



**U.S. Office of Personnel Management
Office of the Inspector General
Office of Audits**

Final Audit Report

**Audit of
BlueCross BlueShield of Tennessee
Chattanooga, Tennessee**

**Report Number 1A-10-15-21-023
August 25, 2022**

Executive Summary

Audit of BlueCross BlueShield of Tennessee

Report No. 1A-10-15-21-023

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Why did we conduct the audit?

We conducted this limited scope audit to obtain reasonable assurance that BlueCross BlueShield of Tennessee (Plan) is complying with the provisions of the Federal Employees Health Benefits Act and regulations that are included, by reference, in the Federal Employees Health Benefits Program (FEHBP) contract. The objectives of our audit were to determine if the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract.

What did we audit?

Our audit covered miscellaneous health benefit payments and credits, such as refunds and medical drug rebates, as well as administrative expense charges and statutory reserve payments for contract years 2016 through 2020, as reported in the Annual Accounting Statements. We also reviewed the Plan's cash management activities and practices related to FEHBP funds for contract years 2016 through 2020, and the Plan's Fraud and Abuse Program activities for contract year 2020.



Michael R. Esser
*Assistant Inspector General
for Audits*

What did we find?

We questioned \$916,907 in health benefit charges, administrative expenses, cash management activities, and lost investment income (LII). The BlueCross BlueShield Association and/or Plan agreed with \$309,703 and disagreed with \$607,204 of the questioned amounts. As part of our review, we verified that the Plan subsequently returned the uncontested questioned amounts of \$309,703 to the FEHBP because of the audit.

Our audit results are summarized as follows:

- **Miscellaneous Health Benefit Payments and Credits** – We questioned \$607,204 where the Plan had not recovered and/or returned funds to the FEHBP for claim overpayments. We also questioned \$68,417 for provider audit recoveries that the Plan had not returned to the FEHBP, \$52,800 for a hospital settlement that the Plan incorrectly charged to the FEHBP, and \$1,068 for applicable LII on these questioned amounts.
- **Administrative Expenses** – We questioned \$43,907 in unallowable consulting and travel costs that were charged to the FEHBP and \$3,734 for LII on these questioned charges.
- **Statutory Reserve Payments** – The Plan calculated and charged statutory reserve payments to the FEHBP in accordance with Contract CS 1039 and applicable laws and regulations.
- **Cash Management** – We determined that the Plan reported an incorrect working capital deposit in the 2020 Annual Accounting Statement. In January 2021, the Plan also held a working capital deposit of \$139,777 over the amount needed to meet the Plan's daily cash needs for FEHBP claim payments. Since the Plan held these excess working capital funds in the dedicated Federal Employee Program investment account, LII is not applicable on these excess funds.
- **Fraud and Abuse Program** – The Plan is in compliance with the communication and reporting requirements for fraud and abuse cases set forth in FEHBP Carrier Letter 2017-13.

Abbreviations

| | |
|--------------------|--|
| AAS | Annual Accounting Statement |
| Association | BlueCross BlueShield Association |
| BCBS | BlueCross and/or BlueShield |
| BCBSA | BlueCross BlueShield Association |
| CFR | Code of Federal Regulations |
| FAR | Federal Acquisition Regulations |
| FEHB | Federal Employees Health Benefits |
| FEHBAR | Federal Employees Health Benefits Acquisition Regulations |
| FEHBP | Federal Employees Health Benefits Program |
| FEP | Federal Employee Program |
| FSTS | FEP Special Investigations Unit Tracking System |
| LII | Lost Investment Income |
| LOCA | Letter of Credit Account |
| OIG | Office of the Inspector General |
| OPM | U.S. Office of Personnel Management |
| Plan | BlueCross BlueShield of Tennessee |
| SIU | Special Investigations Unit |
| SPI | Special Plan Invoice |

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I. Background

This final report details the findings, conclusions, and recommendations from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of Tennessee (Plan). The Plan is located in Chattanooga, Tennessee.

The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits (FEHB) 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. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The BlueCross BlueShield Association (Association or BCBSA), on behalf of participating local BlueCross and/or BlueShield (BCBS) plans, has entered into a Government-wide Service Benefit Plan contract (Contract CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers. The Plan is one of 34 BCBS companies participating in the FEHBP. These 34 companies include 60 local BCBS plans.

The Association has established a Federal Employee Program (FEP¹) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BCBS plans, and OPM.

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by the Service Benefit Plan Administrative Services Corporation, an affiliate of CareFirst BCBS, located in Washington, D.C. These activities include acting as intermediary for claims processing between the Association and local BCBS plans, processing and maintaining subscriber eligibility, adjudicating member claims on behalf of BCBS plans, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of FEHBP claims, and maintaining claims payment data.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and Plan management. In addition, working in partnership with the Association,

¹ Throughout this report, when we refer to "FEP," we are referring to the Service Benefit Plan lines of business at the Plan. When we refer to the "FEHBP," we are referring to the program that provides health benefits to Federal employees, annuitants, and eligible family members.

management of the Plan is responsible for establishing and maintaining a system of internal controls.

All findings from our previous audit of the Plan (Report No. 1A-10-15-14-030, dated December 24, 2014), for contract years 2008 through 2013, have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference on November 18, 2021; and were presented in detail in a draft report, dated December 16, 2021. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report.

II. Objectives, Scope, and Methodology

Objectives

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objectives were as follows:

Miscellaneous Health Benefit Payments and Credits

- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.
- To determine whether credits and miscellaneous income relating to FEHBP benefit payments were returned timely to the FEHBP.

Administrative Expenses

- To determine whether administrative expenses charged to the contract were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable regulations.

Statutory Reserve Payments

- To determine whether the Plan charged statutory reserve payments to the FEHBP in accordance with the contract and applicable laws and regulations.

Cash Management

- To determine whether the Plan handled FEHBP funds in accordance with the contract and applicable laws and regulations concerning cash management in the FEHBP.

Fraud and Abuse Program

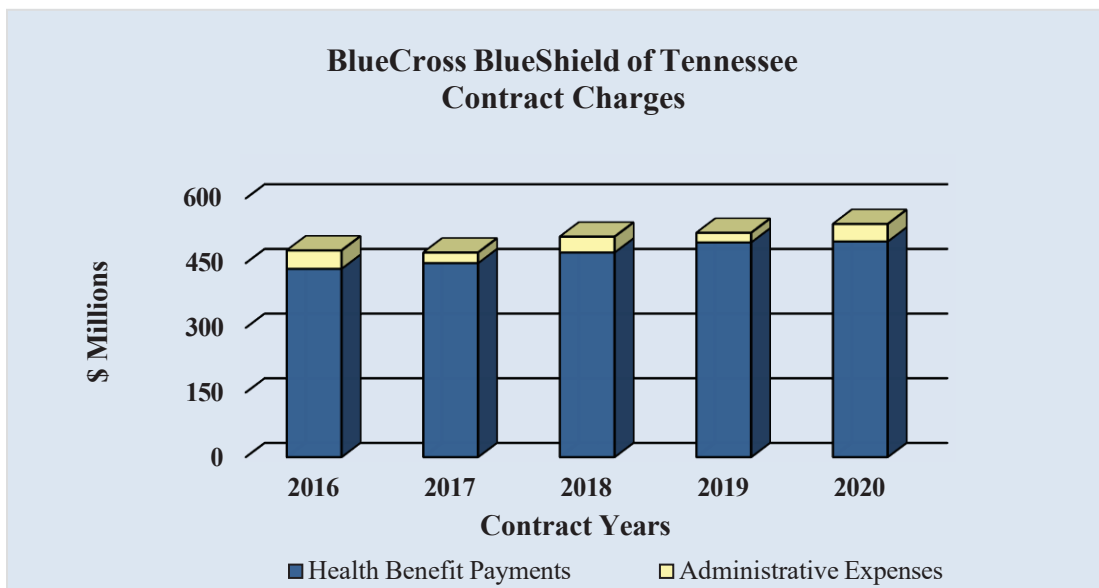
- To determine whether the Plan's communication and reporting of fraud and abuse cases complied with the terms of Contract CS 1039 and Carrier Letter 2017-13.

Scope

We conducted our limited scope performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and 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.

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements pertaining to Plan codes 390, 392, 890, and 892 for contract years 2016 through 2020. During this period,

the Plan paid approximately \$2.4 billion in FEHBP health benefit payments and charged the FEHBP approximately \$166.4 million in administrative expenses (see chart below). The Plan also charged the FEHBP approximately \$59.3 million in statutory reserve payments.



Specifically, we reviewed miscellaneous health benefit payments and credits (such as cash receipt and provider offset refunds, medical drug rebates, and special plan invoices), administrative expense charges, and statutory reserve payments for contract years 2016 through 2020, as reported in the Annual Accounting Statements. We also reviewed the Plan’s cash management activities and practices related to FEHBP funds for contract years 2016 through 2020, and the Plan’s Fraud and Abuse Program activities for contract year 2020.

In planning and conducting our audit, we obtained an understanding of the Plan’s internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify significant matters involving the Plan’s internal control structure and operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan’s system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations (FAR) and Federal Employees Health Benefits Acquisition Regulations (FEHBAR), as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and Federal regulations. Exceptions noted in the areas reviewed are set forth in detail in the “Audit Findings and Recommendations” section of this audit report. With respect to the items not tested, nothing

came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the Plan and the FEP Director's Office. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

The audit fieldwork was performed remotely in the Cranberry Township, Pennsylvania; Jacksonville, Florida; and Washington, D.C. areas from July 22, 2021, through November 18, 2021. Throughout the audit process, the Plan did a great job providing complete and timely responses to our numerous requests for explanations and supporting documentation. We really appreciated the Plan's cooperation and responsiveness during the pre-audit and fieldwork phases of this audit.

Methodology

We obtained an understanding of the internal controls over the Plan's financial, cost accounting, and cash management systems by inquiry of Plan officials.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of **miscellaneous health benefit payments and credits**. For contract years 2016 through 2020, we judgmentally selected and reviewed the following FEP items:

Health Benefit Refunds

- A high dollar sample of 50 FEP health benefit refunds returned via provider offsets, totaling \$12,671,756 (from a universe of 189,190 FEP refunds returned via provider offsets, totaling \$130,334,593, for the audit scope). Our sample included the 10 highest dollar provider offsets from each year of the audit scope.
- A high dollar sample of 50 FEP cash receipt health benefit refunds, totaling \$8,527,288 (from a universe of 11,647 FEP cash receipt refunds, totaling \$21,599,082, for the audit scope). Our sample included the 10 highest dollar cash receipt refunds from each year of the audit scope.

Other Health Benefit Payments, Credits, and Recoveries

- A judgmental sample of 25 FEP provider and hospital audit recoveries, totaling \$2,285,237 (from a universe of 1,823 FEP provider and hospital audit recoveries, totaling \$10,462,930, for the audit scope). The Plan provided two types of audit recoveries for this universe (i.e., provider audit and hospital credit balance audit recoveries). For this

sample, we selected the three highest dollar provider audit recoveries and the two highest dollar hospital credit balance audit recoveries from each year of the audit scope.

- A judgmental sample of 30 FEP subrogation recoveries, totaling \$1,761,499 (from a universe of 7,370 FEP subrogation recoveries, totaling \$11,267,378, for the audit scope). Our sample included the five highest dollar subrogation recoveries from each year of the audit scope, and five additional recoveries from the audit scope that were judgmentally selected based on our nomenclature review of the Plan's universe.
- A high dollar sample of 10 FEP medical drug rebate amounts, totaling \$1,200,313 (from a universe of 71 FEP medical drug rebate amounts, totaling \$2,351,836, for the audit scope). Our sample included the two highest dollar rebate amounts from each year of the audit scope.
- A high dollar sample of 15 FEP claim overpayment write-offs, totaling \$878,425 (from a universe of 5,674 FEP claim overpayment write-offs, totaling \$2,187,250, for the audit scope). Our sample included the 15 highest dollar write-offs from the audit scope. We reviewed these claim overpayment write-offs to determine if the Plan made diligent efforts to recover the applicable funds before writing these overpayments off.
- A judgmental sample of 5 FEP fraud recoveries, totaling \$43,968 (from a universe of 48 FEP fraud recoveries, totaling \$68,953, for the audit scope). For this sample, we selected the five highest dollar fraud recoveries from the audit scope.
- A judgmental sample of 18 special plan invoices (SPI), totaling \$3,269,327 in net FEP payments (from a universe of 367 SPI's, totaling \$3,838,702 in net FEP payments, for the audit scope). We judgmentally selected these SPI's based on our nomenclature review of high dollar invoice amounts. For this sample, we selected two SPI's with the highest dollar payment amounts and two SPI's with the highest dollar credit amounts (excluding SPI's for medical drug rebates and fraud recoveries) from each year in the audit scope (if applicable). SPI's are used by the Plan to process items such as miscellaneous health benefit payment and credit transactions that do not include primary claim payments or checks.
- A judgmental sample of other miscellaneous health benefit payments (such as Medicare Part B incentives, member annual physical incentives, and diabetes and hypertension management) that were processed and charged to the FEHBP by the Association on behalf of the local BCBS plans. Specifically, from the audit scope, we selected 4 invoices that included FEP payment amounts of \$207,442 for BCBS of Tennessee (from a universe of 56 invoices that included total FEP payment amounts for all BCBS plans combined). For this sample, we selected the contract year with the highest total dollar payment amounts and from that year we judgmentally selected four high dollar invoices to review.

We reviewed these samples to determine if health benefit refunds and recoveries, medical drug rebates, and miscellaneous credits were timely returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP. The results of these samples were not projected to the universe of miscellaneous health benefit payments and credits, since we did not use statistical sampling.

We judgmentally reviewed **administrative expenses** charged to the FEHBP for contract years 2016 through 2020. Specifically, we reviewed administrative expenses relating to cost centers; natural accounts; pensions; post-retirement benefits; employee health benefits; out-of-system adjustments; executive compensation limits; Association dues; prior period adjustments; lobbying; and Patient Protection and Affordable Care Act fees.² We also reviewed the statutory reserve payments charged to the FEHBP for contract years 2016 through 2020. We used the FEHBP contract, the FAR, the FEHBP, and/or the Affordable Care Act (Public Law 111-148) to determine the allowability, allocability, and reasonableness of charges.

We reviewed the Plan's **cash management activities and practices** to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations. Specifically, we reviewed letter of credit account (LOCA) drawdowns, working capital calculations, adjustments and/or balances, United States Treasury offsets, and interest income transactions for contract years 2016 through 2020, as well as the Plan's dedicated FEP investment account activity during the scope and balance as of December 31, 2020. As part of our testing, we selected and reviewed a judgmental sample of 94 LOCA drawdowns, totaling \$219,426,159 (from a universe of 1,232 LOCA drawdowns, totaling \$2,399,677,177, for contract years 2016 through 2020), for the purpose of determining if the Plan's drawdowns were appropriate and adequately supported. Our sample included 20 weeks of LOCA drawdowns that were selected based on the week with the highest dollar drawdown day within the highest dollar drawdown month from each quarter in the audit scope. The sample results were not projected to the universe of LOCA drawdowns, since we did not use statistical sampling.

We also interviewed the Plan's Special Investigations Unit regarding the compliance of the **Fraud and Abuse Program**, as well as reviewed the Plan's communication and reporting of fraud and abuse cases to test compliance with Contract CS 1039 and FEHBP Carrier Letter 2017-13.

² In general, the Plan records administrative expense transactions to natural accounts that are then allocated through cost centers to the Plan's various lines of business, including the FEP. For contract years 2016 through 2020, the Plan allocated administrative expenses of \$187,367,753 (before adjustments) to the FEHBP, from 355 cost centers that contained 209 natural accounts. From this universe, we selected a judgmental sample of 60 cost centers to review, which totaled \$130,237,019 in expenses allocated to the FEHBP. We also selected a judgmental sample of 65 natural accounts to review, which totaled \$123,275,435 in expenses allocated to the FEHBP through the cost centers. Because of the way we select and review each of these samples, there is a duplication of some of the administrative expenses tested. We selected these cost centers and natural accounts based on high dollar amounts, our nomenclature review, and our trend analysis. We reviewed the expenses from these cost centers and natural accounts for allowability, allocability, and reasonableness. The results of these samples were not projected to the universe of administrative expenses, since we did not use statistical sampling.

III. Audit Findings and Recommendations

A. Miscellaneous Health Benefit Payments and Credits

1. Claim Overpayment Write-Offs: \$607,204

The Plan was not diligent in its efforts to recover \$607,204 in FEP claim overpayments. These claim overpayments were originally set up as auto-recoupments (provider offsets), where the Plan would reduce future benefit payments to the providers for the purpose of recovering the refunds related to the overpayments, but were then subsequently written off by the Plan. We noted that these FEP claim overpayments were outstanding from approximately 7 to 13 years. Based on Contract CS 1039, the Plan must make a prompt and diligent effort to recover an erroneous health benefit payment until the debt is paid in full or determined to be uncollectible. Unless the Plan provides support that these claim overpayments were uncollectible, we can only conclude that the Plan did not make diligent efforts to recover these funds before writing them off. Therefore, the Plan should immediately recover and return \$607,204 to the FEHBP for these claim overpayments.

48 CFR 31.201-5 states, “The applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the contractor shall be credited to the Government either as a cost reduction or by cash refund.”

Contract CS 1039, Part II, Section 2.3(g) states, “If the Carrier [or OPM] determines that a Member’s claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider.” Section 2.3(g) also states, “Prompt and diligent effort to recover erroneous payments means that upon discovering that an erroneous payment exists, the Carrier shall –

- (1) Send a written notice of erroneous payment to the member or provider . . .
- (2) After confirming that the debt does exist . . . send follow-up notices to the member or the provider at 30-, 60- and 90-day intervals, if the debt remains unpaid and undisputed;
- (3) The Carrier may offset future Benefits payable . . . to a provider on behalf of the Member to satisfy a debt due under the FEHBP if the debt remains unpaid and undisputed for 120 days after the first notice . . .
- (4) After applying the first three steps, refer cases when it is cost effective to do so to a collection attorney or a collection agency if the debt is not recovered; . . .
- (5) Make prompt and diligent effort to recover erroneous payments until the debt is paid in full or determined to be uncollectible by the Carrier because it is no longer cost effective to pursue further collection efforts or it would be against equity and good conscience to continue collection efforts;

- (6) Additional prompt and diligent efforts are required for significant claim overpayments that exceed \$10,000 per each claim. Examples of such efforts include copies of dated notices, offset attempt(s) made, certified letter communication(s), and third-party collection efforts to the extent required under (g)(4) above. The Carrier should maintain and provide to OPM upon request, documentation of those efforts.”

During contract years 2016 through 2020, there were 5,674 FEP claim overpayment write-offs, totaling \$2,187,250. From this universe, we selected and reviewed a judgmental sample of 15 FEP claim overpayment write-offs, totaling \$878,425. For our sample, we selected the 15 highest dollar write-offs to determine if the Plan made diligent efforts to recover the applicable funds before writing these overpayments off.

Based on our review of these write-offs, we determined that the Plan was not diligent in its efforts to recover 13 FEP claim overpayments, totaling \$526,959. Specifically, we determined the following:

- For eight claim overpayments, totaling \$276,060, the Plan set up auto-recoupments to recover these overpayments. However, the Plan could not provide support to demonstrate that follow-up notices were sent to the providers at 30, 60 and 90-day intervals as required by the contract or that these claim overpayments were sent to a collection attorney or agency.
- For five claim overpayments, totaling \$250,899, the Plan set up auto-recoupments to recover these overpayments and sent three letters to the providers. However, the Plan did not comply with the 30, 60 and 90-day notice intervals as required by the contract **and** did not send these claim overpayments to a collection attorney or agency. We also noted that almost 10 years had passed between when the last letters were mailed by the Plan to when the overpayments were written off. During this time lapse, no additional efforts were made by the Plan to collect these FEP claim overpayments.

The Plan did not make diligent efforts to recover \$607,204 in FEP claim overpayments.

All of these claim overpayments were over \$10,000 and at least should have been sent to a collection attorney or a collection agency. After additional research, the Plan stated that prior to 2016 a decision was made (reason unknown) to not use a collection attorney or agency to recover FEP claim overpayments. The Contract makes it clear that the Plan should take all reasonable steps to

increase the chances of recovering FEP claim overpayments, especially significant overpayments of \$10,000 or more. Since the Plan did not send claim overpayments to collection attorneys or agencies, we are also questioning all claim overpayment write-off amounts of \$10,000 or more for the audit scope. We identified six additional claim

overpayment write-offs, totaling \$80,245, that were set up as auto-recoupments but were not sent to a collection attorney or agency.

Additionally, the Plan stated that these FEP claim overpayments were primarily written off due to the age of the receivables and providers going out of business, as well as various issues with transferring carryover files from the Plan's Legacy Claims System to the Facets Claims System. The Plan also stated that these issues caused some of the supporting documentation for the overpayments to not be available, which in turn affected the Plan's ability to continue to pursue these recoveries. However, the FEHBP should not be harmed due to the Plan's inability to maintain documentation necessary to pursue recoveries, especially when the Plan did not follow the required overpayment recovery steps to demonstrate due diligence efforts before writing the claim overpayments off. Because of the Plan's lack of due diligence, this reduced the Plan's chance of recovering these FEP claim overpayments.

In total, we determined that the Plan was not diligent in its efforts to recover 19 FEP claim overpayments (13 plus 6), totaling \$607,204 (\$526,959 plus \$80,245). Since these claim overpayments were each over \$10,000, the contract also requires additional prompt and diligent efforts by the Plan. We do recognize that the Plan set up auto-recoupments to recover these claim overpayments as well as supported that some refund request letters were sent to the providers; however, we still conclude that overall, the Plan did not make adequate diligent efforts to recover these funds before writing them off. Also, the Plan did not make additional prompt and diligent efforts (such as sending certified letters, calling the providers, using third-party collection efforts, and/or documenting reasons for delays and/or disagreements) before writing off these significant claim overpayments.

We also noted that the Association approved two special plan invoices, totaling \$1,494,447, for Plan claim overpayment write-offs in October 2018. However, we could not determine if the Association verified that the Plan followed the applicable steps for due diligence in Section 2.3(g) of Contract CS 1039, before approving these write-offs. Although most of these write-offs were for claim overpayments less than \$10,000, we noted that all 19 of our questioned claim overpayment write-offs were included in these two special plan invoices.

Recommendation 1:

We recommend that the contracting officer require the Plan to return \$607,204 to the FEHBP for the claim overpayments that were written off by the Plan without adequate support and/or justification, whether recovered or not, as diligent efforts to recover were not made.

Association/Plan Response:

“The Plan continues to disagree with this recommendation. The overpayments were set up for offset between 2011 and 2014; with the claim actually being paid before that time period. As a result, the requirement to maintain support for the overpayment recovery activity passed before this audit started.

Per SECTION 3.8 CONTRACTOR RECORDS RETENTION, the Carrier will retain and make available all records applicable to a contract term that support the annual statement of operations and . . . the rate submission for that contract term for a period of six years after the end of the contract term to which the records relate. In all cases, the claims were paid in excess of six years of the contract term.

Per SECTION 4.4 AUDIT DISPUTES

Paragraph (c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1 shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the Contract.

Additionally, SECTION 5.36 (d)(1) . . . states that a claim by the Contractor (or the Contracting Officer) shall be made in writing and, unless otherwise stated in this contract, submitted within 6 years after accrual of the claim to the Contracting Officer . . . A claim by the Government against the Contractor shall be subject to a written decision by the Contracting Officer. All claims in this finding are more than 6 years old and cannot be submitted as a claim against the Plan.

Furthermore, the write-offs did not create new ‘charges’ to the contract. It was merely an accounting entry to write off outstanding receivables; therefore, the claim write-offs are past both the time limits in the Records Retention Clause and in the Disputes Clause.”

OIG Comments:

We disagree with the Association/Plan response for three reasons. First (Due Diligence Requirements), the FEHBP contract includes specific due diligence requirements for documenting and pursuing the collections of overpayments, which there is no evidence the Plan followed. Second (Records Retention Requirement), the records retention requirement includes a longer period for retaining records related to overpayment collections. Specifically, the record retention period in this case does not begin until the claim overpayments are written off by the Plan. Third (Contract Claim Rights), based on the FAR and Contract Disputes Act, OPM’s period for making a breach of contract claim for return of an overpayment has not lapsed, because the accrual period for a contract claim does not begin until the date when all events that fix the alleged liability and permit

assertion of the claim were known or should have been known. Accordingly, we believe that the six-year statute of limitation period for a contract claim on the \$607,204 in overpayments did not begin until 2018, when the claims were written off by the Plan. Our three reasons for disagreeing with the Association/Plan response are discussed in greater detail below.

Due Diligence Requirements

As we previously cited from Section 2.3(g) of Contract CS 1039, prompt and diligent efforts are required by the Plan to recover claim overpayments. Four overpayment refund request letters are required for claim overpayments; specifically, after the first refund request, the Plan must send three more refund request letters at 30, 60, and 90-day intervals. However, additional prompt and diligent efforts are also required for claim overpayments of \$10,000 or more. For example, the Plan could have mailed dated notices and/or certified letters, called the providers, and/or used third-party collection efforts when cost effective. There is no evidence that the Plan fully complied with the due diligence requirements in Section 2.3(g), which also required performing additional prompt and diligent recovery efforts for these questioned overpayments exceeding \$10,000.

In addition, the Plan stated that prior to 2016 a decision was made not to use a collection attorney or agency to recover FEP claim overpayments. However, no reason was provided. Unless there is substantial evidence to support that using a collection service was not cost effective, then there is no plausible basis for the Plan not using such a service. For the questioned overpayment write-offs, the Plan did not comply and/or demonstrate compliance with these overpayment recovery requirements nor respond to our conclusion regarding the Plan's lack of due diligence with the recovery efforts.

Records Retention Requirement

In general, the Association/Plan disagreement with our monetary recommendation (repayment of the questioned claim overpayments) is that these "overpayments were set up for offset between 2011 and 2014; with the claim actually being paid before that time period. As a result, the requirement to maintain support for the overpayment recovery activity passed before this audit started." As support, the Association/Plan cites Contract CS 1039, Part III, Section 3.8 (Contract Records Retention), which states in general that all contract related records should be retained for a period of six years after the contract has ended.

However, the FEHBP contract and Federal regulations provide exceptions to this general rule. A key provision left out of the Association/Plan response when quoting Contract CS 1039, Part III, Section 3.8 is that Section 3.8 expressly states that FAR 52.215-2(f) supersedes the terms in this section. FAR 52.215-2(f) states, "The Contractor shall make available at its office at all reasonable times the records, materials, and other evidence . . .

for examination, audit, or reproduction, until 3 years after final payment under this contract or for any shorter period specified in subpart 4.7, Contractor Records Retention, of the Federal Acquisition Regulation (FAR), or for any longer period required by statute or by other clauses of this contract. In addition . . . The Contractor shall make available records relating to appeals under the Disputes clause or to litigation or the settlement of claims arising under or relating to this contract until such appeals, litigation, or claims are finally resolved.”

“Other Clauses” in the FEHBP contract refer to Contract CS 1039, Part II, Section 2.3, which states for payments over \$10,000 the Carrier should maintain and provide to OPM upon request, documentation of those efforts. This requirement of the contract coupled with the FAR 52.215-2(f) requirement that the Contractor is required to make available records related to the settlement of claims arising under or relating to the contract until such claims are finally resolved, effectively extends the Plan’s period to keep these documents beyond the six-year records retention period.

Given that these claim overpayments were not resolved, the FEHBP contract and Federal regulations required the Plan to keep sufficient records of the Plan’s due diligence efforts that were undertaken for collection of these overpayments. Thus, the Association/Plan assertion that the records retention period for documentation of the overpayment collection efforts has passed is not supported by the FEHBP contract or Federal regulations.

Contract Claim Rights

The Association/Plan states that “the write-offs did not create new ‘charges’ to the contract. It was merely an accounting entry to write off outstanding receivables; therefore, the claim write-offs are past both the time limits in the Records Retention Clause and in the Disputes Clause.” Federal contract regulations are in direct opposition to the Association/Plan assertion.

Contract CS 1039, Part V, Section 5.36(a) states, “This contract is subject to 41 U.S.C [United States Code] chapter 71, Contract Disputes.” 41 U.S.C chapter 71 is also known as the Contract Disputes Act. The Contract Disputes Act governs post-award monetary claims (such as a breach of contract), non-monetary claims (such as a claim for time or interpretation issues for a specification), and claims arising out of an implied-in-fact contract between the Federal Government and a Contractor.

41 U.S.C. § 7103(a)(4)(A) states that “[a] claim by the Federal Government against a contractor relating to a contract shall be submitted within 6 years after the accrual of the claim.” Per FAR 33.201, a contract claim will continue to accrue until “the date when all events, that fix the alleged liability of either the Government or the contractor and permit assertion of the claim, were known or should have been known.”

The OIG did not identify these overpayment issues in previous audits because these claim overpayments were not written off by the Plan until 2018. Therefore, a contract claim disputing the overpayment write-offs would not have accrued until 2018. Accordingly, a claim for recoupment of these questioned amounts is still available because the six-year contract claim period did not begin until 2018.

Recommendation 2:

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that FEP claim overpayments are adequately pursued, monitored, recovered, and returned to the FEHBP, as required by Section 2.3(g) of Contract CS 1039.

Association Response:

“BCBSA [BlueCross BlueShield Association] will work with the Plan to provide evidence demonstrating that the Plan implemented a procedure to use collection agencies for overpayments greater than \$10,000. Documentation will be provided once the Final Report is issued.”

Recommendation 3:

We recommend that the contracting officer require the Association to implement corrective actions to ensure that the BCBS plans have followed proper overpayment recovery steps and demonstrated diligent recovery efforts, as required by Section 2.3(g) of Contract CS 1039, before the Association approves the plans’ claim overpayment write-offs.

Association Response:

“BCBSA will enhance current procedures as necessary to ensure Plans follow overpayment recovery steps and provide evidence to support due diligence efforts before approving Plan claim overpayment write-offs.”

2. Provider Audit Recoveries: \$68,731

Our audit determined that the Plan had not returned provider audit recoveries, totaling \$68,417, to the FEHBP as of June 28, 2021 (Plan’s receipt date of our audit sample). The Plan subsequently returned these questioned provider audit recoveries to the FEHBP on September 14, 2021, from 94 to 214 days late, after receiving our audit sample, and/or because of our audit. As a result, we are questioning \$68,731 for this finding, consisting of \$68,417 for the questioned provider audit recoveries and \$314 for lost investment income (LII) on these provider audit recoveries returned untimely to the FEHBP.

Contract CS 1039, Part II, Section 2.3 (i) states, “All health benefit refunds and recoveries . . . must be deposited into the working capital or investment account [if applicable] within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier.”

FAR 52.232-17(a) states, “all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury . . . which is applicable to the period in which the amount becomes due, . . . and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid.”

For contract years 2016 through 2020, there were 1,823 FEP provider and hospital audit recoveries, totaling \$10,462,930. From this universe, we selected and reviewed a judgmental sample of 25 provider and hospital audit recoveries, totaling \$2,285,237, to determine if the Plan timely returned these recoveries to the FEHBP. Our sample included the three highest dollar provider audit recoveries and the two highest dollar hospital credit balance audit recoveries from each year of the audit scope.

Based on our review, we determined that the Plan had not returned provider audit recoveries, totaling \$68,417, to the FEHBP. The Plan received these recoveries via installment payments from a provider. Specifically, after an audit determined that bills from this provider resulted in an overpayment of \$148,536, the Plan set up an auto-recoupment in May 2019 to collect the overpayment amount. The Plan recovered part of the overpayment by offsetting FEP claims. However, the provider stopped treating FEP subscribers and began closing the business, making recovery of the outstanding balance difficult to collect. Therefore, the provider agreed to pay \$79,492 of the remaining balance via installment payments from January 2021 through June 2021. During this period, the Plan received wire payments, totaling \$79,492, and FEP’s share of these payments totaled \$68,417. When we submitted our audit sample to the Plan for this review on June 28, 2021, the Plan had not returned these FEP provider recoveries of \$68,417 to the FEHBP, even though the Plan had received multiple wire payments from the provider during January 2021 through June 2021. The Plan subsequently returned these provider audit recoveries to the FEHBP on September 14, 2021, from 94 to 214 days late, after receiving our audit sample, and/or because of our audit. Therefore, we are questioning these provider audit recoveries as a monetary finding as well as \$314 for LII on these recoveries returned untimely to the FEHBP (as calculated by the OIG).

In total, the Plan returned \$68,731 to the FEHBP for this audit finding, consisting of \$68,417 for the questioned provider audit recoveries and \$314 for LII on these recoveries returned untimely to the FEHBP.

Association/Plan Response:

The Plan agrees with the finding and recommendations.

OIG Comments:

As part of our review, we verified that the Plan returned \$68,731 to the FEHBP in September 2021 and October 2021, consisting of \$68,417 for the questioned provider audit recoveries and \$314 for LII on the provider audit recoveries returned untimely to the FEHBP.

Recommendation 4:

We recommend that the contracting officer require the Plan to return \$68,417 to the FEHBP for the questioned provider audit recoveries. However, since we verified that the Plan subsequently returned \$68,417 to the FEHBP for the questioned provider audit recoveries, no further action is required for this amount.

Recommendation 5:

We recommend that the contracting officer require the Plan to return \$314 to the FEHBP for the questioned LII calculated on the provider audit recoveries that were returned untimely to the FEHBP. However, since we verified that the Plan subsequently returned \$314 to the FEHBP for the questioned LII, no further action is required for this LII amount.

3. Special Plan Invoices: \$53,554

During our pre-audit phase, the Plan self-disclosed that a special plan invoice (SPI) amount for a non-FEP hospital settlement payment was inadvertently charged to the FEHBP. Specifically, the Plan incorrectly charged \$52,800 to the FEHBP on March 24, 2020, for this SPI payment amount. The Plan subsequently returned this questioned amount to the FEHBP on June 15, 2021, after receiving our audit notification letter and 440 days after incorrectly charging the FEHBP. As a result, we are questioning \$53,554 for this audit finding, consisting of \$52,800 for the questioned hospital settlement payment incorrectly charged to the FEHBP and \$754 for applicable LII on this questioned charge.

Contract CS 1039, Part III, section 3.2 (b)(1) states, “The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable.” Also, as previously cited from FAR 52.232-17(a), all amounts that become payable by the Contractor should include simple interest from the date due.

Regarding reportable monetary findings, Contract CS 1039, Part III, Section 3.16 (a) states, “Audit findings . . . in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that the findings were already identified and corrected . . . prior to audit notification.”

For contract years 2016 through 2020, there were 367 SPI's, totaling \$3,838,702 in net FEP payments, for miscellaneous health benefit payments and credits. From this universe, we selected and reviewed a judgmental sample of 18 SPI's, totaling \$3,269,327 in net FEP payments, for the purpose of determining if the Plan properly calculated, charged and/or credited these SPI amounts to the FEHBP. We judgmentally selected these SPI's based on our nomenclature review of high dollar invoice amounts. Specifically, we selected two SPI's with the highest dollar payment amounts and two SPI's with the highest dollar credit amounts (excluding SPI's for medical drug rebates and fraud recoveries) from each year in the audit scope (if applicable).

Based on our review of these SPI's, we noted one exception where the Plan incorrectly charged \$52,800 to the FEHBP for a non-FEP hospital settlement payment. The Plan also self-disclosed this exception during our pre-audit phase, stating that this inappropriate charge was also identified during a recent Control Performance Review by the Association's FEP Director's Office. Specifically, the Plan prepared an accrual in contract year 2019 for a hospital settlement payment and charged all lines of business before having the impacted claims. The Plan allocated and charged this hospital settlement payment to the FEHBP via the SPI process, using an allocation based on allowed claim dollars. In 2020, the Plan inadvertently did not adjust this accrual based on specific claim details. The specific claim details for this hospital settlement payment did not pertain to FEP members and therefore, should not have been allocated and charged to the FEHBP.

The Plan subsequently returned this questioned SPI amount to the FEHBP on June 15, 2021, after receiving our audit notification letter (dated January 4, 2021) and 440 days after incorrectly charging the FEHBP for the hospital settlement payment. Therefore, we are questioning this SPI amount of \$52,800 as a monetary finding as well as applicable LII of \$754 (as calculated by the OIG). In total, the Plan returned \$53,554 to the FEHBP for this exception, consisting of \$52,800 for the questioned hospital settlement charge and \$754 for applicable LII on this questioned charge.

Association/Plan Response:

The Plan agrees with the finding and recommendations.

OIG Comments:

As part of our review, we verified that the Plan subsequently returned \$53,554 to the FEHBP in June 2021 and November 2021, consisting of \$52,800 for the questioned hospital settlement charge and \$754 for applicable LII.

Recommendation 6:

We recommend that the contracting officer disallow \$52,800 for the questioned hospital settlement payment that the Plan incorrectly charged to the FEHBP. However, since we verified that the Plan subsequently returned \$52,800 to the FEHBP for this questioned charge, no further action is required for this amount.

Recommendation 7:

We recommend that the contracting officer require the Plan to return \$754 to the FEHBP for the questioned LII calculated on the hospital settlement payment incorrectly charged to the FEHBP. However, since we verified that the Plan subsequently returned \$754 to the FEHBP for the questioned LII, no further action is required for this LII amount.

B. Administrative Expenses

The audit disclosed only one minor finding pertaining to administrative expenses. Overall, we concluded that the Plan’s administrative expenses charged to the FEHBP were actual, allowable, necessary, and reasonable expenses incurred in accordance with Contract CS 1039 and applicable Federal regulations, except as noted in the audit finding below for “Unallowable Consulting and Travel Costs.”

1. Unallowable Consulting and Travel Costs: \$47,641

The Plan charged unallowable consulting and travel costs of \$43,907 to the FEHBP for contract years 2016 through 2019. As a result, we are questioning \$47,641 for this audit finding, consisting of \$43,907 for these unallowable charges and \$3,734 for LII on these questioned charges.

As previously cited from Contract CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. Also, as previously cited from FAR 52.232-17(a), all amounts that become payable by the Contractor should include simple interest from the date due.

48 CFR 31.205-21 (b)(2) states that “costs of any activities undertaken to persuade employees, of any entity, to exercise or not to exercise, or concerning the manner of exercising, the right to organize and bargain collectively through representatives of the employees’ own choosing are unallowable. Examples of unallowable costs under this paragraph include . . . the costs of . . . Hiring or consulting legal counsel or consultants.”

48 CFR 31.205-46 (b) states that “Airfare costs in excess of the lowest priced airfare available to the contractor during normal business hours are unallowable except when such accommodations require circuitous routing, require travel during unreasonable hours, excessively prolong travel, result in increased cost that would offset transportation

savings, are not reasonably adequate for the physical or medical needs of the traveler, or are not reasonably available to meet mission requirements.”

Regarding reportable monetary findings, Contract CS 1039, Part III, Section 3.16 (a) states, “Audit findings . . . in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that the findings were already identified and corrected (i.e., administrative expense overcharges . . . were already processed and returned to the FEHBP) prior to audit notification.”

The Plan charged the FEHBP \$43,907 for unallowable costs.

For contract years 2016 through 2020, the Plan allocated administrative expenses of \$187,367,753 (before adjustments) to the FEHBP from 355 cost centers that contained 209 natural accounts. From this universe, we selected a judgmental sample of 60 cost centers to review, which totaled \$130,237,019 in expenses allocated to the FEHBP. We also selected a judgmental sample of 65 natural accounts to review, which totaled \$123,275,435 in expenses allocated to the FEHBP through the cost centers. We selected these cost centers and natural accounts based on high dollar amounts, our nomenclature review, and our trend analysis. We reviewed the expenses from these cost centers and natural accounts for allowability, allocability, and reasonableness.

Except for two instances, we determined that the Plan properly allocated and charged cost center and natural account expenses to the FEHBP. In response to our Standard Information Request (during our pre-audit phase), the Plan disclosed that unallowable consulting and travel costs were inadvertently charged to the FEHBP. Based on our review of the Plan’s supporting documentation, we determined that the Plan charged unallowable consulting and travel costs of \$43,907 to the FEHBP for contract years 2016 through 2019. Specifically, the Plan charged the FEHBP \$40,366 for unallowable consulting expenses from natural account “616000” (Consulting) and \$3,541 for unallowable airfare expenses from natural account “600700” (Travel).

In total, the Plan subsequently returned \$47,641 to the FEHBP for this audit finding, consisting of \$43,907 for unallowable consulting and travel costs that were charged to the FEHBP and \$3,734 for applicable LII on these unallowable charges (as calculated by the Plan). We reviewed and accepted the Plan’s LII calculation. The following is a summary schedule of these questioned amounts.

| Natural Account Number and Name | Questioned Charges | Questioned LII | Total Questioned |
|---------------------------------|--------------------|----------------|------------------|
| 616000 – Consulting | \$40,366 | \$3,537 | \$43,903 |
| 600700 – Travel | 3,541 | 197 | 3,738 |
| Total | \$43,907 | \$3,734 | \$47,641 |

Association/Plan Response:

The Plan agrees with the finding and recommendations.

OIG Comments:

As part of our review, we verified that the Plan returned \$47,641 to the FEHBP on various dates from June 2021 through August 2021, consisting of \$43,907 for the questioned unallowable charges and \$3,734 for applicable LII.

Recommendation 8:

We recommend that the contracting officer disallow \$43,907 for the questioned unallowable consulting and travel costs that were charged to the FEHBP for contract years 2016 through 2019. However, since we verified that the Plan subsequently returned \$43,907 to the FEHBP for these questioned charges, no further action is required for this amount.

Recommendation 9:

We recommend that the contracting officer require the Plan to return \$3,734 to the FEHBP for the questioned LII calculated on the unallowable charges. However, since we verified that the Plan subsequently returned \$3,734 to the FEHBP for the questioned LII, no further action is required for this LII amount.

C. Statutory Reserve Payments

The audit disclosed no findings pertaining to statutory reserve payments. We concluded that the Plan calculated and charged statutory reserve payments to the FEHBP in accordance with Contract CS 1039 and applicable laws and regulations.

D. Cash Management

1. Working Capital Deposit: \$139,777

The Plan did not timely adjust the working capital deposit as required by OPM's "Letter of Credit System Guidelines" for experience-rated carriers. As a result, the Plan reported an incorrect working capital balance in the 2020 Annual Accounting Statement (AAS) and overstated the working capital deposit by \$139,777 in January 2021. The Plan subsequently adjusted the working capital deposit to the correct amount on February 9, 2021, after receiving our audit notification letter. Since these excess working capital funds were in the Plan's dedicated FEP investment account, LII is not applicable for this audit finding.

OPM’s “Letter of Credit System Guidelines” (dated April 2018) state: “Carriers should maintain a working capital balance equivalent to an average of two (2) days of paid claims. The working capital fund should be established using federal funds. Carriers are required to monitor their working capital fund on a monthly basis and adjust if necessary, on a quarterly basis. The interest earned on the working capital funds must be credited to the FEHB Program at least on a monthly basis. The working capital is not required but strongly recommended.” These guidelines also state, “OPM will monitor drawdowns to ensure Carriers are maintaining minimal balances of Federal funds. If OPM determines Carrier-held funds exceed the minimal level, all future requests for funds must be preapproved by OPM.”

Regarding reportable monetary findings, Contract CS 1039, Part III, Section 3.16 (a) states, “Audit findings . . . in the scope of an OIG audit are reportable as questioned charges unless the Carrier provides documentation supporting that the findings were already identified and corrected . . . prior to audit notification.”

We noted that the Plan reviewed the working capital deposit on a regular basis (usually quarterly) during contract years 2016 through 2020 and made several adjustments to the balance during the audit scope. As of December 31, 2020, the Plan held a working capital deposit of \$248,204 (calculated based on checks cleared from the first quarter of contract year 2020) in the dedicated FEP investment account. To determine if the Plan maintained an appropriate working capital deposit, we recalculated what the Plan’s deposit amount should have been (if calculated correctly based on checks cleared from the third quarter of contract year 2020) and determined that, as of December 31, 2020, the working capital deposit should have been \$256,875, instead of the actual deposit held of \$248,204. In addition, we noted that the Plan reported a working capital deposit of \$362,532 in the 2020 AAS (based on checks cleared from the second quarter of contract year 2020), which did not reconcile to the actual deposit held by the Plan (i.e., \$248,204) as of December 31, 2020, or our recalculated amount (i.e., \$256,875).

The Plan held an excess working capital deposit of \$139,777 in January 2021.

The above inconsistencies occurred because the Plan did not always adjust the working capital deposit timely in the month following the quarterly review. During contract years 2016 through 2020, we identified nine instances where the Plan did not timely adjust the working capital deposit in the month following the

quarter. In addition, we noted that on January 12, 2021, the Plan completed the second quarter of contract year 2020 adjustment to increase the working capital balance to \$362,532. However, the Plan should have made the fourth quarter of contract year 2020 adjustment in January 2021 to reduce the working capital deposit to \$222,755. The delay in making the second quarter adjustment resulted in the working capital deposit being overstated by \$139,777 (\$362,532 less \$222,755) in January 2021.

In conclusion, the Plan's untimely adjustments to the working capital deposit caused the balance to be inaccurately reported in the 2020 AAS. The working capital balance should have been the third quarter amount of \$256,875 (as calculated by the OIG) and not the second quarter amount of \$362,532 (as calculated by the Plan). The untimely adjustments also resulted in the Plan maintaining a working capital deposit above the allowed amount in January 2021. During this month, the Plan should have made the fourth quarter of contract year 2020 adjustment, reducing the working capital deposit to \$222,755 instead of increasing the deposit to the second quarter adjustment amount of \$362,532. This timing delay caused the working capital deposit to be overstated by \$139,777 (\$362,532 less \$222,755) in January 2021, resulting in the Plan holding excess FEHBP funds. The Plan subsequently adjusted the working capital deposit to the correct amount on February 9, 2021, after receiving our audit notification letter (dated January 4, 2021). Therefore, we are questioning these excess working capital funds as a monetary finding. Since the Plan maintained the excess working capital funds in the dedicated FEP investment account, these questioned funds are not subject to LII.

Association/Plan Response:

The Plan agrees with the finding and recommendations. Regarding the procedural recommendation, the Association states, "BCBSA will work with the Plan to provide evidence demonstrating that the Plan has implemented the necessary corrective actions to ensure that the working capital deposit process is working properly. Documentation will be provided once the Final Report is issued."

OIG Comments:

As part of our review, we verified that the Plan returned the questioned excess working capital deposit of \$139,777 to the FEHBP on February 9, 2021.

Recommendation 10:

We recommend that the contracting officer require the Plan to return \$139,777 to the FEHBP for the questioned excess working capital deposit. However, since we verified that the Plan subsequently returned \$139,777 to the FEHBP for these excess funds, no further action is required for this questioned amount.

Recommendation 11:

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that the working capital deposit is monitored on a monthly basis, correctly calculated and timely adjusted (if necessary) on a quarterly basis, and accurately reported in the AAS.

E. Fraud and Abuse Program

The Plan timely entered fraud and abuse cases into the Association's FSTS.

The audit disclosed no significant findings pertaining to the Plan's Fraud and Abuse Program activities and practices. For contract year 2020, the Plan opened 35 fraud and abuse cases with potential FEP exposure where affirmative steps were taken (i.e., when the Carrier decides that the received allegation is a potential fraud, waste, and/or abuse issue). From this universe, we selected and reviewed all 35 cases and determined if the Plan timely entered these fraud and abuse cases into the Association's FEP Special Investigations Unit Tracking System (FSTS) and if the Association timely reported these cases to the OIG.³ Based on our review, we identified no significant exceptions with the Plan timely entering cases into the Association's FSTS and the Association timely reporting cases to the OIG. Overall, we determined that the Plan complied with the communication and reporting requirements for fraud and abuse cases that are set forth in Contract CS 1039 and FEHBP Carrier Letter 2017-13.

³ FSTS is a multi-user, web-based FEP case-tracking database application and storage warehouse administered by the Association's FEP Special Investigations Unit (SIU). FSTS is used by the local BCBS plans' SIUs, the FEP Pharmacy Benefit Managers' SIUs, and the Association's FEP SIU to store, track and report potential fraud and abuse activities.

IV. Schedule A – Questioned Charges

BlueCross BlueShield of Tennessee Chattanooga, Tennessee

Questioned Charges

| Audit Findings | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | Total |
|--|-----------------|-----------------|------------------|------------------|------------------|-----------------|------------------|
| A. Miscellaneous Health Benefit Payments and Credits | | | | | | | |
| 1. Claim Overpayment Write-Offs | \$0 | \$0 | \$476,059 | \$107,327 | \$23,818 | \$0 | \$607,204 |
| 2. Provider Audit Recoveries* | 0 | 0 | 0 | 0 | 0 | 68,731 | 68,731 |
| 3. Special Plan Invoices* | 0 | 0 | 0 | 0 | 53,376 | 178 | 53,554 |
| Total Miscellaneous Health Benefit Payments and Credits | \$0 | \$0 | \$476,059 | \$107,327 | \$77,194 | \$68,909 | \$729,489 |
| B. Administrative Expenses | | | | | | | |
| 1. Unallowable Consulting and Travel Costs* | \$14,028 | \$29,551 | \$3,001 | \$1,061 | \$0 | \$0 | \$47,641 |
| Total Administrative Expenses | \$14,028 | \$29,551 | \$3,001 | \$1,061 | \$0 | \$0 | \$47,641 |
| C. Statutory Reserve Payments | | | | | | | |
| Total Statutory Reserve Payments | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| D. Cash Management | | | | | | | |
| 1. Working Capital Deposit | \$0 | \$0 | \$0 | \$0 | \$139,777 | \$0 | \$139,777 |
| Total Cash Management | \$0 | \$0 | \$0 | \$0 | \$139,777 | \$0 | \$139,777 |
| E. Fraud and Abuse Program | | | | | | | |
| Total Fraud and Abuse Program | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Total Questioned Charges | \$14,028 | \$29,551 | \$479,060 | \$108,388 | \$216,971 | \$68,909 | \$916,907 |

*We included lost investment income (LII) within audit findings A2 (\$314), A3 (\$754), and B1 (\$3,734). Therefore, no additional LII is applicable.

Appendix



1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

February 3, 2022

John A. Hirschmann
Group Chief, Experienced Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E. Street, Room 6400
Washington, D.C. 20415-1100

**Reference: OPM Draft Audit Report
BlueCross BlueShield of Tennessee
Audit Report Number 1A-10-15-21-023
December 16, 2021**

Dear Mr. Hirschmann:

This is the Blue Cross Blue Shield of Tennessee response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees Health Benefits Program (FEHBP). Our comments concerning the findings in the report are as follows:

Our comments concerning the findings in the report are as follows:

A. Miscellaneous Health Benefit Payments and Credits

1. Claim Overpayment Write-Offs: \$607,204

Recommendation 1:

We recommend that the contracting officer require the Plan to return \$607,204 to the FEHBP for the claim overpayments that were written off by the Plan without adequate support and/or justification whether recovered or not, as diligent efforts to recover were not made.

Plan Response:

The Plan continues to disagree with this recommendation. The overpayments were set up for offset between 2011 and 2014; with the claim actually being paid before that time period. As a result, the requirement to maintain support for the overpayment recovery activity passed before this audit started.

Per **SECTION 3.8 CONTRACTOR RECORDS RETENTION**, the Carrier will retain and make available all records applicable to a contract term that support the annual statement of operations and . . . the rate submission for that contract term for a period of

Report No. 1A-10-15-21-023

six years after the end of the contract term to which the records relate. In all cases, the claims were paid in excess of six years of the contract term.

Per SECTION 4.4 AUDIT DISPUTES

Paragraph (c) A claim seeking, as a matter of right, the payment of money, in a sum certain, pursuant to 48 CFR section 52.233-1, shall not be made more than five years following the last day prescribed by the contract for filing the calendar year Annual Accounting Statement for the year with respect to which the claim arises. A claim includes, in the case of the carrier, a charge against the Contract.

Additionally, **SECTION 5.36 (d)(1) DISPUTES** states that a claim by the Contractor (or the Contracting Officer) shall be made in writing and, unless otherwise stated in this contract, submitted within **6 years after accrual of the claim** to the Contracting Officer for a written decision. A claim by the Government against the Contractor shall be subject to a written decision by the Contracting Officer. All claims in this finding are more than 6 years old and cannot be submitted as a claim against the Plan.

Furthermore, the write-offs did not create new “charges” to the contract. It was merely an accounting entry to write off outstanding receivables; therefore, the claim write-offs are past both the time limits in the Records Retention Clause and in the Disputes Clause.

Recommendation 2:

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that FEP claim overpayments are adequately pursued, monitored, recovered, and returned to the FEHBP, as required by Section 2.3(g) of Contract CS 1039.

BCBSA Response:

BCBSA will work with the Plan to provide evidence demonstrating that the Plan implemented a procedure to use collection agencies for overpayments greater than \$10,000. Documentation will be provided once the Final Report is issued.

Recommendation 3:

We recommend that the contracting officer require the Association to implement corrective actions to ensure that the BCBS plans have followed proper overpayment recovery steps and demonstrated diligent recovery efforts, as required by Section 2.3(g) of Contract CS 1039, before the Association approves the plans’ claim overpayment write-offs.

BCBSA Response:

BCBSA will enhance current procedures as necessary to ensure Plans follow overpayment recovery steps and provide evidence to support due diligence efforts before approving Plan claim overpayment write-offs.

2. Provider Audit Recoveries: \$68,731

Recommendation 4:

We recommend that the contracting officer require the Plan to return \$68,417 to the FEHBP for the questioned provider audit recoveries. However, since we verified that the Plan subsequently returned \$68,417 to the FEHBP for the questioned provider audit recoveries, no further action is required for this amount.

Plan Response:

The Plan agreed with this recommendation and as stated, no additional action is necessary.

Recommendation 5:

We recommend that the contracting officer require the Plan to return \$314 to the FEHBP for the questioned LII on the provider audit recoveries that were returned untimely to the FEHBP. However, since we verified that the Plan subsequently returned \$314 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Plan Response:

The Plan agreed with this recommendation and as stated, no additional action is necessary.

3. Special Plan Invoices: \$53,554

Recommendation 6:

We recommend that the contracting officer disallow \$52,800 for the questioned hospital settlement payment that the Plan incorrectly charged to the FEHBP. However, since we verified that the Plan subsequently returned \$52,800 to the FEHBP for this questioned charge, no further action is required for this amount.

Plan Response:

The Plan agreed with this recommendation and as stated, no additional action is necessary.

Recommendation 7:

We recommend that the contracting officer require the Plan to return \$754 to the FEHBP for the questioned LII calculated on the hospital settlement payment incorrectly charged to the FEHBP. However, since we verified that the Plan subsequently returned \$754 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Plan Response:

The Plan agreed with this recommendation and as stated, no additional action is necessary.

B. Administrative Expenses

1. Unallowable Consulting and Travel Costs: \$47,641

Recommendation 8:

We recommend that the contracting officer disallow \$43,907 for the questioned unallowable costs that were charged to the FEHBP for contract years 2016 through 2019. However, since we verified that the Plan subsequently returned \$43,907 to the FEHBP for these questioned charges, no further action is required for this amount.

Plan Response:

The Plan agreed with this recommendation and as stated, no additional action is necessary.

Recommendation 9:

We recommend that the contracting officer require the Plan to return \$3,734 to the FEHBP for the questioned LII calculated on the unallowable charges. However, since we verified that the Plan subsequently returned \$3,734 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Plan Response:

The Plan agreed with this recommendation and as stated, no additional action is necessary.

D. Cash Management

1. Working Capital Deposit: \$139,777

Recommendation 10:

We recommend that the contracting officer require the Plan to return \$139,777 to the FEHBP for the questioned excess working capital deposit. However, since we verified that the Plan subsequently returned \$139,777 to the FEHBP for these excess funds, no further action is required for this questioned amount.

Plan Response:

The Plan agreed with this recommendation and as stated, no additional action is necessary.

Recommendation 11:

We recommend that the contracting officer require the Association to provide evidence or supporting documentation demonstrating that the Plan has implemented the necessary corrective actions to ensure that the working capital deposit is monitored on a monthly basis, correctly calculated and timely adjusted (if necessary) on a quarterly basis, as well as accurately reported in the Annual Accounting Statement.

BCBSA Response:

BCBSA will work with the Plan to provide evidence demonstrating that the Plan has implemented the necessary corrective actions to ensure that the working capital deposit process is working properly. Documentation will be provided once the Final Report is issued.

We appreciate the opportunity to provide our response to this Draft Audit Report and request that our comments be included in their entirety as an amendment to the Final Audit Report.

Sincerely,

A large black rectangular redaction box covering the signature of the sender.

, FEP Program Assurance



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