Claim Administration Audit

HEALTH REIMBURSEMENT ARRANGEMENT

State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement Plan

Administered by Via Benefits from Willis Towers Watson

Audit Period: July 1, 2022 through June 30, 2023
Plan Year 2023

Presented to

State of Nevada Public Employees' Benefits Program

December 7, 2023

CLAIM TECHNOLOGIES INCORPORATED

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EXECUTIVE SUMMARY

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

Scope

CTI performed an audit of Via Benefits' administration of the PEBP HRA for the period of July 1, 2022 through June 30, 2023 (plan year 2023). The population of claims and amount paid during the audit period was taken from the paid claim file provided by Via Benefits.

Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$18,183,658
Total Number of Claims Paid/Denied/Adjusted	218,375

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

- Operational Review
- Random Sample Audit
- Eligibility Verification

Auditor's Opinion

Based on these findings, and in CTI's opinion:

1. Via Benefits showed improved service to PEBP's members and exceeded all but one of its performance guarantees for FY2023.
2. Although Via Benefits provided good service to PEBP's members, CTI recommends the following areas for improvement:
    - Track the reasons for overpayments to understand why overpayments occur and prevent them going forward.
    - Focus on increasing overpayment recovery percentage; it is currently at 6%.
    - Provide claim processors with coaching on the processing errors identified during the audit.

Summary of Via Benefits Guarantee Measurements

Based on CTI's Random Sample Audit results, Via Benefits met the Claim Processing Payment Precision and Claim Processing Turnaround Time measurements but did not meet the Claim Financial Precision for PEBP in plan year 2023.

FY 2023 Annual Metrics	Guarantee	Met/Not Met	Penalty
Claim Financial Precision	98%	Not Met–96.17%	$10,000
Claim Processing Payment Precision	98%	Met 99.00%	$0
Claim Processing Turnaround Time	Average 2 business days	Met – 0.41 days	$0
		Total Penalty	$10,000

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of Via Benefits from Willis Towers Watson (Via Benefits) administration of the State of Nevada Public Employees' Benefits Program (PEBP) Medicare Exchange Health Reimbursement Arrangement (HRA) plan. We provide this report to PEBP, the plan sponsor, and Via Benefits, the claim administrator. A copy of Via Benefits' 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 Via Benefits. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between Via Benefits 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 Via Benefits 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 Via Benefits' claim administration were to determine whether:

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

OPERATIONAL REVIEW

Objectives

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

Scope

The scope of our review included:

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

Methodology

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

Findings

We observed the following from Via Benefit's response to the operational review questionnaire:

- Via Benefits provided the following insurance coverage information.

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

- Willis Towers Watson (WTW), parent company of Via Benefits, reported that it had been audited by KPMG LLP, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report and provided CTI a copy of the report. We have asked WTW to forward a copy of the report to PEBP. Any questions regarding the report and impact should be discussed with WTW.
- The business continuity plan provided by Via Benefits included two approaches to data protection; 1) continuous off-site replication to a second, geographically distant location and, 2) the use of daily backups of files and databases.
- Via Benefits indicated no claim processing functions were outsourced; however, it did use subcontractors for other functions such as translation services, data entry, and mail services.
- Refunds and return checks were forwarded to PEBP to deposit to PEBP's bank account.
- Via Benefits indicated PEBP provided the allocation amount that participants were eligible. Effective May 31, 2021, PEBP implemented an $8,000 cap on the available balance.
- Via Benefits provided an HRA overpayment report for FY2023, that showed recovery of 6% of identified overpayments.
    - Overpayment Total: $11,411.25
    - Recovered Total: $683.38
    - Unrecovered Total: $10,727.87
- Via Benefits did not provide the reason for overpayments on the report; however, Via Benefits indicated that HRA eligibility was the biggest reason for overpayments.
- Customer service operations were available via phone Monday through Friday from 5:00 AM to 4:00 PM PST.
- The member online portal allowed claim submission, check claim status, check participant balances, supporting documents submittal, and viewing of historical information.
- Via Benefits communicated with account holders via mail or email. It provided digital newsletters approximately every two months, a one-time enrollment guide mailing when a participant aged into Medicare, and a one-time HRA welcome packet mailing upon initial qualification.
- Via Benefits reported it used secure system passwords and system authorization, as well as separation of duties for system security. It also limited access to eligibility maintenance and claim adjudication.
- Via Benefits' internal system control document provided a thorough overview including detail on data entry logic, duplicate logic, and overpayment logic as examples.
- Web-based security and compliance training was provided by Via Benefits annually to their staff.
- Via Benefits reported there were no privacy or security breaches identified during the audit period.

Performance Guarantee Validation

As part of CTI's audit of PEBP, we reviewed the Performance Guarantees included in its contract with Via Benefits. The self-reported results for plan year 2023 follow.

Metric and Service Objective	Actual	Met/ Not Met
Reports Annual Review: Reports provided within 15 days.	Met	Met
HRA Web Services Annual Review: 99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.5%	Met
Customer Service Abandon Rate Annual Review: The percentage of incoming calls abandoned by participants be 5% or less.	1.34%	Met
Customer Service Speed to Answer Quarter Review: Incoming telephone calls answered in less than or equal to: Ninety seconds in Q1 PY 2023 Five minutes in Q2 PY 2023 Two minutes in Q3 PY 2023 Ninety seconds in Q4 PY 2023	 Q1 PY 2023 – 0:26 Q2 PY 2023 – 1:46 Q3 PY 2023 – 0:30 Q4 PY 2023 – 0:10	Met
Customer Satisfaction Quarter Review: At least 80% of participants surveyed will be satisfied with services.	Q1 PY 2023 – 88.8% Q2 PY 2023 – 90.1% Q3 PY 2023 – 92.1% Q4 PY 2023 – 90.5%	Met
Disclosure of Subcontractors Per Violation: additional subcontractors shall not be engaged, unless at least 60 days prior notice to the engagement of a new subcontractor.	Individual Marketplace Subcontractor list dated April 15, 2021	Met
Unauthorize Transfer of Data Per Violation: All data will be stored, processed, and maintained on designated servers. Any changes must have 60 days notification.	No changes reported	Met

RANDOM SAMPLE AUDIT

Objective

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

Scope

The Random Sample Audit included a random sample of 200 HRA claims paid or denied. Via Benefits' performance was measured for the following key performance categories:

- Claim Financial Precision
- Claim Processing Payment Precision

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

Methodology

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

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

Findings

CTI defines claim financial precision 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. Claim processing payment precision is defined as the total number of payments made correctly without a payment or nonpayment error compared to the total number of payments issued. The sampled claims were selected from the PEBP HRA claims processed during the 2023 plan year.

Via Benefits did not meet the performance guarantee for claim financial precision of 98% and a $10,000 penalty is owed. Via Benefits did meet the performance guarantees for claim processing payment precision and claim turnaround time.

Note: claim processing payment precision includes both financial and procedural errors. A summary of each finding follows the chart below.

Performance Measure	Claims Sampled		Sampled Claims with Errors		Results
	Claims	Dollars Paid	Claims	Dollars Paid	
Claim Financial Precision	200	$24,776.10	1	$949.00	96.17%
Claim Processing Payment Precision	200		2		99.00%
Claim Turnaround Time	Average 2 business days				0.41 days

	Random Sample Findings Detail Report			
Audit Number	**Overpaid**	**CTI's Observation**	**Via Benefits Response**	**CTI's Conclusion**
Financial Errors				
1193	$949.00	The claim was denied for lack of information. However, the image has all information needed to process the claim.	Agree.	Procedural error and overpayment remain. Claim denied in error.
Procedural Only Errors				
1128	NA	The claim submitted was for 2021, 2022, and 2023 and submitted in April of 2023. The claim was split into three claims: • 2021, denied for timely filing and entered January only – should be entered as 1/1/21 – 12/31/21. • 2022, claim was entered for whole year and denied for timely filing. However, since the claim was submitted in April of 2023, this claim should have allowed from April – December 2022. • 2023, was also denied for timely filing. The claims for these dates of service were also submitted via Pass Thru (online portal). The member has been made whole, and the sample claim should have been denied as a duplicate instead of denied for timely filing.	Disagree. The member was made whole via Pass Thru. No financial impact to participant. 2021 – No impact to the participant. The EOB only reflects the beginning date of the premium (End date not reflected Ex 31st) See the snippet of EOB below.	Non-payment/procedural error remains. The sample claim had incomplete dates and the denial reason on the explanation of benefits was incorrect.

Additional Observations

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

Audit Number	Observation
1015	This member died in February 2019 and eligibility was updated in April 2019 reflecting death. Out of sample claims with service dates in 2022 were still being paid creating overpayments totaling $976.36. Overpayments were subsequently identified, and refund pursued on 7/20/23. Conflicting information was passed to Via Benefits from the eligibility vendor, Lifeworks (now TELUS Health).
1099 and 1119	The claims took 15 days (1099) and 11 days to process (1119). Via Benefits stated the SLA was measured quarterly and met in both these quarters. CTI notes Via reported 100% of claims were processed within 5 business days.
1183	Two receipts were combined into one claim; best practice is to separate individual claims to identify and prevent duplicate payments. Via Benefits' protocol is to process claims as one payment for multiple receipts.
1175	The claim payment was approved, and funds were available. However, the claim payment was split unnecessarily. Via Benefits advised this is an information display issue on the member portal and won't affect duplicate claim detection. Via Benefits is investigating the issue.

ELIGIBILITY VERIFICATION

CTI electronically compared dates of service to PEBP's electronic eligibility file received from Lifeworks (now TELUS Health). The screening revealed that some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health for their review and comment. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Description	Claim Lines	Members	*Paid Amount
Member Not on File	597	63	$93,024.31
Incurred After Member Benefit End Date	292	129	$45,083.01
Incurred Prior to Member Benefit Begin Date	15	7	$2,380.71
TOTALS	**904**	**199**	**$140,488.03**

**CTI notes that 0.77% of PEBP's total medical spend processed by Via Benefits was identified as paid for members who may not have been eligible for coverage. These results are within the norm of less than 1% CTI generally reports.*

PLAN YEAR 2023 RECOMMENDATIONS

CTI has the following recommendations based on the findings of the Plan Year 2023 audit of Via Benefits:

1. The overpayment report provided by Via Benefits should specify the reason for overpayments. If the reasons are not currently captured and tracked, CTI recommends doing so. Tracking the reason for overpayments will allow both the PEBP and Via Benefits to understand why overpayments occur and help determine the steps necessary to prevent them going forward.
2. The overpayment recovery percentage of 6% is low and processes should be put in place by Via Benefits to attempt to increase the success rate of overpayment recovery.
3. Via Benefits should coach its claims processors on errors identified during the audit including:
    - Overlooked supporting documentation submitted with the claim
    - Incorrect denial reason
    - Incomplete date of service entered

CONCLUSION

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

APPENDIX – ADMINISTRATOR RESPONSE TO INITIAL REPORT

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

October 9, 2023

State of Nevada Public Employees Benefits Program:

On behalf of Willis Towers Watson (WTW) regarding the draft report of the Audit of the State of Nevada Public Employees' Benefits Program Health Savings Account and Health Reimbursement Arrangement for the period of July 2022-June 2023 please see our response to the report and the auditor's recommendations below:

- Claim Technologies Incorporated noted that of the 200 claims reviewed there were one financial error and two claims processing errors after review with the auditors, WTW disagrees to these findings. WTW agrees to one financial error, and one claims processing error.
    - Regarding claim # 1128: The claim was not flagged as duplicate because there was a difference in the service end date as mentioned. However, since the claim resulted in a denial, there was no payment or financial impact to the participant. This would be considered a Process Error as defined below (outside the scope of the Payment and Financial Accuracy measures listed in the PEBP audit).
        - **Definition:** Process accuracy measures the percentage of claim items adjudicated correctly in terms of instances. Process accuracy captures errors that do not affect the financial or payment outcome. Instead, it focuses on data entry, procedural compliance, and following best practices.

Observation #1:

This issue is related to participant, [redacted]). While Via Benefits did originally receive and load the date of death [redacted], several subsequent files were received that "revived" the account. The first file received and loaded that "revived" the account by not including the dated of death was loaded on [redacted] 2019. The date of death was then sent and loaded again on [redacted] 2019. However, a file was then loaded on [redacted] 2019 to remove the death status again. Via Benefits didn't receive and load a new file on the account until [redacted] 2023. This new file included a different date of death of [redacted].

In summary, it seems that the conclusions drawn may be influenced by inaccurate data received by Via Benefits from Nevada PEBP/LifeWorks.

In November 2022, Nevada PEBP agreed to allow Via Benefits to update death statuses and divorce statuses based on notification over the phone. For example, John Smith passes away on 6/15/2023. His son calls Via Benefits on 6/29/2023 to report that Mr. Smith has passed away. Via Benefits will manually update the death status on the account which will end the participants HRA eligibility and Mr. Smith will be included on a weekly "Death" status report that is made available to Nevada PEBP. This process will help eliminate overpayments as Via Benefits does not have to wait for a death status to be sent over on a file to be loaded to update the account and end the HRA eligibility.

Observation #2:

Per the claims processing turnaround time the vendor agrees that the processing of claims will typically require no more than two business days, a calculation commencing from the point of receiving a complete claim until its adjudication by an examiner. Additionally, they have committed to ensuring that 98% of all claims will be processed within a five-business-day turnaround time. This timeframe will be computed based on the total duration measured in business days/the count of total claims. The SLA metric results are provided to Nevada PEBP through the "Quarterly Update" reporting provided for the Nevada PEBP board meetings. Here is an example of how this information is provided in that report:

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.19 Days	Yes

The report indicates that Via Benefits met the average Claims Turnaround Time metric that "claims process will average two (2) business days or less" and provides the number of days for processing in the "outcome" section.

Observation #3:

Below is our logic and rules on why we combined the claim into one claim line instead of multiple lines:

The term, "Clubbing," refers to combining multiple expense amounts and/or dates of service found on supporting documentation and entering them into one claim line instead of several individual claim lines in the CPI.

Heath Care Expenses Only
Do not use Clubbing Rules for Catastrophic Drug Claims (CatRx) or Special Payment Claims.

Required Information
In order to "Club," expenses, the requirements below must be met. Eligible Health Care Expenses that are on the same document (EOB, receipt, statement, or invoice) and meet the criteria below, must be clubbed into one claim line entry if applicable.
Expenses must be for the same person (participant or dependent)

- Expenses must be on the same document (Please note that multiple individual strips or receipts that are put on one piece of paper should not be clubbed)
- Expenses must be for the same provider
- Expenses must be for the same Category/Claim Type
- Expenses must be for the same calendar year

Guidance
Common documentation that can be used to club expenses:

- Prescriptions
  - Cash register receipts (Meaning all eligible items contained in one receipt should be clubbed including tax on those items if applicable)
  - Ledgers from the pharmacy
- Dental Expenses
  - Invoice

- Statement
- Ledger
- EOB

- Medical Expenses
  - EOB
  - Invoice
  - Statement
  - Ledger

Claim Entry Instructions

- If there are multiple years on the same document, do not enter a line that crosses plan years when clubbing.
  - Processor must enter a clubbed line for expenses within the same year.
    - For example, if the ledger has dates from 2017 and 2018 - processor would club all expenses for 2017 and enter into one claim line and then enter a second line for expenses from 2018.
- If the required information listed above is not met, do not club the lines. Enter the Health Care Expenses on individual claim lines per claim processing guidelines.

Observation #4:

This is a display issue in the member portal. The claim and amount and EOB show the data is in one claim, however the portal is showing the payment split in two. As this is a display issue, this will not cause a duplicate claim issue. There is currently being research done as to why the portal is displaying this way.

Eligibility Verification:

The ability for claims to be reimbursed from a participants HRA is based on multiple factors such as eligibility, qualification, and the claim information and supporting documentation. Some participants may no longer be eligible for the HRA or qualified for the HRA, but the claim information submitted can still be used to process a reimbursement from the participants' account. For example, Via Benefits was able to confirm that some of the accounts that are part of the Eligibility Verification impact were deceased retirees where claims that were incurred when the participant was alive were submitted after the date of death. These claims were determined eligible and processed accordingly based on their date of service. Other accounts were determined to be participants that lost funding qualification due to an update from the carrier that was later corrected.

Recommendation #1:

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

WTW Response:

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

- "Negative Account Balance" - In many cases these overpayments happen due to a late notification that the participant has passed away, so funding is removed from the account and claims paid from those funds are then denied and placed into overpayment. This can also happen if a participant has a retroactive loss of their HRA funding qualification.
- "Claims Overpayment" - These overpayments can be tied a claim that was approved but then later determined to be an ineligible expense, for example a claim that was later identified a duplicate claim.
- Our current overpayment report does not provide more detailed information on why a specific overpayment occurred on an account. Manual research would need to occur on the individual participant to confirm the specific reason for an overpayment.
- We are continuing to work on improving the overpayment process and participants can now resolve their overpayments through the portal. They have the option to pay online or submit a help ticket. The amount of calls we take regarding overpayments has decreased more than half because of this change.
- In November 2022, Nevada PEBP agreed to allow Via Benefits to update death statuses on notification over the phone. For example, John Smith passes away on 6/15/2023. His son calls Via Benefits on 6/29/2023 to report that Mr. Smith has passed away. Via Benefits will manually update the death status on the account which will end the participants HRA eligibility and Mr. Smith will be included on a weekly "Death" status report that is made available to Nevada PEBP. This process will help eliminate overpayments as Via Benefits does not have to wait for a death status to be sent over on a file to be loaded to update the account and end the HRA eligibility.

Recommendation #2:

The overpayment recovery percentage of 6% is low and processes should be put in place by Via Benefits to attempt to increase the success rate of overpayment recovery.

WTW Response:

Via Benefits either mails or emails participants multiple communications related to overpayments in an attempt to have the participant recover the overpaid amount back to the plan. Participants will receive an Explanation of Payment when a claim that was previously approved and reimbursed is subsequently denied and placed into overpayments. Via Benefits also sends participants Overpayment Notices on a monthly basis for up to 3 months after an overpayment is generated on an account. Note that overpayment recovery on a retiree HRA account is historically difficult as many overpayments are generated by participants who pass away and their account has claims automatically reimbursed until their death status is loaded to end their eligibility. In these cases, the participants estate would be responsible for recovering the overpayment.

Participants have the capacity to rectify overpayments via the self-service portal, accompanied by the option to assign a general reason for the occurrence of the overpayment, thus enhancing transparency in understanding its origins. These process refinements and overarching improvements have yielded a significant reduction in instances of overpayment.

Recommendation #3:

Via Benefits should coach its claims processors on errors identified during the audit including:

- Overlooked supporting documentation submitted with the claim.
- Incorrect denial reason

- Incomplete date of service entered.

WTW Response:

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

In conclusion this audit has provided valuable insights. We are confident the recommendations outlined in this report will contribute to the continued success of service to the participants. We appreciate the cooperation demonstrated by Claim Technologies Incorporated on behalf of the State of Nevada Public Employees' Benefits Program. We look forward to our continued partnership.

Claim Technologies Incorporated representatives may from time to time provide observations regarding certain tax and legal requirements including the requirements of federal and state health care reform legislation. These observations are based on our good-faith interpretation of laws and regulations currently in effect and are not intended to be a substitute for legal or tax advice. Please contact your legal counsel and tax accountant for advice regarding legal and tax requirements.

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