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

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# Final Audit Report

**AUDIT OF THE FEDERAL EMPLOYEES HEALTH  
BENEFITS PROGRAM OPERATIONS  
AT AVMED**

**Report Number 1C-ML-00-19-019  
May 18, 2020**

# EXECUTIVE SUMMARY

## *Audit of the Federal Employees Health Benefits Program Operations at AvMed*

Report No. 1C-ML-00-19-019

May 18, 2020

### **Why Did We Conduct The Audit?**

The primary objective of the audit was to determine whether AvMed (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 procedures 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. In our opinion, 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 2876, the Office of the Inspector General (OIG) completed a performance audit of the FEHBP MLR submissions to OPM for contract years 2013 and 2014. We conducted our audit fieldwork from July 8, 2019, through January 15, 2020, at the Plan's offices in Gainesville, Florida, and in our OIG offices.

### **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, in contract years 2013 and 2014, our audit identified that the Plan had weak internal controls over portions of the FEHBP MLR reporting process. This control environment resulted in inaccurate reporting of fraud reduction expenses and recoveries, as well as capitation expenses derived using a methodology that did not adhere to applicable regulations and the Plan's own policy in 2014. Furthermore, the Plan had inadequate oversight to ensure accuracy of the FEHBP claims processing and reporting used in the numerator of the MLR.

The monetary impact of these issues was not significant enough to affect the 2013 and 2014 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 lead to incorrect reporting of the MLR in future years.



**Michael R. Esser**  
*Assistant Inspector General  
for Audits*

# ABBREVIATIONS

<b>CAC</b>	<b>Chiro Alliance Corporation, Inc.</b>
<b>CFR</b>	<b>Code of Federal Regulations</b>
<b>CL</b>	<b>Carrier Letter</b>
<b>Contract</b>	<b>Contract CS 2876</b>
<b>CPT</b>	<b>Current Procedural Terminology</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>FFS</b>	<b>Fee for Service</b>
<b>F&amp;A</b>	<b>Fraud &amp; Abuse</b>
<b>HMO</b>	<b>Health Maintenance Organization</b>
<b>MLR</b>	<b>Medical Loss Ratio</b>
<b>OIG</b>	<b>Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>Plan</b>	<b>AvMed</b>
<b>Quest</b>	<b>Quest Diagnostics Incorporated</b>
<b>SAS</b>	<b>Statistical Analysis System</b>
<b>SSSG</b>	<b>Similarly-Sized Subscriber Group</b>
<b>U.S.C.</b>	<b>United States Code</b>

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# I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at AvMed (Plan). The audit was conducted pursuant to the provisions of Contract CS 2876 (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 2013 and 2014, and was conducted at the Plan's offices in Gainesville, Florida.

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

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

The MLR was established to ensure that health plans are meeting specified thresholds for spending on medical care and health care quality improvement measures, and thus limiting spending on administrative costs, such as executive salaries, overhead, and marketing of the health plan. However, 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 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.

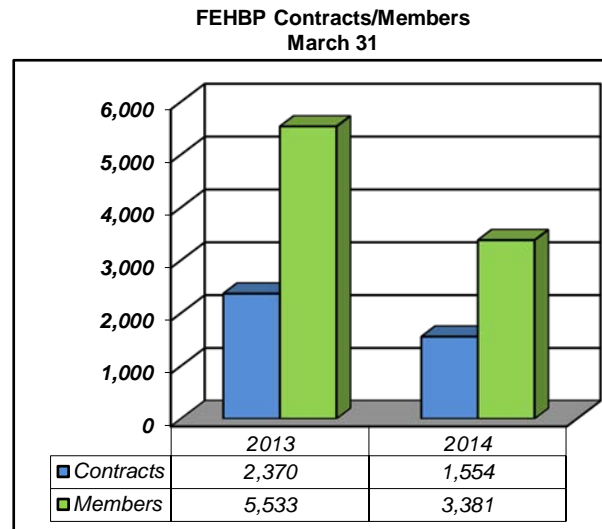
Starting with the pilot program in 2012 and for all non-traditional community-rated FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. This FEHBP-

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 2003 and provides health benefits to FEHBP members in South Florida.



A prior audit of the Plan covered the 2012 MLR submission. In that audit, we determined that the Plan inappropriately included a transport reinsurance claim totaling \$182,000 in its MLR calculation. The Plan agreed with the finding and the audit was closed.

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.

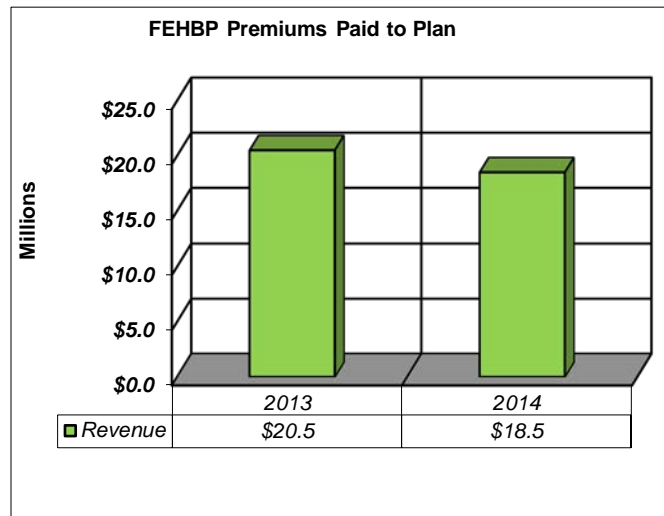
Although the FEHBP premiums used in the MLR calculation are ultimately determined by the premium rates proposed by the Plan and certified and paid by OPM, the OPM rating instructions no longer provide sufficient criteria to evaluate the fairness of those rates against the standard market value of similarly-sized 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 2013 and 2014. For these years, the FEHBP paid approximately \$39 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;
- 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 July 8, 2019, through January 15, 2020, at the Plan's offices in Gainesville, Florida, as well as in our offices in Cranberry Township, Pennsylvania and Washington, D.C.

## **METHODOLOGY**

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



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

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

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

# III. AUDIT FINDINGS AND RECOMMENDATIONS

## A. INTERNAL CONTROLS REVIEW

Per the Contract, Section 5.64, Contractor Code of Business Ethics and Conduct, “(c) ... The Contractor shall establish the following within 90 days after the contract award .... (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 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 internal controls system did not sufficiently meet the contractual criteria in the following ways:

### 1. Inaccurate MLR Reporting

We identified errors caused by a lack of documented policies and procedures and related oversight of the FEHBP MLR reporting process. Although these errors are procedural in nature, if left unaddressed they could materially affect future FEHBP MLR reporting requirements. As such, we identified the following:

#### a. Inaccurately Reported Fraud Reduction Expenses and Recoveries

In 2013 and 2014, we found that the Plan inaccurately and inconsistently reported fraud reduction expenses and recoveries to OPM.

Plans that contract with the FEHBP are required to file an annual Fraud and Abuse report (F&A) with OPM as established in FEHBP Program Carrier Letter (CL) 2003-25. The reporting of FEHBP specific fraud recoveries are part of the filing requirements on the F&A report, which is due March 31<sup>st</sup> for the preceding calendar year. Additionally, FEHBP contracted plans that are subject to OPM's MLR rules may report fraud reductions expenses (line 2.16a) and fraud recoveries that reduce paid claims (line 2.16b) on the MLR form for the prior calendar year. The MLR fraud reduction expenses and recoveries are regulated by 45 CFR §158.140(b)(2)(iv), which allows incurred claims adjustments (numerator of the MLR) from claims payments recovered through fraud reduction efforts no greater than fraud reduction expenses. However, in the FEHBP MLR form, both lines 2.16a and 2.16b must be

populated for the allowable fraud reduction expense total to be properly incorporated in the FEHBP MLR calculation.

Based on the FEHBP filing requirements and criteria, we found that the Plan reported actual FEHBP calendar year 2013 fraud recoveries on the F&A report, but allocated a portion of their large group book of business fraud recoveries to the FEHBP based on member months. The variation in fraud recovery reporting methods produced fundamentally different totals for the same calendar year and did not meet the requirements of 45 CFR §158.170 which states, “[MLR] allocation(s) ... should be based on a generally accepted accounting method that is expected to yield the most accurate results.”

Additionally, in contract year 2014 we found that the Plan incorrectly reported fraud reduction expenses as fraud recoveries that reduce paid claims. Furthermore, the Plan did not populate both 2014 FEHBP MLR form lines 2.16a and 2.16b, resulting in an increase to paid claims that was not applicable.

Although these errors were not significant enough to change the 2013 and 2014 MLRs, they represent weaknesses in the Plan’s internal controls related to OPM reporting requirements.

**Plan’s Response**

***The Plan agrees with this finding. It stated that its MLR preparation procedures have been updated to ensure accurate completion and validation of lines 2.16a and 2.16b and consistency with OPM’s Annual Fraud and Abuse Report.***

**b. Inaccurate Capitation Reporting**

During our review of the Plan’s capitation reporting process, we found that the 2013 and 2014 FEHBP capitation amounts were developed using an allocation methodology and did not report the actual capitation expenses attributable to the FEHBP. Although this was the Plan’s methodology in 2013, the Plan updated their policy to report actual capitation costs on the FEHBP MLR form in 2014. However, the updated 2014 policy was not utilized when completing the 2014 FEHBP MLR form.

Per 45 CFR 158.140(a), “direct claims paid to or received from providers, including under capitations contracts with physicians” are to be utilized in the MLR reporting. Additionally, 45 CFR 158.170(b)(1) states, “Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most

accurate results.” However, the Plan did not report actual FEHBP capitation cost, opting to allocate capitation expense from their large group book of business based on a ratio of FEHBP member months over large group member months. This methodology did not meet the regulations.

Furthermore, the Plan stated that they updated their 2014 capitation expense reporting process to report actual FEHBP capitation expense on the 2014 FEHBP MLR form. However, upon review we determined that the prior year method of allocating capitation expenses from the large group was used and the new process was not actually implemented.

The variance between the allocated and actual FEHBP capitation expense did not have a monetary impact on the MLR calculations in our audit scope. However, the Plan should strengthen their internal controls so that the most accurate data is utilized in the MLR calculation and updates to FEHBP MLR policies and procedures are implemented when policy changes are made.

**Plan’s Response:**

*The Plan agrees with this finding. It stated that guidance from OPM's Office of Actuaries indicates that the use of member months over the experience period is an acceptable methodology. However, it will update its MLR preparation and review procedures to ensure actual FEHBP specific capitation costs are included in the filing based on the audit finding.*

**2. Inadequate Oversight to Ensure Accuracy of Claims Processing and Reporting**

As part of the FEHBP MLR requirements and specified in CL 2014-18 and CL 2015-11, all plans subject to OPM’s MLR rules must submit detailed claims data used in the MLR calculation to OPM’s OIG. This data is sampled and tested by the OIG to determine the level of reliance that can be attributed to each Plans’ reported incurred claims total used in the numerator of the MLR.

Per our review of a sample number of medical claims, we found the following issues:

**a. Missing Claim Line Data**

We determined that the Plan did not submit all of the claim line level detail required by CL 2014-18. Specifically, the CL requires that the detailed claims line level data include FEHBP claims incurred during calendar year 2013, and paid through June 30,

2014. In the claims data, the claim line number and the total claim line number fields should represent the line number assigned to the specific charge line and the total number of line charges for each claim, respectively.

However, we found that the medical claims data did not include all of the claim lines for 3 of the 75 (4 percent) claims we reviewed. Additionally, the Plan does not have a process in place to reconcile the claims form and claim line data to the reports submitted to the OPM OIG and used in the FEHBP MLR. Although the impact of this issue did not materially change the MLRs in our audit scope, future MLR calculations may be over or under-stated if all claim lines are not accurately reported and used to populate the FEHBP MLR forms. Furthermore, if this issue is not addressed, the Plan will not be in compliance with the claims data requirement CLs moving forward.

**Plan's Response:**

*The Plan disagrees with this finding. It stated that it has reviewed and verified that the original data file submitted to OPM included all claim lines and the file was submitted in compliance with OPM's prescribed format and layout. The Plan stated that the claim lines are visible when opening the file with a text editor program and the data discrepancy is a software related issue pertaining to Excel.*

**OIG Comment:**

All carriers were instructed to provide the MLR claims data to the OIG in the mandatory layout outlined in CL 2014-18. CL 2014-18 further instructs carriers to provide the data in a fixed width flat file (text) and seek pre-approval from the OIG for any other format. The file is loaded into the OIG's Statistical Analysis System (SAS) and queried by the OIG. Excel is used to export the query results to obtain the Plan's comments during the OIG's claims review. Ultimately, it is the Plan's responsibility to ensure that the claims data is accurate and completely visible in the file submitted to the OIG.

**b. Fee-For-Service Claims Paid for Capitated Providers**

During our review of the sampled claims, we identified Fee-For-Service (FFS) claims paid for providers under capitation agreements with the Plan. The capitated costs are paid monthly to the providers based on FEHBP membership and the contracted rate. The total FEHBP capitated costs are added to the incurred FFS claims as part of the

MLR numerator. However, if FFS claims were also paid for services reimbursed under a capitated contract, the service may be accounted for in the MLR twice. The total capitated costs for use in the FEHBP MLR numerator are regulated by CL 2012-13 and CL 2013-11, which state, “Capitation and other costs considered as claims for MLR calculation that can be attributed to an FEHB benefit should be allocated in accordance with [U.S. Department of Health and Human Services] instructions. Any method other than member months over the experience period must be explained and approved by OPM’s Office of the Actuaries.” Furthermore, 45 CFR 158.140(a) states, “direct claims paid to or received by providers, including under capitation contracts with physicians” should be included in the incurred claims total of the MLR numerator.

However, in cases where there are FFS claims paid for a capitated provider, duplicate payment for member services may occur. Specifically, we found the following issues:

**i. Quest Diagnostics**

The Plan holds a capitation agreement with Quest Diagnostics Incorporated (Quest) that outlines capitated payments for member services designated by Current Procedural Terminology (CPT) code. During the review of our sampled claims, we found Quest FFS claims that could potentially be designated as capitated services. Due to this issue, we expanded our review of Quest FFS claims to all of the 2013 and 2014 FEHBP MLR medical claims data. Ultimately, we found 17 FFS claims paid to Quest in 2014 on CPT codes that were not specifically listed in the contract. Although the contract stipulates that “Specialty Testing” can be reimbursable if determined to be a covered service, documentation to support a covered service benefit was not provided.

**Plan’s Response:**

*The Plan disagrees with this finding. It stated that copies of the contract and amendment were provided that indicate certain CPT codes are paid as FFS, specifically the questioned claim samples.*

**OIG Comment:**

The documentation provided by the Plan included a thirteenth amendment to the Quest contract effective April 1, 2013. The thirteenth amendment stated, “Quest will receive capitation for Members in all counties inside and outside the AvMed

service area in the state of Florida except for the following counties, which are excluded from the Agreement: Clay[,], Duval[,], Nassau[, and] St. Johns[.]” We found that the 17 FFS Quest claims in 2014 were incurred in the county of Hillsborough (Tampa, Florida), which is not excluded by the thirteenth amendment. Furthermore, the CPT codes for these claims are not specifically listed in the contract, and the Plan did not supply documentation that supports that these 17 claims are considered “Specialty Testing”. As such, we maintain that these claims should not have been paid as FFS nor included in the 2014 FEHBP MLR medical claims data.

## **ii. Chiro Alliance Corporation**

The Plan holds an Outpatient Medical Services Agreement with Chiro Alliance Corporation, Inc. (CAC) that contains payment agreements for “Health Maintenance Organization (HMO) Products” and “All Other Products.” Specifically, HMO products are paid on a capitation basis and all other products are reimbursable on an FFS basis. Although the Plan’s contract with OPM designates both the high and standard option benefits as HMO products, we found that the Plan paid an FEHBP CAC member claim on an FFS basis. For this reason, we expanded our review of CAC providers to all of the 2013 and 2014 FEHBP MLR medical claims data. Our review of the expanded sample identified 194 CAC claims paid on an FFS basis.

### **Plan’s Response:**

***The Plan disagrees with this finding. It stated that the FEHBP included a high and standard option for 2013 and 2014. The high option was capitated for CAC services and the standard option was not, and therefore, it is appropriate to include capitated and FFS claims payments for the FEHBP.***

### **OIG Comment:**

We maintain that both the FEHBP high and standard options are HMO products as indicated in the 2013 and 2014 FEHBP brochure, and that the Plan’s contract with CAC clearly states that HMO products are to be paid on a capitation basis. Per the 2013 and 2014 Contract Section 1.13(a), “OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The Carrier bears full responsibility for the accuracy of its FEHB brochure.” As such, the FEHBP standard option CAC claims should fall under

the capitation agreement. Furthermore, these FFS CAC claims should not have been included in the 2013 and 2014 FEHBP MLR medical claims data.

**c. Members Misclassified or Unsupported**

During our review of 75 sampled claims, we identified 13 dependents less than 26 years of age that were incorrectly designated in the Plan's system as overage dependents. Due to the propensity for this issue, we expanded our review to include all of the Plan's 2013 and 2014 MLR claims data. This expanded review identified 657 members in 2013 and 579 members in 2014 as overage dependents when they were all less than age 26.

Furthermore, during our review of the initial claims sample, we identified three dependent members that were misclassified as subscribers in the Self Only tier. Additionally, the eligibility for one FEHBP subscriber could not be confirmed.

These issues stem from weak internal controls and oversight pertaining to the enrollment status field in the Plan's claims processing system. Additionally, the Plan's system lacks the programming to reconcile member birth dates to enrollment status. Although the Plan's misclassification of overage dependents did not result in the incorrect payment of claims during our audit scope, it could result in claims processing errors and the denial of dependent claim payments when coverage is available in future contract years. Furthermore, the incorrect classification of subscribers and dependents could lead to coverage issues for FEHBP members.

**Plan's Response:**

*The Plan agrees with this finding. It stated that it has corrected and updated all misclassifications of covered members. Furthermore, all impacted members' claims were originally paid correctly, with no impact to claims or premium payments.*

**d. Record Retention**

The Plan did not maintain contract termination language to ensure that contracts for four claims in our sample were effective during contract year 2013. Additionally, the contract pricing documentation provided by the Plan for six claims was not effective for contract year 2013.



OPM's Contract Section 1.11(b) requires insurance Plans to maintain all records relating to the contract and to make these records available for a period of time specified by Federal Employees Health Benefits Acquisition Regulation 1652.204-70. The referenced clause is incorporated into the contracts at Section 3.4, which requires the Plan to maintain "all records applicable to a contract term ... for a period of six years after the end of the contract term to which the claim records relate."

The missing contract language and pricing documentation indicate that the Plan does not have adequate internal controls in place to ensure that provider contracts and related pricing are kept current in the claims system and are filed for future use. Since the provider contract coverage terms and pricing were not available, the validity of the FEHBP claims could not be verified. Furthermore, the use of out of date contracts can result in incorrect pricing and payment of claims.

**Plan's Response:**

*The Plan agrees with this finding.*

**e. Claims Pricing Issue**

During our review of the claims samples, we identified one claim that was not priced according to the contract terms.

Per Contract Section 1.13, "(a) OPM and the Carrier shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The Carrier bears full responsibility for the accuracy of its FEHB brochure."

The Plan lacked adequate internal controls and oversight to identify that the claim was not priced according to the applicable contract terms. An FEHBP claim was paid at a rate that was not consistent with the terms of the provider contracts. This could result in the understatement or overstatement of FEHBP adjusted incurred claims and the MLR calculation.

**Plan's Response:**

*The Plan agrees that the claim was paid incorrectly.*

## **Conclusion – Internal Controls Review**

Based on our review, we found that the Plan had weak internal controls surrounding portions of the FEHBP MLR calculations that resulted in inaccurate MLR reporting. Furthermore, there is inadequate oversight to ensure that FEHBP claims are priced and reported according to the provider contracts and that those contracts are available and current.

### **Recommendation 1**

We recommend that the Plan strengthen their internal controls surrounding the review and reporting of the fraud reduction expenses and recoveries for the FEHBP MLR calculation.

### **Recommendation 2**

We recommend that the Plan report FEHBP specific capitation expenses on the FEHB MLR form to comply with applicable regulations and its own internal policy.

### **Recommendation 3**

We recommend that the Plan strengthen their internal controls so that policy and procedure updates are implemented in a timely manner.

### **Recommendation 4**

We recommend that the Plan implement an internal control process that reconciles the claim line detail from FEHBP member claim forms to the MLR claims data submitted to the OIG.

### **Recommendation 5**

We recommend that the Plan implement policies and procedures to ensure that FFS claims are not also paid on services by providers under capitation agreements, and that FEHBP member costs are only accounted for once in the FEHBP MLR.

### **Recommendation 6**

We recommend that the Plan implement policies and procedures to verify enrollment status (relationship codes) in its claims system.

### **Recommendation 7**

We recommend that the Plan adhere to the record retention clause in the FEHBP contract and maintain all records, including contract termination language and pricing data, for every FEHBP contract year.

### **Recommendation 8**

We recommend that the Plan strengthen its oversight and internal controls to ensure that claims are priced according to the contract terms and that the total collected copay is credited to the claim prior to payment.

## **B. MEDICAL LOSS RATIO REVIEW**

During the 2013 MLR filing period, the Plan's MLR was 79.56 percent, which did not meet OPM's lower threshold of 85 percent, resulting in a penalty due OPM of \$1,113,923. For the 2014 MLR filing period, the Plan's MLR was 102.31 percent, which exceeded OPM's upper threshold of 89 percent, resulting in a credit of \$2,409,828 that can be used to offset future penalties through contract year 2019. As stated in section A of this report, there were issues found in the reporting of the Plan's FEHBP MLRs for contract years 2013 and 2014. However, these issues were not material enough to monetarily impact the MLRs reported to OPM. We accept the Plan's filed FEHBP MLR's for 2013 and 2014.

# EXHIBIT A

## Medical Claims Sample Selection Criteria and Methodology

Universe Criteria	Universe (Number)	Universe (Dollars)	Sample Criteria and Size	Sample Type	Results Projected to the Universe?
Medical claims incurred from 1/1/2013 through 12/31/2013	31,062 claims	\$13,092,081	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

# APPENDIX



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Group Chief,  
Community-Rated Audits Group  
U.S. Office of Personnel Management Office of the Inspector General

Re: Audit of the Federal Employees Health Benefits Program Operations at AvMed Report Number 1C-ML-00-19-019

March 9, 2020

Dear **Deleted by the OIG – Not Relevant to the Final Report**:

AvMed is responding to the Draft Audit Report for OPM/OIG's audit of AvMed's MLR Calculation for the FEHB program for policy years 2013 and 2014. Please note:

- We have provided responses within the body of the Draft Report, so that we may address each item directly, where necessary, under the heading "AvMed Draft Audit Response:".
- For each finding, we have indicated where AvMed continues to agree or disagree with the findings.
- In specific examples where supporting documents were needed, you will find them as attachments in the body of the response.
- However, where supporting documentation is PHI-related or is considered proprietary in nature, we have sent such items to OPM/OIG through the SFTP portal set up for that purpose, and have identified the unique file names used in the responses.

Please review our Draft Audit Report response, and if you need any clarification for further explanation, please get in touch with us.

Sincerely,

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cc: **Deleted by the OIG – Not Relevant to the Final Report**

## A. INTERNAL CONTROLS REVIEW

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### 1. Inaccurate MLR Reporting

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#### a. Inaccurately Reported Fraud Reduction Expenses and Recoveries

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**AvMed Draft Audit Response:** The plan agrees with the finding and has updated its MLR preparation procedures to ensure accurate completion of form lines 2.16 and 2.16b consistent with actual FEHB fraud reduction expenses and recovery amounts reported in the annual Fraud & Abuse report filed with OPM, including validation of these amounts during the MLR review process.

#### b. Inaccurate Capitation Reporting

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**AvMed Draft Audit Response:** While AvMed agrees that CFR 158.140(a) requires "direct claims paid to or received from providers, including under capitations contracts with physicians" to be used for MLR reporting, we would like to note

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Capitation and other costs considered as claims for MLR calculation that can be attributed to an FEHB benefit should be allocated in accordance with HHS instructions. Any method other than member months over the experience period must be explained and approved by OPM's Office of the Actuaries.

There is a similar instruction for 2014.

This instruction appears to direct plans to use member months over the experience period, or at least indicates that it is an acceptable methodology to use. AvMed relied on this instruction, when determining how to comply with this reporting requirement. However, based on the audit finding the Plan will update MLR preparation and review procedures to ensure actual FEHBP specific capitation costs are included in the filing rather than using an allocation.

### 2. Inadequate Oversight to Ensure Accuracy of Claims Processing and Reporting

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a. Missing Claim Line Data

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**AvMed Draft Audit Response:** The plan disagrees with this finding. AvMed has reviewed the original data file submission, and has verified that: 1) all claim lines were included in the original data submission; and 2) the file was submitted in compliance with the prescribed format and layout. No data is missing from that file.

AvMed was able to replicate the issue OPM was seeing when opening the file in Excel. However, the claim lines were in the original file delivered to OPM, and all claim lines can be seen when opening the file with a text editor program. Therefore, the apparent data discrepancy appears to be a software issue related to opening the file in Excel, and not a deficiency with the file that AvMed submitted.

b. Fee-For-Service Claims Paid for Capitated Providers

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i. Quest Diagnostics

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**AvMed Draft Audit Response:** The plan disagrees with this finding. Here is our [prior] response **Deleted by the OIG – Not Relevant to the Final Report**, which we confirm is still applicable to this issue:

AvMed previously provided copies of Agreements for Quest Diagnostics. Please refer to the 12<sup>th</sup> Amendment, which covers the time period of the audit, and was previously submitted to OPM **Deleted by the OIG – Not Relevant to the Final Report**. This document indicates that certain CPT codes were to be paid Fee-For-Service under the terms of the contract. Specifically, for the claim samples in question, the CPT Code listing includes the codes under which the three claims samples were paid FFS. The contract language confirms that although coverage is capitated, certain codes also prompt fee-for-service payments.

ii. Chiro Alliance Corporation

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**Plan's Response:**

*The Plan disagrees with this finding. Specifically, the Plan states, “In 2013 and 2014, the FEHB program included both a High Option and Standard Option. The High Option was capitated for Chiro Alliance Corporation services. The Standard Option was not capitated for Chiro Alliance Corporation services. Therefore, it is appropriate to have both capitated payments and FFS claims payments for FEHB for 2013 and 2014.”*

**AvMed Draft Audit Response:** The plan disagrees with this finding, and is reaffirming our response above.

c. **Members Misclassified or Unsupported**

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**AvMed Draft Audit Response:** The plan agrees with this finding. AvMed has corrected all misclassifications to date to all covered members. Please note that all impacted members’ claims were originally paid correctly; there was no impact to claims or premium payments.

d. **Record Retention**

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**AvMed Draft Audit Response:** AvMed has re-reviewed this finding and is in agreement.

e. **Claims Pricing Issues**

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Claims Sample #59: Please see attached **Deleted by the OIG – Not Relevant to the Final Report**

The claim paid using the **Deleted by the OIG – Not Relevant to the Final Report**

AvMed Fee schedule instead of the **Deleted by the OIG – Not Relevant to the Final Report** Medicare Allowable schedule.

**As result, the claim was paid incorrectly.**

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## **Report Fraud, Waste, and Mismanagement**

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

**By Internet:** <http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse>

**By Phone:** Toll Free Number: (877) 499-7295  
Washington Metro Area: (202) 606-2423

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