Cherry Bekaert LLP
CPAs & Advisors

Independent Accountant's Report on Applying Agreed-Upon Procedures

Honorable Members of the District School Board
District School Board of Osceola County, Florida
Kissimmee, Florida

Dear Members:

We have performed the procedures enumerated below, which were agreed to by the District School Board of Osceola County (the "District"), solely to assist you in evaluating the processing of claims by the third party administrator, Cigna Healthcare ("Cigna"), for the year ended June 30, 2016. District management is responsible for the District's accounting records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are as follows:

1. We inquired of Missy Beherns, Client Senior Analyst for Cigna, to identify existing policies and procedures related to the claims processing system that were in place, and she advised us that those policies and procedures were as follows (we did not perform any procedures to verify Ms.Beherns' representations):

The Osceola School District (OSD) is self-insured for employee health insurance. The OSD collects money for participant health insurance contributions from its employees and retirees and regularly electronically transfers these funds, along with OSD's employer contributions, into its Health and Life Insurance Trust Fund bank account. Funds are transferred from this account into an account that is controlled by Cigna to fund claims as they are paid.

When an insured employee, retiree, or dependent of OSD (member) receives medical services from a health care provider ("provider"), the provider submits a claim form, either electronically or manually, to Cigna requesting payment for the services provided. Paper claims are imaged and transcribed by Cigna's subservice vendor into a standard electronic format, which is then transmitted electronically to Cigna, along with an image of the claim documentation. Claims are validated electronically by Cigna for completeness and accuracy of claim data, claim eligibility, and participant eligibility. The Cigna claim system automatically cross-references on-line data files, including eligibility information, detailed benefit descriptions, claim history for each employee, and coordination of benefit information, to verify that the claim being considered does not duplicate a claim previously submitted. The Cigna claim system edits each service line in a claim to detect possible duplicate payments and compares dates, type of service, and the provider's name and tax ID number with those of previously processed claims. Claims that are incomplete or fail critical edit checks oftentimes are either resolved internally by Cigna personnel or are sent back to providers electronically for issue resolution. Cigna's claims system automatically denies non-covered items based on diagnosis codes, procedure codes, inappropriate service dates entered for claims, or claims exceeding plan limitations. The system automatically inputs a reason code documenting why a claim has been denied, and processors can enter additional explanatory notes as needed. Claims that are resolved are returned to the electronic load process for adjudication or returned to providers with a letter of explanation describing why a particular claim was not paid. Claims are then routed electronically to the designated Cigna claims office for processing. Cigna's system attempts to adjudicate each claim electronically.

Claims are paid by Cigna only for covered expenses for eligible employees or retirees and their eligible dependents as described in applicable Plan documents and District policies. Participant eligibility information is fed into Cigna's claims processing system from information received from OSD. Just prior to the beginning of an October 1 - September 30 "Plan Year," OSD will hold an Open Enrollment period, where participants can make additions, deletions or changes to their insurance information and coverages. Only under certain circumstances can any changes be made outside of the Open Enrollment period. OSD employees are responsible for ensuring the accuracy of all eligibility information, which is generally uploaded electronically via automated file feed or through Cigna's online Employer Maintenance Tool. Eligibility information is maintained in Cigna's Central Eligibility Database ("CED"). Corrections are made by Cigna as needed, an error report and a "default cancel" report are generated, and OSD is advised of any errors or missing information needed to correct/complete its electronic eligibility data.

Claims must include all appropriate information sufficient for them to be able to be processed, including participant name, participant alternate member identifier, employer name and account number, patient name and participant relationship, health care professional name, address, tax identification number, and itemization of each service rendered including a general description, date performed, fees, service location, and diagnosis. Patient information and provider information on submitted claims must reconcile to data in Cigna's systems. Otherwise, the claims will be researched and denied if not satisfactorily resolved. If Cigna is the secondary payer, claims must include a copy of the primary carrier's explanation of benefits.

Cigna's claim system electronically processes routine claims based on system edits, which are established within the claims processing system. If the system cannot electronically process the claim, the system places a hold code on the claim and the claim is then sent to a "bucket", where it will be given to a claims processor and/or quality reviewer for further processing.

Each claims processor has a dollar amount limitation that he or she can authorize. The starting limit amount is $1,000 for first level claims processors. This limit then increases, depending upon the quality levels, experience, and performance levels of the claims processor. Any claims that are over the processors' payment limit must be evaluated on a pre-payment basis by a quality reviewer.

Additional screenings may occur in conjunction with Cigna's cost-containment programs. The Complex Claim Review program (also known as bill review or "CCR") is a value added cost containment program that provides a detailed pre-payment review of facility claims. A systematic edit routes claims greater than $75,000 to a highly skilled processor for review to determine if the claim meets the criteria for nurse review. If the claim meets criteria for screening, the review is performed by a cross-functional Cigna team, which conducts an extensive examination of billing and payment accuracy, requesting itemized bills and/or medical records to support the total bill. The review may apply to participating facility claims paid on a percent of charge basis, or billed charges for non-participating facilities. Once the claim has been reviewed through CCR, instructions for payment or denial are electronically passed to the processor and the claim is then finalized accordingly.

Claim amounts over $250,000 are required to receive a panel review. The panel is made up of quality reviewers, High Cost Claim Unit personnel, eligibility personnel, provider relations personnel, Client Service Executives (CSE's) and Claim Managers. The panel reviews the contracts, eligibility, benefits, authorizations, and itemized bills.

Claims with reimbursement charges of $5,000 or greater are subject to a pre-disbursement systemic quality review. Claims that meet complexity and/or high risk criteria route to a highly skilled team for high dollar review. The quality auditor will review the claim for accuracy and then route the claim back to the original processor or dedicated team for release.

Targeted claims with billed charges between $35,000 and $75,000 may be selected through systematic edits to route into a highly skilled unit for processing. These claims go through one-touch processing with end to end adjudication by highly-skilled processors, utilizing detailed quality checklists and controls. Additional post payment reviews are performed on this unit via Random Audits and Performance Guarantee Audits. Claims resulting in payments in excess of $250,000 are still subject to panel review.

Processors' decisions to continue processing claims or to deny them are stored electronically with system-based override codes. Generally the claims system identifies the claims processor ultimately responsible for the result of a processed claim.

The terms of OSD's plans govern the amounts of applicable deductibles and co-insurance, as well as individual and family annual out-of-pocket limitations, lifetime maximum benefit limits, and other applicable plan design features. This plan information is electronically uploaded or entered into Cigna's system whenever there is a plan design change and is tested prior to use to ensure the information operates correctly prior to use in claims processing. The pre-programmed information automatically computes the deductibles to apply as well as co-insurance amounts to be paid when each claim is processed. The system accumulates paid co-insurance amounts within the system during each applicable plan year.

Only authorized users are able to access claim data. Access controls include unique user IDs and passwords for all users of Cigna's claims processing application systems. To enhance security, Cigna's system requires a new password to be chosen periodically. User ID features include role-based access controls which assign appropriate access permissions/limitations based on user's responsibility level within Cigna.

OSD utilizes Cigna's Personal Health Solutions ("PHS") model for pre-certification. PHS helps ensure that participants and their dependents receive coverage for the most appropriate inpatient services, helping them find lower cost services or avoid unnecessary medical treatments and procedures. It also enables integration of case management services, allowing Cigna and OSD to identify the need for additional assistance to help participants improve their health and productivity. The PHS process includes pre-certification for inpatient services, including all inpatient admissions and non-obstetric observation stays, experimental and investigational procedures, cosmetic procedures, and certain maternity stays longer than 48 hours. The PHS process also includes inpatient case management, with continued stay review beginning soon after admissions and continuing throughout a patient's stay in the hospital and discharge planning and immediate referral to nurse care managers for coordination of services that occur post-discharge, such as home health care and therapies. Generally, only inpatient services are required to have a pre-certification.

A pre-certification request can be made by the participant or the service provider. A Cigna Healthcare nurse evaluates pre-certification requests and determines what services are covered based on plan benefit provisions and based on nationally-recognized pre-certification guidelines. Any time a Cigna Healthcare nurse cannot approve coverage for clinical reasons, the case is referred to a Cigna Healthcare doctor who considers each case. The doctor may speak with the treating physician to obtain additional information. The customer and the provider will be notified in writing if a pre-certification request cannot be approved based on the information received and the plan benefit provisions.

Cigna uses a "pay and chase" policy relative to administration of coordination of benefits ("COB") investigation and processing. OSD has elected a $300 threshold for COB investigation. In situations where the existence of other insurance is unknown, when the claim payment is less than $300, Cigna will pay the claim as the primary insurer and request the customer to provide updated other insurance information. For claims with payments in excess of $300, the claim will be pended for other insurance information. Cigna will follow up with the customer at 30, 60 and 90 days. At 90 days, the claim will be denied with a reason code, reflecting the requested COB information has not been received. The claim can be reconsidered upon receipt of the requested information. Should the results of COB investigation determine another carrier should have been primary, Cigna will review all claims impacted by other primary coverage and request refunds on any claims which had been paid prior to the COB update. The requests go through Cigna's recovery vendor, Accent. COB information is documented in

Cigna's claims, imaging or call tracking systems, depending on the source of the data. All COB information is documented in the eligibility system, which directly feeds into the COB field on the notes screen in the claims system. This field includes the date investigated, information on other insurance coverage that may exist, and which plan is primary. If a previous investigation has established another carrier is primary, and a claim is received without the primary carrier explanation of benefits, the claim will be pended requesting the primary insurance payment information be submitted.

Once the claim is processed it is then classified as an "adjudicated" claim. Cigna then pays the provider from OSD's account. This payment is made in whatever method preferred by the provider whether by electronic funds transfer or by check.

In cases where customers will owe an amount other than a copayment, once a claim is processed participants are sent an Explanation of Benefits ("EOB"), which show the details about the claim, including the date and type of services rendered, provider name, explanation of calculated benefits, charge amounts, issued check amounts, deductibles, out-of-pocket, maximum limits reached and amount of member responsibility. Individual EOB's are also available online at mycigna.com.

Adjustments to previously processed claims can be initiated in several ways, including detection of errors by internal or external audits, customer service calls from members or providers, member or patient letters of inquiry, receipt of pended claim correspondence or additional information, and the claim appeals process. When a claim is received in a processing center, it is assigned a document control number for tracking purposes. When adjustments need to be made, they are processed on the original claim number and the entire claim is reprocessed. The claim will be processed according to any additional or corrected information received. Once a claim is reprocessed, a corrected EOB and check, if applicable, will be issued to the provider and to the participant. Claims adjustments can be tracked from reports that are requested by management.

OSD receives, on a monthly basis, a paid claims report summarizing all claims paid by Cigna, a high claimants report, online banking reports to assist in reconciling OSD's general ledger to the banking records, statistics on admissions and bed days compared to the same period a year ago and a quarterly Consultative Analytical Package that details current medical and prescription utilization compared to the same period in the prior year.

2. We selected a sample of 45 claims processed and closed between July 1, 2015 and June 30, 2016. The following is a summary of the procedures performed and the findings noted:

    A. We compared the patient name, date of service, claim amount and provider specified on the Remittance Advice to related information from Cigna’s claim processing systems.

        No exceptions were noted.

    B. We read the Remittance Advice for each claim and noted whether each claim was accepted or denied. For accepted claims, we performed the following procedures:

        1) We inspected documentation provided by the District and Cigna to verify patient eligibility.

            No exceptions were noted.

        2) We compared claim payments with limits of coverage.

            No exceptions were noted.

        3) We inspected pre-certification documentation for compliance with those services required by the Plan Document provided by the District.

No exceptions were noted.

4) We visually inspected the documentation supporting each claim to ensure that all documentation required by Cigna's contract terms and policy to process each claim was properly included.

   No exceptions were noted.

5) We inspected documentation on secondary payer claims for proper coordination of benefits (COB).

   No exceptions were noted.

C. For denied claims, we compared the reasons for claim rejection to reasons allowed in the Plan Document provided by the District.

   No exceptions were noted.

We were not engaged to, and did not, conduct an audit, the objective of which would be the expression of an opinion on the claims processed by Cigna for the District. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of District management and is not intended to be, and should not be, used by anyone other than that specified party.

Orlando, Florida
October 25, 2016