

**PUBLIC SCHOOL EMPLOYEES'
RETIREMENT SYSTEM
HEALTH OPTIONS PROGRAM**

CORESOURCE

**ANALYSIS AND EVALUATION
OF CLAIMS PROCESSING AND
PAYMENT PROCEDURES**

**FOR THE PERIOD
JANUARY 1
THROUGH
DECEMBER 31, 2006**

**PRESENTED
OCTOBER 23, 2007**

SUBMITTED BY:

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CONFIDENTIALITY STATEMENT

Release of electronic and hardcopy information for this analysis required execution of an agreement signed by The Segal Company and CoreSource.

All audit information and findings prepared and presented in this report are considered confidential and proprietary. Sharing of contents with any other party or the copying of information herein is expressly prohibited without the written consent of the agreeing parties.

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SECTION I – SUMMARY

This report analyzes and evaluates claims processing and payment procedures utilized by CoreSource in the administration of Public School Employees' Retirement System Health Options Program (PSERS HOP) group benefits. Ms. Carol Hoel and Mr. Don Cardone conducted the onsite review at CoreSource's Lancaster, Pennsylvania claims office the week of August 20, 2007.

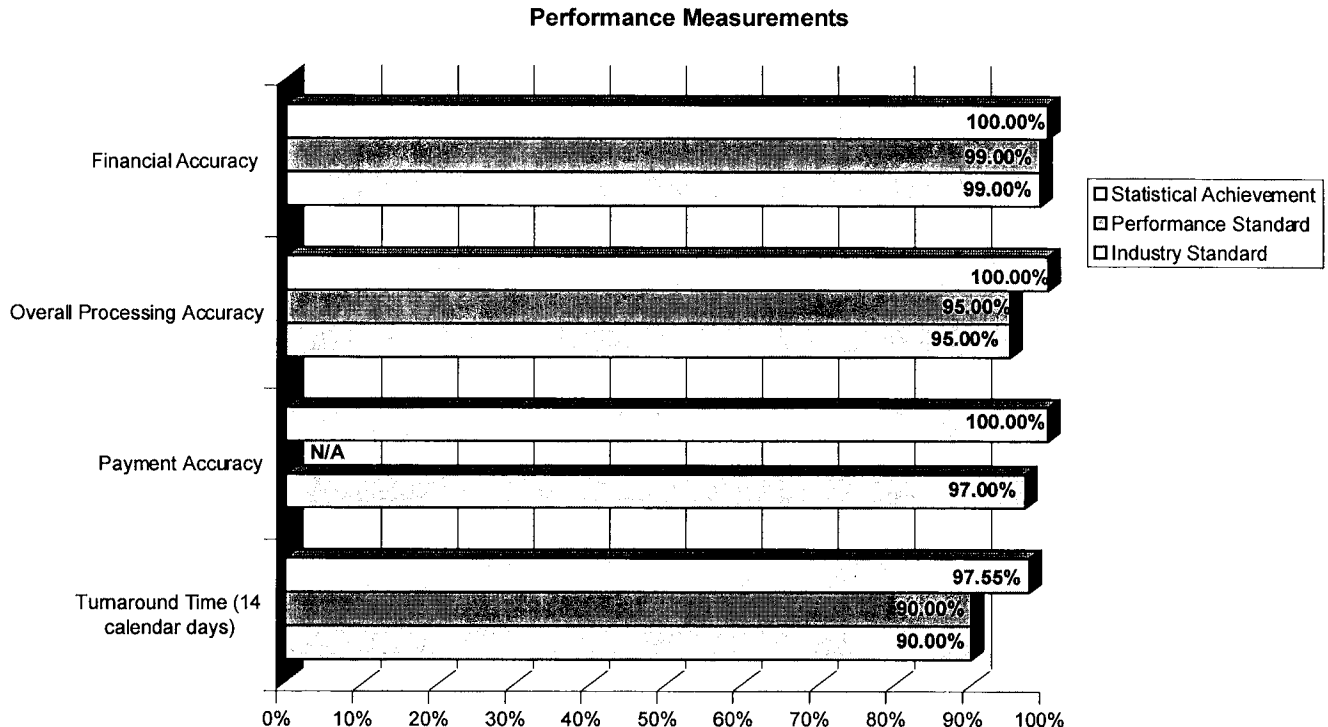
A data file of all claims with benefit payments processed during the period January 1 through December 31, 2006 was provided by CoreSource for our sampling purposes. Benefit payments totaling \$63,587,217.07 were paid on behalf of eligible employees and their dependents during the audit period.

Our analysis of 210 stratified claims represents benefit payments for \$1,766,987.56. CoreSource also provided a separate file of zero payment claims for selecting 15 target samples.

The auditors completed a form for each claim selected in the sample; this worksheet was the primary documentation on which our report is based. Due to the confidentiality of names, diagnosis, etc., claims addressed within this report are referred to as "Worksheets."

AUDIT RESULTS

A recap of the accuracy rates achieved by CoreSource during the twelve-month audit period follows. Performance and industry standards are offered for comparison. Based on the statistical analysis, CoreSource was above performance and industry standards for all categories of benefit accuracy and processing timeliness.



Industry standards are developed through ongoing review and comparison of measures utilized by major carriers and third party administrators nationwide. Standards include acceptable performance for administration of fully-insured and self-insured corporate, public, and multi-employer plan benefits.

Detailed descriptions of the audit findings are presented in Section II. No payment errors were found; two procedural errors were identified. Exhibit A presents a detailed analysis of claims processing turnaround time.

An additional 15 claims were sampled to verify accuracy of denials and ensure deductible and coinsurance amounts were properly applied; no errors were identified.

Results of achievement for this audit period meet or exceed findings for the prior audit period (January 1 through December 31, 2005). Errors identified in our prior review were resolved prior to release of our final report on June 22, 2006.

RECOMMENDATION

The following suggestion is offered for clarification regarding coordination of benefits with another group health plan; details related to this topic are included in Section II. CoreSource was presented with a draft report on September 7th for their review and comment. Their October 8th reply to the following recommendation is paraphrased in italics below; other response comments are included in Section II. Their complete response can be found in Section III.

- PSERS HOP and CoreSource should discuss appropriate procedures for scheduled inquiries to identify possible group coverage through retirees' or spouses' active employment. Industry best practice supports annual inquiries for verification; however, it may be appropriate to reduce frequency for retirees and dependents over age 65 who are enrolled in the 65-Special Program. Benefits should be coordinated when other primary coverage is confirmed. (COORDINATION OF BENEFITS, PAGE 4)

CoreSource will meet with PSERS HOP to discuss if procedures should be implemented for scheduled inquiries for other group insurance under an active plan. PSERS has not required this process to date.

This report would be incomplete without recognition of the assistance and cooperation extended to us by CoreSource personnel in preparing for this project and during the onsite phase of our review.

SECTION II – CLAIMS AUDIT REVIEW

A total of 1,078,617 PSERS HOP claims, representing \$63,587,217.07 in benefit payments, were paid during the period January 1 through December 31, 2006. Our statistical audit sample of 210 claims reviewed \$1,766,987.56 in benefits paid on behalf of eligible employees and their dependents. An additional 372,963 claims resulting in no benefit payment were excluded from the statistical calculations. The number of zero payment claims (25.7% of total processed claims) is comprised of denials, deductible expenses, and claims requiring additional information.

An integral part of our analysis includes a review of individual claim payments to ensure accuracy in benefit determinations and compliance with established administrative procedures. Our stratified sampling process allows us to project the accuracy of all claims based on the results of our audit selection. A detailed breakdown of the strata used in this analysis can be found in Exhibit B at the end of this section.

For purposes of our audit, a claim is defined as “all charges submitted and processed for payment under one claim number.” Prior history and accumulators (deductibles, coinsurance, and benefit maximums) were reviewed, as applicable, on each claim. In addition to verifying the amount paid, claims audited were thoroughly reviewed to determine that:

- Claims were paid in strict accordance with Plan provisions.
- Amounts paid were within the designated preferred provider organization (PPO) schedules and/or usual, customary, and reasonable (UCR) allowances for the area where treatment was rendered, with due consideration given for the severity of the condition treated. We did not determine medical necessity, but did ascertain CoreSource reviewed or referred claims for such review as appropriate.
- Claims were paid only on behalf of eligible individuals, based on eligibility provided by PSERS HOP.
- Documentation (provider bills, physician statements, surgical reports, etc.) was on file for claims paid and was verified when necessary.
- Benefits were paid under the proper benefit classification, diagnostic, and procedure codes.
- Appropriate benefit limitations, deductibles, coinsurance, and out-of-pocket maximums were applied.
- Arithmetic calculations were correct.
- Coordination of benefits with other coverage and third party liability provisions were enforced, where applicable.

- Duplicate payments were properly denied.
- Payments were made to the proper party (*i.e.*, the provider of service if benefits were assigned; the employee if benefits were not assigned).
- Turnaround time for processing of claims was within performance and industry standards.

COORDINATION OF BENEFITS

During our individual claims review, Segal’s auditors requested verification of CoreSource’s process for other insurance investigation. CoreSource replied that they assume primary status for retirees enrolled in the Traditional High and Standard Plan (Individuals Not Eligible for Medicare); they take a secondary position to Medicare for retirees enrolled in the 65–Special Program. They do not apply coordination of benefits (COB) with individual Medicare supplement plans. CoreSource states they do not routinely request COB verification from retirees or dependents given the population and enrollment process of PSERS HOP. Other insurance is investigated as received with claim submissions.

The COB provisions under the Traditional High and Standard Plan Summary and the 65-Special Program Plan define rules for determining payor order and coordinating benefits with other group coverage. Segal recommends PSERS HOP and CoreSource discuss appropriate procedures for scheduled COB inquiries to identify possible secondary status under the following scenarios:

- Retirees with other group insurance through active employment
- Retirees with other group insurance through a spouse’s active employment
- Dependents with other group insurance through retiree’s or spouse’s active employment
- Dependents with retiree benefits through a prior active group plan

Segal recognizes that the number of retirees with other insurance may be minimal; however, industry best practice supports annual inquiries for verification. It may be appropriate to reduce frequency for retirees and dependents over age 65 who are enrolled in the 65-Special Program. Benefits should be coordinated according to Plan provisions when other primary coverage is confirmed.

SELECTION OF CLAIMS

The selection of claims was stratified by dollar amount to give large claims more valid representation in the sample. The methodology of our stratified selection process utilizes formulae designed to take full advantage of statistical sampling procedures that allow a quantifiable degree of confidence so the results obtained in the audit sample are a true reflection of the actual way all claims were processed during the audit period.

PROCESSING ACCURACY

For comparison to performance and industry standards, processing errors would be classified as “payment” or “procedural.” Procedural errors do not involve a variance in payment. Of the 210 stratified claims audited, 208 were processed without error. No payment errors were identified; the following two procedural errors were assessed.

- Worksheet 193 (J) – Benefits for Life Time Reserve days were originally denied during coordination with Medicare. The claim was subsequently adjusted for corrected payment. Segal notes that this sample corresponds to the error identified in CoreSource’s response as Worksheet 194.
- Worksheet 201 (K) – Refunds were requested for primary payments when Medicare coverage was identified on a later claim; however, PSERS HOP was primary per CoreSource’s claim history of dialysis for End Stage Renal Disease (ESRD).

A basic principle of the sampling technique is that the audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels for comparison to performance and industry standards.

Based on the statistical findings reflected in the following chart, CoreSource exceeded performance and industry standards in all benefit accuracy categories and processing timeliness.

Performance Measurements				
Category	Sample Results	Stratified Achievement	Industry Standards	Performance Standards
Financial Accuracy (dollar value)	100%	100%	99%	99%
Overall Processing Accuracy (without payment or procedural error)	99.05%	100%*	95%	95%
Payment Accuracy (free from financial error)	100%	100%	97%	N/A
Turnaround Time (within 14 calendar days)	90.48%	97.55%	90%	90%

* Due to rounding at the second decimal point.

All questions and comments regarding the statistical and target claims samples were reviewed daily with CoreSource. In their written response, CoreSource indicates retraining has been provided as applicable. They will also evaluate implementing a revised process for determining the order of benefit payment with Medicare on ESRD claims.

TURNAROUND TIME

Turnaround time was calculated from the date a claim was received to the date it was processed by payment or denial. Claims that required additional information were calculated using the longest interval between the received date as stamped on the claim and date the claim was denied for additional information, or the date a response was received and date the claim was processed by payment or denial. This analysis included routine delays due to internal review or provider maintenance; delays realized for draft issuance were excluded from our analysis.

As noted in our analysis of accuracy levels, the process of stratification requires an adjustment in our audit observations. This is also true for the analysis of turnaround time. Accordingly, our analysis weights claims by strata, giving due consideration to the processing complexity for claims that are similarly grouped (*e.g.*, small dollar claims require less time to process than large dollar claims subject to internal reviews).

CoreSource bases timeliness on calendar days, which includes holidays and weekends. Claims are not pended for additional information; however, a denial is issued to the provider requesting additional information.

Based on the extrapolated analysis for 210 sampled claims, 97.55% of all claims were processed within 14 calendar days. This exceeds performance and industry standards that indicate 90% of all claims should be processed within 14 calendar days; 90% was achieved at 10 days for all claims processed. Processing time of 33 days was evidenced on one sampled claim. A detailed analysis of the turnaround time observed on the claims audited is included as Exhibit A at the end of this section.

In their written response, CoreSource indicates claims supervision has been advised to increase vigilance on ageing claims; management will review weekly turnaround time reports to ensure prompt handling.

EXHIBIT A – TURNAROUND TIME ANALYSIS

Calendar Days	Number of Claims	Individual Percent	Cumulative Percent*
1	1	0.02%	0.02%
2	5	2.63%	2.64%
3	18	9.07%	11.71%
4	32	19.65%	31.36%
5	25	16.33%	47.70%
6	31	18.65%	66.35%
7	30	14.84%	81.19%
8	17	4.21%	85.40%
9	5	1.81%	87.21%
10	10	4.76%	91.98%
11	5	2.24%	94.22%
12	2	0.00%	94.23%
13	7	2.42%	96.65%
14	2	0.90%	97.55%
15	7	2.25%	99.80%
16	3	0.18%	99.98%
17	1	0.00%	99.98%
18	2	0.01%	99.99%
20	1	0.00%	99.99%
21	2	0.00%	100.00%
22	1	0.00%	100.00%
28	1	0.00%	100.00%
30	1	0.00%	100.00%
33	1	0.00%	100.00%
Total	210	100.00%	*may not add due to rounding

EXHIBIT B – STRATIFICATION TABLE

Strata	Dollar Range of Strata	Number in Audit Selection	Number of Claims in Range	Dollar Amount in Audit Selection	Total Dollar Amount in Strata
A	\$0.01 - \$9.99	45	362,164	\$259.34	\$2,160,176.47
B	\$10.00 - \$19.99	40	317,108	\$586.31	\$4,543,190.04
C	\$20.00 - \$59.99	35	250,426	\$1,211.61	\$8,284,031.08
D	\$60.00 - \$199.99	20	101,147	\$2,282.90	\$10,687,109.77
E	\$200.00 - \$574.99	10	27,505	\$3,390.90	\$8,769,641.34
F	\$575.00 - \$1,349.99	10	16,771	\$9,086.79	\$15,174,006.06
G	\$1,350.00 - \$2,499.99	10	1,777	\$18,366.99	\$3,230,080.58
H	\$2,500.00 - \$5,749.99	10	1,387	\$33,608.09	\$4,866,528.44
I	\$5,750.00 - \$20,999.99	10	263	\$84,979.81	\$2,493,894.87
J	\$21,000.00 - \$74,999.99	10	59	\$349,155.62	\$2,114,499.22
K	\$75,000.00 - \$242,160.12	10	10	\$1,264,059.20	\$1,264,059.20
Totals		210	1,078,617	\$1,766,987.56	\$63,587,217.07

SECTION III – CORESOURCE’S RESPONSE TO DRAFT REPORT

CoreSource’s letterhead response is presented on the following page.

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CORESOURCE

A Trustmark Company

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October 8, 2007

Ms. Carol S. Hoel, HIA
The Segal Company
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Phoenix, AZ 85018

RE: CoreSource Response to the 2007 PSERS HOP Claims Audit by The Segal Company

Dear Carol:

CoreSource agrees with the findings of the Segal claims auditors. CoreSource acknowledges and appreciates the comparisons to Industry Standards that highlight CoreSource's statistical achievement as exceeding both Industry Standards and our Performance Guarantees.


Regarding the recommendation pertaining to coordination of benefits (COB), CoreSource will meet with PSERS to discuss procedures it may wish to consider for scheduled inquiries to identify possible group coverage through retirees' or spouses' active employment for COB use. To date, PSERS has not required this process.

Regarding the procedural errors identified on Worksheets 194 (J) and 201 (K), as acknowledged with the auditor, these were analyst errors that were corrected by CoreSource during follow-up processing. Re-training was provided, as applicable. CoreSource will evaluate implementing a revised process for ESRD claims. The new process would entail pending all ESRD claims until the order of benefit determination is made, starting with the date of the first dialysis.

Regarding the limited number of exception claims that exceeded turnaround time standards, Claims supervision has been advised to increase vigilance on aging claims. Management will be reviewing weekly turnaround time reports to ensure that aging claims are promptly addressed.

We appreciate the opportunity to respond to the audit findings, and please let us know if we can be of further assistance.

Sincerely,


Kevin F. Magrann, CEBS
Director, Client Management

KFM/cyh