



**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 HEALTH PLAN OF NEVADA**

Report Number 1C- NM-00-18-047

November 14, 2019

EXECUTIVE SUMMARY

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

Report No. 1C-NM-00-18-047

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Why Did We Conduct The Audit?

The primary objective of the audit was to determine if Health Plan of Nevada (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 1942, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2014 and 2015. We conducted our audit fieldwork from January 14, 2019, through June 27, 2019, at the Plan's offices in Las Vegas, Nevada, and in our OIG offices.



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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. This resulted in a reduction to the Plan's MLR credit in contract year 2014. Although we found issues in contract year 2015 as well, those adjustments did not have a monetary impact. Specifically, our audit identified the following:

- The Plan does not have sufficient internal controls over the FEHBP MLR process.
- The Plan submitted 2014 and 2015 claims data to the OPM OIG that did not support the incurred claims used in the Plan's FEHBP MLR filings. The 2014 claims data also included non-FEHBP claims.
- The Plan made improper medical claims payments for genetic testing claims, as well as claim payments for Medicare-aged members that should have been covered by Medicare.
- The Plan erroneously adjusted its premium income on the 2014 FEHBP MLR filing.
- The Plan did not adequately support the rates used to price claims in 2014.
- The Plan inappropriately included retroactive adjustments for prior year capitation payments in the 2014 and 2015 incurred claims reported on the FEHBP MLR filings.

ABBREVIATIONS

CFR	Code of Federal Regulations
CL	Carrier Letter
Contract	Contract CS 1942
FEHBP	Federal Employees Health Benefits Program
FFS	Fee-for-Service
MLR	Medical Loss Ratio
OIG	Office of Inspector General
OPM	U.S. Office of Personnel Management
PCP	Primary Care Provider
Plan	Health Plan of Nevada
QHI	Quality Health Improvement
SSSG	Similarly-Sized Subscriber Group
U.S.C.	United States Code

TABLE OF CONTENTS

	<u>Page</u>
EXECUTIVE SUMMARY	i
ABBREVIATIONS	ii
I. BACKGROUND	1
II. OBJECTIVES, SCOPE, AND METHODOLOGY	3
III. AUDIT FINDINGS AND RECOMMENDATIONS	6
A. Medical Loss Ratio Review	6
1. Overstated MLR Credit	6
2. No Penalty or Credit Due.....	6
3. MLR Claims Data	7
a. Inaccurate Claims Data.....	7
b. Claims Pricing Review.	9
i. Improper Payment and Untimely Authorization of Genetic Testing Claims	10
1. Lack of Prior Authorization and Verification of Medical Necessity	10
2. Lack of Verification of Medical Necessity	11
3. Untimely Authorization	11
ii. Benefits Not Properly Coordinated with Medicare	13
1. Improper Payment of Claims for Medicare Advantage Member ..	14
2. Inadequate Support for Claims Coordination and Payment	15
4. Quality Health Improvements.....	16
5. Premium Review.....	16

6. Federal and State Taxes and Licensing or Regulatory Fees	17
B. Procedural Findings	18
1. Insufficient Support for Claims Pricing	18
2. Retroactive Capitation Adjustments	20
C. Internal Controls Review	21
1. Inaccurate MLR Reporting	22
a. Claims	22
b. Premium	22
2. Procedural Issues	22
a. Insufficient Support for Claims Pricing	22
b. Retroactive Capitation Adjustments	22
3. Claims Paid for Capitated Services	23
4. QHI Policies and Procedures	23

Exhibit A (Summary of Penalty and Credit Adjustments)

Exhibit B (2014 Medical Loss Ratio Calculation)

Exhibit C (2015 Medical Loss Ratio Calculation)

Exhibit D (Claims and Capitation Sample Selection Criteria/Methodology)

APPENDIX (Plan’s Response to the Draft, dated August 15, 2019)

REPORT FRAUD, WASTE, AND MISMANAGEMENT

I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Health Plan of Nevada (Plan). The audit was conducted pursuant to the provisions of Contract CS 1942 (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 and 2015, and was conducted at the Plan's office in Las Vegas, Nevada.

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 FR 19522). The MLR is the proportion of FEHBP premiums collected by a carrier in a calendar year that is spent on health care service costs 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.

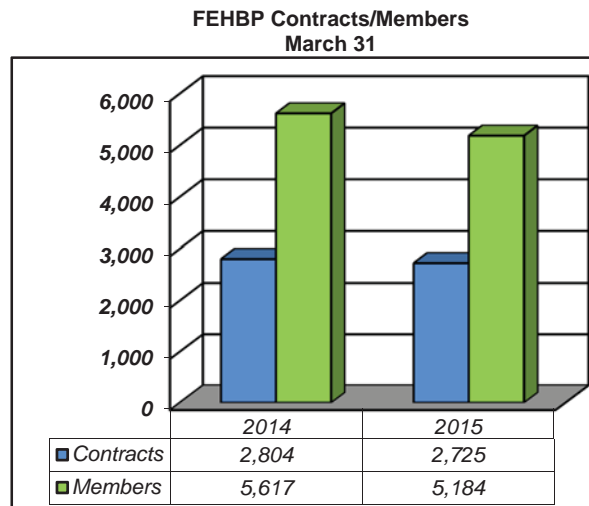
Community-rated carriers participating in the FEHBP are subject to various Federal, state and local laws, regulations, and ordinances. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

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.

The Plan has participated in the FEHBP since 1984 and provides health benefits to FEHBP members in the Clark, Esmeralda, and Nye Counties of Nevada.

A prior audit of the Plan covered contract year 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.

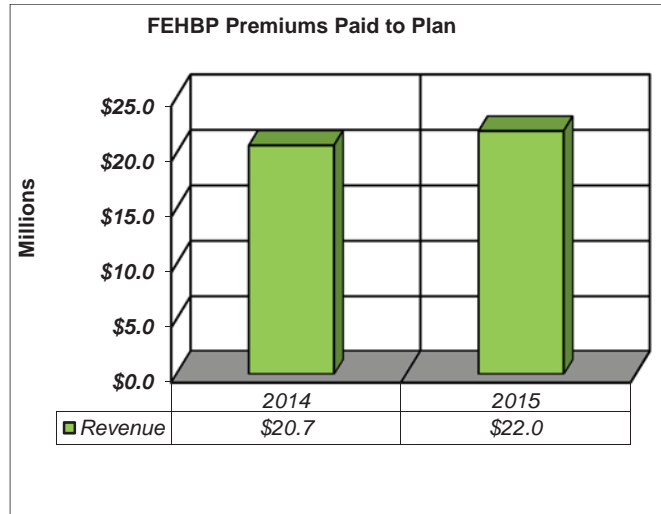
SCOPE

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 and 2015. For these years, the FEHBP paid approximately \$42.7 million in premiums to the Plan.

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;
- medical 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 June 27, 2019, at the Plan's offices in Las Vegas, Nevada, 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 expenses, taxes and regulatory fees, and any other applicable costs to verify that the cost data used to develop the

MLR was accurate, complete, and valid. We also examined the methodology used by the Plan in determining the premium in the MLR calculations. Finally, we used the Contract, the OPM rate instructions, 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 for medical claims and capitations, along with the methodology, are detailed in Exhibit D 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. MEDICAL LOSS RATIO REVIEW

The Certificates of Accurate Medical Loss Ratio (MLR) that the Plan signed for contract years 2014 and 2015 were defective. The Certificate of Accurate MLR states that the Federal Employees Health Benefits Program (FEHBP)-specific MLR is accurate, complete, and consistent with the methodology in 48 CFR 1615.402(c)(3)(ii). In accordance with Federal regulations and the Office of Personnel Management (OPM) Community Rating Guidelines, our audit identified the following issues:

1. Overstated MLR Credit \$31,696

During the 2014 MLR filing period, the Plan calculated an MLR ratio of 89.16 percent, which exceeded OPM's upper threshold of 89 percent and resulted in a credit due to the Plan of \$31,696. However, during our review of the FEHBP MLR filing, we identified issues that resulted in an audited MLR of 88.09 percent, resulting in the removal of the 2014 credit. The specific issues and resulting variances that led to the removal of the credit illustrated in Table I will be discussed throughout the report.

Table I - Overstated MLR Credit					
Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Penalty/Credit	Audited Credit	Overstated Credit
2014	89.16%	88.09%	\$31,696	\$0	\$31,696

2. No Penalty or Credit Due \$0

During the 2015 MLR filing period, the Plan calculated an MLR ratio that met the OPM prescribed lower threshold of 85 percent, but did not exceed the upper threshold of 89 percent. However, our review of the Plan's MLR filing disclosed issues within the MLR calculation. These adjustments, while reportable, were not significant enough to result in a penalty due to OPM or a credit due the Plan, as illustrated in Table II.

Table II - No Monetary Adjustment					
Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Penalty/Credit	Audited Penalty/Credit	Additional Amount Due
2015	86.80%	86.39%	\$0	\$0	\$0

Plan Response:

The Plan acknowledged an error in their 2014 MLR submission and immaterial errors in their 2015 MLR submission. The Plan stated that when the errors were identified it refiled the submission with the auditors. It added this qualifying statement to all of the finding responses in which the Plan acknowledged the reported errors, and ultimately stated that because the resubmission was provided to the auditors, no further action is required relative to the 2014 and 2015 MLR submissions.

OIG Comment:

We reported findings identified with our review of the original MLR submissions. OPM Carrier Letters (CL) 2013-11 and 2014-16, and our audit notification letter, indicate that submissions should not be refiled for MLR Calculations that are under audit. Therefore, the Plan's resubmission of the MLRs to the auditors acts as audit documentation and does not absolve them from taking actions to resolve the identified 2014 and 2015 audit issues.

3. MLR Claims Data

a. Inaccurate Claims Data

The Plan submitted 2014 and 2015 claims data to the OPM OIG that did not support the incurred claims used in the Plan's FEHBP MLR filings. In addition, the claims data submitted in 2014 included non-FEHBP claims. As a result, the Plan is not in compliance with OPM instructions.

The claims data submitted to OPM OIG and used in the FEHBP MLR did not meet applicable instructions and regulations in contract years 2014 and 2015.

OPM CL 2013-11 and CL 2014-16 direct Plans to submit calendar year 2014 and 2015 claims data that support the MLR. Both CLs also state that only FEHBP claims for covered benefits may be used in the MLR calculation.

The claims data submitted by the Plan to the OPM OIG in 2014 and 2015 did not support the incurred claims used in the FEHBP MLR

calculation. Rather, the Plan used medical and pharmacy claims accounts from its general ledger to report incurred claims on the FEHBP MLR filings. However, the claims captured in these accounts did not tie to the claims data submitted to the OPM OIG, reportedly due to adjustments and retroactive transactions in the general ledger that were not reflected in the statistical claims data due to timing. Moreover, the

general ledger claims also varied from the incurred claims reported on the MLR forms in both years due to the mistaken inclusion of an account with no FEHBP impact. Therefore, we cannot rely on this data to support the incurred claims expense for the numerator of the MLR in either 2014 or 2015.

Because the Plan did not have claims support that tied to its MLR filing, we used the total medical and pharmacy claims that were submitted to the OPM OIG for our recalculation of the 2014 and 2015 MLR. However, we also identified issues with this data. Specifically, the Plan erroneously included claims for an affiliated company in the 2014 data, and it did not include calendar year claims through the end of the applicable run-out periods in both 2014 and 2015. This was due to errors in how the data was pulled, and according to the Plan, it has subsequently updated its process.

These combined issues may also be a result of insufficient internal controls over the FEHBP MLR reporting process to support compliance with OPM instructions. Despite the errors in the claims data submission to the OPM OIG, we used this data for our recalculation of the MLR in both years, after removing the non-FEHBP claims from the 2014 data, in order to comply with the OPM CLs.

Plan Response:

The Plan acknowledged the differences in the financial and statistical data and stated that it plans to implement a process to reconcile the statistical and financial claims data "to illustrate differences which are not statistically significant" even though it asserted that it is in compliance with the OPM CLs. The Plan also acknowledged the erroneous inclusion of the account with no FEHBP impact as well as the issue with the run-out periods. The Plan intends to implement a process going forward that includes account mapping for inclusion of only relevant accounts and will ensure that claims data for the appropriate run-out period is included. However, the Plan disagreed that it had insufficient internal controls over the MLR reporting process, stating that it has implemented "rigorous controls, review processes and procedures" and that it "takes the necessary steps to implement relevant changes and process improvements" prescribed by OPM. The Plan added that it "continually monitors its procedures to self-identify areas that can be strengthened."

OIG Comment:

The Plan's intention to reconcile the financial and statistical data does not demonstrate how it intends to be in compliance with OPM's annual CLs, which specifically state that the claims data submitted to OPM should be used for MLR reporting. Regardless, we cannot verify any process improvements that the Plan intends to implement to address the identified issues. We will evaluate the effectiveness of any updated controls during future audits.

In addition, although the Plan stated that it has controls, review processes, and procedures in place to address OPM's requirements, and claims to monitor and identify improvements, our review did not support this. First, the Plan confirmed during the audit that the only documented MLR reporting procedure is a commercial procedure, which includes a flowchart showing that financial data is used for MLR reporting. As we identified in the finding, the use of financial data that does not tie to the data submitted to the OPM OIG does not comply with OPM requirements. Moreover, if the Plan's review and monitoring processes were effective, the Plan would have caught the inclusion of the erroneous account as well as the claims run-out error prior to reporting. However, these issues were not identified until the auditors began their review. As a result, we will continue to recommend that the Plan develop more internal controls to comply with OPM instructions.

b. Claims Pricing Review

Based on our review of a statistical sample of 75 medical claims for contract year 2014, we identified issues with prior authorization and medical necessity determinations for genetic testing claims and coordination of benefits for Medicare aged members. As a result, we removed \$13,164 in improper medical claims payments from the Plan's total incurred claims reported on the 2014 FEHBP MLR calculation, as illustrated in Table III below.

Finding	Total Claims Questioned	Total Improper Claims Payments
Improper Payment for Genetic Testing Claims	5	\$ 9,223
Benefits Not Properly Coordinated with Medicare	6	\$ 3,941
Total	11	\$ 13,164

i. Improper Payment and Untimely Authorization of Genetic Testing Claims

The Plan did not prior-authorize and/or validate medical necessity for five genetic testing claims, totaling \$9,223 in 2014.

OPM Contract CS 1942 (Contract) Section 2.2 states that the Plan “shall provide the Benefits as described in the agreed upon brochure text found in Appendix A.”

Section 3 of the benefit brochure in Appendix A states that the primary care physician who orders genetic disease testing must obtain prior approval from the Plan. It goes on to specify that the Plan will consider if the service is medically necessary before it grants approval. The requirements for genetic disease testing to be medically necessary and prior-authorized by the Plan are reiterated in Section 5(a).

Genetic testing claims were paid by the Plan without providing prior authorization and/or the validation of medical necessity.

During our initial review, we identified one genetic testing claim, totaling \$5,836, that did not appear to be prior-authorized by the Plan. In addition, the Plan did not support the medical necessity of the claim procedures. Although the Plan did subsequently provide a letter of medical necessity from the referring physician, they also clarified that this letter had been requested during the appeal process for a different claim associated with the member. The Plan provided this letter to demonstrate why the member required genetic disease testing. However, it did not support the type of testing performed under our sampled claim.

Because the Plan could neither support that it prior-authorized the claim nor that it validated medical necessity, we expanded our review to include all claims in 2014 and 2015 with genetic testing procedure codes. We identified an additional six paid claims for genetic testing procedure codes in 2014; no additional paid claims were identified in 2015.

As a result of our expanded review, we identified the following issues:

1. Lack of Prior Authorization and Verification of Medical Necessity

For one claim in the expanded review, as well as the claim from our original review discussed above, the Plan did not prior-authorize or verify medical necessity for procedures ordered by a capitated provider. According to the

Plan, the Plan does not prior-authorize procedures that are referred by capitated providers and automatically considers them medically necessary with no further documentation required or reviewed. The Plan noted that this is an undocumented administrative rule.

Delegating this authority to a provider without any process of verification does not comply with the Contract and associated benefit brochure. Moreover, if the Plan does not validate that providers have done their due diligence to determine medical necessity, providers may abuse their authority and authorize unnecessary or potentially uncovered services simply because they know the Plan will approve them without question. In addition, the member is also at risk not only of unnecessary testing but also potential financial liability if the Plan later denies the claim as a result of a subsequent claims review or audit.

2. Lack of Verification of Medical Necessity

The Plan did not sufficiently support the determination of medical necessity for two claims. For one claim, the provider noted that the requested procedures were for the “diagnosis and treatment of infertility.” This was inconsistent with the diagnosis code used for the genetic testing, which specifically excludes fertility related testing. In addition, medical necessity was not supported for the type of genetic testing that was performed. For another claim, the requesting provider cited advanced maternal age as the rationale for the procedure. However, the member was 34 at the time of the procedure. The minimum advanced maternal age is commonly identified in practice as 35, and the diagnosis code itself is defined as a first time mother over the age of 35. Furthermore, beyond age, the support did not indicate any other associated health concerns that would necessitate genetic testing.

3. Untimely Authorization

The Plan did not appropriately prior-authorize two claims. The authorization for both claims was granted one day after the procedures were performed.

In general, these issues stemmed from insufficient internal controls to validate medical necessity and ensure prior authorization, which is not only a Contract compliance issue but also puts both the Plan and the member at risk. By not properly validating the medical necessity of claims, the Plan did not effectively manage its cost of care, as claims costs were paid for potentially

unnecessary or unallowable procedures. By not properly prior-authorizing the claims, the member was put at risk of being liable for payment if the Plan subsequently denied the procedure after it had already been performed.

In total, we removed \$9,223 in claims paid related to genetic testing from the Plan's total incurred claims used in the 2014 FEHBP MLR calculation, as illustrated in Table III.

Plan Response:

The Plan maintained that the genetic testing claims were paid appropriately and that the documentation provided during the audit supports that the Plan determined medical necessity. Per the Plan's response, it "will allow a provider functioning as a Primary Care Provider (PCP), in this case an Obstetrician, to make clinical decisions about the medical necessity and appropriateness of some services." The Plan also stated that "the responsibility for care of the patient is assigned to the Provider through the capitated arrangement" and because the PCP who ordered the test has the "clinical qualification to determine the necessity of the test ... the Plan deem[ed] the service medically necessary and authorized." While the Plan agreed that genetic disease testing does require both medical necessity and prior authorization in order to be covered, the Plan referred to the letter from the provider indicating medical necessity of the test for this member, specifically citing the patient being "at-risk" of an autosomal recessive genetic disorder. The Plan added that the provider also included applicable criteria for medical necessity standards. The Plan disagreed that it does not do its due diligence and noted that it evaluates providers' behavior and billing patterns, which factors into the providers' "ongoing contract status, reimbursement rate, and participation in various clinical review programs" The Plan also disagreed "that the member would be at risk; the scenario where a provider functioning as a PCP ordering a test would not result in a claim denial that is a member responsibility." Finally, the Plan did not directly address the two other claims for which we identified insufficient support for medical necessity, nor the two claims for which it granted untimely prior authorization, except to say that it provided medical necessity support during the audit and has policies and procedures in place to ensure prior-authorization when it is required.

OIG Comment:

We remain unable to validate that the genetic testing claims should have been paid. As stated in the finding, the letter provided by the Plan did not tie to our sampled claims for the member who had genetic testing ordered by a capitated provider. Nevertheless, the Plan maintained that the letter should suffice as support for testing of autosomal recessive genetic disorders. Although this kind of testing made up most, but not all, of the testing on our sampled claims, the letter requested testing related to a specific autosomal genetic disorder, which results in anemia. Per the National Institutes of Health, inheriting a specific type of genetic disorder is determined based on the type of chromosome or gene that is affected. Therefore, because the letter and the criteria it cited supports the medical necessity for testing related to a specific genetic disorder, it does not support why the provider believed the testing under our sampled claims to be necessary, since the testing under those claims was for other disorders. Therefore, the medical necessity of these two claims remains unsupported, and as such, we cannot verify that the claims should have been paid.

However, the more serious concern is the Plan's insistence that it is appropriate to “deem” procedures as medically necessary and authorized simply because they were ordered by a capitated provider, which has implications not only for the questioned claims but also for any claim with the same requirements ordered by a capitated provider. As stated in the finding, delegating this authority to the provider without any type of independent verification that medical necessity has been established prior to authorizing the claim for payment is a failure to comply with the Contract and benefit brochures, which places the onus of performing these tasks on the Plan, not the providers. Evaluating provider behavior and billing patterns does not verify that the provider is making supportable medical necessity determinations for services. In addition, by stating that there is no situation in which a test ordered by a PCP would result in a claim denial that would be a member responsibility implies that this would not occur because when that PCP orders the test, the Plan considers all claims necessary and pays it without question. This inherent policy can lead to gross overpayments on medical services that were not covered and/or not warranted.

ii. Benefits Not Properly Coordinated with Medicare

The Plan did not properly coordinate the payment of four Medicare claims in 2014. In addition, we did not have adequate support to verify that two additional claims were appropriately coordinated. As a result, we removed \$3,914 from the

Plan's total incurred claims used in the 2014 FEHBP MLR calculation, as illustrated in Table III.

Contract Sections 2.6(a) and (b) require the Plan to coordinate Federal employee health benefit payments with the payment of Medicare benefits. The Contract directs the Plan not to pay contracted benefits "until it has determined whether it is the primary Carrier or unless permitted to do so by the Contracting Officer." Contract Section 2.6(c) directs the Plan to "follow the order of precedence established by the [National Association of Insurance Carriers] Group Coordination of Benefits Model Regulation, Rules for Coordination of Benefits"

The National Association of Insurance Carriers Coordination of Benefits Model Regulation, dated October 2013, states, "The plan that covers a person as an active employee ... is the primary plan. The plan covering that same person as a retired or laid-off employee ... is the secondary plan."

The Center for Medicare and Medicaid Services' Handbook entitled, "Medicare & Other Health Benefits: Your Guide to Who Pays First," states that when a retiree over the age of 65 incurs healthcare costs, Medicare is the primary payor and the retiree health plan is secondary. If the employee is still working, then the group health plan is the primary payor and Medicare is secondary.

Based on our claims review, we identified the following issues with the coordination of benefits:

1. Improper Payment of Claims for Medicare Advantage Member

The Plan paid one claim for a member as the primary payor when it should have paid secondary to Medicare. The member was a retiree who had a Medicare Advantage Plan, which includes both Parts A and B coverage. Therefore, the FEHBP should have paid secondary to the Medicare Advantage Plan.

As a result, we expanded our sample to include all claims incurred by this member in 2014. Based on the claims data, the member only incurred three additional claims for the year, all of which were on the same date as our sampled claim. As such, the improper payments appear to have been an isolated human error.

In total, we removed \$3,941 of claims expense from the total incurred claims used in the 2014 MLR calculation.

2. Inadequate Support for Claims Coordination and Payment

We could not verify that two claims for Medicare-aged members were appropriately coordinated with Medicare.

The Plan paid one skilled nursing facility claim for a member with Medicare Part A coverage, even though Medicare Part A covers this type of care under certain circumstances. The documentation provided by the Plan was not sufficient to verify whether these circumstances were met, which would have necessitated coordination of the claim with Medicare.

In addition, the Plan did not provide the Medicare remittance to support the amount that the Plan paid as the secondary payor for one claim.

We did not remove the value of these claims from the Plan's reported incurred claims because they were ultimately immaterial.

Plan Response:

The Plan acknowledged that the Medicare Advantage plan should have paid primary for one member, which was the result of human error. The Plan disagreed that the other questioned claims were processed incorrectly and believed the documentation was sufficient. The Plan provided additional information to support the claim and noted that "The services outlined in the claims were not eligible for coordination either due to the nature of the service or type of coverage the member might have had, if any, with Medicare." The Plan also noted that it coordinates "benefits with all third parties as is required by the FEHBP contract."

OIG Comment:

We reviewed the additional documentation provided by the Plan, but it was still insufficient to verify whether two claims were appropriately coordinated with Medicare. We are continuing to question these claims.

4. Quality Health Improvements

Our review determined that the Quality Health Improvements (QHI) expenses reported in the Plan's 2014 and 2015 FEHBP MLR filings were allowable per 45 CFR 158.150-151 and reasonably allocated consistent with 45 CFR 158.170. However, we did identify a lack of procedural controls over the Plan's QHI process, which is presented as part of our Internal Controls finding in Section C.

Plan Response:

The Plan did not respond to this section of the report.

5. Premium Review

The Plan erroneously adjusted its premium income on the 2014 FEHBP MLR filing. As a result, it overstated premium income by \$2,053.

45 CFR 158.130(a)(1) requires the Plan to report earned premium on a direct basis for each MLR reporting year. OPM's FEHBP Program CL 2013-11 clarifies that OPM will provide plans with the amount of incurred premium to be used in the MLR calculation from the OPM subscription income reports, unless the Plan elects to use its own premium.

The Plan used OPM's premium income for the audit scope. However, in 2014, the Plan adjusted OPM's premium on the MLR filing for an allocated portion of the commercial business's bad debt expense. OPM's guidance specifically states that it will provide the amount of premium to be used and does not support this type of adjustment. The Plan acknowledged that the adjustment was a mistake and should not have been included since it was using the premium income provided by OPM.

Therefore, we removed \$2,053 from the premium income reported on the 2014 FEHBP MLR filing.

Plan Response:

The Plan acknowledged that the premium adjustment was erroneous and merits correction.

6. Federal and State Taxes and Licensing or Regulatory Fees

Our review determined that the amounts reported in Section 3 “Federal and State Taxes and Licensing or Regulatory Fees” on the Plan's FEHBP MLR filing are supported, allowable, and allocated based on the principles and methods described in the Public Health Service Act section 2718 and 45 CFR 158.161, 162, and 170.

Plan Response:

The Plan did not respond to this section of the report.

Conclusion – MLR Review

We made adjustments to the FEHBP MLRs, as discussed throughout the report. The results of these adjustments indicated that a credit reduction in the amount of \$31,696 is due for contract year 2014. Even though the 2015 MLR filing required adjustments due to the identified audit issues, there was no financial impact to the MLR that was submitted to OPM.

In general, the errors identified above were related to oversights, human error, or deficiencies in the Plan’s processes. However, the root cause of these issues relates to insufficient internal controls to support the FEHBP MLR calculation and reporting process that complies with applicable Federal and contractual requirements. Without detailed, written policies and procedures to govern and oversee MLR data collection and reporting, the Plan is at risk for continued reporting inconsistencies and errors that may have material impacts on the MLR calculation.

Recommendation 1

We recommend that the Contracting Officer reduce the Plan's MLR credit by \$31,696 for contract year 2014.

Recommendation 2

We recommend that the Contracting Officer verify that the Plan has implemented process improvements to comply with the instructions in OPM's annual CLs and ensure that the submitted claims data supports the incurred claims reported on the MLR filings.

Recommendation 3

We recommend that the Plan develop internal controls to promote compliance with OPM instructions, including procedures for more stringent review of the data used in the MLR submission to prevent and detect errors.

Recommendation 4

We recommend that the Plan revise its policies and procedures to ensure that it appropriately and timely prior-authorizes claims and that proof of medical necessity is fully validated when required by the Contract, regardless of the type of provider requesting the service.

Recommendation 5

We recommend that the Plan develop and implement controls to ensure claims payments are for benefits expressly allowed per the FEHBP benefit brochure.

Recommendation 6

We recommend that the Contracting Officer direct the Plan to provide additional supporting documentation to verify that two questioned claims were appropriately coordinated with Medicare or appropriately paid.

B. PROCEDURAL FINDINGS

1. Insufficient Support for Claims Pricing

The Plan did not adequately support the rates used to price 9 of 75 sampled claims in 2014.

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 Federal Employee Health Benefit Acquisition Regulation 1652.204-70. The referenced clause is incorporated into the contract at Section 3.4, which requires the carrier to maintain individual enrollee and/or patient claim records “for six years after the end of the contract term to which the claim records relate.”

Based on our review, the Plan did not price four claims according to the rates specified in the contract that was provided. For an additional claim, the Plan provided a contract with an attached fee schedule to support its pricing, but the fee schedule did not include the

procedure code that was billed on the claim. In addition, the contract did not specify any other allowable rates for procedure codes that may not be included in the fee schedule. The contract for another claim did not include pharmacy information necessary to fully price the claim. Finally, three claims were supported by a contract that did not include signed pages of the contract. The rate used to price two of the three claims was supported by an internal memo, emails, and handwritten notes that indicated the rate, which was originally effective in 2009, was still effective in 2012. The Plan claimed that the rate continued to be effective in 2014. However, the rate was in conflict with the rate schedule that was included as an attachment to the contract, effective as of 2010, which was used when pricing the third claim.

As a result of the issues identified above, we were unable to support the appropriate pricing of these nine claims. Because the amount of these claim payments was ultimately immaterial, we did not consider this a monetary finding for purposes of the MLR. However, the issues demonstrate a lack of adequate controls over the maintenance of claims pricing records.

Due to insufficient provider contract support, pricing on 12 percent of the FEHBP sampled claims could not be verified.

Throughout our review of these and other claims, we observed and encountered obstacles to obtaining the correct contract pages with rates that were in effect during the 2014 contract year, in some cases going through multiple versions of the rates before receiving the pages applicable to 2014. For these nine claims, the documentation was ultimately insufficient to support the pricing.

The Plan maintains evergreen contracts that are not necessarily renegotiated regularly, which is a standard practice in the industry. However, when changes are made to the contracted rates, valid copies should be maintained in such a way that the rates used to price claims in any given contract year are appropriately supported and readily available upon request, in accordance with Contract Sections 1.11 and 3.4.

Plan Response:

The Plan disagreed that it did not have controls in place for contract maintenance and maintains that its contract administration controls are demonstrated by various memos, notes, contract amendments, and automatic renewals. The Plan believed the lack of materiality associated with the questioned claims demonstrates that controls were "more than sufficient to support official contract records to support the pricing of claims."

OIG Comment:

The documentation cited by the Plan does not support its claim that it has sufficient controls over contract administration and maintenance. As noted in the finding, even after repeated attempts to obtain the relevant contract information and receiving multiple versions, we still could not support the pricing for these nine claims. Moreover, we could not support the pricing for 12 percent of total sampled claims (9 of 75 claims) based on the Plan's documentation, which is significant even if the dollar value is immaterial. As such, strengthened controls over the maintenance of accurate contract records to support claims pricing is still warranted.

Recommendation 7

We recommend that the Plan develop policies and procedures to ensure the maintenance of accurate and official contract records to support the pricing of claims, in accordance with the Contract.

2. Retroactive Capitation Adjustments

The Plan inappropriately included retroactive adjustments for prior year capitation payments in the 2014 and 2015 incurred claims reported on the FEHBP MLR filings.

45 CFR 158.140(a) states that the MLR reports required in 45 CFR 158.110 must include incurred claims for covered services, including capitation payments. 45 CFR 158.140(b)(1)(ii) states that incurred claims must be adjusted for overpayment recoveries received.

OPM CL 2013–11 specifies that only claims and applicable recoveries incurred in calendar year 2014 and paid or received through June 30, 2015, must be included in the MLR calculation. CL 2014-16 provides the same guidance relative to the 2015 MLR reporting year.

We judgmentally selected the two capitated providers with the largest total payments in 2014 and 2015 and reviewed the capitation payments reported for each of the providers. Based on our review, we observed that the Plan adjusted its June 2014 capitation payment for one of the providers by the amount of a retroactive recovery related to the December 2013 capitation payment. The Plan noted that all capitation payments to providers consist of similar retroactive adjustments that are netted against the current period. According to the Plan, these adjustments are the result of changes in

eligibility and/or rates. The Plan incorporates adjustments for the six months prior to the current payment.

Using this process, the Plan is factoring in six months of prior period adjustments, which can include adjustments related to capitation payments that were not paid in the MLR reporting year. As a result, the Plan is not in compliance with OPM guidance for reporting incurred claims and recoveries. We did not observe a material impact to the incurred claims reported on the FEHBP MLR filings based on our review. However, the Plan is misrepresenting the actual capitation payments made in the MLR reporting year and, therefore, may be over- or understating incurred claims, depending on the type of adjustment.

Plan Response:

The Plan stated that it "made an adjustment to limit retroactive adjustments to the current MLR contract year."

OIG Comment:

We are unable to verify the adjustment referenced by the Plan's response as it was outside our audit scope. We will evaluate the Plan's update to its process in future audits.

Recommendation 8

We recommend that the Contracting Officer verify that the Plan made an adjustment to limit its retroactive adjustments to the current MLR reporting year.

C. INTERNAL CONTROLS REVIEW

The Plan did not maintain an adequate system of internal controls to govern the MLR process or claims pricing.

Per Contract Section 5.64, "(c)...The Contractor shall establish the following ... (2) An internal controls system. (i) The Contractor's internal control system shall-- (A) Establish standards and procedures to facilitate timely discovery of improper conduct in connection with Government contracts; and (B) Ensure corrective measures are promptly instituted and carried out. (ii) At a minimum, the Contractor's internal control

The inadequate maintenance of internal controls surrounding the MLR process led to numerous reporting errors and contract compliance issues.

system shall provide for ... (A) Assignment of responsibility at a sufficiently high level and adequate resources to ensure effectiveness of the business ethics awareness and compliance program and internal control system.”

However, we found that the Plan’s internal controls system did not sufficiently meet the contract criteria in the following ways:

1. Inaccurate MLR Reporting

We identified errors caused by a lack of documented policies and procedures and insufficient oversight related to the FEHBP MLR processes. Ultimately, these errors resulted in defective Certificates of Accurate MLR in 2014 and 2015 and an overstated credit in 2014, as presented in Sections A.1 and A.2. The errors included:

a. Claims

The Plan reported claims on the FEHBP MLR filing that did not tie to the claims data submitted to OPM and included accounts that did not relate to the FEHBP. In addition, the Plan made improper payments of claims related to genetic testing and coordination of benefits. See Section A.3.

b. Premium

The Plan erroneously adjusted OPM’s premium. See Section A.5.

2. Procedural Issues

a. Insufficient Support for Claims Pricing

The Plan did not adequately support the rates used to price nine claims in 2014. See Section B.1.

b. Retroactive Capitation Adjustments

The Plan inappropriately included retroactive adjustments for prior year capitation payments in the 2014 and 2015 incurred claims reported on the FEHBP MLR filings. See Section B.2

3. Claim Paid for Capitated Service

The Plan incorrectly paid a Fee-for-Service (FFS) claim that was considered a contracted capitated service. According to the Plan, this error was inadvertent because the provider had both a capitated and FFS tax identification number. Although the dollar value of the claim was immaterial, this raises continued concerns related to the Plan's internal controls over claims processing and payment.

4. QHI Policies and Procedures

The Plan does not have documented policies and procedures governing the QHI process. 45 CFR 158.170(b) states that the MLR report must include a detailed description of the expense allocation methods, including for QHI expenses. The Plan referred to Part 4 of the FEHBP MLR filings to address this requirement. However, neither the descriptions in Part 4, nor the narrative of its process, which was dated outside the audit scope, were reflective of the process demonstrated during the audit. Plan personnel acknowledged that it did not have a procedure document for the complete process, end-to-end. Without documented policies and procedures over the process, the Plan is at risk for potential reporting errors, process inconsistencies from year-to-year, and continuity of operations issues in the event of employee turnover. Although this issue did not appear to affect reporting in 2014 and 2015, it leaves the Plan open to the ongoing risk of errors or inconsistencies in future reporting years.

Conclusion – Internal Controls Review

Based on the expansiveness of these errors across multiple Federally regulated requirements, the Plan did not have the contractually required oversight at a sufficiently high level, which impacts the effectiveness of the internal control system as it relates to the oversight of the FEHBP MLR.

Plan Response:

The Plan disagreed that it did not have "the contractually required oversight" and cited the lack of materiality of the identified errors to the MLR as "significant in demonstrating that the internal controls employed by the Plan are more than sufficient" Also, the Plan stated that it takes compliance with the Contract, OPM instructions, and federal rules and regulations very seriously and has policies, procedures, and controls in place over the areas of concern noted by the auditors. They concluded that audit findings "represent the exception to the process and, where there were issues identified requiring adjustment to any specific policy or procedure, the Plan has made changes to mitigate or eliminate any

future recurrence. In the case of an error as a result of human intervention or error in judgement, those items have been addressed as well." This included an adjustment to the FFS claim that was inadvertently included in the Plan's claims data.

OIG Comment:

Although the Plan believes that the lack of materiality of the audit issues is "significant" to support that it has sufficient internal controls in place, those audit issues ultimately resulted in the removal of the Plan's MLR credit in 2014. The removal of the total credit is a material impact, which stemmed from claims data errors and our removal of 11 claims, totaling \$13,164, from the Plan's reported incurred claims. In addition, we could not reprice 12 percent of the claims that we reviewed, and have serious concerns about the Plan's standard process of automatically paying claims submitted by capitated providers without verifying that the provider established medical necessity. Finally, we cannot verify that the Plan removed the erroneously paid FFS claim from its claims data.

Recommendation 9

We recommend that the Plan add internal control policies to mitigate the risk of duplicative billings of capitated services as FFS claims when the provider has multiple tax identification numbers.

Recommendation 10

We recommend that the Plan develop documented policies and procedures to govern the collection and reporting of MLR data that comply with laws, regulations, and the OPM contract, including: accurate claims reporting, processing, and payment; premium and capitations adjustments; comprehensive record keeping for data used to price claims; and QHI.

EXHIBIT A

Health Plan of Nevada - Plan Code NM Summary of Penalty and Credit Adjustments

Contract Year 2014 - Overstated Credit

Medical Loss Ratio Credit	\$0
Amount Credited	\$31,696
Total Overstated Credit	<u><u>\$31,696</u></u>

Contract Year 2015 - No Penalty or Credit

Medical Loss Ratio Penalty/Credit	\$0
Amount Paid/Credited	\$0
Total Penalty/Credit Due	<u><u>\$0</u></u>

EXHIBIT B

Health Plan of Nevada - Plan Code NM 2014 Medical Loss Ratio Calculation

	Plan	Audited
2014 FEHBP MLR Lower Threshold (a)	85%	85%
2014 FEHBP MLR Upper Threshold (b)	89%	89%
<u>Claims Expense</u>		
Medical Incurred Claims (Includes Dental & Vision)	\$7,664,144	\$7,475,325
Pharmacy Incurred Claims	\$4,579,776	\$4,577,516
Less: Incorrectly Paid Medical Claims		(\$13,164)
Capitation	\$5,528,944	\$5,528,944
Adjusted Incurred Claims	\$17,772,864	\$17,568,621
Less: Healthcare Receivables	(\$723,086)	(\$723,086)
Expenses to Improve Health Care Quality	\$191,976	\$191,976
Total MLR Numerator	\$17,241,754	\$17,037,511
<u>Premium Expense</u>		
Premium Income	\$20,750,104	\$20,748,051
Less: Federal and State Taxes and Licensing or Regulatory Fees	(\$1,412,960)	(\$1,412,960)
Total MLR Denominator (c)	\$19,337,144	\$19,335,091
FEHBP MLR Calculation (d)	89.16%	88.09%
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	\$0	\$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	\$31,696	\$0
Total Credit Overpayment		\$31,696

EXHIBIT C

Health Plan of Nevada - Plan Code NM 2015 Medical Loss Ratio Calculation

	Plan	Audited
2014 FEHBP MLR Lower Threshold (a)	85%	85%
2014 FEHBP MLR Upper Threshold (b)	89%	89%
<u>Claims Expense</u>		
Medical Incurred Claims (Includes Dental & Vision)	\$8,939,929	\$8,859,562
Pharmacy Incurred Claims	\$5,281,464	\$5,277,346
Capitation	\$4,689,773	\$4,689,773
Adjusted Incurred Claims	\$18,911,166	\$18,826,681
Less: Healthcare Receivables	(\$1,263,040)	(\$1,263,040)
Expenses to Improve Health Care Quality	\$128,356	\$128,356
Total MLR Numerator	\$17,776,482	\$17,691,997
<u>Premium Expense</u>		
Premium Income	\$22,023,688	\$22,023,688
Less: Federal and State Taxes and Licensing or Regulatory Fees	(\$1,544,844)	(\$1,544,844)
Total MLR Denominator (c)	\$20,478,844	\$20,478,844
FEHBP MLR Calculation (d)	86.80%	86.39%
Penalty Calculation (If (d) is less than (a), ((a-d)*c)	\$0	\$0
Credit Calculation (If (d) is greater than (b), ((d-b)*c)	\$0	\$0
Total Credit Overpayment		\$0

EXHIBIT D

Claims and Capitation Sample Selection Criteria/Methodology

Medical Claims Pricing 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	15,715 claims	\$8,167,885	Utilized RAT-STATS (90% Confidence Level 50% Anticipated Rate of Occurrence and 20% Desired Precision Range), which generated a sample size of 75. Then utilized SAS to randomly select 75 incurred, unadjusted medical claims.	Statistical	No

Capitations Sample

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Capitated Providers in 2014	59 capitated providers	\$5,545,974	Selected the top two capitated providers whose payments made up over 50% of total capitations in 2014 (largest total payments)	Judgmental	No
Capitated Providers in 2015	61 capitated providers	\$4,734,940	Selected the top two capitated providers whose payments made up over 50% of total capitations in 2015 (largest total payments)	Judgmental	No

APPENDIX



August 15, 2019

Deleted by the OIG – Not Relevant to the Final Report

U.S. Office of Personnel Management

Office of the Inspector General

Deleted by the OIG – Not Relevant to the Final Report

**RE: Comments to the Draft Audit Report on Health Plan of Nevada,
Plan Code NM, Report No. 1C-NM-00-18-047**

Deleted by the OIG – Not Relevant to the Final Report

On July 3, 2019, the United States Office of Personnel Management, Office of the Inspector General (“OPM/OIG”) submitted to Health Plan of Nevada (“the Plan”) a “Draft Report” (1C-NM-00-18-047) (“Draft Report”), detailing the results of its audit of the Federal Employees Health Benefits Program (“FEHBP”) operations of the Health Plan of Nevada (“the Plan”), rate code NM, for contract years 2014 and 2015. Upon submission, OPM/OIG requested the Plan provide comments to the Draft Report.

The Plan appreciates the opportunity to respond to this Draft Report and the willingness of OPM to help resolve the outstanding issues in this audit. The Plan has used its best efforts to obtain all relevant information to respond to the Draft Report’s findings and recommendations. This Response will address each issue presented in the Draft Report.

The overall findings as stated in the Draft Report are:

- *“The Plan submitted 2014 and 2015 claims data to the OPM OIG that did not support the incurred claims used in the Plan’s FEHBP MLR filings. The 2014 claims data also included non-FEHBP claims.”*
- *“The Plan made improper medical claims payments as a result of issue with prior authorization and medical necessity determinations for genetic testing claims and coordination of benefits for Medicare aged member.”*
- *“The Plan erroneously adjusted its premium income on the 2014 FEHBP MLR filing.”*
- *“The Plan did not adequately support the rates used to price **Deleted by the OIG – Not Relevant to the Final Report** claims in 2014.”*

- *“The Plan inappropriately included retroactive adjustments for prior capitation payments in the 2014 and 2015 incurred claims reported on the FEHBP MLR filings.”*
- *“The Plan does not have sufficient internal controls over the FEHBP MLR process.”*

The Plan will address each of the findings identified in the Draft Report in the order in which they appear.

Overstated MLR Credit

The Auditors state *“...the Plan calculated an MLR ratio....which exceeded OPM’s upper threshold of 89 percent and resulted in a credit...However, during our review....we identified issues that resulted in a lower audited MLR.”*

The Plan acknowledges there was an error in the original MLR form submitted to support contract year 2014. In developing the support for the audit team, the Plan identified the error and refiled the 2014 MLR form with OIG’s auditors during the audit. The process that resulted in this error has been updated to avoid the error from recurring.

No Penalty or Credit Due

The Draft Report indicates *“During the 2015 MLR filing period, the Plan calculated an MLR ratio that met the OPM prescribed lower threshold of 85 percent, but did not exceed the upper threshold of 89 percent. However, our review of the Plan’s MLR filing disclosed issues within the MLR calculation. These adjustments, while reportable, were not significant enough to result in a penalty due to OPM or a credit due the Plan...”*

The Plan acknowledges there was an immaterial adjustment required to the originally submitted MLR form for contract year 2015. The Plan refiled the MLR form with OIG’s auditors during the audit.

MLR Claims Data

a. Inaccurate Claims Data

The auditors state *“Although the Plan did submit medical and pharmacy claims data to the OPM OIG for contract years 2014 and 2015, the data did not support the incurred claims used in the FEHBP MLR calculation. Rather, the Plan used medical and pharmacy claims accounts from its general ledger to report incurred claims on the FEHBP MLR filings. However, the claims captured in these accounts did not tie to the claims data submitted to OPM OIG, reportedly due to adjustments and retroactivity in the general ledger that were not reflected in the statistical claims data due to timing.”*

The Plan acknowledges that due to timing, adjustments, retroactivity, and the fact that the general ledger is based on financial data -- whereas the claims data was extracted from the dynamic claims source systems -- the statistical data provided on a claim line basis will not necessarily match exactly. The Plan will be implementing a process to reconcile MLR claims data (statistical data) to the general ledger (financial data) to illustrate the differences which are not statistically significant.

The auditors further state *“[T]he general ledger claims also varied from the incurred claims*

reported on the MLR forms in both years due to the mistaken inclusion of an account with no FEHBP impact... and [the Plan] did not include calendar year claims through the end of the applicable run-out periods in both 2014 and 2015. This was due to errors in how the data was pulled, and according to the Plan, it has subsequently updated its process.”

The Plan identified the error and submitted a revised healthcare cost tie out in response to **Deleted by the OIG – Not Relevant to the Final Report**. Additionally, the Plan submitted revised MLR Forms for contract years 2014 and 2015 titled **Deleted by the OIG – Not Relevant to the Final Report** removing the payments. The Plan has implemented a process to ensure the correct runout period is included in the data going forward as well as revising the account map of relevant accounts to be included for the data pull.

The final statement in this section by OIG auditors state: *“These combined issues may be a result of insufficient internal controls over the MLR reporting process to support compliance with OPM instructions. Despite the errors in the claims submission to OPM OIG, we used the data for our recalculations of the MLR in both years after removing the non-FEHBP claims from the 2014 data, in order to comply with the OPM Carrier Letters.”*

The Plan disagrees with the OIG Auditors assessment that “insufficient internal controls over the MLR reporting process to support compliance with OPM instructions” is a valid characterization of the Plan’s operations. There are rigorous controls, review processes and procedures that have been implemented by the Plan since the introduction of the FEHBP-specific MLR process by OPM. As with any complex processes that span multiple departments there are opportunities for improvement particularly as methodologies, regulations and instructions are introduced or changed by the regulating body (in this case OPM). As changes/modifications to existing processes are identified, the Plan takes the necessary steps to implement relevant changes and process improvements. A crucial part of any strong internal controls process is to constantly review the procedures implemented to ensure continued applicability and adequacy of those procedures. The Plan continually monitors its procedures to self-identify areas that can be strengthened.

b. Claims Pricing Review

The Audit Report states: *“...For one claim in the expanded review, as well as the claim from our original review..., the Plan did not prior authorize or verify medical necessity for procedures ordered by a capitated provider. According to the Plan, the Plan does not prior authorize procedures that are referred by capitated providers and automatically considers them medically necessary with no further documentation required or reviewed. The Plan noted that this is an undocumented administrative rule. Delegating this authority to a provider without any process of verification does not comply with the Contract and associated benefit brochure. Moreover, if the Plan does not validate that the providers have done their due diligence to determine medical necessity, providers may abuse their authority and authorize unnecessary or potentially uncovered services simply because they know the Plan will approve them without question. In addition the member is also at risk not only of unnecessary testing but also potential financial liability if the Plan later denies the claim as a result of a subsequent claims review or audit.”*

The Plan will allow a provider functioning as a Primary Care Provider (PCP), in this case an

Obstetrician, to make clinical decisions about the medical necessity and appropriateness of some services. The Plan disagrees with the insinuation that we did not do our due diligence. Part of the ongoing relationship with providers that function as PCPs is to evaluate their behavior and billing patterns based upon their submitted encounters and the ancillary services they order. Their ongoing contract status, reimbursement rate, and participation in various clinical review programs is based upon the Plan's ongoing review of their data. The Plan disagrees that the member would be at risk; the scenario where a provider functioning as a PCP ordering a test would not result in a claim denial that is a member responsibility.

The Audit Report states: *“Based on our review of a statistical sample of...medical claims for contract year 2014, we identified issues with prior authorization and medical necessity determinations for genetic testing claims and coordination of benefits for Medicare aged members. As a result, we removed...improper medical claims payments from the Plan's total incurred claims reported on the 2014 FEHBP MLR calculation....”*

The Plan agrees that the benefit offered to the FEHBP for contract years 2014 and 2015 with respect to Genetic disease testing stipulates both a medical necessity and prior authorization in order to be covered. To demonstrate medical necessity, the Plan provided a letter from the provider indicating the medical necessity of the test including the criteria used to make the determination. The genetic testing was in regard to an autosomal recessive genetic disorder and the patient was within the defined “at-risk” population for said disorder.

The member's PCP, who has clinical qualification to determine the necessity of the test, ordered the test, therefore the Plan deems the service medically necessary and authorized. In this arrangement with this Provider, the responsibility for care of the patient is assigned to the Provider through the capitated arrangement. The provider in this case also provided additional medical necessity standards as developed by the American College of Obstetricians and Gynecologists as well as the Genetics Committee of the Society of Obstetricians and Gynaecologists of Canada to demonstrate the recommendations that apply to this patient in particular.

The Plan's position was communicated through the audit process and the underlying supporting documentation provided at that time satisfies the medical necessity component of the FEHBP contract. As referenced above, the Plan regularly reviews the behavior of providers like the ones in these claims to determine if there is a billing pattern that should be addressed. The Plan asserts that the decision was appropriate and the claims associated with the genetic testing were paid appropriately.

Benefits Not Properly Coordinated with Medicare

The Audit Report states: *“The Plan did not properly coordinate the payment of ... Medicare claims in 2014. In addition, we did not have adequate support to verify that ...additional claims were appropriately coordinated....Contract Sections 2.6(a) and (b) require the Plan to coordinate Federal employee health benefit payments with the payment of Medicare benefits.”* *“Based on our claims review, we identified the following issues with coordination of benefits:*

- *The Plan paid one claim for a member as the primary payor when it should have paid secondary to Medicare. The member was a retiree who had a Medicare Advantage Plan,*

which includes both Parts A and B coverage. Therefore, the FEHBP should have paid secondary to the Medicare Advantage Plan.

The Plan acknowledges that this claim should have been processed with the Medicare Advantage paying first.

- We could not verify that **Deleted by the OIG – Not Relevant to the Final Report** claims for Medicare-aged members were appropriately coordinated with Medicare.

The Plan paid **Deleted by the OIG – Not Relevant to the Final Report** claims for members aged 65 and older as the primary payor but did not support what type of Medicare coverage these members had. As such, we cannot determine that the Plan appropriately paid the claims.

The Plan disagrees with the assessment that the documentation was not sufficient or that the claims were processed incorrectly. **Deleted by the OIG – Not Relevant to the Final Report** The Plan is providing additional information on these claims (please refer to the Appendix which contains the additional information for the claims identified in the OIG Auditors' workpapers). **Deleted by the OIG – Not Relevant to the Final Report**

With respect to the coordination of benefits with Medicare, the Plan does coordinate benefits with all third parties as is required by the FEHBP contract. In certain cases, the Plan is not provided with information on third party coverage (including Medicare Advantage Plans that annuitants may have in addition to their FEHBP coverage). The Plan does rely on the member to provide information and has specific processes to obtain this information as members age-in to Medicare eligibility and at the time of submission of a claim. In an instance where, based on the diagnosis or nature of injury on a claim, there may potentially be a third party payer (i.e., auto accident, work-related injury, etc.); a

proactive call/letter is sent to the member to obtain information on where/how injury was sustained and to confirm whether there is a third party that is liable for the claim.

As with any process where human intervention is involved, there is a potential for error. In the case of one member where benefits were not correctly coordinated with Medicare the auditors state: "...the improper payments appear to have been an isolated human error." The Plan agrees with this assessment.

Premium Review

The Draft Audit Report states: "*The Plan erroneously adjusted its premium income on the 2014 FEHBP MLR filing. As a result, it overstated premium income....*"

The Plan acknowledges an erroneous immaterial adjustment **Deleted by the OIG – Not Relevant to the Final Report** to premium income occurred on the 2014 FEHBP MLR filing. The Plan re-filed the 2014 MLR with corrections to the OIG Auditors during their onsite visit.

Conclusion – MLR Review

The Draft Audit Report states: *“We made adjustments to the FEHBP MLRs as discussed throughout the report. The results of these adjustments indicated that a credit reduction...is due for contract year 2014. Even though the 2015 MLR filing required adjustments due to the identified audit issues, there was not financial impact to the MLR that was submitted to OPM.”* The Draft Audit Report goes on to state: *“In general, the errors identified above were related to oversights, human error, or deficiencies in the Plan’s processes. However, the root cause of these issues is a lack of internal controls to support the MLR calculation and reporting process that complies with applicable federal and contractual requirements.”*

The Plan strongly disagrees with the auditors’ assessment that *“...the root cause of these issues is a lack of internal controls to support the MLR calculation and reporting process....”* The Plan does acknowledge the existence of immaterial errors in both the 2014 and 2015 MLR filings. However, the errors identified by the auditors fall into one of two categories:

- Errors in judgement / human errors – These can be made in any process where human intervention/judgement is required regardless of the rigor around internal controls and as previously stated by the auditors, they *“appear to have been an isolated human error.”*
- Disagreement in the existence of an error (i.e., auditors identifying benefits paid as a result of “Improper/Untimely Authorization of Medical Necessity” and “Not Properly Coordinated with Medicare”) - The Plan disagrees with the classification of these claims as errors and has provided documentation that the Plan determined is sufficient to support the proper payment of these claims.

In either case, the impact to the overall MLR calculation is either minimal or non-existent and therefore would seem to conflict with the characterization *“...a lack of internal controls...”* as stated by the auditors. Instead, the valid errors are a result of human error which is a part of any system that employs processes dependent upon human intervention. The lack of materiality of any valid error in the overall MLR review is significant in demonstrating that the internal controls employed by the Plan are more than sufficient to support MLR calculation and reporting process.

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INTERNAL CONTROLS REVIEW

The Draft Audit Report states: *“The Plan did not maintain an adequate system of internal controls to govern the MLR process or claims pricing.....we found that the Plan’s internal controls system did not sufficiently meet the contract criteria in the following ways...Inaccurate MLR Reporting... Claims...Premium....”*

The Draft Audit Report further states: *“Based on the expansiveness of these errors across multiple federally regulated requirements, the Plan did not have the contractually required oversight at a sufficiently high level. Furthermore, the Plan does not have adequate resources to ensure the effectiveness of the internal control system as it relates to the oversight of the FEHBP MLR.”*

The Plan strongly disagrees with the characterization *“...the Plan did not have the contractually required oversight.....the Plan does not have the contractually required oversight...”* The lack of materiality of any valid error in the overall MLR review is significant in demonstrating that the internal controls employed

by the Plan are more than sufficient to govern the MLR process, claims pricing and MLR calculation and reporting process. The MLR process utilized for the FEHBP specific calculation closely mirrors the MLR process the Plan employs for the annual HHS MLR submission which occurs each June. The Federal Regulations applicable to this filing are the basis upon which OPM built the FEHBP-specific MLR Form and in fact modified the HHS Form through elimination of certain data. The rigor employed to be in compliance with all applicable Federal Rules and Regulations is applied to both calculations equally and the Plan firmly asserts that it is in compliance with all such requirements. The Plan does possess more than adequate resources to ensure the effectiveness of the internal control system as it relates to oversight of the FEHBP MLR. **Deleted by the OIG – Not Relevant to the Final Report**

Conclusion

The Plan has provided a response to each of the items identified with the Draft Audit Report. As stated within this response, there are findings with which the Plan is in agreement with the OIG Auditors. The Plan refiled the MLR Forms for both 2014 and 2015 and modified all items in which the Plan agreed with the OIG Auditors. These forms were submitted to the Auditors at the time of the audit. For this reason, the Plan does not feel any action is required to be taken by the Plan relative to the MLR filings for 2014 and 2015.

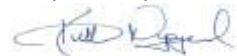
With respect to the items with which the Plan disagrees with the OIG Auditors as outlined in its responses above, the Plan's view is that there is no action required. It should be noted that regardless of the nature of any discrepancy or validated error, the impact to the FEHBP was nominal or had no material effect on the overall financial results. Indeed, the financial impact for 2014 and 2015 keeps the MLR within the 85% - 89% corridor established by OPM.

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The Plan appreciates the opportunity to respond to the Draft Audit Report. Once you have had an opportunity to review the information contained in this response, please contact me if you have any questions or require additional information.

Thank you for your assistance in resolving the issues identified in the Draft Report.

Respectfully,



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Director, Federal Programs

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