HealthSCOPE had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with HealthSCOPE in writing about any errors or observations using system-generated response forms. We sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from HealthSCOPE's reply.

Financial Accuracy

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 claims sampled and reviewed revealed $177.81 in underpayments and no overpayments, for an absolute value variance of $177.81.

The weighted Financial Accuracy rate was 99.29%.

Financial Accuracy Detail Report						
Error Description	**Audit No.**	**Under Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**	
Copay Calculation	1020	$14.01	Agree with the error. The claim should have paid at 100%.	As agreed, procedural error and underpayment remain.	☐ M ☒ S	
Subtotal	**1**					
Other Error	1053	$163.80	Agree with the error. This claim should have paid under the correct category with no cost share.	As agreed, procedural error and underpayment remain.	☐ M ☒ S	
Subtotal	**1**					
TOTALS	**2**	**VARIANCE $177.81**			**M: 0**	**S: 2**

Accurate Payment

CTI defines Accurate Payment as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 2 incorrectly paid claims and 198 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	2	0	99.00%

Accurate Processing*

CTI defines Accurate Processing as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
195	2	3	97.50%

Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Managed Care				
Copay Calculation	1020	Agree with the error. The claim should have paid at 100%.	As agreed, procedural error remains.	☐ M ☒ S
Other Error	1113	***Initial Response:*** Agree. The EOB comment code 64 should have been removed. ***Draft Response:*** HSB does not agree with CTI conclusion. The claim was paid correctly for the newborn per MPD. The EOB comment code 64 should have been removed.	As agreed, procedural error remains.	☒ M ☐ S
Policy Provision				
Other Error	1053	Agree with the error. This claim should have paid under the correct category with no cost share.	As agreed, procedural error remains.	☐ M ☒ S
	1111	***Initial Response:*** Agree. Used incorrect EOB comment code on the denial.	As agreed, procedural error remains.	☒ M ☐ S

Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
		Draft Response: HSB does not agree with CTI conclusion. The claim did not have pricing from HTH and was a NICU claim. The incorrect EOB comment was used.		
	2015	***Initial Response:*** Agree with the error. NEV.11054607 was denied as a duplicate in error. ***Draft Response:*** The claim denied as a duplicate in error. HSB does agree with the procedural error for the denial of the claim.	As agreed, procedural error remains.	☒ M ☐ S

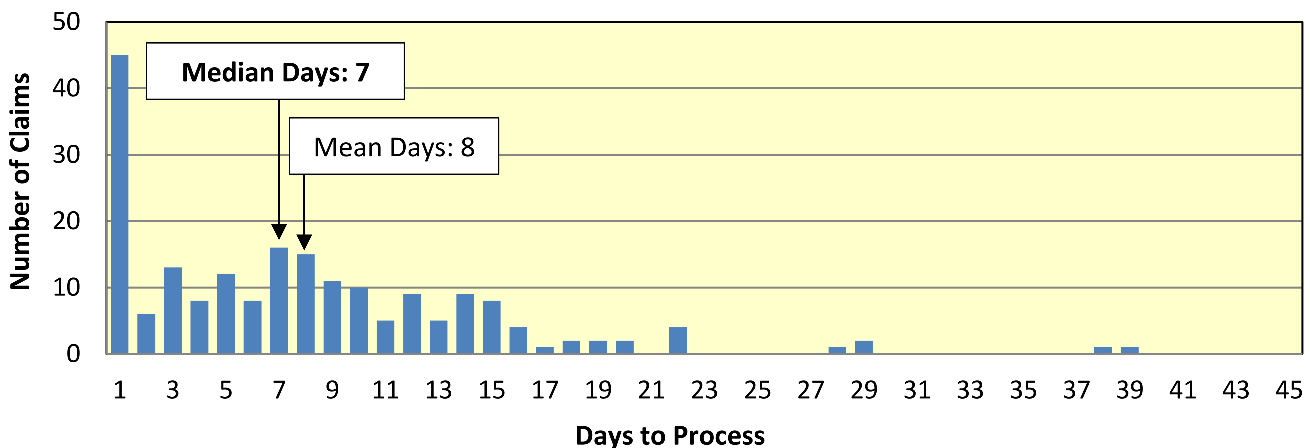
**Note that Accurate Processing Frequency is for PEBP's information only. It is not a performance guarantee measure that must be met by HealthScope.*

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



Health Reimbursement Arrangement (HRA) Findings

CTI also reviewed 50 HRA claims as part of our random sample. We communicated with HealthSCOPE in writing about any errors or observations found using response forms. In addition, we sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports.

Of the 50 claims reviewed, our audit revealed one observation of 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
No doctors note included with receipt for an air purifier. Per policy documentation, it is required.	HRA1032

DATA ANALYTICS

Medical Findings

This component of our audit used your electronic claim data 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.

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways PEBP can maximize benefit plan administration and performance.

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services – such as durable medical equipment
- Non-facility services – such as an office visit
- Facility inpatient – such as services received at a hospital
- Facility outpatient – such as services received at a surgical center

Report

The following report relied on the data and data fields provided by your administrator. We made no assumptions when requested data fields were not provided.

Provider Discount Review PEBP - HealthSCOPE				
Paid Dates 7/1/2021 through 9/30/2021				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$3,395,187	$3,617,372	51.6%	$2,818,819
Non-Facility	$29,863,023	$31,390,993	51.2%	$19,352,618
Facility Inpatient	$19,021,283	$33,045,581	63.5%	$18,233,860
Facility Outpatient	$18,812,106	$39,684,251	67.8%	$14,859,956
Total	**$71,091,599**	**$107,738,197**	**60.2%**	**$55,265,253**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$3,292,507	$3,602,707	52.2%	$2,787,520
Non-Facility	$28,577,940	$31,388,166	52.3%	$18,910,018
Facility Inpatient	$18,957,498	$32,904,987	63.4%	$18,202,475
Facility Outpatient	$18,635,512	$38,936,397	67.6%	$14,754,959
Total In-Network	**$69,463,457**	**$106,832,257**	**60.6%**	**$54,654,972**
% of Eligible Charge -	97.7%	% Claim Frequency -	85.3%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$102,680	$14,665	12.5%	$31,299
Non-Facility	$1,285,083	$2,827	0.2%	$442,599
Facility Inpatient	$63,785	$140,594	68.8%	$31,385
Facility Outpatient	$176,594	$747,855	80.9%	$104,997
Total Out of Network	**$1,628,142**	**$905,940**	**35.8%**	**$610,281**
% of Eligible Charge -	2.3%	% Claim Frequency -	14.7%	

**Paid claim totals exclude claims from members aged 65 and older.*

PEBP's members had utilization of network or secondary network medical providers at 97.7% of all allowed charges and 85.3% of all claims.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. The claims screened included all medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified all claims in the audit universe that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include physician and other medical professional claims.

Report
We screened 100% of non-facility claims against OIG's LEIE and no sanctioned providers were identified as receiving payment from the administrator during the audit period.

PPACA Preventive Services Coverage Compliance
The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for all health plans (unless grandfathered) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. Our review analyzed in-network preventive care services to determine if your administrator paid services in compliance with PPACA guidelines.

Scope
Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%.

Our review did not include services:

- performed by an out-of-network provider;
- adjusted or paid more than once (duplicate payments) during the audit period; or
- for which PPACA requirements suggest a frequency limitation such as one per year.

Our data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Reports
We analyzed the payments to determine if they were compliant. Types of services for which we identified non-compliance (if any) are listed first and the percentage of allowed charge paid is in the last column. To demonstrate full compliance with PPACA's requirements, the last column of this report should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

Because services may be denied for reasons other than exclusion or limitation of non-covered services (e.g., a service could be denied because the patient was ineligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 95.22% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 4.78% is available upon request.

The following reports provide an outline for discussion between PEBP and HealthSCOPE.

Preventive Care Services Compliance Review Paid at Less than 100%

PEBP - HealthSCOPE

Audit Period 7/1/2021 - 9/30/2021

Plans: All

Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	**Preventive Service Benefit**	**#**	**#**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**%**
USPSTF-A	Ambulatory blood pressure screening - adult	2	0	2	$626	0	$0	0	$0	0	$0	.00%
ACIP	Immunizations - DTP >18	1	1	0	$0	0	$0	0	$0	0	$0	.00%
HHS	Breastfeeding support and counseling - women	33	0	16	$3,750	7	$330	3	$151	7	$1,113	21.21%
USPSTF-B	Breast cancer chemoprevention counseling- >17	8	0	3	$248	3	$150	0	$0	2	$164	25.00%
USPSTF-A,B	Rh incompatibility screening - pregnant women	104	11	31	$1,055	14	$639	22	$170	26	$166	27.96%
USPSTF-A	HIV screening - pregnant women	16	0	9	$578	0	$0	2	$48	5	$216	31.25%
USPSTF-B	BRCA screening counseling - women	30	2	5	$1,884	8	$330	3	$153	12	$8,411	42.86%
USPSTF-A	Hepatitis B screening - women	43	2	16	$337	0	$0	6	$41	19	$678	46.34%
USPSTF-A	Urinary tract infection screening - pregnant women	88	4	30	$601	1	$114	12	$234	41	$474	48.81%
USPSTF-B	Hearing loss screening - 0 - 90 days	2	0	0	$0	0	$0	1	$8	1	$326	50.00%
USPSTF-B	Tobacco use counseling - >18	46	5	12	$204	1	$19	6	$33	22	$446	53.66%
USPSTF-A	Syphilis screening - pregnant women	155	0	53	$371	0	$0	11	$42	91	$377	58.71%
USPSTF-A	Syphillis screening	65	4	20	$80	0	$0	5	$4	36	$148	59.02%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	9	1	2	$15	0	$0	1	$1	5	$35	62.50%
USPSTF-A	HIV screening - >14	188	7	57	$1,178	2	$71	8	$43	114	$2,647	62.98%
USPSTF-B	Depression screening - >18	39	1	10	$145	3	$17	1	$1	24	$420	63.16%
USPSTF-B	Depression screening - 12-18	108	0	29	$204	8	$100	1	$1	70	$545	64.81%
HHS	Gestational Diabetes Mellitus screening - women	155	7	41	$432	0	$0	10	$12	97	$684	65.54%
USPSTF-B	Hepatitis C Virus (HCV) Screening	211	7	46	$605	0	$0	17	$59	141	$2,260	69.12%
USPSTF-A,B	Chlamydia infection screening - women	293	2	65	$2,256	1	$94	13	$113	212	$8,153	72.85%
USPSTF-B	Gonorrhea screening - female	283	2	60	$2,324	1	$94	14	$195	206	$7,794	73.31%
Bright Futures	Tuberculin testing - <21	19	0	4	$38	0	$0	1	$2	14	$191	73.68%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	719	1	153	$1,843	0	$0	18	$89	547	$7,558	76.18%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	528	11	90	$1,508	2	$42	15	$60	410	$5,518	79.30%
USPSTF-B	Alcohol misuse - screening and counseling	18	2	2	$37	1	$20	0	$0	13	$234	81.25%
USPSTF-B	Healthy diet counseling	202	3	12	$635	13	$712	8	$203	166	$20,538	83.42%
Bright Futures	Dyslipidemia screening - 2-20	71	2	4	$46	0	$0	1	$4	64	$709	92.75%
ACIP	Immunizations - Hepatitis B >18	45	4	0	$0	0	$0	2	$53	39	$3,846	95.12%
ACIP	Immunizations - Hepatitis A >18	21	0	1	$117	0	$0	0	$0	20	$1,721	95.24%
Bright Futures	Lead screening - <21	24	1	1	$11	0	$0	0	$0	22	$409	95.65%
HHS	Contraceptive methods - women	477	1	11	$2,629	1	$20	4	$111	460	$155,785	96.64%
USPSTF-A	Colorectal cancer screening - 45-75	684	15	13	$1,707	2	$100	6	$187	648	$278,099	96.86%
Bright Futures	Iron Supplement - <21	112	1	1	$2	0	$0	2	$1	108	$386	97.30%
ACIP	Immunizations - Herpes Zoster >59	304	3	3	$654	0	$0	4	$176	294	$78,483	97.67%
HHS	Wellness Examinations - >18	923	4	12	$817	0	$0	9	$98	898	$139,945	97.71%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,321	5	18	$629	1	$29	11	$64	1,286	$41,212	97.72%
Bright Futures	Hearing Screening 0-21 yrs	238	15	1	$32	0	$0	4	$42	218	$7,511	97.76%
USPSTF-B	Breast cancer mammography screening - >39	4,065	2	69	$5,325	4	$80	11	$269	3,979	$381,607	97.93%
ACIP	Immunization Administration - >18	1,718	43	7	$301	0	$0	10	$102	1,658	$72,465	98.99%
HHS	Wellness Examinations - women	2,796	6	10	$945	3	$85	0	$0	2,777	$438,439	99.53%
Bright Futures	Developmental Autism screening - <3	216	0	1	$10	0	$0	0	$0	215	$3,819	99.54%
ACIP	Immunizations - Human papillomavirus	420	3	0	$0	0	$0	1	$36	416	$138,939	99.76%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	862	0	1	$39	0	$0	1	$10	860	$31,540	99.77%
HRSA/HHS	Wellness Examinations - <19	2,817	6	2	$61	0	$0	2	$24	2,807	$336,645	99.86%

PPACA Preventive Services Coverage Compliance Detail Report

QID	Error Description	Under Paid	HealthSCOPE Response	CTI Conclusion	Manual or System
1	Deductible Applied	$481.67	Agree. Claim should have been paid at 100% of PPO allowed amount.	As agreed, procedural deficiency and	☒ M ☐ S

PPACA Preventive Services Coverage Compliance Detail Report					
QID	**Error Description**	**Under Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
2	Coinsurance Applied	$185.57	Agree. Claim should have been paid at 100% of PPO allowed amount.	underpayment remain.	☒ M ☐ S
7	Copay Applied	$50.00	Agree. Claim should have been paid at 100% of PPO allowed amount.		☒ M ☐ S

Preventive Care Services Compliance Review Paid at 100%

PEBP - HealthSCOPE

Audit Period 7/1/2021 - 9/30/2021

Plans: All

Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	**Preventive Service Benefit**	**#**	**#**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**%**
ACIP	Immunization Administration - <19	3,026	24	0	$0	0	$0	0	$0	3,002	$113,963	100.00%
ACIP	Immunizations - DTP <19	813	5	0	$0	0	$0	0	$0	808	$64,595	100.00%
ACIP	Immunizations - Meningococcal <19	377	1	0	$0	0	$0	0	$0	376	$72,884	100.00%
ACIP	Immunizations - Rotavirus <19	264	2	0	$0	0	$0	0	$0	262	$37,186	100.00%
ACIP	Immunizations - Hepatitis A <19	232	1	0	$0	0	$0	0	$0	231	$12,351	100.00%
ACIP	Immunizations - Meningococcal >18	163	0	0	$0	0	$0	0	$0	163	$39,650	100.00%
USPSTF-B	Vision screening - 3- 5	159	11	0	$0	0	$0	0	$0	148	$1,634	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	156	0	0	$0	0	$0	0	$0	156	$61,719	100.00%
FDA/CDC	Immunizations - Covid19	151	0	0	$0	0	$0	0	$0	151	$8,618	100.00%
ACIP	Immunizations - Varicella <19	105	0	0	$0	0	$0	0	$0	105	$16,138	100.00%
ACIP	Immunizations - Hepatitis B <19	102	0	0	$0	0	$0	0	$0	102	$5,322	100.00%
ACIP	Immunizations - Influenza <19	78	0	0	$0	0	$0	0	$0	78	$1,684	100.00%
ACIP	Immunizations - Pneumococcal >18	62	1	0	$0	0	$0	0	$0	61	$10,680	100.00%
ACIP	Immunizations - Influenza Age >18	58	1	0	$0	0	$0	0	$0	57	$1,447	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	32	0	0	$0	0	$0	0	$0	32	$1,399	100.00%
ACIP	Immunizations - Varicella >18	9	1	0	$0	0	$0	0	$0	8	$1,811	100.00%
USPSTF-B	Pre-Diabetes/Type 2 Diabetes	1	0	0	$0	0	$0	0	$0	1	$184	100.00%

NCCI Editing Compliance

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

Scope

The two NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the Procedure-to-Procedure (PTP) Edits and Medically Unlikely Edits (MUEs).

Our claim system code editing analysis identified services submitted to the plan and paid by HealthSCOPE that Medicare and Medicaid would have denied. **Since HealthSCOPE paid the billed charges, the payments represent a potential savings opportunity to PEBP.**

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with your administrator to determine the extent to which they incorporate CMS edits. Using these edits typically reduces claim expense and furthers efforts toward achieving standardized code-editing systems for all payers.

PTP Edits Reports

PTP Edits compare procedure codes from multiple claim lines on the same day to identify when procedures submitted on the same claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings you would have realized had the PTP Edits been in place.

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary						
Code	Mod	Code	Mod	Mod Use	Primary Description	Secondary Description	Line Count	Secondary Allowable Benefit
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	19	$11,100
					Standards of medical / surgical practice			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	10	$7,108
					CPT Manual or CMS manual coding instructions			
63081		22551		YES	Remove vert body dcmprn crvl	NECK SPINE FUSE&REMOV BEL C2	2	$6,891
					More extensive procedure			
29880	LT	29877	XS,LT	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$4,153
					Misuse of column two code with column one code			
74177	TC	96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	7	$3,751
					Standards of medical / surgical practice			
92526	GN	97110	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC EXERCISES	14	$2,979
					Misuse of column two code with column one code			
93351		93306		YES	STRESS TTE COMPLETE	TTE W/DOPPLER COMPLETE	1	$2,725
					HCPCS/CPT procedure code definition			
74177		96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	8	$2,587
					Standards of medical / surgical practice			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	4	$2,570
					Standards of medical / surgical practice			
96372		99204		YES	THER/PROPH/DIAG INJ SC/IM	Office/outpatient visit for E&M of new patie	2	$2,500
					Standards of medical / surgical practice			
						Top 10 TOTAL	68	$46,366
						GRAND TOTAL	552	$126,896

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary						
Code	Mod	Code	Mod	Mod Use	Primary Description	Secondary Description	Line Count	Secondary Allowable Benefit
29880	RT	29877	RT	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	2	$2,019
					Misuse of column two code with column one code			
22853	AS	22845	AS	YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/A	INSERT SPINE FIXATION DEVICE	4	$1,428
					HCPCS/CPT procedure code definition			
40805		00170	P1	NO	REMOVAL FOREIGN BODY MOUTH	ANESTH PROCEDURE ON MOUTH	5	$804
					Anesthesia service included in surgical procedure			
45378		00812	QS,QZ	NO	DIAGNOSTIC COLONOSCOPY	Anesthesia for lower intestinal endoscopic	5	$750
					Anesthesia service included in surgical procedure			
43239		00731	QS,QZ,P2	NO	UPPER GI ENDOSCOPY BIOPSY	Anesthesia for upper gastrointestinal endos	1	$662
					Anesthesia service included in surgical procedure			
45380	33	00812	QS,QZ	NO	COLONOSCOPY AND BIOPSY	Anesthesia for lower intestinal endoscopic	4	$583
					Anesthesia service included in surgical procedure			
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	4	$512
					CPT Manual or CMS manual coding instructions			
00400	AA,P3	95955	26,59	NO	ANESTH SKIN EXT/PER/ATRUNK	EEG DURING SURGERY	1	$450
					Standard preparation / monitoring services for anesthesia			
63047		69990	59	NO	Remove spine lamina 1 lmbr	MICROSURGERY ADD-ON	1	$422
					Misuse of column two code with column one code			
90460		99394		YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 12-17	2	$418
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	29	$8,048
						GRAND TOTAL	122	$14,160

MUE Reports

An MUE is an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. MUE errors could be caused by incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

CTI's MUE analyses are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line count Exceeding Limit**	**Gross Benefit Allowed**
90999	1	DIALYSIS PROCEDURE	9	$32,022
		Rationale: Clinical: CMS Workgroup		
29827	1	ARTHROSCOP ROTATOR CUFF REPR	1	$20,236
		Rationale: CMS Policy		
93657	2	Tx l/r atrial fib addl	1	$15,955
		Rationale: Clinical: Data		
C2630	3	CATH, EP, COOL-TIP	1	$13,320
		Rationale: Clinical: Data		
23430	1	REPAIR BICEPS TENDON	1	$10,118
		Rationale: CMS Policy		
97799	1	PHYSICAL MEDICINE PROCEDURE	16	$9,824
		Rationale: Clinical: CMS Workgroup		
J9070	55	CYCLOPHOSPHAMIDE 100 MG INJ	1	$6,998
		Rationale: Clinical: Data		
96372	5	THER/PROPH/DIAG INJ SC/IM	2	$5,235
		Rationale: Clinical: Data		
99218	1	INITIAL OBSERVATION CARE	13	$5,115
		Rationale: Code Descriptor / CPT Instruction		
88185	35	FLOWCYTOMETRY/TC ADD-ON	2	$4,941
		Rationale: Clinical: Data		
		Top 10 TOTAL	**47**	**$123,765**
		GRAND TOTAL	**266**	**$223,486**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line count Exceeding Limit**	**Gross Benefit Allowed**
J9355	105	INJ TRASTUZUMAB EXCL BIOSIMI	4	$55,034
		Rationale: CMS Policy		
95165	30	ANTIGEN THERAPY SERVICES	10	$10,880
		Rationale: Clinical: Data		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	6	$4,200
		Rationale: Clinical: Society Comment		
88341	13	Immunohistochemistry or immunocytochemistry, per spe	4	$2,881
		Rationale: Clinical: Data		
87799	3	DETECT AGENT NOS DNA QUANT	3	$2,534
		Rationale: Clinical: Data		
J0475	8	BACLOFEN 10 MG INJECTION	1	$2,368
		Rationale: Prescribing Information		
63045	1	Remove spine lamina 1 crvl	2	$2,075
		Rationale: Anatomic Consideration		
88305	16	TISSUE EXAM BY PATHOLOGIST	1	$2,053
		Rationale: Clinical: Data		
95079	2	Ingest challenge addl 60 min	4	$1,709
		Rationale: Clinical: Society Comment		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	2	$1,680
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**37**	**$85,414**
		GRAND TOTAL	**161**	**$109,229**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	Service Unit Limit	Procedure Description	Line count Exceeding Limit	Gross Benefit Allowed
E0465	2	Home ventilator, any type, used with invasive interface, (e	7	$20,689
		Rationale: Nature of Equipment		
E0466	2	Home ventilator, any type, used with non-invasive interfa	3	$5,400
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	18	$2,178
		Rationale: Nature of Equipment		
E0601	1	CONT AIRWAY PRESSURE DEVICE	2	$1,389
		Rationale: Nature of Equipment		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	9	$878
		Rationale: Anatomic Consideration		
V2520	2	CONTACT LENS HYDROPHILIC	7	$720
		Rationale: Anatomic Consideration		
B4035	1	ENTERAL FEED SUPP PUMP PER D	2	$635
		Rationale: Code Descriptor / CPT Instruction		
E0260	1	HOSP BED SEMI-ELECTR W/ MATT	3	$542
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	4	$362
		Rationale: Nature of Equipment		
E0265	1	HOSP BED TOTAL ELECTR W/ MAT	1	$340
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**56**	**$33,133**
		GRAND TOTAL	**86**	**$34,910**

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods:

- Simple – One day
- Minor – Ten days
- Major – Ninety days

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code but must submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss our findings, we will help you identify strategies to monitor and eliminate unbundling within your plan.

Audit Period 7/1/2021 - 9/30/2021									
Provider Id	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
362193608	4	$13,435	1	20.0%	$508	0	$0	1	$216
203516398	0	$0	2	100.0%	$620	0	$0	2	$200
850955444	1	$180	1	50.0%	$180	0	$0	1	$192
474436324	48	$9,600	3	5.9%	$485	1	$100	1	$187
330423270	0	$0	1	100.0%	$694	0	$0	1	$170
910858192	80	$27,279	32	28.6%	$4,525	29	$3,001	1	$169
880133501	151	$59,394	33	17.9%	$8,330	33	$4,792	1	$164
020566741	29	$10,759	8	21.6%	$608	6	$905	1	$133
203416144	1	$163	1	50.0%	$139	1	$69	0	$0
203395567	95	$22,754	6	5.9%	$6,815	5	$1,134	0	$0
Top 10	**409**	**$143,564**	**88**	**17.7%**	**$22,905**	**75**	**$10,001**	**9**	**$1,431**
Overall Total	**2,774**	**$809,086**	**477**	**14.7%**	**$94,408**	**457**	**$57,537**	**9**	**$1,431**

CONCLUSION

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

27 Corporate Hill Drive
Little Rock, AR 72205

April 8, 2022
Amended on May 2, 2022

Claim Technologies Incorporated
100 Court Avenue Suite 306
Des Moines, IA 50309

Dear Ms. Nisius,

Thank you for the opportunity to work with CTI on our mutual client State of Nevada Public Employees' Benefit Program.

Appendix – Administrator's Response to Draft Report for State of Nevada Public Employees' Benefit Program.

HealthSCOPE Benefits has reviewed Audit Number 1.FY22.Q1 draft report and would like to add the response to the conclusions within the audit report.

Summary of HealthSCOPE's Guarantee Measurements:
Quarterly Guarantee: Financial Accuracy:
HealthSCOPE Benefits would like to request CTI to review the financial accuracy and guarantee definition per the PEBP contract with HealthSCOPE Benefits. Please confirm the CTI calculation on the financial accuracy and percentage identified on the draft response report.

TARGETED SAMPLE ANALYSIS:

Fraud, Waste, and Abuse Detail Report:

QID 27 – HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

QID 28 - HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

Duplicate Payment Detail Report:

QID 18- HSB does agree with CTI conclusion. Duplicate claim was paid in error.

QID 19 - HSB does agree with CTI conclusion. Duplicate claim was paid in error.

QID 22 - HSB does agree with CTI conclusion. Duplicate claim was paid in error.

QID 23 – HSB does agree with CTI conclusion. Duplicate claim was paid in error.

QID 24 - HSB does agree with CTI conclusion. Duplicate claim was paid in error.

QID 25 - HSB does agree with CTI conclusion. Duplicate claim was paid in error.

Exclusion Detail Report:

QID 43 - HSB does agree with CTI conclusion. The claim should have denied to request medical records.

RANDOM SAMPLE AUDIT:

Financial Accuracy Detail Report:

Audit No. 1020 – HSB does agree with CTI conclusion. The outpatient lab should have been paid at 100%.

Audit No. 2015 – HSB does agree with CTI conclusion. The claim denied as a duplicate in error. HSB does agree with the procedural error for the denial of the claim.
Update on the financial error charged for $332.00 underpayment. HSB does not agree with the financial error charged based on the maximum dental benefit of $1500.00. The claim would not have paid anything out as the dental maximum was met prior to Audit No. 2015 was processed.

Audit No. 1053 – HSB does agree with CTI conclusion. The office exam related to COVID testing should have paid with no cost share.

Accurate Processing Detail Report:

Audit No. 1020 – HSB does agree with CTI conclusion. The outpatient lab should have been paid at 100%.

Audit No. 1113 – HSB does not agree with CTI conclusion. The claim was paid correctly for the newborn per MPD. The EOB comment code 64 should have been removed.

Audit No. 2015 – HSB does agree with CTI conclusion. The claim denied as a duplicate in error.

Audit No. 1053 – HSB does agree with CTI conclusion. The office exam related to COVID testing should have paid with no cost share.

Audit No. 1111 – HSB does not agree with CTI conclusion. The claim did not have pricing from HTH and was a NICU claim. The incorrect EOB comment code was used.

Observation HRA:

Audit No. HRA1032 – The claim was denied correctly on the account. The EOB comment code should have been removed from the claim.

PPACA Preventive Services Coverage Compliance Detail Report:

QID 1 – HSB does agree that the claim should have paid at 100% of the PPO allowed amount.

QID 4 – QID 3 and QID 4 are the same claim as outline on the ESAS. HSB does not agree with the error. Claim NEV.11160409 was reconsidered on 11/23/2021 to pay at 100% prior to the audit.

QID 6 – HSB does not agree with the error. Claim NEV.11160041 was reconsidered on 10/19/2021 to pay at 100% prior to the audit.

QID 2 – HSB does agree that the claim should have paid at 100% of the PPO allowed amount.

QID 7 – HSB does agree that the claim should have paid at 100% of the PPO allowed amount.

Thank you,

Jennifer Spencer, Associate Director of Quality Assurance
HealthSCOPE Benefits, Inc

CLAIM TECHNOLOGIES
INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com

4.2.2

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

    4.2 Acceptance of Claim Technologies Incorporated quarterly audit findings:

        4.2.1 Audit of HealthSCOPE Benefits for the timeframe of July 1, 2021 – September 30, 2021

        4.2.2 Audit of HealthSCOPE Benefits for the timeframe of October 1, 2021 – December 31, 2021

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees Benefit Program Plans

Administered by HealthScope Benefits

Audit Period: October 1, 2021 through December 31, 2021
Audit Number 1.FY22.Q2

Presented to

State of Nevada Public Employees Benefit Program

May 13, 2022

CLAIM TECHNOLOGIES INCORPORATED

Proprietary and Confidential

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

AUDIT OBJECTIVES 4

OPERATIONAL REVIEW PERFORMANCE GUARANTEES 5

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS 6

RANDOM SAMPLE AUDIT 9

DATA ANALYTICS 12

CONCLUSION 21

APPENDIX – Administrator's Response to Draft Report 22

EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of HealthScope Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees Benefit Program's (PEBP) medical, dental, and health reimbursement arrangement (HRA) plan.

Scope

CTI performed an audit of HealthSCOPE's administration of the PEBP's medical, dental and HRA for the period of October 1, 2021 through December 31, 2021 (quarter 2 (Q2) for Fiscal Year (FY) 2022). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Medical and Dental	
Total Paid Amount	$51,106,258
Total Number of Claims Paid/Denied/Adjusted	202,245
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$1,203,011
Total Number of Claims Paid/Denied/Adjusted	12,796

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

- Operational Review – Performance Guarantees Only
- 100% Electronic Screening with Targeted Samples
- Random Sample Audit
- Data Analytics

Auditor's Opinion

Based on these findings, and in our opinion:

1. HealthSCOPE improved its Financial Accuracy measurement in Q2 FY2022 and no penalty is owed.
2. HealthSCOPE should:
   - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings in Paid Greater than Charged, Spinal Region Upcoding, and Duplicate Claims Payments.
   - Review the Random Sample Audit results and discuss whether changes need to be made to reduce preventive services payment errors.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both claims processing measurements for the PEBP in Q2 FY2022.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.70%	None.
Payment Accuracy	98%	Met – 99.00%	None.

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of HealthScope Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees Benefit Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and HealthSCOPE, the claim administrator. A copy of HealthSCOPE's response to these findings can be found in the Appendix of this report.

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 PEBP and HealthSCOPE. 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 HealthSCOPE and PEBP.

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 HealthSCOPE used to pay PEBP'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.

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

- HealthSCOPE followed the terms of its contract with PEBP;
- HealthSCOPE paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by HealthSCOPE was incurred.

OPERATIONAL REVIEW PERFORMANCE GUARANTEES

Performance Guarantees

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with HealthSCOPE. The results for Q2 FY2022 follow.

Metric	Guarantee Measurement	Actual	Met/ Not Met
Financial Accuracy	99% or greater of the dollars paid for the audited medical/dental claims to be paid accurately.	99.70%	Met
Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately.	99.00%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.95%	Met
Customer Service	• Telephone Response Time less than 30 seconds for inbound calls. • Telephone Abandonment Rate less than 3% • First call Resolution greater or equal to 95%	11 Seconds Less than .01% 97.65%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	No exceptions noted. NA – Annual Report	Met NA
Disclosure of Subcontractors	• Report access of PEBP data within 30 calendar days • Removal of PEBP member PHI within 3 business days after knowledge	No exceptions noted. No exceptions noted.	Met Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS) software identified and quantified potential claim administration payment errors. PEBP and HealthSCOPE should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by HealthSCOPE during the audit period for both medical and dental claims. The accuracy and completeness of HealthSCOPE's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by HealthSCOPE, 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 claims to provide insight into HealthSCOPE's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note than using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched HealthSCOPE's administration.
- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The following detail report shows, by category, the number of line items or claimants with process improvement opportunities remaining after our analysis and removal of verified false positives. A CTI auditor reviewed the responses and supporting documentation. The administrator responses are copied directly from HealthSCOPE's reply to audit findings.

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q2 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Paid Greater than Charged	4	2	$644	$4,582
Invalid Procedure Codes	1,170	951	$132,188	$87,584
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,105	419	$73,126	$39,022

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended. For each potential error, we sent an ESAS Questionnaire (QID) to HealthSCOPE for written response. After review of the response and additional information provided, CTI confirmed the potential for process improvement. Note that all recommendations for HealthSCOPE process improvements will be included in the Q4 FY2022 report.

Manually adjudicated claims were processed by an individual claims processor. Auto-adjudicated claims were paid by the system with no manual intervention.

Paid Greater Than Charged Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
22	Paid Greater Than Charged	$3,127.32	Agree. Claim was split and the Medicare allowed amount is incorrect.	As agreed, procedural deficiency and overpayments remain.	☒ M ☐ S
23		$158.41	Agree. Claim was not coordinated with Medicare correctly.		☒ M ☐ S

Invalid Procedure Codes Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
31	Invalid Procedure Codes	$10,764.25	Agree. Should have denied the service for medical necessity.	As agreed, procedural deficiency and overpayments remain.	☒ M ☐ S

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
46	Spinal Region Upcoding	$28.51	Disagree. Claim was paid according to the Chiropractic Benefits per the MPD. Claim was not submitted for FWA.	Procedural deficiency and overpayment remain. The description for CPT codes for chiropractic care includes the number of regions of the spine or extraspinal regions treated and should be supported by the diagnosis. The provider billed five or more spinal regions treated; however, the diagnosis billed supported treatment of only two spinal regions. These procedures are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☒ M ☐ S
47		$10.16			☒ M ☐ S
48		$28.70			☒ M ☐ S
49		$45.00			☒ M ☐ S

Categories for Potential Amount at Risk

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where, in our opinion, process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from HealthSCOPE's reply to audit findings.

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q2 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payments				
Providers and/or Employees	179	51	$101,430	$19,406

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended.

Duplicate Payments Detail Report				
QID	**Under/ Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
37	$61.60	Agree. Provider submitted two claims with two different TAX ID numbers.	Procedural deficiency and overpayment remain.	☐ M ☒ S

There were also three errors found under the dental benefit plan for invalid procedure codes paid totaling $487.30 including:

- one Bone Graft in Conjunction with Periradicular Surgery;
- one Semi-Precision Abutment; and
- one Lingual Frenectomy.

In CTI's experience the PEBP's dental plan document is vague and/or silent on a number of dental services. We recommend that the language be updated to indicate specifically which services are covered and which are excluded. This will eliminate the option for medical necessity which means any claim currently submitted is being paid.

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's statistically valid Random Sample Audit included a stratified random sample of 200 paid or denied claims. HealthSCOPE's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

In addition, CTI sampled 50 health reimbursement arrangement (HRA) claims to ensure payment and processing accuracy.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information HealthSCOPE had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with HealthSCOPE in writing about any errors or observations using system-generated response forms. We sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from HealthSCOPE's reply.

Financial Accuracy

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 claims sampled and reviewed revealed $287.06 in underpayments and no overpayments, for an absolute value variance of $287.06.

The weighted Financial Accuracy rate was 99.70%.

Financial Accuracy Detail Report					
Error Description	**Audit No.**	**Under Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Coinsurance	1088	$269.70	Agree. Claim should have been paid 100% of the PPO allowed amount.	As agreed, procedural error and underpayment remain. Claim should have been paid at 100% of the PPO allowed amount.	☐ M ☒ S
Subtotal	**1**				
Deductible	1197	$17.36	Agree. CPT code 80061 and 83036 should have been paid at 100% of PPO allowable based on the diagnosis and procedure billed. CPT 80053 should apply to the deductible as it is not mandated under HCR to pay as preventive.	As agreed, procedural error and underpayment remain. CPT codes 80061 and 83036 should have been paid at 100%.	☐ M ☒ S
Subtotal	**2**				
TOTALS	**2**	**VARIANCE $287.06**			**M: 0** **S: 2**

Accurate Payment

CTI defines Accurate Payment as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 2 incorrectly paid claims and 198 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	2	0	99.00%

Accurate Processing

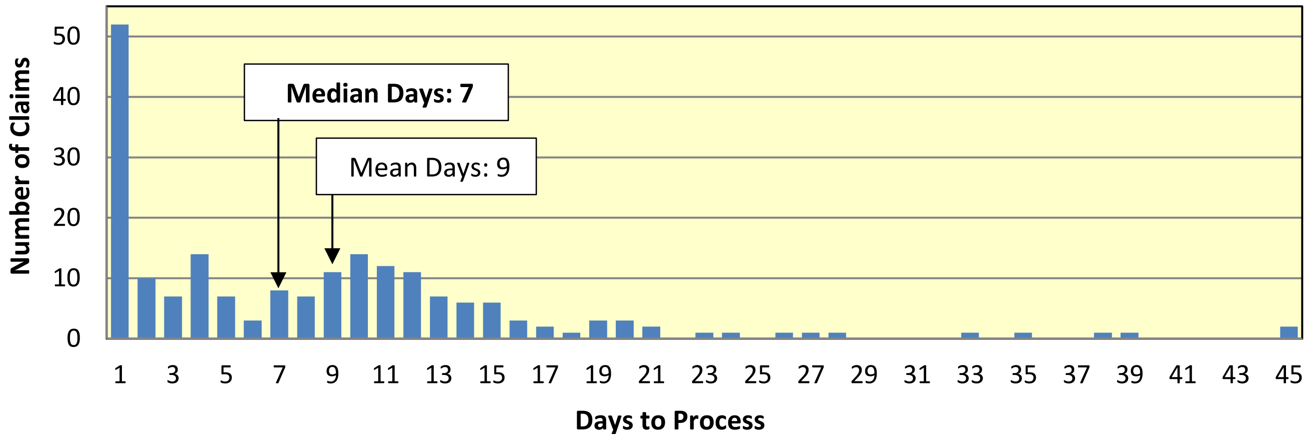
CTI defines Accurate Processing as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
198	2	0	99.00%

Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Managed Care				
Coinsurance	1088	Agree. Claim should have been paid 100% of the PPO allowed amount.	As agreed, procedural error remains. Claim should have been paid at 100% of the PPO allowed amount.	☐ M ☒ S
Policy Provision				
Deductible	1197	Agree. CPT code 80061 and 83036 should have been paid at 100% of PPO allowable based on the diagnosis and procedure billed. CPT 80053 should apply to the deductible as it is not mandated under HCR to pay as preventive.	As agreed, procedural error remains. CPT codes 80061 and 83036 should have been paid at 100%.	☐ M ☒ S

Claim Turnaround
CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.



Health Reimbursement Arrangement (HRA) Findings

CTI also reviewed 50 HRA claims as part of our random sample. We communicated with HealthSCOPE in writing about any errors or observations found using response forms. In addition, we sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports.

Of the 50 claims reviewed, our audit revealed one observation of 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 member had two payments for the same provider, on the same day, and the same amount. System did not flag as a duplicate.	HRA 1041

DATA ANALYTICS

Medical Findings

This component of our audit used your electronic claim data 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.

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways PEBP can maximize benefit plan administration and performance.

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services – such as durable medical equipment
- Non-facility services – such as an office visit
- Facility inpatient – such as services received at a hospital
- Facility outpatient – such as services received at a surgical center

Report

The following report relied on the data and data fields provided by your administrator. We made no assumptions when requested data fields were not provided.

Paid Dates 10/1/2021 through 12/31/2021				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$3,298,970	$6,083,522	64.8%	$2,839,106
Non-Facility	$26,053,465	$27,607,851	51.4%	$17,359,527
Facility Inpatient	$16,335,124	$27,058,713	62.4%	$15,500,301
Facility Outpatient	$13,351,930	$31,130,993	70.0%	$10,274,328
Total	**$59,039,490**	**$91,881,079**	**60.9%**	**$45,973,262**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$3,134,104	$6,083,674	66.0%	$2,758,871
Non-Facility	$25,048,600	$27,607,980	52.4%	$17,015,346
Facility Inpatient	$16,165,119	$27,002,105	62.6%	$15,378,876
Facility Outpatient	$13,237,108	$30,054,129	69.4%	$10,198,543
Total In-Network	**$57,584,930**	**$90,747,887**	**61.2%**	**$45,351,637**
% of Eligible Charge -	97.5%	% Claim Frequency -	86.7%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$164,867	-$151	-0.1%	$80,235
Non-Facility	$1,004,865	-$129	0.0%	$344,181
Facility Inpatient	$170,005	$56,608	25.0%	$121,425
Facility Outpatient	$114,822	$1,076,865	90.4%	$75,784
Total Out of Network	**$1,454,560**	**$1,133,192**	**43.8%**	**$621,624**
% of Eligible Charge -	2.5%	% Claim Frequency -	13.3%	

**Paid claim totals exclude claims from members aged 65 and older.*

PEBP's members had utilization of network or secondary network medical providers at 97.5% of all allowed charges and 86.7% of all claims.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. The claims screened included all medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified all claims in the audit universe that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include physician and other medical professional claims.

Report
We screened 100% of non-facility claims against OIG's LEIE and two sanctioned providers were identified as receiving payment from the administrator during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	JAMES SHELBY	3	$1,780	$1,742	$928
1205023512	20180920	N/A	1128b5	ROOZBEH BADII	2	$705	$214	$214
				Totals	**5**	**$2,485**	**$1,956**	**$1,142**

According to the OIG, James Shelby was excluded on December 19, 2019, with a felony-controlled substance conviction and Roozbeh Badii was excluded on September 20, 2018, with an exclusion or suspension under the federal or state health care program.

PPACA Preventive Services Coverage Compliance
The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for all health plans (unless grandfathered) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. Our review analyzed in-network preventive care services to determine if your administrator paid services in compliance with PPACA guidelines.

Scope
Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%.

Our review did not include services:

- performed by an out-of-network provider;
- adjusted or paid more than once (duplicate payments) during the audit period; or
- for which PPACA requirements suggest a frequency limitation such as one per year.

Our data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Reports
We analyzed the payments to determine if they were compliant. Types of services for which we identified non-compliance (if any) are listed first and the percentage of allowed charge paid is in the last column. To demonstrate full compliance with PPACA's requirements, the last column of this report should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

Because services may be denied for reasons other than exclusion or limitation of non-covered services (e.g., a service could be denied because the patient was ineligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 96.24% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 3.76% is available upon request.

The following reports provide an outline for discussion between PEBP and HealthSCOPE.

Preventive Care Services Compliance Review Paid at Less than 100%												
PEBP - HealthSCOPE												
Audit Period 10/1/2021 - 12/31/2021												
Plans: All												
Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older												
		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	**Preventive Service Benefit**	**#**	**#**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**%**
USPSTF-B	Breast cancer chemoprevention counseling- >17	8	0	4	$682	1	$50	2	$34	1	$154	12.50%
HHS	Breastfeeding support and counseling - women	33	1	9	$1,879	14	$660	4	$183	5	$759	15.63%
USPSTF-A,B	Rh incompatibility screening - pregnant women	110	33	21	$907	4	$324	25	$106	27	$1,168	35.06%
USPSTF-B	BRCA screening counseling - women	19	1	4	$504	3	$130	3	$418	8	$2,688	44.44%
USPSTF-A	HIV screening - pregnant women	24	7	7	$342	0	$0	2	$17	8	$347	47.06%
USPSTF-B	Tobacco use counseling - >18	29	1	7	$128	1	$25	6	$20	14	$341	50.00%
USPSTF-B	Hearing loss screening - 0 - 90 days	4	0	1	$42	0	$0	1	$8	2	$231	50.00%
USPSTF-B	Pre-Diabetes/Type 2 Diabetes	2	0	1	$31	0	$0	0	$0	1	$184	50.00%
USPSTF-A	Hepatitis B screening - women	37	4	14	$552	0	$0	2	$7	17	$746	51.52%
HHS	Gestational Diabetes Mellitus screening - women	120	7	26	$340	0	$0	23	$33	64	$613	56.64%
USPSTF-A	Syphillis screening	40	0	12	$45	0	$0	5	$4	23	$87	57.50%
USPSTF-A	Urinary tract infection screening - pregnant women	82	4	14	$522	2	$19	13	$49	49	$727	62.82%
USPSTF-B	Hepatitis C Virus (HCV) Screening	185	5	41	$668	2	$100	15	$54	122	$1,825	67.78%
USPSTF-B	Depression screening - >18	61	1	11	$147	2	$17	6	$11	41	$690	68.33%
USPSTF-A	HIV screening - >14	201	2	51	$1,185	1	$70	9	$56	138	$3,342	69.35%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	10	0	3	$12	0	$0	0	$0	7	$35	70.00%
USPSTF-A	Syphilis screening - pregnant women	146	2	30	$125	0	$0	13	$13	101	$775	70.14%
USPSTF-B	Depression screening - 12-18	71	0	14	$76	5	$52	2	$2	50	$340	70.42%
USPSTF-B	Gonorrhea screening - female	250	2	51	$1,959	1	$94	20	$165	176	$6,776	70.97%
USPSTF-A,B	Chlamydia infection screening - women	265	3	52	$2,039	1	$94	20	$170	189	$7,570	72.14%
Bright Futures	Tuberculin testing - <21	8	0	1	$18	0	$0	1	$2	6	$92	75.00%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	672	0	155	$1,686	0	$0	8	$29	509	$6,467	75.74%
USPSTF-B	Healthy diet counseling	301	85	21	$1,865	3	$94	26	$744	166	$24,989	76.85%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	523	6	89	$1,220	0	$0	11	$63	417	$5,779	80.66%
USPSTF-B	Alcohol misuse - screening and counseling	25	1	3	$56	1	$18	0	$0	20	$369	83.33%
Bright Futures	Hearing Screening 0-21 yrs	218	22	6	$159	0	$0	10	$76	180	$5,679	91.84%
Bright Futures	Iron Supplement - <21	98	0	4	$9	0	$0	1	$1	93	$227	94.90%
ACIP	Immunizations - Pneumococcal >18	50	1	2	$220	0	$0	0	$0	47	$7,883	95.92%
USPSTF-A	Colorectal cancer screening - 45-75	657	2	10	$1,091	7	$350	2	$69	636	$272,959	97.10%
Bright Futures	Dyslipidemia screening - 2-20	36	1	1	$9	0	$0	0	$0	34	$321	97.14%
HHS	Wellness Examinations - >18	820	1	11	$682	1	$30	7	$90	800	$131,267	97.68%
USPSTF-B	Breast cancer mammography screening - >39	3,881	7	50	$3,552	15	$440	21	$406	3,788	$364,052	97.78%
HHS	Contraceptive methods - women	450	3	8	$976	0	$0	1	$53	438	$151,622	97.99%
Bright Futures	Developmental Autism screening - <3	192	0	3	$30	0	$0	0	$0	189	$2,964	98.44%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,270	4	15	$484	1	$71	2	$8	1,248	$37,152	98.58%
HHS	Wellness Examinations - women	2,486	3	14	$1,302	1	$25	6	$202	2,462	$415,745	99.15%
ACIP	Immunizations - Influenza Age >18	1,733	6	9	$337	1	$37	4	$40	1,713	$61,208	99.19%
ACIP	Immunizations - Herpes Zoster >59	250	1	1	$175	0	$0	1	$33	247	$74,675	99.20%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	819	0	4	$196	0	$0	1	$19	814	$29,048	99.39%
ACIP	Immunization Administration - >18	3,284	63	5	$475	1	$80	8	$130	3,207	$107,498	99.57%
HRSA/HHS	Wellness Examinations - <19	2,443	1	2	$225	1	$30	1	$6	2,438	$296,818	99.84%

PPACA Preventive Services Coverage Compliance Detail Report					
QID	**Error Description**	**Under payment**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
1	Coinsurance Applied	$66.03	Agree. Claim should have paid at the routine benefit.	As agreed, procedural deficiency and underpayments remain.	☒ M ☐ S
6		$213.14	Agree. Claim paid under the surgical category in error.		☒ M ☐ S
9		$377.60	Agree. CPT 81162-33 should have denied. The remaining test on the claim paid as illness as defined in the MPD correctly.		☒ M ☐ S
4	Deductible Applied	$508.87	Agree. Claim should have been paid at the routine benefit.		☐ M ☒ S
11		$102.68	Agree. Claim should have been paid at the routine benefit.		☒ M ☐ S
5	Copayment Applied	$224.50	Agree. Claim should have been paid under the routine benefit.		☒ M ☐ S
10		$71.23	Agree. Claim should have been paid under the routine benefit for 88175.		☒ M ☐ S

Preventive Care Services Compliance Review Paid at 100%

PEBP - HealthSCOPE

Audit Period 10/1/2021 - 12/31/2021

Plans: All

Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	**Preventive Service Benefit**	**#**	**#**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**%**
ACIP	Immunization Administration - <19	4,100	24	0	$0	0	$0	0	$0	4,076	$131,790	100.00%
ACIP	Immunizations - Influenza <19	2,044	1	0	$0	0	$0	0	$0	2,043	$55,136	100.00%
ACIP	Immunizations - DTP <19	639	2	0	$0	0	$0	0	$0	637	$72,427	100.00%
FDA/CDC	Immunizations - Covid19	315	0	0	$0	0	$0	0	$0	315	$13,605	100.00%
ACIP	Immunizations - Rotavirus <19	271	0	0	$0	0	$0	0	$0	271	$44,970	100.00%
ACIP	Immunizations - Human papillomavirus	241	0	0	$0	0	$0	0	$0	241	$84,612	100.00%
ACIP	Immunizations - Hepatitis A <19	213	1	0	$0	0	$0	0	$0	212	$11,777	100.00%
ACIP	Immunizations - Meningococcal <19	165	0	0	$0	0	$0	0	$0	165	$34,928	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	126	1	0	$0	0	$0	0	$0	125	$52,576	100.00%
USPSTF-B	Vision screening - 3- 5	115	1	0	$0	0	$0	0	$0	114	$915	100.00%
ACIP	Immunizations - Hepatitis B <19	104	0	0	$0	0	$0	0	$0	104	$5,756	100.00%
ACIP	Immunizations - Varicella <19	100	0	0	$0	0	$0	0	$0	100	$15,631	100.00%
ACIP	Immunizations - Meningococcal >18	98	0	0	$0	0	$0	0	$0	98	$24,579	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	31	0	0	$0	0	$0	0	$0	31	$1,643	100.00%
ACIP	Immunizations - Hepatitis B >18	30	1	0	$0	0	$0	0	$0	29	$2,288	100.00%
Bright Futures	Lead screening - <21	16	1	0	$0	0	$0	0	$0	15	$149	100.00%
ACIP	Immunizations - Hepatitis A >18	8	0	0	$0	0	$0	0	$0	8	$809	100.00%
ACIP	Immunizations - Varicella >18	8	0	0	$0	0	$0	0	$0	8	$1,368	100.00%
ACIP	Immunizations adult - Influenza Age (FluMist) 19-49	2	0	0	$0	0	$0	0	$0	2	$50	100.00%

NCCI Editing Compliance

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

Scope

The two NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the Procedure-to-Procedure (PTP) Edits and Medically Unlikely Edits (MUEs).

Our claim system code editing analysis identified services submitted to the plan and paid by HealthSCOPE that Medicare and Medicaid would have denied. **Since HealthSCOPE paid the billed charges, the payments represent a potential savings opportunity to PEBP.**

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with your administrator to determine the extent to which they incorporate CMS edits. Using these edits typically reduces claim expense and furthers efforts toward achieving standardized code-editing systems for all payers.

PTP Edits Reports

PTP Edits compare procedure codes from multiple claim lines on the same day to identify when procedures submitted on the same claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings you would have realized had the PTP Edits been in place.

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary					Line	Secondary
Code	Mod	Code	Mod	Mod Use	Primary Description	Secondary Description	Count	Allowable Benefit
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	11	$6,003
					Standards of medical / surgical practice			
70553		70555	50	YES	Mri brain stem w/o & w/dye	FMRI BRAIN BY PHYS/PSYCH	1	$3,680
					CPT Manual or CMS manual coding instructions			
99151		99285		YES	MOD SED SAME PHYS/QHP INITIAL 15 MINS <5 YRS	EMERGENCY DEPT VISIT	1	$3,097
					Standards of medical / surgical practice			
74177	TC	96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	5	$2,630
					Standards of medical / surgical practice			
74340		43752		NO	X-RAY GUIDE FOR GI TUBE	NASAL/OROGASTRIC W/STENT	1	$2,357
					CPT Manual or CMS manual coding instructions			
74177		74176		YES	CT ABD & PELV W/CONTRAST	CT ABD & PELVIS	1	$2,083
					HCPCS/CPT procedure code definition			
45385		45390		YES	LESION REMOVAL COLONOSCOPY	Colonoscopy, flexible; with endoscopic muc	1	$2,011
					CPT Manual or CMS manual coding instructions			
92526	GN	97110	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC EXERCISES	7	$1,857
					Misuse of column two code with column one code			
74177		96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	15	$1,605
					Standards of medical / surgical practice			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	3	$1,507
					Standards of medical / surgical practice			
						Top 10 TOTAL	**46**	**$26,831**
						GRAND TOTAL	**349**	**$55,747**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary		Mod Use	Primary Description	Secondary Description	Line Count	Secondary Allowable Benefit
Code	Mod	Code	Mod					
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	19	$2,643
					CPT Manual or CMS manual coding instructions			
90471		99396	0	YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	10	$2,273
					CPT Manual or CMS manual coding instructions			
90471		99214		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of estab pat	11	$2,062
					CPT Manual or CMS manual coding instructions			
96372		99214		YES	THER/PROPH/DIAG INJ SC/IM	Office/outpatient visit for E&M of estab pat	12	$1,882
					Standards of medical / surgical practice			
22853		22846		YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/AI	INSERT SPINE FIXATION DEVICE	2	$1,636
					HCPCS/CPT procedure code definition			
90460		99392		YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 1-4	14	$1,452
					CPT Manual or CMS manual coding instructions			
29880		29876		YES	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$1,358
					Standards of medical / surgical practice			
90471		99395		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 18-39	7	$1,305
					CPT Manual or CMS manual coding instructions			
90471		99214	0	YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of estab pat	6	$1,266
					CPT Manual or CMS manual coding instructions			
22853		22845		YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/AI	INSERT SPINE FIXATION DEVICE	2	$1,208
					HCPCS/CPT procedure code definition			
						Top 10 TOTAL	84	$17,084
						GRAND TOTAL	599	$52,914

MUE Reports

An MUE is an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. MUE errors could be caused by incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

CTI's MUE analyses are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
63030	1	LOW BACK DISK SURGERY	1	$22,070
		Rationale: CMS Policy		
29888	1	KNEE ARTHROSCOPY/SURGERY	1	$15,404
		Rationale: CMS Policy		
27446	1	REVISION OF KNEE JOINT	1	$11,449
		Rationale: CMS Policy		
93460	1	R&L HRT ART/VENTRICLE ANGIO	1	$5,822
		Rationale: Nature of Service/Procedure		
94640	1	AIRWAY INHALATION TREATMENT	5	$3,615
		Rationale: Clinical: Data		
99218	1	INITIAL OBSERVATION CARE	5	$3,218
		Rationale: Code Descriptor / CPT Instruction		
87635	2	Infectious agnt detection by nucleic acid; svre acute resp	1	$3,127
		Rationale: Nature of Analyte		
J9070	55	CYCLOPHOSPHAMIDE 100 MG INJ	1	$2,870
		Rationale: Clinical: Data		
88342	4	IMMUNOHISTOCHEMISTRY	2	$2,618
		Rationale: Clinical: Data		
99153	12	MOD SED SAME PHYS/QHP EACH ADDL 15 MINS	8	$2,319
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	26	$72,513
		GRAND TOTAL	125	$99,930

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
97153	32	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	1,081	$262,764
		Rationale: Clinical: Society Comment		
J9355	105	INJ TRASTUZUMAB EXCL BIOSIMI	4	$57,175
		Rationale: CMS Policy		
15111	5	EPIDRM AUTOGRFT T/A/L ADD-ON	1	$3,824
		Rationale: Clinical: Data		
19316	1	SUSPENSION OF BREAST	1	$2,812
		Rationale: CMS Policy		
J0475	8	BACLOFEN 10 MG INJECTION	2	$2,538
		Rationale: Prescribing Information		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	8	$2,208
		Rationale: Clinical: Society Comment		
95165	30	ANTIGEN THERAPY SERVICES	1	$1,461
		Rationale: Clinical: Data		
J3480	40	INJ POTASSIUM CHLORIDE	9	$1,453
		Rationale: Clinical: Data		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	3	$1,450
		Rationale: Clinical: CMS Workgroup		
31572	1	LARYNGOSCOPY FLEXIBLE ABLATJ DESTJ LESION(S) UNI	2	$1,338
		Rationale: CMS Policy		
		Top 10 TOTAL	**1,112**	**$337,022**
		GRAND TOTAL	**1,200**	**$352,074**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
E0465	2	Home ventilator, any type, used with invasive interface, (e	4	$11,495
		Rationale: Nature of Equipment		
E0486	1	ORAL DEVICE/APPLIANCE CUSFAB	1	$6,375
		Rationale: Nature of Equipment		
E0265	1	HOSP BED TOTAL ELECTR W/ MAT	7	$2,380
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	18	$1,913
		Rationale: Nature of Equipment		
E2402	1	NEG PRESS WOUND THERAPY PUMP	1	$679
		Rationale: Nature of Equipment		
V2520	2	CONTACT LENS HYDROPHILIC	7	$520
		Rationale: Anatomic Consideration		
E0443	1	PORTABLE 02 CONTENTS, GAS	5	$499
		Rationale: Code Descriptor / CPT Instruction		
K0001	1	STANDARD WHEELCHAIR	4	$448
		Rationale: Nature of Equipment		
E0260	1	HOSP BED SEMI-ELECTR W/ MATT	1	$239
		Rationale: Nature of Equipment		
K0003	1	LIGHTWEIGHT WHEELCHAIR	1	$168
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**49**	**$24,716**
		GRAND TOTAL	**71**	**$25,750**

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee

Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods:

- Simple – One day
- Minor – Ten days
- Major – Ninety days

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code but must submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss our findings, we will help you identify strategies to monitor and eliminate unbundling within your plan.

Audit Period 10/1/2021 - 12/31/2021									
Provider Id	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee Periods		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
860800150	17	$46,951	3	15.0%	$17,934	1	$455	2	$897
680334324	16	$11,970	2	11.1%	$8,633	0	$0	1	$744
203395567	81	$39,963	7	8.0%	$7,758	7	$1,338	3	$728
880133501	142	$54,122	18	11.3%	$5,356	14	$1,819	3	$532
941709925	50	$31,241	41	45.1%	$7,377	37	$5,773	2	$448
680405220	11	$6,907	5	31.3%	$923	3	$406	2	$358
020566741	27	$8,532	9	25.0%	$3,787	7	$953	1	$266
880107997	38	$15,800	8	17.4%	$2,188	5	$437	2	$222
852187390	7	$684	5	41.7%	$1,167	2	$138	2	$194
471471596	0	$0	1	100.0%	$946	0	$0	1	$187
Top 10	**389**	**$216,168**	**99**	**20.3%**	**$56,068**	**76**	**$11,319**	**19**	**$4,576**
Overall Total	**2,554**	**$813,607**	**462**	**15.3%**	**$118,303**	**403**	**$47,558**	**39**	**$6,416**

CONCLUSION

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

27 Corporate Hill Drive
Little Rock, AR 72205

May 6, 2022

Claim Technologies Incorporated
100 Court Avenue Suite 306
Des Moines, IA 50309

Dear Ms. Nisius,

Thank you for the opportunity to work with CTI on our mutual client State of Nevada Public Employees' Benefit Program.

Appendix – Administrator's Response to Draft Report for State of Nevada Public Employees' Benefit Program.

HealthSCOPE Benefits has reviewed Audit Number 1.FY22.Q2 draft report and would like to add the response to the conclusions within the audit report.

OPERATIONAL REVIEW PERFORMANCE GUARANTEES:

HealthSCOPE Benefits would like to request CTI update the "Disclosure of Subcontractors" as the information was submitted to CTI.
The Master List for Disclosure of Subcontractors has not changed as we have not added any new subcontractors in the last year; therefore, this report will remain the same throughout the transition to the UMR platform.

TARGETED SAMPLE ANALYSIS:

Paid Greater Than Charged Detail Report:

QID 22 – HSB does agree with CTI conclusion. The claim was split and the Medicare allowed amount was calculated incorrectly.

QID 23 – HSB does agree with CTI conclusion. The claim was not coordinated with Medicare correctly.

Invalid Procedure Codes Detail Report:

QID 31 – HSB does agree with the CTI conclusion. Code 0656T/22899 was denied by the UM vendor for necessity. All other procedures were authorized for this date of service.

Fraud, Waste, and Abuse Detail Report:

QID 46 – HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

QID 47 - HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

QID 48 – HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

QID 49 - HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

Duplicate Payment Detail Report:

QID 37- HSB does agree with CTI conclusion. The provider billed under two separate TAX ID numbers.

<u>RANDOM SAMPLE AUDIT:</u>

<u>Financial Accuracy Detail Report</u>:

Audit No. 1088 – HSB does agree with CTI conclusion. The claim should have paid at 100% of the PPO allowed amount.

Audit No. 1197 – HSB does agree with CTI conclusion. CPT code 80061 and 83036 should have paid at 100% of the PPO allowable based on the diagnosis and procedure billed. There is an underpayment of $17.36.

Accurate Processing Detail Report:

Audit No. 1088 – HSB does agree with CTI conclusion. The claim should have paid at 100% of the PPO allowed amount.

Audit No. 1197 – HSB does agree with CTI conclusion. CPT code 80061 and 83036 should have paid at 100% of the PPO allowable based on the diagnosis and procedure billed. There is an underpayment of $17.36.

Observation:

Audit Number HRA 1041 – HRA department will verify with the member on the transaction in question. There have been situations that a member owes a provider for a previous expense and pays the provider/merchant at the same time for both transactions.

PPACA Preventive Services Coverage Compliance Detail Report:

QID 1 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 6 – HSB does agree with CTI conclusion. The claim was paid under the incorrect benefit category.

QID 9 – HSB does agree with CTI conclusion. CPT 81162-33 should have denied.

QID 4 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 11 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 5 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 10 - HSB does agree with CTI conclusion. CPT 88175 should have paid at the routine benefit.

Thank you,

Jennifer Spencer, Associate Director of Quality Assurance
HealthSCOPE Benefits, Inc

CLAIM TECHNOLOGIES
INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com

4.3

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.3 Approval of PEBP Master Plan Documents for Plan Year 2023 including Master Plan Documents for the Consumer Driven High Deductible (CDHP) Plan, Low Deductible (LD) Plan and Exclusive Provider Organization (EPO) Plan

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Executive Officer

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STEVE SISOLAK
Governor

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 26, 2022

Item Number: IV.III

Title: Summary of Changes to finalized Plan Year 2023 Master Plan Documents

SUMMARY

In the process of transitioning plan design to the new Third Party Administrator (UMR) system, there were some technical variances identified. Additionally, discussion with the new Utilization Management vendor has provided some recommended changes. This has resulted in changes in the Master Plan Documents since the March 24, 2022 board meeting.

The overall changes are generally benefit enhancements.

REPORT

OVERALL CHANGES
Changes were made to the listed sections and are noted on the Master Plan Documents, respectively.

Utilization Management

- "Pregnancy" section should be removed from plan documents because the MPD's sufficiently address pregnancy.

Benefits

- Chemotherapy
    - Enhancement: "Patients undergoing chemotherapy may be eligible for 1 wig, any type, synthetic or not, per Plan Year (excluding sales tax)."
- Speech Therapy

  - Clarification: There was a conflict between benefits and exclusions for Speech Therapy. The exclusion was updated to cooperate with the benefit.
- Bariatric Surgery
  - Removal of the 10% weight loss requirement.

Limitations and Exclusions
- Cosmetic Services and Surgery reflects overall changes primarily removing a list of excluded examples.
- Gender Dysphoria and/or Gender Services reflects overall changes primarily removing a list of excluded examples.
- Rehabilitation Therapy reflects changes for childhood speech disorders.

Key Terms and Definitions
- Cosmetic Surgery or Treatment had examples removed.
- Step Therapy to include Nevada Senate Bill 290 requirements for PEBP health plans.

BENEFIT CHANGES BY PLAN TYPE

The following changes were made specific to the listed plans and are noted on the Master Plan Documents, respectively.

Consumer Driven Health Plan

Benefit Change
- Telemedicine: removed reference to copays. The CDHP does not have copayments. The following changes are per the Doctor on Demand contract rate change with our Third-Party Administrator:
  - Psychology Visit (50-min visit) is increasing to $129, after deductible.
  - Psychiatry Visit (initial 45-min visit) is decreasing to $229, after deductible.

  This is updated on page 77 for the CDHP.

Health Savings Account
- Added Calendar Year 2023 Contribution Limits: On April 29, 2022, the Internal Revenue Service (IRS) announced the 2023 inflation-adjusted amounts for Health Savings Accounts (HSAs). For calendar year 2023, the annual limitation on deductions for an individual with self-only coverage under a high-deductible health plan is $3,850. The annual limitation on deductions for an individual with family coverage under a high-deductible health plan is $7,750. This is updated on page 22 for the CDHP.

Low Deductible PPO

Benefit Change
- Skilled Nursing Facility has two different day limits in page 34 and page 75 reflecting 100 days and 60 days, respectively. This is updated to show 100 days on page 75 of the LD-PPO.

Premier Plan
Benefit Change

- Skilled Nursing Facility has two different day limits in page 37 and page 78 reflecting 100 days and 60 days, respectively. This is updated to show 100 days on page 78 on the EPO.
- Mammogram benefits were adjusted to match the previously approved, enhanced CDHP and LD-PPO Plan. This allows screening mammograms "beginning at age 35 for members with a high-risk of breast cancer." This is reflected on page 75 of the EPO.

Full edited versions of the MPD's can be accessed electronically here:
https://pebp.state.nv.us/meetings-events/board-meetings/may-26-2022-board-meeting/

5.

5. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: May 26, 2022

Item Number: V

Title: Executive Officer Report

SUMMARY

This report provides the Board and members of the public information on PEBP operations.

REPORT

STAFFING UPDATE

PEBP is happy to announce the addition of several staff, just in time for Open Enrollment. Several candidates were hired to fill member services unit positions and some positions were filled through internal promotional candidates. There are still several vacancies remaining though, and with the 25%+ overall vacancy rate in the state, recruiting continues to be a challenge.

PEBP currently has seven positions vacant of the 34 total positions. There will be an additional two vacancies in June. One resignation and one retirement, bringing the total vacant positions to nine.

PATIENT PROTECTION COMMISSION BENCHMARK ANALYSIS

In December 2021, Governor Sisolak signed an Executive Order instituting a cost-growth benchmark program that serves as a cost-containment strategy in limiting how much a state's health care spending can grow each year. The Patient Protection Commission, partnering with the Peterson Milbank Foundation and Bailit Health, has been tasked with overseeing this effort.

On May 3, 2022, PEBP, with the assistance of Aon Consulting, presented the Phase 1 analysis for the Health Care Cost Growth Benchmark analysis. Both PEBP and Medicaid presented detailed reports breaking down health care spending by age, gender, and services as well as where those services are being provided. This is the first of several steps to better understand cost drivers and attempt to slow health care cost growth along with improving access for Nevadans. PEBP will continue to partner with Nevada Medicaid and the PPC to produce additional analysis. Additionally, the PPC has also requested that commercial carriers participate in this project as well. The presentation materials and meeting recording can be accessed on the PPC website here: https://ppc.nv.gov/Meetings/Meetings/

STRATEGIC PLANNING

PEBP held its annual strategic planning meeting in April this year. Holding it earlier in the year not only provided vendor partners an opportunity to present new ideas, services, and vision to the program, it also allowed PEBP to plan for any budget-impacting ideas more effectively as staff begins to embark on the biennial budget building process.

PEBP staff would like to thank the Board members and the vendor representatives who attended and participated in these discussions. The pandemic has certainly made strategic planning challenging at best, so it is exciting to finally be able to assess more long-term initiatives.

OPEN ENROLLMENT

As of the date this report was written, PEBP's annual open enrollment has gone much more smoothly than expected. The transition back to Lifeworks has thankfully exhibited less issues than was anticipated and members are generally able to access their portal and make benefit selections incident-free.

PEBP's Open Enrollment meetings were performed virtually again this year and we are pleased to announce that yet again, the accessibility of the virtual webinars resulted in high participation rates:

North – 694
South – 509
Medicare – 55

Total = 1,258

6.

6. Enrollment and Eligibility System Transition Update (Nik Proper, Operations Officer) (Information/Discussion)

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: May 26, 2022

Item Number: VI

Title: Enrollment and Eligibility System Transition Update

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information on the transition of PEBP's enrollment and eligibility system.

REPORT

ENROLLMENT AND ELIGIBILITY SYSTEM UPDATE

At the March 24, 2022 Board Meeting, the decision was made to transition from Benefitfocus back to PEBP's prior enrollment and eligibility vendor, Lifeworks. On 5/2/22 the Lifeworks system went live successfully for members. Staff and agency representatives were successfully granted access prior to the member portal going live. While successful overall, there are some challenges and risks PEBP encountered that are being mitigated.

Current Challenges and Risks:

- Data Discrepancies: This transition consisted of PEBP staff independently running Excel reports in the Benefitfocus system to send to Lifeworks. The reports were not in the ideal format and did not contain the ideal identifiers necessary for Lifeworks to upload the data as accurately as it could. This process caused some accounts and some member changes including new hires, and qualifying life events that occurred since January to not be reflected accurately.
  Impact: Roughly 200 tracked members.

Mitigation: PEBP staff in conjunction with Lifeworks, and Agency Representatives, are correcting account statuses and coverages.

- File Integrations
  File integrations with agencies and most vendors are set up correctly and timely. The file integration with HPN was unable to be set up in the same format prior to January causing Lifeworks, PEBP, and HPN to come up with a solution through June.
  Impact: Added short term workload on Lifeworks and PEBP staff to reflect HPN member changes.
  Mitigation: Lifeworks, in conjunction with PEBP, will be working on a manual enrollment spreadsheet for May and June changes before the new file format and structure can be set up with HPN for July forward.

- Voluntary Benefits: Benefitfocus administered voluntary benefits from January through April. In April, PEBP received some member complaints regarding claims being denied for members due to non-payment of premiums. PEBP reached out to Benefitfocus/LSI and the voluntary benefit carrier that denied the claims to discover that Benefitfocus did not remit any premiums to carriers since January. PEBP reached out to the Division of Insurance (DOI) as the regulatory agency for assistance in getting the members' claims paid, and the premiums remitted to carriers.
  Impact: Three members with claims originally denied have been paid. Potential impact could have been much greater.
  Mitigation: The DOI has been in contact with the voluntary benefit carriers to pay claims without receiving premiums remitted from Benefitfocus. The DOI has also been in contact with Benefitfocus for status updates. Collected premiums have currently been remitted by Benefitfocus for January and February and are in progress for March and April.

Open Enrollment:

Open Enrollment began May 16th and will continue through the 31st. Open Enrollment events were queued successfully, and no major issues have been reported as of the date this report was written. In anticipation of open enrollment, recognizing the existing staffing shortages, PEBP staff created an online form for password reset assistance (which is historically a significant percentage of calls taken during OE) that began 5/5/22. Through the first week of open enrollment, staff processed over 2,000 password reset form requests, which enabled members to login to their accounts successfully. This directly impacts the call center workload during this high-volume time.

7.

7. Discussion and possible action regarding the framework for development of the Agency Budget Request for the 2023-2024 Biennium (Laura Rich, Executive Officer) **(For Possible Action)**

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Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 26, 2022

Item Number: VII

Title: Framework for development of the Agency Budget Request for the 2024-2025 Biennium

SUMMARY

This report provides updates on budget direction and proposed budget recommendations for PEBP's Agency Request FY24/25 Budget submission.

REPORT

BACKGROUND

During the statewide budget kickoff meeting in March, agencies were given direction to build their FY24/25 agency request budget using two times the FY23 cap. This is effectively a "flat" budget. Recognizing the impact flat budgets could have on employee health benefits, PEBP immediately brought the issue to the attention of the Governor's Office and began discussions on possible alternatives.

BUDGET DIRECTION

The message from the Governor's Office has been very clear; there is no desire to cut employee health benefits and active measures would be taken to avoid a scenario in which the PEBP Board is asked to reduce or remove benefits in order to meet budget requirements. As a result, PEBP began discussing possible options with both the Governor's Office and Governor's Finance Office and ultimately, PEBP was granted the authority to submit its agency request budget using projected costs to maintain current benefit levels (while still spending down any excess). This means that PEBP will be working with our actuary, Segal, this summer to project FY24/25 costs using current plan benefit design while taking into account projected trends over the biennium.

BUDGET ENHANCEMENTS

There is no guarantee that any additional benefits will be included in the Governor's Recommended Budget (Gov Rec) above and beyond the current benefit levels in place today; therefore, PEBP is only recommending minor staff enhancements to be included in the agencies' budget request.

The most concerning gap at PEBP by far is the lack of health care specific legal resources available to the program. Although PEBP leans on the Attorney General's Office for legal support, the Deputy AG (DAG) assigned to PEBP is usually assigned to several other agencies and does not necessarily have subject matter expertise in health care specific matters. Each time the agency is assigned a new DAG, there is a substantial learning curve and the constant and increasing need for legal assistance exposes the agency to potential risk if the representing counsel is unfamiliar with health care law. As the agency grows and health care legislation becomes more and more complex, the need for industry specific legal experience increases, in addition to the time a DAG must dedicate specifically to PEBP. It is staffs' opinion that an in-house legal counsel would be highly beneficial to the program by not only providing on-going legal expertise in specific health care related issues but could also assist in benefit compliance reviews and contracting matters.

In an attempt to remain cost neutral, staff is recommending eliminating the Chief Information Officer (CIO) position and replacing it with an in-house counsel. In the last several years, PEBP has steadily transitioned much if its IT responsibilities and oversight to the states' Enterprise IT Services (EITS) and vendors. IT responsibilities remain, but those duties can be shifted to the remaining two IT staff. As such, PEBP is also recommending reclassifying the ITP II and III to a III and IV, respectively. The chart below illustrates the projected cost differential:

Current Position		Requested Position		Differential
Chief Information Officer (U2805)	$112,798.00	Lead Insurance Counsel (U9073)	$120,344.00	$ 7,546.00
IT Professional 2 (Grade 38-10)	$ 87,320.16	IT Professional 3 (Grade 40-10)	$ 95,672.16	$ 8,352.00
IT Professional 3 (Grade 40-10)	$ 95,672.16	IT Professional 4 (Grade 42-10)	$104,901.12	$ 9,228.96
Total Cost Differential				**$ 25,126.96**

It's important to note that although this is on the surface a $25,000 enhancement in our budget, it can be argued that an in-house counsel will reduce PEBP's yearly AG assessment by at least that dollar amount or more, so it is realistic to expect this request to ultimately *save* the program rather than *cost* the program.

TIMELINE

All agencies are required to submit their respective budget requests by the end of August. GFO spends the remainder of the year reviewing each agencies' budget request and working with agency heads to address questions, issues, or necessary changes. Once this process is complete, it becomes part of the Governor's Recommended Budget, which remains confidential until it is publicly announced in January, prior to the commencement of the biennial legislative session. During the course of the legislative session, agencies are required to present their Gov Rec approved budgets to the legislature and ultimately, those budgets receive final approval in April/May just in time for the start of the fiscal year.

Recommendation:
Approve the submission of PEBP's agency request budget based on existing plan benefit design through the biennium and 2) include enhancement request for in-house counsel and upgrade of two existing IT positions.

8.

8. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

   8.1 Contract Overview

   8.2 New Contracts

      8.2.1 Vivo

   8.3 Contract Amendments

      8.3.1 Segal

      8.3.2 Claims Technologies Inc.

   8.4 Contract Solicitations

   8.5 Status of Current Solicitations

LAURA RICH
Executive Officer

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AGENDA ITEM

[X] Action Item
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Date: May 26, 2022

Item Number: VIII

Title: Contract Status Report

Summary

This report addresses the status of PEBP contracts to include:

1. Contract Overview
2. New Contracts for approval
3. Contract Amendments for approval
4. Contract Solicitations for approval
5. Status of Current Solicitations

8.1 Contracts Overview

Below is a listing of the active PEBP contracts as of April 30, 2022.

PEBP Active Contracts Summary							
Vendor	**Service**	**Contract #**	**Effective Date**	**Termination Date**	**Contract Max**	**Current Expenditures**	**Amount Remaining**
Aetna	In-state PPO Network	23846	7/1/2021	6/30/2022	$ 7,127,250.00	$ 1,207,943.50	$ 5,919,306.50
American Health Holdings	PPO Utilization Management Case Management	21376	7/1/2019	6/30/2022	$ 8,000,000.00	$ 5,600,136.96	$ 2,399,863.04
AON Consulting	Consulting Services	17596	7/1/2016	6/30/2022	$ 3,651,585.00	$ 230,922.89	$ 3,420,662.11
Express Scripts, Inc.	Pharmacy Benefit Manager	17551	4/12/2016	6/30/2022	$ 302,920,638.00	$ 289,098,111.27	$ 13,822,526.73
HealthScope Benefits	TPA	11825	2/8/2011	6/30/2022	$ 62,894,027.00	$ 62,364,767.66	$ 529,259.34
HealthScope Benefits	National PPO	13330	7/1/2012	6/30/2022	$ 15,455,000.00	$ 12,942,728.27	$ 2,512,271.73
HealthScope Benefits	Dental Claims	14574	7/9/2013	6/30/2022	$ 6,100,000.00	$ 5,643,350.49	$ 456,649.51
HealthScope Benefits	Flexible Spending Account	14465	7/1/2013	6/30/2022	$ 125,000.00	$ -	$ 125,000.00
Hometown Health Providers	In-state PPO Network	15510	7/1/2014	6/30/2022	$ 9,955,139.00	$ 8,567,045.59	$ 1,388,093.41
Labyrinth Solutions, Inc.	Benefits Management System	23678	12/14/2021	4/30/2022	$ 7,328,667.00	$ 285,715.74	$ 7,042,951.26
The Standard	Group Basic Life Insurance	14276	7/1/2013	6/30/2022	$ 80,587,091.00	$ 79,438,701.96	$ 1,148,389.04
CliftonLarsonAllen	Financial Auditor	24088	5/1/2021	12/31/2024	$ 212,485.00	$ 50,710.00	$ 161,775.00
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 33,316,170.14	$ 158,777,677.86
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 280,836.48	$ 1,320,776.52
United Healtcare Insurance	Group Basic Life Insurance	25607	7/1/2022	6/30/2026	$ 12,824,248.00	$ -	$ 12,824,248.00
Claim Technologies	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,551,662.00	$ 108,000.00	$ 1,443,662.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 3,990,000.00	$ -	$ 3,990,000.00
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 65,413,106.00	$ -	$ 65,413,106.00
Carson City Airport Authority	NRS 287.025	10335	2/1/2010	2/1/2034	$ 146,160.00	$ -	$ 146,160.00
Clean Water Coalition	NRS 287.025	11373	10/1/2010	6/1/2050	$ 359,040.00	$ -	$ 359,040.00

Recommendation

No action necessary

8.2 New Contracts

Below are the new contract ratification requests.

8.2.1 VIVO

PEBP contracted with Vivo for installation of video meeting equipment for the PEBP board room on March 24, 2022 with a termination date of April 30, 2022. Due to a piece of equipment arriving damaged and a delay in receiving a replacement, a new contract needs to be approved allow for work to be performed through June 15, 2022.

Recommendation

PEBP recommends the Board authorize staff to complete another short term contract between PEBP and Vivo for equipment installation.

8.3 Contract Amendment Ratifications

Below are the contract amendment ratification requests.

8.3.1 SEGAL

PEBP contracted with Segal for actuarial consulting services which became effective April ,12 2022, and has a termination date of June 30, 2027. This amendment adds contract authority to allow PEBP to have Segal perform work in Fiscal Year 2022 related to analysis necessary for the Patient Protection Commission's Cost Growth Benchmark analysis. This amendment increases the contract by $50,000 retroactively effective from April 12, 2022.

Recommendation

PEBP recommends the Board authorize staff to amend the contract between PEBP and Segal for actuarial consulting services in contract #25557 to retroactively increase the contract maximum.

8.3.2 CLAIM TECHNOLOGIES, INC.

PEBP contracted with Claim Technologies Inc. for health claim auditing services which became effective November 9, 2021 and has a termination date of June 30, 2027. This amendment increases the contract maximum by $30,000 to include an additional PBM audit for Fiscal Year 2020 that was inadvertently missed during the transition between vendors.

Recommendation

PEBP recommends the Board authorize staff to amend the contract between PEBP and Claim Technologies, Inc. for health claim auditing services in contract #24030 to increase the contract maximum and add language for an additional audit.

8.4 Contract Solicitation Ratifications

PEBP does not currently have any contract solicitations for ratification.

8.5 Status of Current Solicitations

The chart below provides information on the status of PEBP's in-progress solicitations:

Service	Anticipated/ Actual RFP release date	Anticipated/ Actual NOI	Winning Vendor	Anticipated Board Approval
Eligibility and Enrollment System	TBD			

9.

9. Public Comment

10.

10. Adjournment