U.S. Office of Personnel Management

Office of the Inspector General

Office of Audits

Final Audit Report

Audit of the Federal Employee Health Benefit Operations at Group Health Cooperative of South Central Wisconsin

Report Number 1C-WJ-00-19-004
February 14, 2022

Executive Summary

Audit of the Federal Employees Health Benefits Program Operations at Group Health Cooperative of South Central Wisconsin

Report No. 1C-WJ-00-19-004 **February 14, 2022**

Why Did We Conduct the Audit?

The primary objective of the audit was to determine whether Group Health Cooperative of South Central Wisconsin (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).

What Did We Audit?

Under Contract CS 1828, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions for contract years 2014 through 2016. Our audit fieldwork was conducted from January 14, 2019, through April 29, 2020, at the Plan's offices in Madison, Wisconsin, 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. Specifically, our audit identified the following:

- The Plan had various benefit configuration and cost-sharing application issues with the processing of medical claims in contract year 2016.
- The Plan did not properly calculate the non-income tax fees reported on the 2014 through 2016 FEHBP MLR submissions.
- The Plan did not maintain documentation to support the data included in the fraud, waste, and abuse reports submitted to OPM.

The monetary impact of these issues was not significant enough to affect the 2014 through 2016 MLRs reported to OPM. However, if the issues outlined in this report are not addressed, they have the potential to affect the pricing and payment of FEHBP member claims and reporting of the MLR in future years.

Our audit also found that the Plan correctly adjudicated its encounters and allocated its costs associated with its internal providers. The Plan also correctly adjudicated the claims and reconciled the payments associated with its external capitated providers.

Abbreviations

ACA	**Patient Protection and Affordable Care Act**
CFR	**Code of Federal Regulations**
Contract	**Contract CS 1828**
CPAP	**Continuous Positive Airway Pressure**
EMST	**Electronic Muscle Stimulation Therapy**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulation**
FEHBP	**Federal Employees Health Benefits Program**
FWA	**Fraud, Waste, and Abuse**
HIPF	**Health Insurance Providers Fee**
MLR	**Medical Loss Ratio**
NAIC	**National Association of Insurance Commissioners**
OI	**Office of Investigations**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PCORI	**Patient-Centered Outreach Research Institute**
Plan	**Group Health Cooperative of South Central Wisconsin**
SHCE	**Supplemental Health Care Exhibit**

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I. Background

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at Group Health Cooperative of South Central Wisconsin (Plan). The audit was conducted pursuant to the provisions of Contract CS 1828 (Contract); 5 United States Code 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 Madison, Wisconsin, and in our Office of the Inspector General (OIG) offices.

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 (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, in our opinion 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.

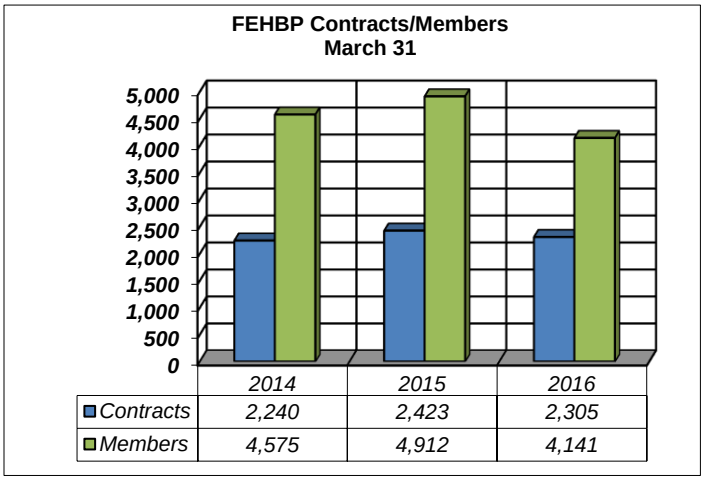
The FEHBP-specific MLR rules are based on the MLR standards established by the Patient Protection and Affordable Care Act (P.L. 111-148) and defined by the U.S. Department of Health and Human Services in 45 CFR Part 158. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific 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	2,240	2,423	2,305
Members	4,575	4,912	4,141

The Plan has participated in the FEHBP since 1979 and provides health benefits to FEHBP members in South Central Wisconsin. This is the first audit of the Plan's FEHBP MLR submissions; however, a previous premium rate audit of contract years 2010 through 2012 identified defective pricing findings totaling $1.9 million to the FEHBP. This prior audit was conducted under the old SSSG rating guidelines and the findings were deemed not relevant to our MLR criteria.

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.

It should be noted that throughout the audit, the Plan was cooperative with the audit team in providing requested information and was open to implementing recommended improvements to operations.

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.

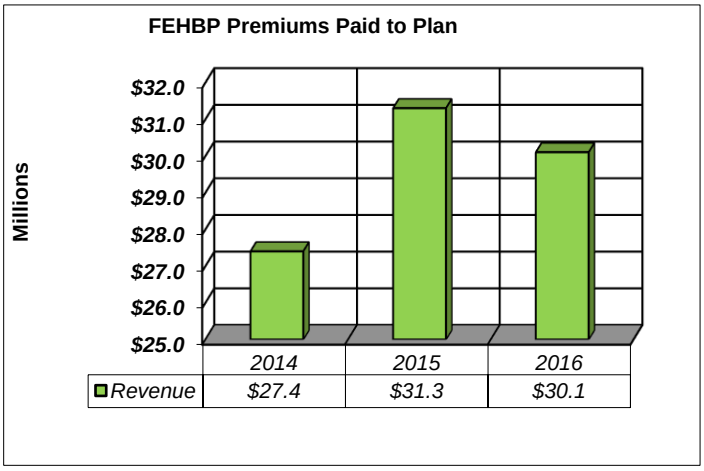
Our audits of the MLR submission filed with OPM are completed in accordance with the criteria expressed in OPM's rating instructions. The MLR audit evaluation includes an assessment of key components of the MLR calculation, including allowable claims, capitations, health care expenses, and quality health 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 $88.8 million in premiums to the Plan.

The OIG's 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. 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 April 29, 2020, at the Plan's offices in Madison, Wisconsin, and in our OIG offices in Cranberry Township, Pennsylvania; Jacksonville, Florida; 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, the Plan's internal clinic costs, external capitations, and any other applicable expenses considered in the calculation of the MLR and premium rates to verify that the cost data used was accurate, complete, and valid. Finally, we used the Contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), the OPM rate instructions, and applicable Federal regulations to determine the propriety of the Plan's MLR.

To gain an understanding of the internal controls over the Plan's FEHBP MLR submissions as well as its claims processing system, we reviewed the Plan's FEHBP MLR, internal clinic cost, external capitation and claims policies and procedures. We also interviewed appropriate Plan officials regarding the controls in place to ensure that the MLR and premium rate 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, along with the methodology, are detailed in Exhibit A at the end of this report.

We also reviewed the Plan's Fraud, Waste, and Abuse Manual and other related procedures, including case referrals to OPM, to assess if the Plan was meeting the criteria established by OPM.

III. Audit Findings and Recommendations

A. Medical Loss Ratio Review

The Certificates of Accurate MLR signed by the Plan 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). The Plan submitted FEHBP MLRs and received subsequent credits for contract years 2014 through 2016 as stated in Table I below. Our review of the Plan's FEHBP MLR submissions and related documentation disclosed issues within the MLR calculation. These adjustments, while reportable, were not significant enough to result in a credit adjustment due to OPM.

	Table I – MLR Adjustments					
Year	Plan's MLR Ratio	Audited MLR Ratio	Plan's Current Credit	Plan's Current Penalty	Audited Credit	Credit Adjustment Due to OPM
2014	101.34%	101.34%	$3,324,830	$0	$3,324,830	$0
2015	101.89%	101.89%	$3,974,320	$0	$3,974,320	$0
2016	106.30%	106.30%	$5,136,235	$0	$5,136,235	$0

1. Claims Pricing Review

Based on our review of a statistical sample of 50 medical fee-for-service claims for contract year 2016, we found the Plan incorrectly paid claims for the non-covered electronic muscle stimulation therapy (EMST) benefit, copays were not collected for all services for dependent children age 19 and under, and an incorrect reimbursement rate was used for a provider for continuous positive airway pressure (CPAP) machines related to sleep apnea. We expanded the results of our review to contract years 2014 and 2015 and found the monetary impact of these issues was not material for each year; however, procedural adjustments are needed to ensure these issues do not more significantly impact the future processing and payment of claims.

The Plan's claim configuration and control processes allowed for numerous FEHBP processing and pricing errors.

a. Electronic Muscle Stimulation Therapy

We identified a claim for a chiropractic EMST procedure that the Plan improperly covered. The Plan stated that claims with the EMST service were covered per the structure of the provider contracts. Even though the provider contract covers this service, the FEHBP benefit brochures for all years in the audit scope specifically denotes chiropractic EMST as a non-covered benefit and should not have been covered by the Plan for FEHBP members. OPM Contract section 1.13 states that the Plan "bears full responsibility for the accuracy of its FEHB brochure." Section 2.2 of the Contract states that the Plan "shall provide the Benefits as described in the agreed upon brochure text found in Appendix A." Section 5 of the benefit brochure states that "Adjunctive procedures such as … electronic muscle stimulation" are not covered.

b. Copays for Children Age 19 and Under

We found that the Plan did not always deduct the applicable copay from the allowed amount prior to paying claims for children age 19 and under. Per the Plan's FEHBP benefit brochure, only certain benefits such as well baby and child visits, vision services, and hearing services have age-related copay exemptions. Some other FEHBP benefits for children age 19 and under, such as office visits and outpatient mental health visits, have $10 applicable copays; however, the Plan stated that they do not collect copayments on any service for children age 19 and under. This procedure is not in compliance with Contract sections 1.13 and 2.2 as noted in a. above.

c. CPAP Machine Reimbursement

During our claims review, we identified a claim provided by SSM Health at Home for a CPAP machine related to diagnosis for sleep apnea that the Plan did not price according to the terms of the provider contract.

Contract Section 2.3(g) states that the Plan is responsible "to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program."

Recommendation 1: We recommend that the Plan update their internal practices and benefit configuration system to deny chiropractic EMST benefits in accordance with the FEHBP benefit brochure.

Plan Response: "The Plan agrees that the FEHBP benefit brochure for 2014-2016 did not communicate the coverage for electronic muscle stimulation therapy. The Plan will work to align provider contracts, internal processes and the FEHB brochure by either: 1) communicating to its network chiropractic providers that this will be a non-covered benefit for FEHB members or 2) updating the FEHB brochure to show coverage of this benefit."

Recommendation 2: We recommend the Plan change their internal practices and benefit configurations to collect the appropriate copays for FEHBP member children age 19 and younger in accordance with the benefit brochure.

Recommendation 3: We recommend that the Plan receive explicit approval from OPM for any further instances in which the cost-sharing arrangements administered by the Plan differ from the benefit brochure and that these benefit deviations be communicated to the FEHBP members.

Plan Response: "The Plan agrees that the FEHBP benefit brochure for 2014-2016 did not communicate copay exemptions for children for all relevant services. The Plan will confirm that internal practices and benefit configurations align to the FEHBP benefit brochure. Due to the change in the FEHBP benefit brochure template in 2017, the Plan believes it has received approval from OPM via the annual renewal process with regard to cost-sharing arrangements for primary care office visits and mental health services, but the Plan will seek additional feedback and explicit approval from OPM if any cost-sharing arrangements remain unclear."

Recommendation 4: We recommend that the Plan enhance their internal controls surrounding the implementation of provider contract pricing in the claims system, to ensure that claims are priced and paid according to the contract terms.

Plan Response: "The Plan agrees with the findings. The Plan will determine ways to enhance internal controls around updating and maintaining provider fees schedules."

2. Taxes and Regulatory Fees

Our review of the Federal and State Taxes and Licensing or Regulatory Fees uncovered inconsistencies on the Plan's FEHBP MLR submissions for contract years 2014 through 2016. Specifically, the Plan elected to not deduct the Community Benefits expenses, incorrect member months and fees were used to determine the Patient-Centered Outcome Research Institute (PCORI) fee, and the Health Insurance Providers Fees (HIPF) fee

incorrectly excluded the Medicaid Premiums and used incorrect premiums in various years.

a. Community Health Benefit

45 CFR 158.161-162 states that non-profit and for-profit health plans may exclude community benefit expenditures, subject to limitations of the tax that would have been paid, in lieu of State Taxes. Community benefit expenditures are defined as activities or programs that improve access to health services or enhance public health and relief of government burden. Based on our review, the Plan, as a non-profit health plan, may exclude community benefit expenditures in lieu of state premium taxes; however, the Plan did not utilize the community benefit expenses in the MLR submissions due to the lack of desk procedures. Utilizing the Community Benefit expenses could have increased the total Federal and State taxes and fees to be excluded from premiums.

b. PCORI

The PCORI Fee is imposed on applicable issuers per the Patient Protection and Affordable Care Act (ACA) provision 6301. 26 CFR 46.4375-1(c) states that this fee is calculated as the product of the average number of covered lives for the calendar year and the applicable annual rate.

Based on our review of the Plan's support for PCORI Fee, we identified that the Plan incorrectly and inequitably allocated PCORI expenses in contract years 2014 through 2016. Specifically, the Plan used member months that did not correspond to the timing requirements specified by OPM and the policy year requirements outlined in 26 CFR 46.4375-1(c). In addition, due to the member month timing issue, the Plan utilized the prior period PCORI fees in their calculation of PCORI expenses, when the current member months and PCORI rates were applicable. We recalculated the PCORI expense utilizing the methodology set forth in 26 CFR 46.4375-1(c) and found the differences between the reported and audited amounts to be immaterial for the years in our scope.

c. HIPF

26 CFR 57 provides guidance on the annual fee imposed on covered entities engaged in the business of providing health insurance. The HIPF is imposed on an issuer of fully insured health plans with at least $25 million in net premiums in proportion to the issuer's market share, for year 2014 and beyond. Based on our review of the

Plan's support for the HIPF, we have identified the Plan incorrectly excluded the Medicaid Premiums, to arrive at the "base premiums" amount in contract year 2014.

The Plan also incorrectly and inequitably allocated the HIPF expenses in contract years 2014 and 2016. Specifically, the Plan did not use the net premiums written and timing conditions that correspond to the requirements specified in 26 CFR 57 Section 9010 of the ACA. Although the Plan allocated HIPF expenses to the FEHBP, the allocation for the premiums used in the 2014 calculation should have been from the 2013 Amended National Association of Insurance Commissioners (NAIC) Statement, which we were able to validate to the general ledger. Additionally, the Premiums used in the 2016 calculation should have been from the 2015 NAIC Statement and Supplemental Health Care Exhibit (SHCE) which we were able to validate to the general ledger.

We recalculated the HIPF utilizing the methodology set forth in the applicable criteria and found the differences between the reported and our audited amounts to be immaterial for the years in our scope.

Conclusion

We determined that the differences between the Plan's initially reported amounts and our audited amounts were immaterial to the MLR denominator, and, for that reason, we accepted the Plan's Federal and State Taxes and Licensing or Regulatory Fees expenses in the audited 2014 through 2016 FEHBP MLR calculations. Even though the variances were considered immaterial for the years under review, we determined that the Plan is not in compliance with Contract Section 5.64(c)(2) by not maintaining an adequate system of internal controls. The root cause of the support and calculation issues stem from a lack of internal controls over the highly manual process of collecting, allocating, and reporting tax amounts on the MLR form, coupled with a lack of formal policies and desk procedures in contract year 2014 through 2016. While the errors were immaterial for the years under review, without adequate policies, procedures, and oversight of manual processes, the Plan is at risk for errors that may ultimately become more material and, subsequently, impact the reported MLR denominator.

Recommendation 5: We recommend that the Plan review the criteria at 45 CFR 158.161-162 for non-profit health plans and to assess, calculate, and utilize, if applicable, the community benefit expenditure exclusion from premiums on the FEHBP MLR form in future years.

Recommendation 6: We recommend that the Plan develop policies and procedures to govern the process of collecting and allocating cost data that is reported on the FEHB MLR Form, to include additional oversight and review per the Contract and ensure that

allocation be based on a generally accepted accounting method that is expected to yield the most accurate results, as specified in 45 CFR 158.170.

Recommendation 7: We recommend that the Plan utilize the methodology set forth in 26 CFR 46.4395(c)(2)(v)(a) with the effective rate for each year as defined by the Internal Revenue Service guidelines. The Plan should utilize the supported member month data, on a calendar year basis, in both the calculation of the total PCORI expense and the allocation to the FEHBP.

Recommendation 8: We recommend that the Plan utilize the net premiums written and timing conditions methodology set forth in 26 CFR 57 Section 9010 of the ACA. The Plan should utilize the general ledger supported premiums from the NAIC Statement and SHCE in both the calculation of the total PCORI expense and the allocation to the FEHBP.

Plan Response: "The Plan agrees with the findings. The Plan has updated its policies and procedures for reporting taxes and regulatory fees on the FEHB MLR form. The Plan will also review the criteria for community benefit expenditures."

OIG Comment: We support the Plan updating their policies and procedures related to reporting taxes and regulatory fees as well as continuing to assess criteria related to the community benefit expenditures. Any updates will be assessed in further detail during future audits of the Plan.

3. GHC Clinic Encounters and Allocations

We determined that the capitated encounters costs for the Plan's own providers reported on the FEHBP MLR submissions were reasonable, accurate, and acceptable under the MLR requirement established by OPM and the laws and regulations governing the FEHBP.

4. External Capitation Claims and Payments

We determined the external capitated claims costs reported on the Plan's MLR submissions to be reasonable, accurate, and acceptable under the MLR requirements established by OPM and the laws and regulations governing the FEHBP.

B. Fraud, Waste, and Abuse

1. Fraud, Waste, and Abuse Case Referral Reporting

The Plan was unable to provide support for the data included in their Fraud, Waste, and Abuse (FWA) reports that were submitted to OPM for contract years 2014 through 2016. Even though each year's report stated that there were zero FWA activities, it is imperative that the Plan maintain the supporting documentation to ensure voluntary thresholds are not implemented for reporting opened cases and possible exposure.

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

The Plan did not have effective policies in place in contract years 2014 through 2016 to support their FWA data. The Plan implemented a new FWA manual in early 2019 and our initial analysis has determined it meets the standards outlined in recent Carrier Letters.

The Plan did not have effective policies in place to support fraud, waste, and abuse data requirements.

Because we were unable to verify the data submitted in the 2014-2016 FWA reports, there is a concern that data reported for fraud cases is not accurate and the OPM OIG Office of Investigations (OI) may not be aware of relevant fraud cases and investigations conducted at the Plan. The OPM OIG OI also has the ability to store, compare, analyze, and compile the data submitted by the Plan with the data provided from other FEHBP carriers to perform FEHBP-wide analysis to help with the detection and possible prevention of fraud.

Recommendation 9: We recommend that the Plan implement policies to store the background data for the annual FWA reports for the time frames required in the Contract signed with OPM and to ensure the data reported meets the requirements stated in the relevant OPM Carrier Letters.

Plan Response: "The Plan agrees with the findings and reaffirms the Plan's implementation of a new FWA manual and processes in 2019, including effective policies and procedures regarding FWA activities and record retention practices."

OIG Comment: During our audit, we determined that the Plan's FWA manual that went into effect as of January 2019 met all of the requirements outlined in OPM Carrier Letter 2017-13 for a FWA manual. Due to the FWA manual implementation falling outside of the scope of our audit, we cannot comment on the effectiveness of the FWA manual or any other policies and procedures introduced after the scope of our reviews.

Exhibit

Group Health Cooperative of South Central Wisconsin

Medical Claim, GHC Clinic, and External Capitation Sample Selection Criteria and Methodology

Universe Criteria 1/1/2014 – 12/31/2014	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Incurred Medical fee-for-service claims	13,106 claims	$4,080,549	Used SAS [1] to randomly select 50 fee-for-service claims.	Random	No
GHC Clinic Internal Capitations	37,282 claims	$4,883,556	Used SAS to randomly select 10 GHC internal capitation claims.	Random	No
External Capitations	23,027 claims	$5,128,168	Used SAS to randomly select 10 external capitation claims.	Random	No

[1] SAS Enterprise Guide is a software used to analyze data allowing users to access and manipulate data quickly.

Appendix

Group Health Cooperative of South Central Wisconsin Response to Report Number 1C-WJ-00-19-004 – Provided to the OIG on June 25, 2020, via email.

Finding A. 1. a.

The Plan agrees that the FEHBP benefit brochure for 2014-2016 did not communicate the coverage for electronic muscle stimulation therapy. The Plan will work to align provider contracts, internal processes and the FEHB brochure by either: 1) communicating to its network chiropractic providers that this will be a non-covered benefit for FEHB members or 2) updating the FEHB brochure to show coverage of this benefit.

Finding A. 1. b.

The Plan agrees that the FEHBP benefit brochure for 2014-2016 did not communicate copay exemptions for children for all relevant services. The Plan will confirm that internal practices and benefit configurations align to the FEHBP benefit brochure. Due to the change in the FEHBP benefit brochure template in 2017, the Plan believes it has received approval from OPM via the annual renewal process with regard to cost-sharing arrangements for primary care office visits and mental health services, but the Plan will seek additional feedback and explicit approval from OPM if any cost-sharing arrangements remain unclear.

Finding A. 1. c.

The Plan agrees with the findings. The Plan will determine ways to enhance internal controls around updating and maintaining provider fees schedules.

Finding A. 2

The Plan agrees with the findings. The Plan has updated its policies and procedures for reporting taxes and regulatory fees on the FEHB MLR form. The Plan will also review the criteria for community benefit expenditures.

Finding B. 1.

The Plan agrees with the findings and reaffirms the Plan's implementation of a new FWA manual and processes in 2019, including effective policies and procedures regarding FWA activities and record retention practices.

Group Health Cooperative of South Central Wisconsin

[redacted]
Chief Compliance Officer

Report Fraud, Waste, and Mismanagement

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