U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

AUDIT OF THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM OPERATIONS AT AULTCARE HEALTH PLAN

Report Number 1C-3A-00-18-052
November 25, 2019

EXECUTIVE SUMMARY

Audit of the Federal Employees Health Benefits Program Operations at AultCare Health Plan

Report No. 1C-3A-00-18-052 **November 25, 2019**

Why Did We Conduct The Audit?

The primary objective of the audit was to determine whether AultCare Health Plan (Plan) complied with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). To accomplish this objective, we verified whether the Plan met the Medical Loss Ratio (MLR) requirements and thresholds established by the U.S. Office of Personnel Management (OPM).

Due to changes to our audit scope resulting from OPM's implementation of its MLR methodology, we cannot express an opinion on the fairness of the premium paid for benefits received. Our audit process was limited to an assessment of the Plan's MLR, which is representative of the Plan's cost of doing business with the FEHBP. The MLR calculation is neither transparent nor a fair assessment of the FEHBP rates, concerns that we are addressing with OPM through other channels.

What Did We Audit?

Under Contract CS 2723, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2014 through 2016. We conducted our audit fieldwork from January 14, 2019, through May 30, 2019, at the Plan's offices in Canton, Ohio, and in our OIG offices.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We determined that portions of the MLR calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM for contract years 2014 through 2016. This resulted in overstated MLR credits of $[redacted] for contract year 2014. Although we identified issues in contract years 2015 and 2016, they did not result in a penalty due to OPM or a credit due to the Plan. Specifically, our audit identified the following:

- The Plan lacked strong internal controls and written policies and procedures over its capitation rate-setting methodology.
- The Plan used an inconsistent approach to record FEHBP expenses in its general ledger.
- The Plan did not submit its claims data in accordance with OPM Carrier Letters.
- The Plan erroneously included healthcare receivables in its FEHBP MLRs.
- The Plan incorrectly allocated its Patient Centered Outcome Research Institute fees in 2014 through 2016.
- The Plan did not have sufficient internal controls over its FEHBP MLR processes and it did not maintain all supporting documentation for its 2014 through 2016 FEHBP MLRs.
- The Plan included inaccurate medical and capitation claims expenses in its 2014 MLR.

ABBREVIATIONS

AIC	**AultCare Insurance Company**
CFR	**Code of Federal Regulations**
Contract	**Contract CS 2723**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
HDHP	**High Deductible Health Plan**
HMO	**Health Maintenance Organization**
MLR	**Medical Loss Ratio**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PCORI	**Patient Centered Outcomes Research Institute**
Plan	**AultCare Health Plan**
QHI	**Quality Health Improvement**
SSSG	**Similarly-Sized Subscriber Group**
U.S.C.	**United States Code**

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I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at AultCare Health Plan (Plan). The audit was conducted pursuant to the provisions of Contract CS 2723 (Contract); 5 United States Code (U.S.C.) Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract years 2014 through 2016, and was conducted at the Plan's offices in Canton, Ohio.

The FEHBP was established by the Federal Employees Health Benefits Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents, and is administered by the U.S. Office of Personnel Management's (OPM) Healthcare and Insurance Office. The provisions of the Federal Employees Health Benefits Act are implemented by OPM through regulations codified in 5 CFR Chapter 1, Part 890. Health insurance coverage is provided through contracts with health insurance carriers who provide service benefits, indemnity benefits, or comprehensive medical services.

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio (MLR) requirement to replace the similarly-sized subscriber group (SSSG) comparison requirement for most community-rated FEHBP carriers (77 Federal Register 19522). The MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements.

The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing of the health plan. However, the FEHBP MLR is not as transparent as intended and does not provide an assessment of the fairness of the premium paid for benefits received. As this continues to be a significant Program concern for us, we are addressing this issue with OPM through other channels.

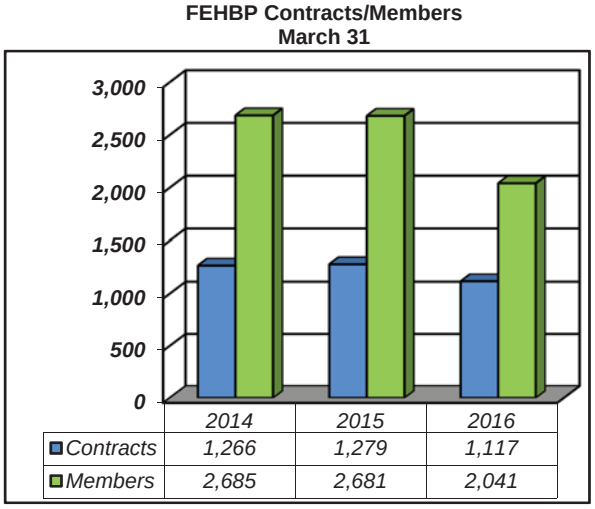
The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. However, beginning in 2013, the MLR methodology was required for all community-rated carriers, except those that are state-mandated to use traditional community rating. State-mandated traditional community-rated carriers continue to be subject to the SSSG comparison rating methodology.

Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-

specific MLR calculation required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due.

Community-rated carriers participating in the FEHBP are subject to various Federal, state and local laws, regulations, and ordinances. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The number of FEHBP contracts and members reported by the Plan as of March 31 for each contract year audited is shown in the chart to the right.



	2014	2015	2016
Contracts	1,266	1,279	1,117
Members	2,685	2,681	2,041

The Plan has participated in the FEHBP since 1996 and provides health benefits to FEHBP members in the Stark, Carroll, Holmes, Tuscarawas, and Wayne counties, as well as the Canton metropolitan area in Ohio.

There were no previous MLR audits of the Plan. However, a prior SSSG audit of the Plan covered contract years 2010 through 2012. The audit did not identify any findings or questioned costs, and no corrective action was necessary.

The preliminary results of this audit were discussed with Plan officials at an exit conference and in subsequent correspondence. A draft report was also provided to the Plan for review and comment. The Plan's comments were considered in preparation of this report and are included, as appropriate, as an Appendix to the report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary objective of this performance audit was to determine whether the Plan complied with the provisions of its Contract and the laws and regulations governing the FEHBP. Specifically, we verified whether the Plan met the MLR requirements and thresholds established by OPM and paid the correct amount to the Subsidization Penalty Account, if applicable.

Our audits of the MLR submission filed with OPM are completed in accordance with the criteria expressed in OPM's rating instructions. The MLR audit evaluation includes an assessment of key components of the MLR calculation, including allowable claims, capitations, health care expenses, and quality health improvements (numerator), and the premium received, excluding applicable tax expenses (denominator). The result of the MLR calculation must meet OPM's prescribed thresholds. If the calculation falls below the threshold, the health plan must pay a penalty determined by the variance between the actual MLR ratio and the established threshold.

Although the FEHBP premiums used in the MLR calculation are ultimately determined by the premium rates proposed by the Plan and certified and paid by OPM, the OPM rating instructions no longer provide sufficient criteria to evaluate the fairness of those rates against the standard market value of similarly-sized groups. Furthermore, per the OPM rating instructions, health plans can utilize OPM's total reported premium as the denominator in the MLR calculation, which when utilized is not subject to audit. Since the majority of health plans choose this option, the premiums utilized in the MLR calculation are frequently not available for audit, and the fairness of the FEHBP premium rates cannot be evaluated. As this continues to be a significant Program concern for us, we are addressing this issue with OPM through other channels.

SCOPE

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

This performance audit covered contract years 2014 through 2016. For these years, the FEHBP paid approximately $[redacted] in premiums to the Plan.

[redacted]

The Office of the Inspector General's (OIG) audits of community-rated carriers are designed to test carrier compliance with the FEHBP contract, applicable laws and regulations, and the rate instructions. These audits are also designed to provide reasonable assurance of detecting errors, irregularities, and illegal acts.

We obtained an understanding of the Plan's internal control structure, but we did not use this information to determine the nature, timing, and extent of our audit procedures. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- the FEHBP MLR calculations were accurate, complete, and valid;
- claims were processed accurately;
- appropriate allocation methods were used; and
- any other costs associated with its MLR calculations were appropriate.

In conducting the audit, we relied to varying degrees on computer-generated billing, enrollment, and claims data provided by the Plan. We did not verify the reliability of the data generated by the various information systems involved. However, nothing came to our attention during our audit utilizing the computer-generated data to cause us to doubt its reliability. We believe that the available data was sufficient to achieve our audit objectives. Except as noted above, the audit was conducted in accordance with generally accepted government auditing standards, issued by the Comptroller General of the United States.

We conducted our audit fieldwork from January 14, 2019, through May 30, 2019, at the Plan's offices in Canton, Ohio, as well as in our offices in Cranberry Township, Pennsylvania, and Washington, D.C.

METHODOLOGY

We examined the Plan's MLR calculations and related documents as a basis for validating the MLR. Further, we examined medical claim payments, quality health improvement (QHI)

expenses, taxes and regulatory fees, premium income, and any other applicable costs to verify that the cost data used to develop the MLR was accurate, complete, and valid. Finally, we used the Contract, the OPM rate instructions, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and applicable Federal regulations to determine the propriety of the Plan's MLR calculations.

To gain an understanding of the internal controls over the Plan's MLR process and claims processing system, we reviewed the Plan's MLR and claims policies and procedures and interviewed appropriate Plan officials regarding the controls in place to ensure that MLR calculations and claims pricing were completed accurately and appropriately. Other auditing procedures were performed as necessary to meet our audit objectives.

The tests performed on the medical claims, along with the methodology, are detailed in Exhibit C at the end of this report. Due to current contract limitations, our review of the Pharmacy claims was limited to the Plan's policies and procedures and did not include an evaluation of the contract pricing of pharmacy claims or benefits received.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. INTERNAL CONTROLS REVIEW

1. Capitation Arrangement

AultCare Health Plan (Plan) did not have strong internal controls and lacked written policies and procedures over its capitation rate-setting methodology.

Section 5.64(c)(2)(ii)(A) of the Contract CS 2723 (Contract) states that the Contractor's internal control system will at a minimum provide for "Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the ... internal control system." The Contract further states at Section 5.64(c)(2)(ii)(C)(1), (2) and (3) that the Contractor's internal control system should provide "Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with … the special requirements of Government contracting … ."

The Plan and [redacted] are both under the same parent entity, Aultman Health Foundation. During our audit, we determined that the Plan paid [redacted] a flat per member per month capitation expense to provide coverage to its Federal Employee Health Benefits Program (FEHBP) enrollees at certain [redacted] facilities. [redacted] It was also noteworthy that the Plan's audited financial statements state this [redacted].

The lack of strong internal controls related to the capitation arrangement may present an opportunity for the Plan to circumvent the intent of the MLR.

The Plan was unable to provide sufficient evidence to demonstrate that its capitation expenses were based on a well-defined rate setting method and that the rates were established as though the two entities were not related parties. The Plan provided conflicting information on the use of actuarial analysis in its rate-setting process. Furthermore, the support provided during the audit did not demonstrate that [redacted] Additionally, in contract years 2014 and 2016, the Plan did not establish [redacted]. Lastly, the Plan paid capitated rates for members with other primary coverage, even though it processes and pays secondary claims on a fee-for-service basis. In other words, the Plan pays the secondary claims to

the hospital in addition to the monthly capitation rate for those members. As such, no benefits were received for those members for the Plan's capitation payment.

The lack of strong internal controls related to the capitation arrangement presents an opportunity for the Plan to circumvent the intent of the Medical Loss Ratio (MLR) by [redacted]. In addition, the Plan may be over-paying its capitation expenses by including members who have the Plan as a secondary insurance.

Plan Response:

The Plan agreed with the capitation arrangement finding.

2. General Ledger and Allocation Errors

The Plan used an inconsistent approach to record its FEHBP-related expenses in its general ledger accounts and did not calculate certain expenses using the appropriate FEHBP-related accounts. In addition, the Plan did not have written policies and procedures over allocating its general ledger expenses to the FEHBP MLR.

The Plan did not accurately allocate and report some FEHBP expenses in its MLR calculation for contract years 2014 through 2016.

Per 45 Code of Federal Regulations (CFR) 158.170(b), issuers are required to use methods to allocate costs based on generally accepted accounting methods that generate the most accurate results. In addition, section 5.64(c)(2)(ii)(A) of the Plan's contract with OPM states that the Contractor's internal control system will at a minimum provide for "Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the … internal control system." The Contract further states at Section 5.64(c)(2)(ii)(C)(1), (2H) and (3) that the Contractor's internal control system should provide "Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with … the special requirements of Government contracting … ."

The Plan offered a Health Maintenance Organization (HMO) and a High Deductible Health Plan (HDHP) option for FEHBP members. The Plan reported its FEHBP HMO plan expenses in its HMO general ledger and its FEHBP HDHP plan expenses in its AultCare Insurance Company (AIC) general ledger accounts. [redacted] This method

of selectively recording expenses for the FEHBP HDHP product between two different general ledger segments did not result in allocations that yielded the most accurate results as required by 45 CFR 158.170(b) and was not a generally accepted accounting method. As a result, the Plan did not accurately allocate and report these FEHBP expenses within the MLR calculation for contract years 2014 through 2016. While we determined the overall effect of the errors was immaterial to the FEHBP MLR calculations, the Plan's internal control weaknesses may have a larger impact on future years, if not addressed. The details for each affected MLR component are below.

a. Regulatory Filing Fees

The Plan allocated its regulatory filing fees to the FEHBP MLR by calculating a premium ratio based on the FEHBP HMO general ledger premium over the general ledger premiums for all market segments. The ratio was then applied to both the HMO and AIC Regulatory Filing Fee general ledger account totals, even though the Plan accounted for its regulatory filing fee expenses and the premiums for the FEHBP HMO and FEHBP HDHP plans within the HMO general ledger account. Allocating regulatory fees from an account that does not contain FEHBP plan expenses is not based on an accounting method that yields the most accurate results in accordance with 45 CFR 158.170(b). Consequently, we concluded that this methodology resulted in allocating improper costs to the FEHBP.

b. Medical Incentives

Similar to the regulatory filing fees, the Plan allocated its 2014 paid FEHBP medical incentives by calculating a premium ratio based on the FEHBP HMO general ledger premium over the total HMO group general ledger premium. This ratio was applied to the HMO and AIC medical incentives general ledger expenses to arrive at the FEHBP medical incentives expense recorded on the MLR submission. [redacted]
Consequently, we concluded that this methodology resulted in allocating improper costs to the FEHBP MLR.

Furthermore, the Plan erroneously used the 2013 medical incentives general ledger expense rather than the 2014 medical incentives general ledger expense to allocate the expense to the 2014 FEHBP MLR; and, erroneously excluded an adjustment in its calculation of the 2015 medical incentives expense recorded on the FEHBP MLR. As a result, we determined that the Plan did not allocate costs based on a generally

accepted accounting method that generated the most accurate results, in accordance with 45 CFR 158.170(b).

c. Pharmacy Rebates

The Plan used the HMO pharmacy rebates expense, as recorded in its general ledger, to populate the MLR submission. However, a small percentage of the HMO general ledger expense used in the Plan's MLR submission was not attributable to the FEHBP. In addition, the Plan did not include any pharmacy rebates applicable to the FEHBP HDHP plan because the Plan felt the HMO expense adequately represented the portion of rebates related to the FEHBP. The Plan's practice of allocating the entire HMO general ledger pharmacy rebate to the FEHBP and omitting a pharmacy rebate for the portion of the FEHBP that is recorded in the AIC group is not based on an accounting method that yields the most accurate results in accordance with 45 CFR 158.170(b).

Plan Response:

The Plan agreed that it should ensure its accounting processes allocate expenses appropriately for purposes of the MLR. It also agreed to document and improve its policies, procedures, and internal controls to ensure its allocation methodologies used to calculate the FEHBP MLR are consistently applied and yield accurate results. It will devote resources to ensure that the internal controls are effective and maintain oversight over the MLR.

3. Claims Data Submission Non-Compliance

The Plan did not comply with Attachment 1 of OPM FEHBP Carrier Letters 2015-11, 2016-10, and 2017-06. The Carrier Letters specifically require that the Plan submit the copayment amount due from the member for each FEHBP claim line submitted as a field in its data. However, in each contract year reviewed, 2014 through 2016, the Plan input zero dollars as the copayments for each claim. Based on additional claim support reviewed during the audit, copayments were applied, where appropriate, to medical claims in each of the scope years. As a result, the Plan's data submissions were inaccurate and did not comply with the OPM FEHBP Carrier Letter instructions.

Plan Response:

The Plan did not respond to this audit finding.

OIG Comment:

This finding was identified as a result of our review of documentation in the Plan's response to other findings in the draft audit report.

4. Healthcare Receivables

The Plan erroneously included healthcare receivables in its 2014 through 2016 FEHBP MLR submissions. Section 5.64(c)(2)(ii)(A) of the Contract states that the Contractor's internal control system will at a minimum provide for "Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the ... internal control system." The contract further states at Section 5.64(c)(2)(ii)(C)(1), (2) and (3) that the Contractor's internal control system should provide "Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with … the special requirements of Government contracting … ."

The Plan did not have documented policies and procedures for recording its healthcare receivables on its MLR form, which resulted in the Plan recording healthcare receivables that were not applicable to the FEHBP. Specifically, the Plan's lack of policies and procedures resulted in the allocation of pharmacy rebate receivables as healthcare receivables in the 2014 through 2016 MLR forms. However, those receivables were already included in the Plan's pharmacy rebates, which were deducted from the Plan's claims to derive the claims expense reported in Line 2.1b of the MLR Form. Consequently, we determined that the healthcare receivables understated the Plan's MLR for 2014 through 2016. While we determined the overall effect of the error was immaterial to the FEHBP MLR calculations in 2014 through 2016, the error may have a larger impact on future years if the Plan does not strengthen its internal controls.

Plan Response:

"AultCare [agreed] to improve its policies and procedures and internal controls to ensure that allocation methodologies used for calculation of the FEHBP MLR are consistently applied and yield accurate results."

5. PCORI Fee

The Plan incorrectly allocated its Patient Centered Outcomes Research Institute (PCORI) fees in contract years 2014 through 2016.

Per the Affordable Care Act provision 6301, the PCORI fee is imposed on applicable issuers and is based on the average number of lives covered under the policy or plan. As

stated in 26 CFR 46.4375-1(c), the fee is calculated as the product average of covered lives for the calendar year and the applicable annual rate. The allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results per 45 CFR 158.170(b).

The Plan [redacted], which did not yield the most accurate results, as required by 45 CFR 158.170(b). The Plan calculated the premium ratio using the FEHBP premium divided by the premium for all market segments.

We recalculated the PCORI fee utilizing the methodology set forth in 26 CFR 46.4375-1(c)(2)(v)(A), with the effective rate for each year defined by the Internal Revenue Service guidelines. Our calculations resulted in an immaterial variance from what the Plan recorded on its FEHBP MLR forms for 2014 through 2016. While we determined the overall effect of the error was immaterial to the FEHBP MLR calculations in 2014 through 2016, the Plan's non-compliance with 45 CFR 158.170(b) may have a larger impact on the FEHBP MLR in future years, if not corrected.

Plan Response:

"AultCare [agreed] to improve its policies and procedures and internal controls to ensure that allocation methodologies used for calculation of the FEHBP MLR are consistently applied and yield the most accurate results."

6. Lack of Internal Controls over Other MLR Components

In addition to the errors noted above, the Plan lacked written policies and procedures to govern its overall MLR processes, which resulted in discrepancies in the MLR percentages that were filed with OPM. Although we determined these discrepancies to be immaterial, the weaknesses in the internal controls, if not addressed by the Plan, could result in significant MLR penalties in future years. Furthermore, the Plan was unable to provide all of the necessary supporting documentation during the audit, which violated the record retention requirements of its Contract.

A lack of internal controls over the MLR processes resulted in discrepancies in the filed MLRs with OPM. The Plan also did not comply with the Contract's record retention requirements.

Section 5.64(c)(2)(ii)(A) of the Contract states that the Contractor's internal control system will at a minimum provide for "Assignment of responsibility at a sufficiently high

level and adequate resources to ensure effectiveness of the ... internal control system." The contract further states at Section 5.64(c)(2)(ii)(C)(1), (2) and (3) that the Contractor's internal control system should provide "Periodic reviews of company business practices, procedures, policies, and internal controls for compliance with … the special requirements of Government contracting … ."

Additionally, Contract Section 1.11(b) requires insurance carriers to maintain all records relating to the contract and to make these records available for a period of time specified by the FEHBAR 1652.204-70. The referenced clause is incorporated into the Contract at Section 3.4, which requires the carrier to maintain "all records applicable to a contract term ... for a period of six years after the end of the contract term to which the claim records relate."

The Plan erroneously included a claim from [redacted] in its MLR claims data. This claim should have been suppressed within the Plan's capitation reconciliation process. However, the Plan does not have formal documented policies for the capitation reconciliation process to include the manual suppression of payments to its capitated provider. If claims with the capitated provider are included in the Plan's MLR claims data, the total incurred claims recorded on Line 2.1b of the MLR will be overstated, causing an increased MLR percentage. As a result, the Plan is not in compliance with Section 5.64(c)(2)(ii)(A) and (C) of its contract.

Additionally, the Plan did not maintain sufficient documentation to support its quality health improvement (QHI) expenses reported on the MLR form for contract years 2014 and 2016. The support that it was able to provide caused a variance in the filed QHI expenses. We reviewed the Plan's methodology for calculating and allocating its QHI expense and determined it to be adequate. We recalculated the QHI expense and determined that the variance between the support provided and what was recorded in the MLR had an immaterial impact to the overall MLR calculation. Consequently, we accepted the Plan's calculations for MLR purposes. However, the Plan did not have policies and procedures to document the methodology nor did it maintain appropriate supporting documentation as required by 1.11(b) and 3.4 of its Contract.

Moreover, the Plan did not maintain historic versions of its claims training manual, which housed important claims processing information, such as gastroenterology provider rates. It was able to provide internal communications from the timeframe to support the pricing of the gastroenterology claims in question. However, the Plan did not maintain appropriate supporting documentation as required by 1.11(b) and 3.4 of its Contract.

Finally, the Plan erroneously allocated its PCORI fee for contract year 2015 using the premium ratio from 2014. Although, as discussed in A.5 above, the Plan's methodology of allocating the fee based on a premium ratio was not in accordance with Federal regulations, it should also be noted that the Plan did not have documented policies and procedures to ensure the fee was calculated in accordance with its own methodology.

Due to the lack of written policies and procedures over the MLR processes and not maintaining supporting documentation, we determined the Plan did not have sufficient oversight over its MLR calculation during our audit scope.

Plan Response:

"AultCare [agreed] to improve its policies and procedures and internal controls to ensure that allocation methodologies used for calculation of the FEHBP MLR are consistently applied and yield accurate results."

Recommendation 1

We recommend that the Plan strengthen its internal controls over its capitation rate-setting process and create formal policies and procedures that document the methodology used to set the capitation rates. The policies and procedures should clearly define how the rates are determined and define the criteria in which the rates can be adjusted.

Recommendation 2

We recommend that the Plan not pay capitation rates for members who have other primary hospital insurance coverage.

Recommendation 3

We recommend that the Plan adopt a consistent methodology for recording its FEHBP plan expenses within its general ledger system. The Plan should record all FEHBP AIC expenses within the AIC market group general ledger to ensure accurate allocation and expense reporting, per 45 CFR 158.

Recommendation 4

We recommend that the Plan ensure it includes accurate copayment data in its claims data submission to OPM, in accordance with the OPM FEHBP Carrier Letters.

Recommendation 5

We recommend that the Plan develop and maintain detailed policies and procedures over the allocation of expenses to the MLR and ensure those allocation methodologies used in the calculation of the FEHBP MLR are consistently applied and yield the most accurate results.

Recommendation 6

We recommend that the Plan develop written, standardized policies and procedures over its MLR calculation and reporting process.

Recommendation 7

We recommend that the Plan comply with the record retention requirements of its contract.

B. MEDICAL LOSS RATIO REVIEW

The Certificates of Accurate MLR that the Plan signed for contract years 2014 through 2016 were defective. The Certificate of Accurate MLR states that the FEHBP-specific MLR is accurate, complete, and consistent with the methodology in Sec. 1615.402(c)(3)(ii). In accordance with Federal regulations and the OPM Community Rating Guidelines, our audit identified the following issues:

1. Overstated MLR Credit $[redacted]

During the 2014 MLR filing period, the Plan calculated an MLR ratio of 103.13 percent, which exceeded OPM's upper threshold of 89 percent and resulted in a credit to the Plan of $[redacted]. However, during our review of the FEHBP MLR filing, we identified issues that resulted in a lower audited MLR than what was filed by the Plan. We determined that the Plan overstated its credit by $[redacted]. Discussion of the specific issues that led to the overstated credit, listed in Table I below, begin in section B.3 on page 15.

Table I – Overstated MLR Credit

Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Credit	Audited Credit	Overstated Credit
[redacted][1]	[redacted]%	[redacted]%	$[redacted]	$[redacted]	$[redacted]

[1] Per the FEHBP rate instructions, the adjusted FEHBP MLR should be used to calculate a plan penalty and the unadjusted FEHBP MLR should be used to calculate a plan credit.

2. No Additional Credit or Penalty Due $0

During the 2015 MLR filing period, the Plan calculated an MLR ratio of 84.52 percent, which was below OPM's lower threshold of 85 percent, resulting in a penalty of $95,113 (see Table II, below). In 2016, it calculated an MLR ratio of 93.82 percent, which exceeded OPM's upper threshold of 89 percent, resulting in a credit of $641,089 (see Table II, below). However, our review of the Plan's MLR submissions disclosed issues within the MLR calculation, as discussed beginning in section A.1 on page 6. These issues, while reportable, were not significant enough to result in an additional penalty due to OPM or an additional credit due the Plan, listed in Table II.

Table II – No Additional Penalty or Credit Due

Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current (Penalty)/Credit	Audited (Penalty)/Credit	Additional (Penalty)/Credit Due
[redacted][2]	[redacted]%	[redacted]%	($[redacted])	($[redacted])	$[redacted]
[redacted][2]	[redacted]%	[redacted]%	$[redacted]	$[redacted]	$[redacted]

3. Inaccurate MLR Claims Data

The Plan included incorrect medical and capitation claims expenses in its 2014 MLR submission.

45 CFR 158.140 requires the Plan to "include direct claims paid to or received by providers, including under capitation contracts with physicians, whose services are covered by the policy" in its MLR form.

The Plan was unable to support its medical claims expenses and capitation payments submitted on the 2014 MLR form.

The Plan was unable to support its medical and capitation claims expenses submitted on the 2014 MLR form. It provided a breakout of its claims data at the time of the MLR submission that did not match the amount on the 2014 MLR form. In addition, the Plan provided its general ledger documentation for the 2014 capitation payments; however, the data did not match the amount on the 2014 MLR form. The Plan was unable to explain the variances. As a result, we used the Plan's supported MLR medical claims expense of $[redacted] and its general ledger capitation expense of $[redacted].

[2] Per the FEHBP rate instructions, the adjusted FEHBP MLR should be used to calculate a plan penalty and the unadjusted FEHBP MLR should be used to calculate a plan credit.

Plan Response:

The Plan did not respond to the inaccurate claims data finding, which led to the overstated MLR credit in 2014.

Conclusion

We recalculated the Plan's 2014 FEHBP MLR, incorporating the previously mentioned adjustments. A comparison of our audited MLR calculations to those submitted by the Plan showed an overstated FEHBP MLR credit amount of $[redacted] in contract year 2014. This reduces the credit owed to the Plan for contract year 2014 to a total of $[redacted].

Recommendation 8

We recommend that the contracting officer reduce the MLR credit in contract year 2014 to $[redacted].

Recommendation 9

We recommend that the Plan ensure that the data used in the creation of the FEHBP MLR submission to OPM is accurate, complete, and consistent with the methodology stated in 5 CFR Sec. 1615.402(c)(3)(ii) and can be produced upon request during future audits.

Recommendation 10

We recommend that the Plan institute a more stringent FEHBP MLR review process to identify reporting errors prior to submitting the FEHBP MLR to OPM.

EXHIBIT A

AultCare Health Plan – Plan Code 3A
Summary of MLR Credit Adjustment

Contract Year 2014 – Overstated Credit

Plan's Filed 2014 Credit Calculation	$[redacted]
Audited 2014 Credit Calculation	$[redacted]
Overstated Credit	$[redacted]

EXHIBIT B

AultCare Health Plan
2014 Medical Loss Ratio Calculation

	Plan	Audited
2014 FEHBP MLR Lower Threshold (a)	85%	85%
2014 FEHBP MLR Upper Threshold (b)	89%	89%
Claims Expense		
Medical & Pharmacy Incurred Claims	$	$
Less: Pharmacy Rebates	$	$
Plus: Capitation Claims	$	$
Plus: Paid Medical Incentive Pools and Bonuses	$	$
Less: Healthcare Receivables	$	$
Adjusted Incurred Claims	**$**	**$**
Plus: Quality Health Improvement Expenses	$	$
Total MLR Numerator	**$**	**$**
Premium Income	$	$
Less: PCORI Fee	$	$
Less: Regulatory Authority Filing Fees	$	$
Total MLR Denominator (c)	**$**	**$**
FEHBP Unadjusted Medical Loss Ratio (d)	%	%
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	$	$
Credit Adjustment Due to OPM		**$**

EXHIBIT C

Medical Claims Sample Selection Criteria and Methodology

Medical Claims Sample

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Medical claims incurred from 1/1/2014 through 12/31/2014	[redacted] claims	$[redacted]	Utilized RAT-STATS (90% Confidence Level 50% Anticipated Rate of Occurrence and 20% Desired Precision Range), which generated a sample size of [redacted]. Then utilized SAS to randomly select [redacted] incurred, unadjusted medical claims	Statistical	No

APPENDIX

August 2, 2019

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Community-Rated Audit Group
Office of Inspector General
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Re: Response of AultCare Health Plan ("AultCare") to the Draft Report of the Audit of the Federal Employees Health Benefits Program ("FEHBP") Operations at AultCare (Report No. 1C-3A-00-18-052)

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A. Introduction

This letter is the response of AultCare to the above-referenced Draft Report related to the audit by the U.S. Office of Personnel Management ("OPM") of the FEHBP medical loss ratio ("MLR") submission by AultCare for contract years 2014 to 2016 ("the Audit").

B. Overview of Response

AultCare appreciates the opportunity to provide further clarification of its position regarding the proposed findings and recommendations in the Draft Report.

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D. Responses to Specific Findings, Recommendations, and Penalties in the Draft Report

AultCare hereby submits the following responses to the specific findings, recommendations, and penalties contained in the Draft Report.

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4. **Deleted by the OIG – Not Relevant to the Final Report**

AultCare agrees to improve its policies and procedures and internal controls to ensure that allocation methodologies used for calculation of the FEHBP MLR are consistently applied and yield accurate results. (Draft Report, Audit Findings (A)(4-7) and Recommendations 1, 2, 3, 9, 10, 11, 12, and 13).

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b. Medical Incentives

The Plan will not dispute the finding on audit year 2014.

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AultCare does not object to OPM's recommendations that AultCare should make sure its accounting processes allocate expenses appropriately for purposes of MLR. In this regard, AultCare has taken steps to improve its policies and procedures and internal controls to ensure that MLR is reported in accordance with OPM's expectations. AultCare will also devote sufficiently high-level and adequate resources to ensure that internal controls are effective, and maintain proper oversight over MLR in accordance with OPM recommendations. AultCare will also develop written, standardized policies and procedures over its MLR calculation and reporting process, as OPM has recommended, and in fact has begun to do so.

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G. Conclusion

We appreciate the opportunity to provide our response to the Draft Report. In accordance with our conference call last week with the Audit team, we also appreciate the opportunity to continue to have dialogue with OPM, and to provide additional information as requested, in an effort to resolve areas of disagreement as reflected in this response.

This response of AultCare to the Draft Report is supported by the documents, records, data, and justifications provided by AultCare to OPM during the Audit, and the communications between AultCare and OPM related to the Audit, and such documents, records, data, justifications, and communications, all of which are in OPM's possession, are incorporated herein by reference.

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On behalf of AultCare Health Plan:

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Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100

Report No. 1C-3A-00-18-052