



# Dave Yost • Auditor of State

## MEMORANDUM

**TO:** Local Region Chief Auditors

**FROM:** Celena Yoxtheimer, SSAE 16/SOC 1 Coordinator

**DATE:** June 30, 2015

**SUBJECT:** Aultra Administrative Group and AultCare Corp– SSAE 16 & AU-C 402

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Attached is the most recent Type II, unmodified, SSAE 16 SOC 1 report for the above-mentioned service organization related to claims processing services provided on behalf of employers in accordance with the benefits and health insurance plans established for qualified participants. The report covers the period January 1, 2014 through December 31, 2014.

Note that this SAS 70 also includes testing for AultCare Corporation, an affiliate service organization that provides network and claims processing system administration, electronic claims submission services, quality review services, plan building, and funding reconciliation services applicable to the processing of claims.

The carve-out method was used to disclose the organization's use of a subservice organization for processing of their pharmacy claims. Auditors should evaluate the significance of the carve-out disclosure for their respective audits.

Complementary User Entity Controls are documented on pages 11 and 16-17.

**The test results in section IV indicate there were “No relevant exceptions noted.” We confirmed with the IPA, this indicates there were no exceptions identified during test of controls.**

*Note:* Auditors should remember to document SOC 1 reports in accordance with AOSAM 30500 Appendix A. In addition, paragraph .14 states that we should not include complete copies of the reports in our working papers because they may contain confidential or proprietary information for which state or federal law prohibits disclosure – only this memo and pertinent excerpts should be included.

**Report on Controls Placed in Operation and  
Tests of Operating Effectiveness**

**Aultra Administrative Group**

**For the period January 1, 2014 through December 31, 2014**



Business Consultants and  
Certified Public Accountants

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## INDEPENDENT SERVICE AUDITOR'S REPORT

To the Board of Directors  
Aultra Administrative Group  
Canton, Ohio

### Scope

We have examined Aultra Administrative Group's and AultCare Corporation's description of their claims processing system throughout the period January 1, 2014 to December 31, 2014 (the "description") and the suitability of the design and operating effectiveness of Aultra Administrative Group's and AultCare Corporation's controls to achieve the related control objectives stated in the description. AultCare Corporation is an affiliated service organization that provides network and claims processing system administration, electronic claims submission services, quality review services, plan building, and funding reconciliation services applicable to the processing of claims to Aultra Administrative Group. Aultra Administrative Group's description includes a description of AultCare Corporation's claims processing system used by Aultra Administrative Group to process claims for its user entities, as well as relevant control objectives and controls of AultCare Corporation. The description indicates that certain control objectives specified in the description can be achieved only if complementary user entity controls contemplated in the design of Aultra Administrative Group's controls are suitably designed and operating effectively, along with related controls at the service organization. We have not evaluated the suitability of the design or operating effectiveness of such complementary user entity controls.

Aultra Administrative Group and AultCare Corporation use a third party administrator (subservice organization) for the processing of pharmacy claims. Aultra Administrative Group and AultCare Corporation's control objectives and related controls, which are listed in Section IV of this report, include only the control objectives and related controls of Aultra Administrative Group and AultCare Corporation and exclude the control objectives and related controls of the subservice organization.

The information in Section V of management's description of the service organization's system, "Other Information Provided by Aultra Administrative Group," is presented by management of Aultra Administrative Group to provide additional information and is not a part of Aultra Administrative Group's description of its claims processing system made available to user entities during the period January 1, 2014 to December 31, 2014. The information in Section V has not been subjected to the procedures applied in the examination of the description of Aultra Administrative Group's claims processing system and of the suitability of the design of controls and operating effectiveness to achieve the related control objectives stated in the description of the claims processing system and, accordingly, we express no opinion on it.

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To the Board of Directors  
Aultra Administrative Group

### **Service Organization's Responsibilities**

In Section II of this report, Aultra Administrative Group and AultCare Corporation have provided their assertions about the fairness of the presentation of the description and suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in the description. Aultra Administrative Group and AultCare Corporation are responsible for preparing the description and for the assertions, including the completeness, accuracy and method of presentation of the description and the assertions, providing the services covered by the description, specifying the control objectives and stating them in the description, identifying the risks that threaten the achievement of the control objectives, selecting the criteria, and designing, implementing and documenting controls to achieve the related control objectives stated in the description.

### **Service Auditor's Responsibilities**

Our responsibility is to express an opinion on the fairness of the presentation of the description and on the suitability of the design and operating effectiveness of the controls to achieve the related control objectives stated in the description, based on our examination. We conducted our examination in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform our examination to obtain reasonable assurance about whether, in all material respects, the description is fairly presented and the controls were suitably designed and operating effectively to achieve the related control objectives stated in the description throughout the period January 1, 2014 to December 31, 2014.

An examination of a description of a service organization's system and the suitability of the design and operating effectiveness of the service organization's controls to achieve the related control objectives stated in the description involves performing procedures to obtain evidence about the fairness of the presentation of the description and the suitability of the design and operating effectiveness of those controls to achieve the related control objectives stated in the description. Our procedures included assessing the risks that the description is not fairly presented and that the controls were not suitably designed or operating effectively to achieve the related control objectives stated in the description. Our procedures also included testing the operating effectiveness of those controls that we consider necessary to provide reasonable assurance that the related control objectives stated in the description were achieved. An examination engagement of this type also includes evaluating the overall presentation of the description and the suitability of the control objectives stated therein, and the suitability of the criteria specified by the service organization and described in Section II of this report. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

### **Inherent Limitations**

Because of their nature, controls at a service organization or subservice organization may not prevent, or detect and correct, all errors or omissions in claims processing. Also, the projection to the future of any evaluation of the fairness of the presentation of the description, or conclusions about the suitability of the design or operating effectiveness of the controls to achieve the related control objectives, is subject to the risk that controls at a service organization or subservice organization may become inadequate or fail.

To the Board of Directors  
Ultra Administrative Group

### **Opinion**

In our opinion, in all material respects, based on the criteria described in Ultra Administrative Group's and AultCare Corporation's assertion in Section II of this report:

- a. the description fairly presents Ultra Administrative Group's claims processing system and AultCare Corporation's claims processing system used by Ultra Administrative Group to process claims that were designed and implemented throughout the period January 1, 2014 to December 31, 2014.
- b. the controls related to the control objectives of Ultra Administrative Group and AultCare Corporation stated in the description were suitably designed to provide reasonable assurance that the control objectives would be achieved if the controls operated effectively throughout the period January 1, 2014 to December 31, 2014 and user entities applied the complementary user entity controls contemplated in the design of Ultra Administrative Group's and AultCare Corporation's controls throughout the period January 1, 2014 to December 31, 2014.
- c. the controls of Ultra Administrative Group and AultCare Corporation that we tested, which, together with the complementary user entity controls referred to in the scope paragraph of this report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period January 1, 2014 to December 31, 2014.

### **Description of Tests of Controls**

The specific controls tested and the nature, timing, and results of those tests are listed in Section IV of this report.

### **Restricted Use**

This report and the description of tests of controls and results thereof in Section IV of this report are intended solely for the information and use of Ultra Administrative Group, user entities of Ultra Administrative Group's claims processing system during some or all of the period January 1, 2014 to December 31, 2014, and the independent auditors of such user entities, who have a sufficient understanding to consider it, along with other information including information about controls implemented by user entities themselves, when assessing the risks of material misstatements of user entities' financial statements. This report is not intended to be and should not be used by anyone other than these specified parties.

*Bruner Cox LLP*

Canton, Ohio  
June 26, 2015

## Section II

### Management's Assertion, Description of Aultra Administrative Group, General Control Environment, and Overview of Operations

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#### **Management's Assertion**

We have prepared the description of Aultra Administrative Group's claims processing system (description) for user entities of the system during some or all of the period January 1, 2014, to December 31, 2014, and their user auditors who have a sufficient understanding to consider it, along with other information, including information about controls implemented by user entities of the system themselves, when assessing the risks of material misstatements of user entities' financial statements. We confirm, to the best of our knowledge and belief, that:

- a. The description fairly presents the claims processing system made available to user entities of the system during some or all of the period January 1, 2014, to December 31, 2014, for processing their transactions. Aultra Administrative Group uses AultCare Corporation, an affiliated service organization to provide network and claims processing system administration, electronic claims submission services, quality review services, and plan building applicable to the processing of claims. The description in section IV includes both the control objectives and related controls of Aultra Administrative Group and the control objectives and related controls of the affiliated service organization. Aultra Administrative Group uses a third party administrator for the processing of pharmacy claims. The description in section IV of this type 2 report excludes the control objectives and related controls of this third party administrator. The criteria we used in making this assertion were that the description:
  1. presents how the system made available to user entities of the system was designed and implemented to process relevant transactions, including, if applicable:
    - the types of services provided including, as appropriate, the classes of transactions processed.
    - the procedures, within both automated and manual systems, by which services are provided, including, as appropriate, procedures by which transactions are initiated, authorized, recorded, processed, corrected as necessary, and transferred to reports and other information prepared for user entities.
    - the related accounting records, supporting information, and specific accounts that are used to initiate, authorize, record, process, and report transactions; this includes the correction of incorrect information and how information is transferred to the reports and other information prepared for user entities.
    - how the system captures significant events and conditions, other than transactions.
    - the process used to prepare reports and other information for user entities.
    - the specified control objectives and controls designed to achieve those objectives, including as applicable, complementary user entity controls contemplated in the design of the service organization's controls.
    - other aspects of our control environment, risk assessment process, information and communication systems (including related business processes), control activities, and monitoring controls that are relevant to processing and reporting transactions of user entities of the system.
  2. does not omit or distort information relevant to the scope of the claims processing system, while acknowledging that the description is presented to meet the common needs of a broad range of user entities of the systems and their

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Management's Assertion, Description of Aultra Administrative Group, General Control Environment, and Overview of Operations

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- financial statement auditors, and may not, therefore, include every aspect of the claims processing system that each individual user entity of the system and its auditor may consider important in its own particular environment.
3. includes relevant details of the changes to the claims processing system during the period covered by the description.
- b. The controls related to the control objectives stated in the description were suitably designed and operating effectively throughout the period January 1, 2014, to December 31, 2014, to achieve those control objectives. The criteria we used in making this assertion were that:
1. the risks that threaten the achievement of the control objectives stated in the description have been identified by management;
  2. the controls identified in the description would, if operating as described, provide reasonable assurance that those risks would not prevent the control objectives stated in the description from being achieved; and
  3. the controls were consistently applied as designed, and manual controls were applied by individuals who have the appropriate competence and authority.

**Description of Aultra Administrative Group**

Aultra Administrative Group (Aultra) is an Ohio for-profit corporation established by the Aultman Health Foundation (AHF) in May 2006. It received a Third-Party Administrator license from the State of Ohio on July 1, 2006. During 2014, AHF transferred its ownership interest in Aultra to AultCare Holding Company.

The following services are offered by Aultra:

- Administration of payment of benefits (Medical, Dental, Vision, Short Term Disability, Life Insurance Billing and Flexible Spending Accounts)
- Sales and administration of group health insurance
- Administration of several different types of benefit plans, including Preferred Provider Organizations (PPO) and Traditional plans
- Plan document preparation/Group plan interpretation
- Eligibility Processing

AultCare and Aultra have an agreement to share certain functions between the two companies. AultCare provides certain services and functions to Aultra under a Corporate Services arrangement. These services include: Finance, Internal Audit/Quality Review, Reinsurance, Compliance, Information Systems, Claims Payment, and Technical Support.

Aultra contracts with leased networks which best match the employer group population for network providers. The networks are responsible for contracting with providers to accept negotiated fee allowances. When the enrollee utilizes a contracted provider, the provider agrees to not balance bill the enrollee for amounts billed over the contracted rate. When an enrollee visits a non-panel physician, the enrollee will be responsible for the charges that exceed the amounts approved by Aultra. Many times, Aultra will obtain discounts for non-network providers to avoid reasonable and customary application; however, the out of network benefits will still be applicable.

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### Management's Assertion, Description of Aultra Administrative Group, General Control Environment, and Overview of Operations

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Aultra maintains the necessary professional liability insurance and the necessary third-party administrator licensing in accordance with the terms of the group contracts.

This description is intended to provide the State of Ohio Office of the Auditors with the information about the internal control policies and procedures provided by Aultra related to health claims processing services. It is designed to provide sufficient information for the management of the employers utilizing Aultra and the State of Ohio auditors to obtain an understanding of Aultra's control policies and procedures in order to rely on the health insurance claims processed during the timeframe under audit. This report has been prepared taking into consideration the guidance contained in AICPA "Statement on Standards for Attestation Engagements No. 16 (SSAE 16), Reporting on Controls at a Service Organization".

#### **Organizational Structure and Values**

The Aultra Board of Directors oversees the overall business functions of the organization. The Senior VP of Aultra reports to the President/CEO of AultCare. The executive management team consists of Senior Vice Presidents, Vice Presidents and Associate Vice Presidents. Each operational Manager is responsible for the supervision of each Aultra department and reports to a member of the executive management team. Several Committees exist to ensure appropriate corporate level of review and approval of quality assurance and policies and procedures: Quality Management Performance Improvement Committee, Peer Review Committee, Membership Services Committee, Utilization Management Committee, Audit Committee, Investment Committee, Finance Committee, Compliance Committee, Privacy Committee and Executive Compliance Committee.

Aultra is committed to its employees. Aultra's hiring initiatives assure ethical, competent and customer focused people are placed in appropriate positions. All employees participate in new employee orientation where corporate ethical standards, mission and values, HIPAA privacy, workplace safety and corporate compliance policies are introduced. All employees participate in annual training which re-iterates corporate compliance. Employees also receive the appropriate departmental training which may include: one-to-one training, classroom training, departmental mentoring or supplemental training. Formal job descriptions establish expectations of each job's responsibilities, or tasks. Performance evaluations are conducted on an annual basis. Aultra's employees participate in EXCEerator Surveys, to give feedback necessary to continue improvement in the organization, as well as a comparison tool to industry averages. Communication across the organization is accomplished by: Semi-Annual Reviews, AultShare – intranet portal for employees, Leadership Info-Share meetings, Employee Info-Share meetings, Six Minute Scoop – bi-weekly news, as well as Departmental meetings. Employees are recognized for years of service as well as exceptional accomplishments through the Golden Apple and Rising Star Awards.

#### **System, System Access and Support**

The system that Aultra uses to process claims is RIMS (Resource Information Management Systems), supported by the TriZetto Group, who is the developer and the technical support provider for the RIMS System. Also, AultCare's Information Systems (IS) department administers some support. In order to assure proper claims processing, the following components must be setup correctly in RIMS: group plan setup involving proper benefit percentages of covered services, member enrollment, and provider setup. RIMS follows industry standards in compliance with current procedure and diagnosis codes.

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### Management's Assertion, Description of Aultra Administrative Group, General Control Environment, and Overview of Operations

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In addition to claims processing, the RIMS system has standard programs and reports used for communication with other departments and employer groups.

Daily backups and resolving computer problems both related and unrelated to the claims processing system are responsibilities of the Information Systems Department. They are also responsible for generating reports requested by managers and clients.

Security access into the RIMS system is monitored by the System Security Officer. Each employee is assigned an operator code and an adjuster code. The operator code is used to log into the system; the adjuster code is used to allow access to the appropriate RIMS functions by position responsibility, e.g., claims processing, member enrollment, and releasing held claims. Login codes automatically reset every 45 days to achieve proper security standards. An adjuster code is set specifically for the auto adjudication process.

#### **Group/Plan Procurement and Setup**

AultCare's Technical Support receives initial plan designs and retroactive plan changes from sales and is responsible for setting up each plan's benefits into the system. Benefits are maintained via a benefit matrix which contains benefit levels such as coinsurance, deductibles, out of pocket, levels of benefits relating to network and non network providers, etc. The claims payment system calculates the appropriate claim benefits based on the employer group's benefit matrix.

As each plan is completed, the Plan Builder submits the plan to the Quality Review Analyst (QRA) who uses a standardized checklist to review each plan and confirm that each benefit is set up accurately according to the plan design. Plan building review is completed on all new self-funded and unique insured plans. Plan review is also completed on significant changes to plan set-up. Results are recorded and reported and any necessary corrections are made prior to the plan's release for processing of claims.

Membership information is received from the employer's authorized representative via mail, fax or other electronic formats. Membership is entered according to plan guidelines with regard to eligibility, pre-existing condition, creditable coverage, coordination of benefits, administration of COBRA, etc. Upon initial enrollment and annually, appropriate coordination of benefit information is input by member, with regard to National Association of Insurance Commissioners (NAIC) guidelines. Member records are updated as advised by the enrollee or the company's authorized representative to include changes of addresses, addition of dependents, change in location, and verification of active employment or full time student status.

As new groups, members or plan options are added, Member Services is responsible for ordering the member ID cards to be mailed to the members. Identification card review is completed on 100% of members to verify ID card accuracy. All enrollment documents are imaged for future retrieval as needed.

Providers are entered manually or electronically into the RIMS system. Network providers are linked to the appropriate network contracts and fee tables based on their location. Non-network provider information is loaded from information supplied on claim forms submitted. The information entered includes provider Tax Identification number, National Provider Identifier, provider specialty, and payment information.

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### Management's Assertion, Description of Aultra Administrative Group, General Control Environment, and Overview of Operations

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#### **Claims Receipt**

Claims are received daily via mail, fax, interoffice mail, and electronically. Paper claims are sorted according to criteria for the Optical Character Recognition (OCR) process. Paper claims not meeting the criteria for the OCR process are forwarded to Claims Processing for manual entry. Certain pharmacy claims are processed by a third party, Pharmacy Data Management, Inc. (PDM).

Single paged Health Care Finance Administration (HCFA) claim forms are scanned into the OCR system in batches of approximately 50 claims. Data is extracted from each claim and sent through a verification process to review specific fields on each claim in addition to questionable characters. Batches are then sent through a validation process to select or validate additional information (i.e., diagnosis code, CPT code, etc.). Claims are then extracted into a Health Insurance Portability and Accountability Act (HIPAA) 837 file and run through an analyzer to confirm the file is HIPAA compliant. Compliant files are uploaded into the Electronic Data Interchange (EDI) system each day to be supplied to the EDI Support Department the following day.

Non-compliant files are reviewed and modified internally. Non-compliant files that cannot be corrected internally are supplied to Hyland Software, Inc. (OCR Software Vendor) for corrections. When corrected internally or returned from Hyland, the file is run through the analyzer to confirm it was accurately corrected. The file is then placed in the EDI system. The EDI system, Payor Connectivity System (PCS), is configured to reject at the claim or file level.

Electronically submitted claims/files received in the EDI system, including those loaded through the OCR process, and those received from PDM are tracked via a daily electronic claims submission (ECS) report. Defective claims/files are rejected if they contain a syntax error or eligibility error, which requires the entire file or claim to be returned to the provider/vendor for correction. The reports are balanced daily to assure all claims are accounted for.

Electronic files are programmatically sorted and downloaded into the system daily and referenced by a batch and claim reference number as assigned by the system based on the Julian Date.

#### **Claims Processing**

Repricing: Claims which are sent to Aultra directly require repricing. The employees of this area are responsible for ensuring the claim is repriced with the appropriate leased network and negotiated fee schedule. Some leased networks require claims to be sent directly from the provider's office to the leased network. These claims are received either electronically or in paper format and are sent through the adjudication process.

Electronic claims are processed through an automatic adjudication process in which the data is processed through the system matrix and the appropriate benefit is applied. Auto adjudication refers to the process by which a claim can be received electronically from the provider and, given that the claim contains all necessary information, is completely processed by the system without being touched by someone in one of the departments. The system assigns a claim number and adjudicator ID number to each claim adjudicated. Reports are generated to track the claims received and adjudicated electronically.

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Claims that do not meet the system criteria in order to completely adjudicate remain in the system for the Claims Analyst to analyze and manually complete the adjudication process. Each claim is analyzed according to Plan provisions and appropriate benefit application. The system assigns a claim number and the Analyst's ID number to each claim adjudicated.

All claims are edited through a comprehensive clinical based module called ClinicaLogic. ClinicaLogic examines claim coding accuracy, as well as reviews the relationship of the procedure code with the diagnosis code and dates of service. Edits occur during the adjudication process on both manual and electronic claims. ClinicaLogic provides a recommended action for the coding scenario billed. The action taken is communicated to the provider via the provider voucher. Examples of edits include, but are not limited to: lab bundling, services included in the surgical procedure, up-coding, experimental, etc. The edit record remains with the claim in history for retro-review.

For random review of the accuracy of claims payment, the RIMS system is set to randomly select claims processed by each processor which are then placed on hold. The number of randomly selected claims is set based on a given processor's experience and previous quality scores. Target holds are set by provider, dollar amount, processors in training, member holds, and individual group. Once the claim is reviewed, it is released from hold status and continues through the claim payment process. Quality statistics are tracked and reported on an ongoing basis.

### **Claims Payment**

Medical claim payments that produce a paper check are issued by an outside vendor, Advanced Business Fulfillment (ABF). During this process a check file is generated and placed on a website to be picked up by ABF. ABF will print the checks upon notification of the funding and Explanations of Benefits (EOB) will be produced for the provider and employee. Insured product plans close daily, Monday through Friday. Self funded groups close based on a designated schedule. The check file is produced based on a closing schedule for each employer group. A check log is created to list each check file that is generated.

835 Electronic Fund Transfer (EFT) files and 835 Electronic Remittance Advice (ERA) files are generated from the RIMS system during the daily check closing process. The EFT files are converted from the 835 Remit format to the standard Automated Clearing House (ACH) standard banking format.

The 835 Remit file conversion and routing of files to held or released status are performed at night via a scheduled script. A log file is generated to track the processing of each file. Released ERA files are placed in the EDI System for provider retrieval. Released EFT files are placed in bank folders. The following morning EFT files are transmitted from the bank folders to secure bank sites for processing.

EFT and ERA files for self-funded groups are held until funding is received. The release of the EFT and ERA files for self-funded groups is controlled by Ancillary Services.

Ancillary Services prepares and notifies the appropriate self-funded customer of the amount to fund from the claim check cycle. Funds are obtained via check, wire transfer, or draft. Groups

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that use their own checking account are notified to ensure appropriate funds are deposited into the account before the checks are released. The Insured Product checks are released daily.

**Control Objectives and Related Controls**

Aultra's control objectives and related controls are included in section IV of this report in order to eliminate the redundancy that would result from listing them in this section. Although the control objectives and related controls included are included in Section IV, they are, nevertheless, an integral part of Aultra's description of controls.

### Section III User Control Considerations

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Aultra's processing of transactions and the controls over the processing were designed with the assumption that certain controls would be implemented by user organizations. In certain situations, the application of specific controls at user organizations is necessary to achieve certain control objectives included in this report. In such instances, the required user organization controls are identified under the related control objective in Section IV of this report.

This section describes additional controls that should be in operation at user organizations to complement the controls at Aultra. User auditors should determine whether user organizations have established controls to ensure that:

- Timely written notification of changes to the service agreement, user organization employees, and other relevant information is adequately communicated to Aultra.
- Timely review of reports provided by Aultra is performed by user organizations, and written notice of discrepancies is provided to Aultra.
- Instructions and information provided to Aultra from user organizations are in accordance with the provisions of the service agreement.

The list of user organization control considerations presented previously and those presented with certain specified control objectives do not represent a comprehensive set of all the controls that may be employed by user organizations. Other controls may be required at user organizations.

## Section IV Summary of Key Control Testing and Verification

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Our tests of the effectiveness of control objectives included such tests as we considered necessary to evaluate whether those controls, and the extent of compliance with them, are sufficient to provide reasonable, but not absolute, assurance that the specified control objectives were achieved during the period from January 1, 2014 to December 31, 2014. Our tests of the operational effectiveness of control objectives were designed to cover a representative number of transactions and procedures throughout the period January 1, 2014 to December 31, 2014. A random sample of 60 claims was selected to test the intake, eligibility, claims, and disbursement processing. For each of the controls we tested, the following was considered:

- The nature of the item being tested
- The types and competence of available evidential matter
- The nature of the control objective(s) to be achieved
- The assessed level of control risk
- The expected efficiency and effectiveness of the test

The results of testing of the control objectives were satisfactory to conclude that controls were operating effectively to provide reasonable, but not absolute, assurance that the control objectives were achieved during the period January 1, 2014 to December 31, 2014.

The following pages describe those tests performed to verify the control objectives.

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 Summary of Key Control Testing and Verification

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**GENERAL COMPUTER CONTROLS**  
**SYSTEM DEVELOPMENT AND MAINTENANCE**

**Control Objective #1**

Controls provide reasonable assurance that changes to existing system software and implementation of new system software/applications are authorized, tested, approved, properly implemented and documented.

	<b>Description of Controls Provided by Aultra</b>	<b>Tests of Operating Effectiveness</b>
1.1	Externally obtained changes to existing system software and acquisition of new system software are tested at the department and organization levels, the results of which are reviewed by committee or authorized department representative prior to implementation.	Inspected testing documentation and committee correspondence related to the implementation and approval of one change to the RIMS system.
1.2	Internally developed changes to system software are logged in a change log. Each change is tested and approved prior to implementation.	For a sample of 25 internally developed changes, inspected the related change control checklist noting that each change was tested and approved prior to implementation.

**Results of Tests of Operating Effectiveness:** No relevant exceptions noted

Section IV  
 Summary of Key Control Testing and Verification

**PHYSICAL ACCESS AND BACKUP**

**Control Objective #2**

Controls provide reasonable assurance that physical access to facilities, computer equipment and storage media is limited to properly authorized individuals and that programs and data are backed up on a scheduled basis.

	<b>Description of Controls Provided by Aultra</b>	<b>Tests of Operating Effectiveness</b>
2.1	At all times, the Company ensures restricted physical access to computer equipment by way of security access code or magnetically sealed entrances through which no unauthorized personnel can enter without approval.	Observed secured entrances to ensure restricted access.  Observed that the server was located in a room that is locked at all times. Observed information systems department personnel gain access to the room by entering a passcode. Attempted to gain access to the server room; access was denied because we did not enter the correct passcode.
2.2	Daily back ups are performed. Back up tapes are picked up daily by a third party vendor, Monday through Friday, and stored off site in a secure building that is climate and humidity controlled.	For a sample of 4 days, inspected the log of daily back ups and the third party vendor pickup log.

**Results of Tests of Operating Effectiveness:** No relevant exceptions noted

Section IV  
Summary of Key Control Testing and Verification

**LOGICAL ACCESS**

**Control Objective #3**

Controls provide reasonable assurance that logical access to programs, data, systems, security, job-scheduling software, and program documentation and performing accounting functions is limited to properly authorized individuals.

	<b>Description of Controls Provided by Aultra</b>	<b>Tests of Operating Effectiveness</b>
3.1	Logical access to system and application software is restricted to authorized personnel through the use of passwords.	<p>Observed the operating system and RIMS parameters noting that access is restricted with the use of passwords to verify that operating system passwords must conform to minimum complexity requirements.</p> <p>Observed program documentation restricted to Information Systems Department in their restricted electronic file which is password protected. Attempted to gain access to the program documentation through random personnel. Access was denied because we did not enter the correct password.</p>
3.2	Processes exist and are followed so that removing user access to the network occurs timely.	For a sample of 7 terminated employees, inspected system access removal documentation to verify that network access was removed timely.
3.3	Access to RIMS function is controlled through the setup of adjuster codes. The System Security Officer establishes RIMS operator/adjuster codes for newly hired employees and maintains a log which tracks RIMS operator/adjuster code changes for employees who change departments within the organization.	<p>For a sample of 4 employees, inspected respective adjuster code setup in RIMS to verify that access rights were commensurate with their duties.</p> <p>For a sample of 6 employees transferring departments, inspected RIMS access change documentation to verify that RIMS access was changed timely.</p>
3.4	RIMS passwords must be changed every 45 days. Network passwords must be changed every 60 days.	Inspected RIMS and network password settings to determine if password setting for expiration were in accordance with the Company requirements.

**Results of Tests of Operating Effectiveness:** No relevant exceptions noted

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 Summary of Key Control Testing and Verification

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**CLAIMS PROCESSING CONTROLS**

**PLAN REVIEW**

**Control Objective #4**

Controls provide reasonable assurance that the Plan Documents are properly input into the computerized claims processing system.

<b>Description of Controls Provided by Aultra</b>	<b>Tests of Operating Effectiveness</b>
<p>Upon completion of each plan build/change, the Plan Builder submits the plan to the Quality Review Analyst (QRA) for review. The QRA uses a comprehensive checklist designed to assure that benefits are set up accurately per the plan design. The percentage of accuracy is calculated based on a point system, and the results are recorded.</p> <p><b>User Control Consideration:</b>            Timely written notification from appropriate employer group representative of changes and/or amendments to plan design as built into the claims processing system for the user organization.</p>	<p>For a sample of 26 plan changes, inspected documentation from the Quality Review database supporting that the change was reviewed.</p>

**Results of Tests of Operating Effectiveness:** No relevant exceptions noted

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**ENROLLMENT**

**Control Objective #5**

Controls provide reasonable assurance that participant data is accurately input in the computerized claims processing system.

	<b>Description of Controls Provided by Aultra</b>	<b>Tests of Operating Effectiveness</b>
5.1	Each member is assigned a unique identification number, under which all member information is maintained. The member ID number is required to enter and process claim information.	For each enrollee in a sample of 60 claims, verified that the corresponding enrollment and claim data was segregated from other enrollee data through the use of a unique member ID number in the claims processing system.
5.2	<p>Supervisory personnel review a sample of enrollment changes on a bi-weekly basis in order to monitor the accuracy of inputted enrollment updates. Results are documented and reported.</p> <p><b>User Control Considerations:</b>            User organizations are responsible for establishing controls at the user organization to ensure that changes to enrollment are communicated to Aultra accurately and timely.</p> <p>User organizations are responsible for establishing controls at the user organization to restrict and notify of changes to the representative authorized to instruct Aultra regarding activities on behalf of the user organization.</p>	Inspected a sample of 6 bi-weekly reports documenting the result of the internal department review as to the accuracy of inputted enrollment information.

**Results of Tests of Operating Effectiveness:** No relevant exceptions noted

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**CLAIMS RECEIPT**

**Control Objective #6**

Controls provide reasonable assurance that claim submissions are properly tracked and controlled from the time of receipt, are received from authorized sources, and submissions are recorded completely and accurately.

	<b>Description of Controls Provided by Aultra</b>	<b>Tests of Operating Effectiveness</b>
6.1	Vendors and clearinghouses who submit claims electronically must test HIPAA compliant files for compatibility prior to live claims submission. Timely notification of format changes after approval is requested in order to maintain continuity of claims adjudication.	For a sample of 2 new vendors/clearinghouses, inspected ECS testing documentation.
6.2	Electronically submitted claims/files received in the EDI system are tracked via a daily ECS report. Defective files/claims are rejected if they contain eligibility or syntax errors, which require the entire file or claim to be returned to the provider/vendor for correction. The report is balanced daily to ensure all claims are accounted for. These claims are run through a matching program to ensure all elements required are present and loaded into the system. Claims requiring additional matching are manually reviewed in the AultCare EDI Support Department. Once the matching is complete the file is run through the adjudicator. Claims not able to be run through the adjudicator or "fall out" due to not meeting specifications required by the system are routed to the Approving Department or Claims Department for final adjudication of the claim.	Inspected a sample of 25 ECS reports to verify that they were balanced.  For each of the 60 claims selected, verified that the information in the system agreed to that of the bill received.

**Results of Tests of Operating Effectiveness:** No relevant exceptions noted

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**CLAIMS PROCESSING CONTROLS**

**Control Objective #7**

Controls provide reasonable assurance that all claim transactions are processed completely and accurately and in accordance with the plan document.

	<b>Description of Controls Provided by Aultra</b>	<b>Tests of Operating Effectiveness</b>
7.1	The RIMS system provides that claims are processed completely and accurately.	For each of the 60 claims selected verified that the proper amount was paid to the provider or enrollee based on whether the providers were in-network or out-of-network and in accordance with enrollee out-of-pocket expense limitations, deductibles, payment percentages per the plan document, and the type of service provided to the patient
7.2	Analysts compare the results of any actions they take with the on-screen results. Any action taken by an examiner instantly updates the participant's history file for up-to-date tracking of deductibles and coinsurance payments.	Refer to control 7.1 testing.
7.3	As claims are processed in the claims processing system, the system searches the history files for duplicate claim potential by provider, date of service, and total charge. If potential exists, the Analysts are prompted and they can investigate further to verify.	For each of the 60 claims selected, verified that the check was cashed by the payee and cleared the appropriate bank account.
7.4	Only designated personnel have access to the voiding functions. All voids are recorded in the history files on the system with reports going to the Accounting Department.	For a sample of 18 employees, inspected respective adjusted code setup in RIMS to verify that only supervisory personnel have access to void claims.
7.5	All Benefit Analysts have limited access to only those programs necessary for the adjudication of claims. They have inquiry access to eligibility data.	For a sample of 4 employees, inspected respective adjuster code setup in RIMS to verify that access rights were commensurate with their duties.
7.6	Claims are selected for quality review using frequency and dollar thresholds set by processor based on the respective processor's experience and by selected criteria used to focus on specific claims, including but not limited to provider's claims with charges greater than \$30,000, trainees, provider, members, and groups. The Quality Review department completes a review of all claims selected.	Inspected the setup in RIMS to place claims on hold at the processor level for quality review. Inspected the Quality Review department's database of reviewed claims noting that claims were reviewed at the processor level as selected by the RIMS system.  For a random sample of 25 claims in excess of the \$30,000 threshold, verified that they were reviewed by Quality Review.

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**Control Objective #7 (Continued)**

	<b>Description of Controls Provided by Aultra</b>	<b>Tests of Operating Effectiveness</b>
7.7	All participant's histories are updated at the time a new claim is processed to allow for the most up-to-date accuracy of the participant's coinsurance and deductible obligations, and to disallow duplicate claim submissions.	Observed that the RIMS system updates participant histories as each new claim is processed.
7.8	An enrollee's social security number and/or member ID must be entered to manually input a claim. Therefore, if a social security and/or member ID was entered into the RIMS system and it did not match to any enrollees in the system, the claim cannot be entered. The processor must then find out which enrollee the claim should be entered under and also verify that they have the correct social security number and/or member ID.	Inquired of claims processing personnel and observed the process of manually entering claims noting that the RIMS system requires a valid member ID in order to enter claims.

**Results of Tests of Operating Effectiveness:** No relevant exceptions noted

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**CLAIMS PAYMENT**

**Control Objective #8**

Controls provide reasonable assurance that all client claims related transactions, remittances, and payments are accurately tracked and accounted for.

	<b>Description of Controls Provided by Aultra</b>	<b>Tests of Operating Effectiveness</b>
8.1	For each of Aultra's customers, Aultra requires checks to be processed out of the Aultra account or out of the individual customer's account.	Observed that the appropriate checking account information was maintained in the system for each of the employers in the sample during the claims testing process.
8.2	Ancillary Services contacts the employers the morning after the checks were cut to inform them of the amount that needs to be deposited into their reimbursement account. The employers provide an email which indicates that a deposit has been made to the reimbursement account. Customers that do not provide Aultra with checking account access are billed for the necessary charges. Funds received from customers are deposited the day of receipt and reconciled to the outstanding claims prior to the release of payment. The appropriate department is contacted to timely release payment.	For a haphazard sample of 30 daily funding reconciliations, receipt and deposit of funding checks was verified for proper company credit on the daily cash reconciliation and traced to the bank statement or validated bank receipt. In addition, it was verified that the claim checks were released in a timely manner after the funding was received from the client.
8.3	Website access to release checks generated by ABF is assigned only to authorized individuals and controlled through user ID and password.	Inspected the rights assigned to users noting that the ability to release checks is limited to authorized employees. Observed that access to the ABF website requires a user ID and password.
8.4	Access to process EFT files is restricted to authorized individuals through domain security.	Observed that EFT files are restricted to authorized individuals through the use of domain security.

**Results of Tests of Operating Effectiveness:** No relevant exceptions noted

The information in this section is presented by Aultra Administrative Group to provide additional information and is not a part of Aultra Administrative Group's description of controls that may be relevant to user organizations' internal control. Such information has not been subjected to the procedures applied in the examination of the description of the claims processing system and accordingly, Bruner Cox LLP expresses no opinion on it.

#### **Disaster Recovery and Continuity of Operations**

A system recovery plan is documented and tested. The server room is equipped with an automatic fire extinguisher system and the computer systems are on a dedicated electrical circuit segregated for all other output devices to maintain circuit integrity. The system is equipped with an uninterrupted power supply (UPS) unit that will allow for the proper shut down of the system in the event of power loss.

#### **Confidentiality**

Confidentiality agreements, conflict of interest statements, corporate compliance policies, and agreements regarding the use of electronic communications must be signed by each employee at their annual review.

#### **Sales and Retention**

The Sales and Retention Departments are responsible for new group procurement and annual plan renewals, as well as documenting the employer group's intent and coverage requirements of the plan. They also facilitate an employer group's intent to make benefit changes and review various plan options at the annual renewal. The Sales and Retention departments focus on client retention, and provide open enrollment education, as well as assisting with service issues at an employer group level. All information is documented and relayed to the Technical Support Department for initial plan set up or benefit revisions.

#### **Refunds and Voids**

All checks received as a refund are routed to the EDI Support Department at AultCare for logging and routing to the appropriate department. A copy of the check and any detail is sent to the Claims Department to be investigated and written up for resolution. Upon completion paper work is routed back to EDI to complete the refund in the RIMS system and issue proper credit to the client if applicable.

#### **Subrogation**

AultCare's Subrogation Department is responsible for subrogation recovery for Aultra Administrative Group. Responses to subrogation inquiries are routed to the Subrogation Specialist. The Specialist reviews the form to determine if there is a third party responsible. If there is, it is logged into a database. The file is noted and forwarded to Claims Department to release any pending claims or the claims remain held until recovery is made, as determined by the Plan. The Subrogation Specialist will follow up with the appropriate third party representative or outside counsel for resolution.

### **Fraud Prevention**

The Fraud Officer reports to the Associate Vice President of Internal Audit & Fraud, Compliance and is responsible for detection and awareness of employee, enrollee, and provider fraud and abuse. The Fraud Officer trains all employees as needed. Information on Enrollee and Provider Fraud issues are obtained through National Health Care Anti-Fraud Association updates, the Ohio Department of Insurance, Law Enforcement, the FBI, and AultCare's Fraud Hotline. Information received is evaluated by the Fraud Committee. Action plans are implemented based on activity for each provider or type of fraud.

### **Appeals and Grievances**

Appeal and grievances are facilitated through the Compliance Department. Appeals and grievances are distributed to the appropriate operational department to research and resolve according to Plan and regulatory standards. The Grievance and Appeals Coordinator works collaboratively with the operational departments to formulate a response to the appellate. All medical grievances and appeals are responded to the appellate by the Utilization Management department. All documentation to support the decision and/or response is retained and tracked to assure appropriate turn around time and quality. Trends are reported to the Quality Committee.

### **Utilization Management Department**

The Utilization Management Department works under the advisement of the Medical Director and is comprised of Registered and Licensed Practical Nurses along with clerical staff. A Behavioral Health Practitioner directs the utilization management process as it relates to issues pertaining to behavioral health. The Utilization Management team manages the utilization of health care services including but not limited to the following: pre-certification for pre-admission and admission certification, experimental/investigational services, review of and evaluation of requests for health care goods and services on the basis of appropriateness, necessity and quality as well as ensuring that the health care provided is within the parameters of the plan design and within the determined provider network. When it is not possible to provide the services within the network, the Utilization Management team will help the member's physician facilitate a referral to a non-network provider. The Utilization Management team reviews claims for health care goods and services that have been delivered including but not limited to: durable medical equipment, chiropractic, high dollar cases, home health care, experimental/investigational services, and inpatient hospital/skilled nursing facility confinements. New and existing technology are monitored and assessed not less than annually, and as needed. Coverage determinations are based upon scientifically sound, evidence based criteria.

Utilization Management, Case Management and Disease Management work collaboratively to facilitate quality, cost effective care. As indicated, chronic disease and/or catastrophic cases are referred to a Case Manager for coordination of services to achieve this level of care throughout the continuum of care and disease process.