



---

**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  
MD-INDIVIDUAL PRACTICE ASSOCIATION, INC.**

Report Number 1C-JP-00-15-035

February 26, 2016

-- CAUTION --

This audit report has been distributed to Federal officials who are responsible for the administration of the audited program. This audit report may contain proprietary data which is protected by Federal law (18 U.S.C. 1905). Therefore, while this audit report is available under the Freedom of Information Act and made available to the public on the OIG webpage (<http://www.opm.gov/our-inspector-general>), caution needs to be exercised before releasing the report to the general public as it may contain proprietary information that was redacted from the publicly distributed copy.

# EXECUTIVE SUMMARY

## *Audit of the Federal Employees Health Benefits Program Operations at MD-Individual Practice Association, Inc.*

Report No. 1C-JP-00-15-035

February 26, 2016

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

The primary objective of the audit was to determine if MD-Individual Practice Association, Inc. (Plan) was in compliance with the provisions of its contract and the laws and regulations governing the Federal Employees Health Benefits Program (FEHBP). We verified if the Plan met the Medical Loss Ratio (MLR) requirements established by the U.S. Office of Personnel Management (OPM). We also verified if the Plan developed the FEHBP premium rates using complete, accurate and current data.

### **What Did We Audit?**

Under Contract CS 1935, the Office of the Inspector General performed an audit of the FEHBP operations at the Plan. The audit covered the Plan's 2013 FEHBP premium rate build-ups and the MLR submission. Our audit fieldwork was conducted from March 30, 2015 through April 10, 2015, at the Plan's office in Cypress, California.



---

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

### **What Did We Find?**

This report questions \$11,363,178 for inappropriate health benefit charges to the FEHBP. Specifically, our audit identified the following:

- The Plan underpaid its MLR penalty for contract year 2013, as it could not support the capitation and other claim adjustment amounts reported in the MLR form as well as those shown in the claims submission to OPM. Additionally, the Plan did not provide documentation to support the Patient-Centered Outcomes Research Institute fee. As a result, the FEHBP MLR subsidization penalty account was underpaid by the Plan in the amount of \$11,363,178.
- The Plan did not provide the claims data to the Office of the Inspector General in the format required by Carrier Letter 2014-18. Additionally, the Plan's data submission contained information not applicable to the MLR rating and did not match the values that the Plan used in its 2013 MLR calculation.
- The Plan did not comply with Section 5.7(f) of its contract with OPM, as **it did not provide requested data in a timely manner, or at all in some cases. Additionally, access to the Plan's subject matter experts, who could have addressed our questions, was restricted.**
- Finally, the audit showed that the pricing of the FEHBP rates was developed in accordance with applicable laws, regulations, and OPM's Rate Instructions to Community-Rated Carriers for contract year 2013.

# ABBREVIATIONS

<b>ACA</b>	<b>Affordable Care Act</b>
<b>CFR</b>	<b>Code of Federal Regulations</b>
<b>FEHBAR</b>	<b>Federal Employees Health Benefits Acquisition Regulations</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</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>PCORI</b>	<b>Patient-Centered Outcomes Research Institute</b>
<b>Plan</b>	<b>MD-Individual Practice Association, Inc.</b>
<b>SSSG</b>	<b>Similarly Sized Subscriber Group</b>
<b>TCR</b>	<b>Traditional Community Rating</b>

# TABLE OF CONTENTS

	<u>Page</u>
<b>EXECUTIVE SUMMARY</b> .....	i
<b>ABBREVIATIONS</b> .....	ii
<b>I. BACKGROUND</b> .....	1
<b>II. OBJECTIVES, SCOPE, AND METHODOLOGY</b> .....	3
<b>III. AUDIT FINDINGS AND RECOMMENDATIONS</b> .....	7
1. Medical Loss Ratio (MLR) Penalty Underpayment .....	7
2. Carrier Letter 2014-18 Compliance .....	9
3. Availability of Records and Access to Subject Matter Experts .....	10
<b>IV. MAJOR CONTRIBUTORS TO THIS REPORT</b> .....	12
Exhibit A (Summary of Questioned Costs)	
Exhibit B (MLR Questioned Costs)	
Appendix (MD-Individual Practice Association, Inc.’s November 13, 2015 and December 23, 2015 responses to the draft report)	
<b>REPORT FRAUD, WASTE, AND MISMANAGEMENT</b>	

# I. BACKGROUND

This final report details the audit results of the Federal Employees Health Benefits Program (FEHBP) operations at MD-Individual Practice Association, Inc. (Plan). The audit was conducted pursuant to the provisions of Contract CS 1935; 5 United States Code (U.S.C.) Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit covered contract year 2013, and was conducted at the Plan's office in Cypress, California.

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 Chapter 1, Part 890 of Title 5, CFR. 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). MLR is the proportion of FEHBP premiums collected by a carrier that is spent on clinical services and quality health improvements. The MLR for each carrier is calculated by dividing the amount of dollars spent for FEHBP members on clinical services and health care quality improvements by the total amount of FEHBP premiums collected in a calendar year.

The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act (ACA, 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. Beginning in 2013, the MLR methodology was required for all community-rated carriers, except those that are state mandated to use traditional community rating (TCR). State mandated TCR carriers continue to be subject to the SSSG comparison rating methodology.

Starting with the pilot program in 2012 and for all non-TCR FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. OPM required that the FEHBP-specific MLR threshold calculation take place after the ACA-required MLR calculation, and that any rebate amounts due to the FEHBP as a result of the ACA-required calculation be excluded from the FEHBP-specific MLR threshold calculation. Carriers were required 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.

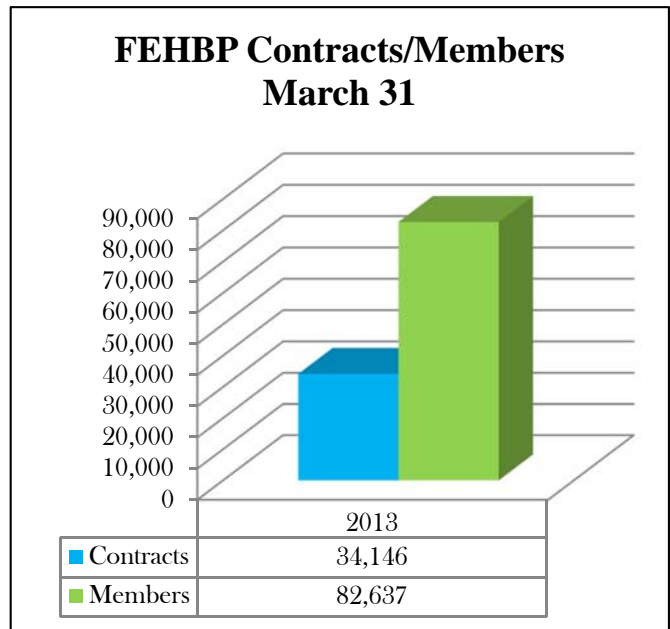
If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due.

Community-rated carriers participating in the FEHBP are subject to various Federal, state and local laws, regulations, and ordinances. While most carriers are subject to state jurisdiction, many are further subject to the Health Maintenance Organization Act of 1973 (Public Law 93-222), as amended (i.e., many community-rated carriers are Federally qualified). In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations promulgated by OPM.

The Plan reported 34,146 contracts and 82,637 members as of March 31, 2013, as shown in the chart below.

In contracting with community-rated carriers, OPM relies on carrier compliance with appropriate laws and regulations and, consequently, does not negotiate base rates. OPM negotiations relate primarily to the level of coverage and other unique features of the FEHBP.

The Plan has participated in the FEHBP since 1983 and provides health benefits to FEHBP members in the Washington, D.C., Maryland, Northern Virginia and Richmond areas. A prior audit of the Plan covered contract years 2010 and 2011. Additionally, a rate reconciliation audit was conducted on contract year 2012. There were no issues identified in these prior audits.



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 the Appendix to the report.

## II. OBJECTIVES, SCOPE, AND METHODOLOGY

### Objectives

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

### 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 year 2013. For contract year 2013, the FEHBP paid approximately \$435.1 million in premiums to the Plan.

The Office of the Inspector General (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. However, the audit included such tests of the Plan's rating system and such other auditing procedures considered necessary under the circumstances. Our review of internal controls was limited to the procedures the Plan has in place to ensure that:

- The rates charged to the FEHBP are developed in accordance with the Plan's standard rating methodology and the claims, factors, trends, and other related adjustments are supported by complete, accurate, and current source documentation; and
- The FEHBP MLR calculation is accurate, complete, and valid; claims are processed accurately; appropriate allocation methods are used; and, that any other costs associated with its MLR calculation are 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.

The audit fieldwork was performed from March 30, 2015 through April 10, 2015, at the Plan’s office in Cypress, California.

**Methodology**

We examined the Plan’s MLR calculation and related documents as a basis for validating the MLR. Further, we examined claim payments and quality health expenses 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 calculation. Finally, we used the contract, the Federal Employees Health Benefits Acquisition Regulations (FEHBAR), and the rate instructions to determine the propriety of the Plan’s MLR calculation.

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

The tests performed, along with the methodology, are detailed below by Medical and Pharmacy claims:

**Medical Claims Sample Selection Criteria/Methodology**

Medical Claims Review Area	Sample Universe Criteria	Sample Universe (Number)	Sample Universe (Dollars)	Sample Size	Sample Type	Results Projected to the Universe?
Coordination of Benefits (COB) – Medicare 2013	Paid claims for patients age 65+	██████████	\$ ██████████	Selected all claims greater than or equal to \$60,000; resulted in 12 claims totaling \$980,368.	Judgmental	No



Medical Claims Review Area	Sample Universe Criteria	Sample Universe (Number)	Sample Universe (Dollars)	Sample Size	Sample Type	Results Projected to the Universe?
Member Enrollment	All medical claims	██████	\$ ██████	Selected all claims greater than or equal to \$99,000; resulted in 22 claims totaling \$2,197,778.	Judgmental	No
Non-Covered Benefits (Radial Keratotomy)	All claim lines with LASIK CPT code 65771	No Hits	N/A	N/A	N/A	N/A
Non-Covered Benefits (Abortion)	All claim lines with elective abortion CPT codes 59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, 59866	█	\$ ██████	Selected 15 highest paid claims, totaling \$10,762.	Judgmental	No
Dependent Eligibility	Members with ages between 26 and 27	█	\$ ██████	Selected all claims greater than or equal to \$1,000; resulted in 40 claims totaling \$298,514.	Judgmental	No
Deceased Member	Members with ages greater than or equal to 90	█	N/A	Selected first 20 members from the universe.	Judgmental	N/A
Bundling/Unbundling	Claims containing all CPT codes 82330, 82374, 82435, 82565, 82947, 84132, 84295, 84520, 80047, 80048	No Hits	N/A	N/A	N/A	N/A

## Pharmacy Claims Sample Selection Criteria/Methodology

Pharmacy Claims Review Area	Sample Universe Criteria	Sample Universe (Number)	Sample Universe (Dollars)	Sample Size	Sample Type	Results Projected to the Universe?
High Dollar Scripts	Pharmacy claims greater than or equal to \$13,000	■	\$ ■	Auditor randomly selected 37 claims from the universe, totaling \$723,554.	Judgmental	No
Dependent Eligibility	Members with ages between 26 and 27	■	\$ ■	Selected first 20 samples from the universe, totaling \$18,781.	Judgmental	No
Deceased Member	Members with ages greater than or equal to 90	■	N/A	Selected first 20 members from the universe.	Judgmental	N/A

We also examined the rate build-up of the Plan's 2013 Federal rate submission and related documents as a basis for validating the Plan's standard rating methodology. We verified that the factors, trends, and other related adjustments used to determine the FEHBP premium rate(s) were sufficiently supported by source documentation. Further, we examined claim payments to verify that the cost data used to develop the FEHBP rates was accurate, complete and valid. Finally, we used the contract, the FEHBAR, and the rate instructions to determine the propriety of the FEHBP premiums and the reasonableness and acceptability of the Plan's rating system.

In addition, we examined the Plan's financial information and evaluated the Plan's financial condition and ability to continue operations as a viable ongoing business concern.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

## 1. Medical Loss Ratio (MLR) Penalty Underpayment

**\$11,363,178**

The MLR methodology replaced the Similarly Sized Subscriber Group requirements with an MLR threshold. Simply stated, the MLR is the ratio of the Federal Employees Health Benefits Program (FEHBP) incurred claims (including expenses for health care quality improvement) to total premium revenue determined by the Office of Personnel Management (OPM). For contract year 2013, the MLR program carriers must meet the OPM-established MLR threshold of 85 percent. Therefore, 85 cents of every health care premium dollar must be spent on health care expenses. If the MLR threshold is less than 85 percent, a carrier will owe a subsidization penalty equal to the difference between the threshold and the carrier's actual MLR.

MD-Individual Practice Association, Inc. (Plan) calculated an MLR of 85.09 percent and paid no penalty to OPM. However, during our review of the Plan's MLR submission, we found the following issues.

### **Capitation**

The Plan was unable to support \$8,427,735 of physician capitations and \$2,724,154 of other capitations reported in the Plan's 2013 MLR filing. To verify the reported capitation amounts, we sorted the primary and third party providers by total capitation paid and selected the top five largest capitation amounts for both categories. We then requested from the Plan the capitation agreements related to the selected providers to support the amounts reported. In almost all cases, the provider contracts did not include an amendment for the current year capitation rates. Additionally, the member months for the selected providers were not available; this is a key component in calculating total capitations paid. Since we could not verify any portion of the capitations that we tested, we removed these capitation amounts from our 2013 audited MLR calculation.

### **Plan Response:**

*“The Plan disagrees with ... removing the capitation amounts from the MLR calculation.” In its response to the Draft report, dated November 13, 2015, the Plan contends that the MLR documentation previously supplied, including queries from the General Ledger, supports the reported MLR numerator, including capitation. Additionally, the Plan provided an illustration of the data components in the MLR numerator. In its corrected response dated December 23, 2015, the Plan provided another example of the data components reported in the MLR numerator (see the Appendix).*

**OIG Comment:**

The Plan was unable to provide the requested capitation agreements to verify the contracted amount and total capitation applied in the MLR calculation. We maintain that the capitation amounts included in the MLR numerator cannot be verified and therefore should not be included.

**Other Claim Adjustments**

Additionally, the Plan was unable to support \$550,241 of claim adjustments related to State Stop Loss, Market Stability, and Medical Pools and Bonuses added to the 2013 MLR claim amounts. Since we could not verify these amounts or the reason why they were included, we removed them from our 2013 audited MLR calculation.

**Plan Response:**

*“The Plan disagrees with the Auditors interpretation that the numbers were in fact included in the MLR calculation ....” In its November 13, 2015 response, the Plan claims that the figure removed was not included in the original MLR calculation and, therefore, should not be removed from the auditor’s calculation. In its corrected response dated December 23, 2015, the Plan does not specifically address this issue again. However, the Plan’s Exhibit II shows State Stop Loss, Market Stability, and Medical Pools and Bonuses as a component of the MLR numerator.*

**OIG Comment:**

The Plan was unable to provide any additional documentation to support the \$550,241 in claim adjustments included in their MLR calculation. Because these claim adjustments could not be supported, we maintain that we were correct in removing them from our audited calculation.

**Patient-Centered Outcomes Research Institute (PCORI)**

The Patient-Centered Outcomes Research Trust Fund fee is a fee imposed on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans that helps to fund the PCORI. According to the Internal Revenue Service (IRS), the PCORI fee is applicable for policy plan years ending after September 30, 2012, and before October 1, 2019, and is an allowable pass-through cost to the FEHBP. The fee by year varies, however; for contract years ending after September 30, 2013, and before October 1, 2014, the applicable amount is \$2.00 per average number of lives covered during the policy year.

The Plan was unable to support the \$251,192 PCORI fee charged to the FEHBP and we contend that the PCORI fee is overstated. Based on the IRS guidance, we applied the \$2.00 per average number of lives to the FEHBP member months for calendar year 2013. The result of this calculation was \$165,679. Since the Plan could not provide support for its reported value and the IRS instructions clearly illustrate how the fee should be calculated, we used the \$165,679 in our 2013 audited MLR calculation.

**Plan Response:**

*The Plan disagrees with the finding and states they are in full compliance with the IRS guidance and have appropriately developed the PCORI fee according to this guidance. Consequently, the Plan maintains that no adjustment to this fee is warranted.*

**OIG Comment:**

The Plan was unable to provide any additional documentation to support the PCORI fee charged in the MLR calculation. Therefore, we contend that our audited calculation, which used a fee of \$165,679, is correct.

**Conclusion**

We removed the capitations and the other claims adjustments from the claims used in our 2013 audited MLR calculation. Additionally, we recalculated the Plan's unsupported FEHBP PCORI fee based on IRS guidelines and adjusted the Federal taxes and assessments portion of the MLR calculation accordingly. Based on these changes, our audited MLR ratio is 82.27 percent, resulting in an MLR subsidization penalty underpayment of \$11,363,178 (see Exhibit B).

**Recommendation 1**

We recommend that the contracting officer require the Plan to pay \$11,363,178 to the MLR subsidization penalty account for contract year 2013.

**2. Carrier Letter 2014-18 Compliance**

**Procedural**

Carrier Letter 2014-18 requires all MLR carriers to submit to the OIG detailed FEHBP claims data used in its MLR calculations in the format specified in the carrier letter. However, the Plan did not provide its claims data in the required format. Additionally, the Plan's data submission contained information not applicable to the MLR rating and did not match the values that the Plan used in its 2013 MLR calculation.

**Plan Response:**

*The Plan acknowledged that there was an issue with the required claims submission. Furthermore, the Plan stated that “It was not the intent ... to be out of compliance with Carrier Letter 2014-18 or any other instruction provided by OPM.” The Plan agrees to comply with formatting requirements as outlined by OPM/OIG in the future.*

**Recommendation 2**

We recommend that the contracting officer require the Plan to comply with the annual MLR carrier letter, which specifies required claims data submissions to the OIG and formatting requirements.

**3. Availability of Records and Access to Subject Matter Experts Procedural**

Contract CS 1935, Section 5.7(f), requires Contractors to “make available at its office at all reasonable times the records, materials, and other evidence ... for examination, audit, or reproduction ... .” Section 5.7(d)(1) also states that the OIG “shall have access to and the right to examine any of the [Plan’s] directly pertinent records involving transactions related to this contract ... and to interview any current employee regarding such transactions.”

However, during the course of the audit we found that the Plan **did not provide requested data in a timely manner, and in some cases, not at all. Additionally, access to the Plan’s subject matter experts having first-hand knowledge of the components of the MLR calculation and related source documentation was restricted.** Failure of the Plan to provide the OIG with the necessary records, materials, evidence, and access to subject matter experts to support the MLR submission is in direct violation of the contract and may lead to incomplete, inaccurate, and/or invalid cost or pricing data.

**Plan Response:**

*The Plan disagrees with the OIG’s characterization that auditor access was restricted, and that the subject matter experts were not made available as requested. Furthermore, the Plan stated that “Due to the complexity of the MLR process and the varying level of specificity required ... the Plan made every effort to ensure the appropriate subject matter experts were available to provide requested information.”*

**OIG Comment:**

During the pre-audit phase of this audit, it was evident that audit requests for documentation were not given priority by the Plan. The pre-audit standard information request was not

completely fulfilled by the requested date, and the on-site portion of the audit began before we received all requested documentation. We met with the Plan on March 23, 2015, to discuss the lack of response to our requests. Additionally, we contacted the OPM Contracting Office to notify them of our concerns.

Our on-site audit work began March 30, 2015, and additional requests for supporting documentation and meeting requests were made to complete the audit program. Again in some cases, support for requests was not provided in a timely manner. Also, meetings and contact information for MLR subject matter experts was greatly restricted. For example, the Plan could not provide sufficient MLR subject matter experts to answer related questions and provide the information needed to confirm the MLR filing, even though many of these meetings were requested prior to arriving on-site.

At the on-site close-out meeting on April 9, 2015, there were still 13 outstanding requests and 3 meetings that were not conducted while on-site, 1 of them being the claims processing meeting. OPM's Contracting Office participated in this meeting and scheduled another separate meeting to discuss the outstanding requests and the Plan's contract compliance.

On May 20, 2015, another information request was sent to the Plan, which contained six requests, including contractual support for the capitation payments and related members. The due date for these requests was May 26, 2015. However, as of the June 2, 2015 exit conference, we still had not received the requested information. The Plan stated that we would receive this information within a week, however, the contracts and membership related to the capitation payments was never provided.

The Plan's inability to make all materials, records, and subject matter experts available during the course of our audit greatly inhibited our ability to complete our review. Consequently, the findings outlined in this report are a direct result of the Plan's inability or unwillingness to address our requests and could have possibly been avoided had this access to information been granted.

### **Recommendation 3**

We recommend that the contracting officer require the Plan to comply with the terms of its contract and make available all materials, records, and subject matter experts during future OIG audits.

# IV. MAJOR CONTRIBUTORS TO THIS REPORT

## COMMUNITY-RATED AUDITS GROUP

██████████, Auditor-in-Charge

██████████, Auditor

██████████, Lead Auditor

██████████, Lead Auditor

---

██████████, Senior Team Leader

██████████, Group Chief



# EXHIBIT A

## MD-Individual Practice Association, Inc. Summary of Questioned Costs

### Contract Year 2013

Medical Loss Ratio Questioned Costs	<u>\$11,363,178</u>
Total Questioned Costs	<u>\$11,363,178</u>

# EXHIBIT B

## MD-Individual Practice Association, Inc. MLR Questioned Costs

<b>FEHBP Medical Loss Ratio</b>		<b>Plan</b>	<b>Audited</b>
OPM MLR Target		85.00%	85.00%
<b>Medical Loss Ratio Numerator</b>	Adjusted Incurred Claims	\$349,858,798	\$338,156,667
	Quality Health Improvement Expenses	\$4,260,507	\$4,260,507
	<b>MLR Numerator</b>	<b>\$354,119,305</b>	<b>\$342,417,174</b>
<b>Medical Loss Ratio Denominator</b>	Premium Income	\$435,090,847	\$435,090,847
	Federal and State Taxes and Licensing or Regulatory Fees	\$18,942,742	\$18,857,229
	Less: RBA Finding(s)	\$0	\$0
	<b>MLR Denominator</b>	<b>\$416,148,105</b>	<b>\$416,233,618</b>
FEHBP MLR Calculation		85.09%	82.27%
Penalty Calculation	<b>Penalty Due to OPM</b>	<b>\$0</b>	<b>\$11,363,178</b>
<b>Questioned Cost (MLR Underpayment)</b>			<b>\$11,363,178</b>

# APPENDIX



EMPLOYER & INDIVIDUAL

5701 Katella Avenue  
Cypress, CA 90630

December 23, 2015

[REDACTED]  
U.S. Office of Personnel Management Office of the Inspector General  
1900 E Street, N.W. Room 64  
Washington, DC 20415

RE: Correction to Comments to the Draft Audit Report on MD Individual Practice Association, Inc. Plan Code JP, Report No. 1C-JP-00-15-035

Dear [REDACTED]:

On November 13, 2015, the Plan provided a response to the Draft Audit Report for MD IPA (1C-JP-00-15-035) ("Draft Report"). Subsequent to submitting the response, the Plan discovered two significant errors made. The first is typographical the Plan inadvertently included an extra digit on Page Two of the response (refer to Exhibit 1) and represented the 2013 Total Medical Incurred Claims as \$3,444,895,693 whereas the actual number should have been \$344,895,693. The total represented on this same page correctly reflected the total of \$349,858,798 as illustrated on Part 2 of the FEHBP-specific MLR submission form. The numerator used for MLR calculation purposes includes the \$349,858,798 plus the Quality Improvement expenses of \$4,260,507 to derive the total \$354,119,305 which is illustrated on Part 5 of the submitted MLR Form. The plan apologizes for this glaring error and any inconvenience or confusion this may have caused.

The second and more critical error the Plan made in its response has to do with the MLR Penalty Underpayment explanation relative to the capitation payments. The Plan provided an explanation that the capitation payment was not included in the MLR figure and provided the components that were (refer to Exhibit I). This explanation was actually comparing the claims line level detail with the MLR aggregate total and was previously provided to the auditors. The information provided was relevant to the audit but was responsive to a different issue than was raised in the Draft Report.

Subsequent to providing the response to the Draft Report, the auditors asked a question regarding a figure on the MLR submission form. In providing the response to that question, the Plan recognized the error it had made in responding to the Draft Report. The MLR submission form

Report No. 1C-JP-00-15-035

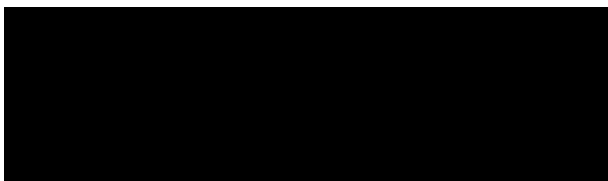
December 23, 2015

correctly includes the capitation payments made on behalf of FEHBP members and is included in the figure on line X of Part Y. The explanation of the capitation payment figure was provided to the auditors (please refer to Exhibit II).

The Plan does want to reiterate that the capitation payments should remain as part of the total figure included in the MLR calculation as these payments reflect the cost associated with the FEHBP membership and are appropriately included in the total claims figure.

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 ongoing cooperation.

Respectfully,

A large black rectangular redaction box covering the signature area.

Director

A small black rectangular redaction box covering the name of the Director.

# EXHIBIT I

(Exhibit I is the Plan's original response to the Draft Report, dated November 13, 2015. Since the Plan provided it again in their revised response, dated December 23, 2015, we've included it only once in the Appendix of this report.)



EMPLOYER & INDIVIDUAL

5701 Katella Avenue  
Cypress, CA 90630

November 13, 2015

[REDACTED]  
U.S. Office of Personnel Management  
Office of the Inspector General  
1900 E Street, N.W. Room 64  
Washington, DC 20415

RE: Comments to the Draft Audit Report on MD Individual Practice Association, Inc. Plan Code JP, Report No. 1C-JP-00-15-035

Dear [REDACTED]:

On September 10, 2015, the United States Office of Personnel Management, Office of the Inspector General ("OPM/OIG") submitted to the Plan a "Draft Report" (1C-JP-00-15-035) ("Draft Report"), detailing the results of its audit of the Federal Employees Health Benefits Program ("FEHBP") operations of the MD Individual Practice Association, Inc. ("MD IPA"), rate code JP, for contract year 2013. Upon submission, OPM/OIG requested that 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.

### **Medical Loss Ratio (MLR) Penalty Underpayment**

In its Draft Report, the auditors stated *"MD-Individual Practice Association, Inc. (Plan) calculated a MLR of 85.09percent and paid no penalty to OPM. However, during our review of the Plan's MLR submission, we found the following issues ..."*

#### **Capitation**

*The Plan was unable to support \$8,427,735 of physician capitations and \$2,724,154 of other capitations reported in the Plan's 2013 MLR filing. "*

November 13, 2015

The Plan disagrees with the auditors removing the capitation amounts from the MLR calculation. As was previously described by the Plan in a letter dated June 10, 2015, and prior to that communication demonstrated through the MLR filing support including the Essbase queries which extract data directly from our General Ledger, the MLR numerator is comprised of the following data elements:

- \$344,895,693 - 2013 Total Medical Incurred Claims (A)
- (\$ ) - June 2014 YTD Incurred Claims (B)
- \$ - June YTD Experience Change (C)
- \$ - 2013 Dental Incurred Claims (D)
- \$ - Allowable Fraud Reduction Expense (E)

---

\$349,858,798

(F) = (A) + (B) - (C) + (D) + (E)

The total figure of \$349,858,798 is seen on the MLR Form Tab 'Pt 5 MLR Calculation' Line 1.2 Total adjusted claims incurred in 2013, paid through 6/30 of 2014. Then Line 1.3 Quality improvement expenses of \$4,260,507 are added to derive the numerator used in the MLR calculation of \$354,119,305.

The figures presented here (and in the original MLR Filing Form submitted) **DELETED BY OIG – NOT RELEVANT FOR FINAL REPORT** demonstrate the numbers referenced by the OIG Auditors are not part of the MLR calculation and therefore should not be removed from the calculation.

#### **Other Claim Adjustments**

The Auditors state *"Additionally, the Plan was unable to support \$550,241 of claim adjustments related to State Stop Loss, Market Stability, and Medical Pools and Bonuses added to the 2013 MLR claim amounts. Since we could not verify these amounts or the reason why they were included, we removed them from our 2013 audited calculation."*

The Plan disagrees with the Auditors interpretation that the numbers were in fact included in the MLR calculation as the components outlined in this letter clearly demonstrate that the figure "removed" by the Auditors was not included in the original MLR calculation and therefore should not be removed from the MLR calculation.

#### **DELETED BY OIG – NOT RELEVANT FOR FINAL REPORT**

#### **PCORI Fee**

The Auditors state *"The Plan was unable to support the \$251,192 PCORI fee charged to the FEHBP and we contend that the PCORJ fee is overstated. Based on the IRS guidance, we applied the \$2.00 per average number of lives to the FEHBP member months for calendar year 2013. The result of this calculation was \$165,679....we used the \$165,679 in our 2013 audited MLR calculation."*

The Plan is unclear where the various numbers utilized in the Draft Audit report were obtained.

November 13, 2015

However, the Plan is in full compliance with the IRS guidance and has appropriately developed the PCORI fee according to said guidance. Therefore, the Plan does not believe the Auditors adjustment is warranted.

### **Conclusion**

In conclusion, the Plan disagrees with the monetary findings contained in the Draft Audit Report for the reasons provided in this correspondence in conjunction with the information provided throughout the audit process.

### **Carrier Letter 2014-18 Compliance**

The Auditors state *"....the Plan's data submission contained information not applicable to the MLR rating and did not match the values that the Plan used in its 2013 MLR calculation. We recommend that the contracting officer require the Plan to comply with the annual MLR carrier letter, which specifies required claims data submissions to the OIG and formatting requirements. "*

The Plan acknowledges that there was an issue with additional information not pertinent to the MLR calculation that was inadvertently included in the detail submitted. It was not the intent of the Plan to be out of compliance with Carrier Letter 2014-18 or any other instruction provided by OPM. The Plan will comply with formatting requirements as outlined by OPM/OIG.

### **Availability of Records and Access to Subject Matter Experts**

The Auditors state *"Per Contract CS 1935, Section 5.7(f), "the Contract shall make available at its office at all reasonable times the records, materials, and other evidence ...for examination, audit, or reproduction ....access to the Plan's subject matter experts having first-hand knowledge of the components of the MLR calculation and related source documentation was restricted. We recommend that the contracting office require the Plan to comply with the terms of its contract and make available all materials, records, and subject matter experts having first-hand knowledge of the MLR calculation submitted to OPM."*

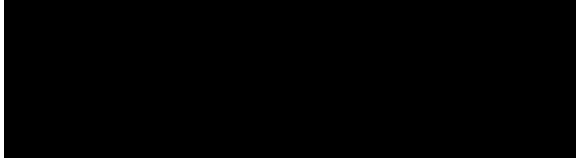
The Plan disputes the characterization that the access of the auditors was restricted. The subject matter experts were made available as requests by the auditors were made. Due to the complexity of the MLR process and the varying level of specificity required by the Auditors, the Plan made every effort to ensure the appropriate subject matter experts were available to provide requested information. In the event that it was determined that additional subject matter experts were required to provide clarity relative to the Auditors inquiry, the Plan made sure to schedule time with the appropriate parties to resolve any questions.

The Plan takes its contractual obligation very seriously and administers the FEHBP to be in compliance with all Federal regulations, contractual provisions and OPM instructions.



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 ongoing cooperation.

Respectfully,

A large black rectangular redaction box covering the signature area.A black rectangular redaction box covering the name.

Director

A black rectangular redaction box covering the title.

# EXHIBIT II

(Cover page only, as provided in Plan's response)

	December Bal
50000 - Physician Claims Paid - RPS	[REDACTED]
50010 - Physician Cap Paid - External	[REDACTED]
50090 - Physician Claims Paid - NonRPS	[REDACTED]
50100 - Outpatient Claims Paid - RPS	[REDACTED]
50200 - Inpatient Claims Paid - RPS	[REDACTED]
50290 - Inpatient Claims Paid - NonRPS	[REDACTED]
50400 - MH/SA Claims Paid - RPS	[REDACTED]
50490 - MH/SA Claims Paid - Non RPS	[REDACTED]
50899 - Other Capitation Pd - External	[REDACTED]
59999 - Miscellaneous Benefits Paid	[REDACTED]
Paid Claims - Medical Change	[REDACTED]
in Payable - Medical Change	[REDACTED]
in Reserve - Medical Rate	[REDACTED]
Credits	[REDACTED]
State Stop Loss, MktStab & CBA	[REDACTED]
Inc Claims Excl Prescriptions	[REDACTED]
Prescription Drugs	[REDACTED]
Pharmaceutical Rebates	[REDACTED]
Claims Incurred	[REDACTED]
Inc Med Inc Pools & Bonuses	[REDACTED]
Total Incurred Claims	344,895,693.23
Net Incurred Claims After Rein	344,895,693.23
Incurred Claims	344,895,693.23



## **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

-- CAUTION --

This audit report has been distributed to Federal officials who are responsible for the administration of the audited program. This audit report may contain proprietary data which is protected by Federal law (18 U.S.C. 1905). Therefore, while this audit report is available under the Freedom of Information Act and made available to the public on the OIG webpage (<http://www.opm.gov/our-inspector-general>), caution needs to be exercised before releasing the report to the general public as it may contain proprietary information that was redacted from the publicly distributed copy.

Report No. 1C-JP-00-15-035