U.S. Office of the Personnel Management

Office of the Inspector General

Office of Audits

Final Audit Report

Audit of Claims Processing and Payment Operations at the Mail Handlers Benefit Plan for Contract Years 2019 and 2020

Report Number 1B-45-00-21-034
August 16, 2022

Executive Summary

Audit of Claims Processing and Payment Operations at
the Mail Handlers Benefit Plan for Contract Years 2019 and 2020

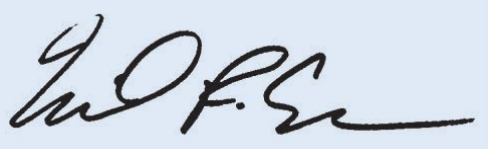
Report No. 1B-45-00-21-034 **August 16, 2022**

Why Did We Conduct the Audit?

The objective of our audit was to determine if the health benefit costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to its members by the Mail Handlers Benefit Plan, as administered by the National Postal Mail Handlers Union and Aetna (Plan) were in accordance with the terms of its contract with the U.S. Office of Personnel Management (OPM).

What Did We Audit?

The Office of the Inspector General (OIG) has completed a performance audit of the FEHBP claim operations at the Plan. Specifically, we performed various claim reviews to determine if the internal controls over the claims processing system were sufficient to ensure that claims were properly processed and paid by the Plan for contract years 2019 and 2020. Our audit work was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.



Michael R. Esser
Assistant Inspector General
for Audits

What Did We Find?

Overall, we found that the Plan's internal controls over its claims processing system were generally effective in ensuring that healthcare claims were properly processed and paid.

However, for the areas reviewed, our audit identified 635 incorrectly paid claims resulting in FEHBP overpayments of $598,819. The claim payment errors identified indicate a need to strengthen procedures and controls related to:

- Allowances applied for non-network drugs; and
- Claims paid after member termination.

Additionally, we found the Plan did not have procedures in place to notify the OPM OIG when claims are submitted by providers debarred from the FEHBP, as required by the OPM OIG's Guidelines for Implementation of FEHBP Debarment and Suspension Orders.

Abbreviations

5 CFR 980	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
ACAS	**Automatic Claim Adjudication System**
Act	**Federal Employees Health Benefits Act**
Aetna	**Claims Administration Corporation, an Aetna Company**
ASG	**OPM OIG's Administrative Sanctions Group**
AWP	**Average Wholesale Price**
CFR	**Code of Federal Regulations**
Contract	**Contract CS 1146 – The contract between the National Postal Mail Handlers and the U.S. Office of Personnel Management**
FEHBP	**Federal Employees Health Benefits Program**
Guidelines	**OMP OIG's Guidelines for Implementation of FEHBP Debarment and Suspension Orders**
HIO	**OPM's Healthcare and Insurance Office**
MHBP	**Mail Handlers Benefit Plan**
NPMHU	**National Posta Mail Handlers Union**
OIG	**The Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Plan	**Aetna and NPMHU as administrators of MHBP**
POS	**Place of Service**
USC	**United States Code**

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Report Fraud, Waste, and Mismanagement

I. Background

This final report details the results of our performance audit of the Federal Employees Health Benefits Program (FEHBP) claims processing and payment operations at the Mail Handlers Benefit Plan (MHBP) for contract years 2019 and 2020. The audit was remotely conducted in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

The audit was conducted pursuant to the provisions of contract CS 1146 (Contract) between the Office of Personnel Management (OPM) and the National Postal Mail Handlers Union (NPMHU); Title 5, United States Code (USC), Chapter 89; and Title 5, Code of Federal Regulations (CFR), Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits Act (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 (HIO) has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the HIO contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the Act are implemented by OPM through regulations codified in 5 CFR 890.

The MHBP is sponsored and administered by the NPMHU. The NPMHU has contracted with the Claims Administration Corporation, an Aetna company (Aetna), to further administer the claims processing and payment operations for MHBP. As both NPMHU and Aetna are joint administrators of MHBP, going forward we will refer to both jointly as the "Plan."

The Plan is a fee-for service experience-rated employee organization plan offering health care benefits to its subscribers. Enrollment in the Plan is open to all Federal employees and annuitants eligible to enroll in the NPMHU and who are, or become, members or associate members of the NPMHU.

Compliance with laws and regulations applicable to the FEHBP, as well as the terms and conditions of the Contract, is the responsibility of Plan management. In addition, the Plan is responsible for establishing and maintaining a system of internal controls.

The most recent audit report issued that covered claim payments for the Plan was report number 1B-45-00-09-062, dated April 14, 2010, which covered claim payments from October 1, 2007, through August 31, 2008. Any findings related to that audit were considered obsolete and not considered as part of planning for this audit.

The results of our audit were discussed with Plan officials throughout the audit and at an exit conference on March 8, 2022. We issued a draft report, dated March 16, 2022, to solicit the Plan's comments to the findings and recommendations. The Plan'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. Objective, Scope, and Methodology

Objective

The objective of our audit was to determine if the health benefit costs charged to the FEHBP and the services provided to FEHBP members were in accordance with the terms of the Contract.

Scope and Methodology

We conducted our 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.

This performance audit included the following reviews for contract years 2019 and 2020:

- claims paid with unlisted procedure codes;
- policies and procedures for debarment;
- place of service claims review; and
- potential duplicate claim payments.

Due to the COVID-19 pandemic we were unable to conduct site visits during the audit. Consequently, all audit fieldwork was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas from September 2021 through March 2022.

We reviewed the Plan's annual accounting statements for contract years 2019 and 2020 and determined that the Plan paid approximately $1.7 billion in health benefit payments over both years.

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structures to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its 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 and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP as they relate to claim payments. With the exception of those areas noted in the "Audit Findings and Recommendations" section of this audit report, we found that the Plan was in compliance with the health benefit provisions of the Contract. With respect to any areas 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. Through the performance of audits and an in-house claims data reconciliation process, we have verified the reliability of the Plan's claims data in our data warehouse, which was used to identify areas to test and to select our samples. The Plan's claims data is provided to the OPM OIG on a monthly basis by the Plan, and after a series of internal steps, uploaded into our data warehouse. 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.

We selected various samples of claims or claim lines to determine whether the Plan complied with the Contract's provisions relative to health benefit payments. We utilized SAS software to select all samples reviewed.

The following specific reviews were conducted during our audit (unless otherwise stated, the samples cover the full scope of the audit, contract years 2019 and 2020):

1. **Unlisted Procedure Code Review** – We identified a universe of 14,881 claim lines, totaling $12,958,762, from all Current Procedural Technology codes and Healthcare Common Procedure Coding System codes containing the words unlisted, miscellaneous, or unclassified.

   From each procedure code which accumulated $50,000 or more in paid claims during our audit scope, we randomly selected 5 claim lines to review. In total, we selected 35 claim lines, totaling $89,535, to determine if the claims underwent adequate review and were paid correctly.

2. **Debarment Policies and Procedures Review** –We reviewed the Plan's debarment processes to determine if they followed the debarment regulations and the OPM OIG's Guidelines for Implementation of FEHBP Debarment and Suspension Orders (Guidelines).

3. **Place of Service (POS) Review** – We identified a universe of 10,398,817 claims, totaling $1,785,266,787, by running a summary table of the claims data for our scope by POS (the location where the service was performed).

   From this universe, we selected a total of 125 claims, totaling $388,238, to determine if the claims were paid accurately according to the provider contract with the Plan and the Plan benefit brochure. Specifically, we randomly selected:

   - 25 claims from each of the three POS groups with five percent or more of the total claim lines. In total, we selected 75 claims, totaling $330,569; and

- 50 claims from the remaining POS groups with amounts paid greater than $1 million, totaling $57,669.

4. **Potential Duplicate Claim Payment Review** – As part of our review, we categorized separate potential duplicate claim payments into three categories – "best matches," "near matches," and "inpatient facility matches." The universe of potential duplicate claim groups was derived from the following search criteria:

   - Our "best match" logic identifies and groups unique claim numbers that contain most of the same claim data, including patient code, procedure code, diagnosis code, and sex code.

   - Our "near match" logic identifies and groups unique claim numbers that contain most of the same claim data, except for patient code, procedure code, diagnosis code, or sex code.

   - Our "inpatient facility match" search criteria identifies duplicate or overlapping dates of service.

   For each of the duplicate claim groups we identified the following universes:

   Universe of Duplicate Claim Payments Identified

Universe of Duplicate Claim Payments	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	1,161	354	1,923	3,438
Potential Overpayment	$6,065,719	$1,174,864	$70,655,712	$77,896,295

   From these universes, we judgmentally selected all duplicate groups with the total potential duplicate payments of $50,000 or greater for "Best" matches and $25,000 or greater for "Near" matches. Additionally, from the "Inpatient Facility Matches" we randomly selected five duplicate groups with total potential duplicate payments of $25,000 or greater. We reviewed the samples to determine if the claims identified were duplicate payments or not and to quantify any potential FEHBP overpayments. (See the table below for a summary of the total samples selected.)

Duplicate Claim Payment Samples Selected

Duplicate Claim Payment Samples	Best Matches	Near Matches	Inpatient Facility Matches	Total
Duplicate Groups	16	4	15	35
Potential Overpayment	$1,928,232	$185,675	$1,566,832	$3,680,739

During our reviews, we utilized the Contract, the 2019 and 2020 Plan benefit brochures, and various manuals and other documents provided by the Plan to determine compliance with program requirements, as well as deriving any amounts questioned. The samples selected and reviewed were not statistically based. Consequently, the results were not projected to their respective universes since it is unlikely that the results are representative of the universes taken as a whole.

III. Audit Findings and Recommendations

The objective of our audit was to determine if the internal controls over the Plan's claims processing system were sufficient to ensure that claims were properly processed and paid by the Plan. Although we identified overcharges of $598,819 to the FEHBP, the overall results of our audit indicate that the internal controls implemented by the Plan are generally working as intended.

1. Claim Payment Errors: $598,819

Our claim reviews found that the Plan incorrectly paid 635 claim lines, resulting in FEHBP overpayments of $598,819. The claim payment errors identified were a result of the following issues which we cover in more detail below:

- Incorrect non-network drug allowance applied; and
- Claims paid after member termination.

Section 3.2(b)(1) of the Contract states that, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable and reasonable."

Additionally, Section 2.3 (g) of the Contract states that if the Plan identifies a claim payment error that it "shall make a prompt and diligent effort to recover the erroneous payment … ."

A. Incorrect Non-Network Drug Allowance Applied

During Aetna's migration of the Plan's legacy claims system into its proprietary Automatic Claim Adjudication System (ACAS) claims processing platform, Aetna did not catch an allowance definition conflict between MHBP's benefit brochure and ACAS related to non-network drugs. This conflict in allowance terminology caused non-network drug claims to be paid incorrectly. We estimate that the Plan overcharged the FEHBP $565,197 for 626 claim lines that were not paid in accordance with the allowance as defined in Section 10 of MHBP's benefit brochure.

The Plan incorrectly paid non-network drug claim lines due to a difference in allowance terminology within MHBP's brochure.

Section 5(f), the prescription drug benefit section of MHBP's 2019 and 2020 benefit brochures, only describes the member's copay or coinsurance responsibilities after application of the Plan's allowance. However, the Plan's non-network allowance for drugs is defined later in Section 10 as 80 percent of the average wholesale price (AWP) of the drug allowance.

When migrating MHBP's health benefits into ACAS, Aetna did not catch the more limiting allowance terminology in Section 10 of the brochure. (Note: These terminology conflicts remained in place through the MHBP's 2022 benefit brochure.) We had to estimate the

overpayment amount because the Plan was unable to provide us with the AWP for all of the claim lines.

The Plan acknowledges that during the migration to ACAS, Section 10's brochure allowance for this benefit was not loaded into the system. Consequently, from 2018 to date, non-network drug claims have been paid using the benefit structure as defined in Section 5(f) of the brochure and loaded into ACAS.

It should be noted that when members seek care from non-network providers, they are responsible for paying the difference between the drug's allowance and the billed charge in addition to any copayments, coinsurance, or deductibles.

As shown below, if priced according to the brochure the Plan's allowance should be based on 80 percent of the AWP. The member would be responsible for both the 30 percent coinsurance and the $280 between the calculated allowance and the billed charge. In the standard pricing that was applied by the Plan, the member is still responsible for the coinsurance and the difference between the allowable and billed charge.

Pricing According to Brochure			**ACAS Standard Pricing**		
Billed Charge		$1,000	Billed Charge		$1,000
AWP		$900			
Allowance – 80 percent of AWP		$720	Allowance		$900
FHBP Payment (70 percent for standard option)		$504	FEHBP Payment (70 percent for standard option)		$630
Member Liability		$496	Member Liability		$370
$216	=	30 percent for standard option	$270	=	30 percent for standard option
+ $280	=	Difference between the allowance and the billed charge	+ $100	=	Difference between the allowance and the billed charge

Our review initially identified three claim lines paid incorrectly by the Plan where it incorrectly applied ACAS standard pricing instead of the brochure's benefit. Once these errors were determined to be a claims system issue, we instructed the Plan to identify all non-network prescription drug claims, to determine the financial impact to the FEHBP. The following summarizes our review:

- 343 claims lines, with overpayments totaling $328,029, where we were able to confirm the Plan allowance and actual overpayment to the FEHBP.

- 283 claim lines, with potential overpayments of $237,168, where we estimated the overpayment based on 20 percent of the claim amount paid because of the absence of the correct allowance (AWP).
- Additionally, the Plan has identified claims paid with this same error in 2018, 2021, and 2022 (outside of our audit scope). The Plan should continue its efforts to identify all claims paid in error because of this system error and initiate recovery of all monies overpaid.

The Plan stated that it inadvertently overlooked the more limiting allowance terminology in Section 10 of MHBP's brochure, as it would have expected this type of terminology to appear in the actual benefits section of the brochure (Section 5). To correct this issue going forward, the Plan intends to remove such language from its benefit brochures beginning in 2023. As a result, the Plan does not intend to modify ACAS for the remainder of 2022 due to the costly nature and the time required by the potential ACAS modifications. Instead, it intends to identify all claims with this error weekly and rework the claims to attempt recovery of any FEHBP overpayments.

For the scope of our audit, we estimate that the Plan overcharged the FEHBP $565,197, for 626 claim lines, due to its claims system not being updated to account for non-standard brochure allowance information.

Recommendation 1:

We recommend that the contracting officer direct the Plan to disallow $565,197 in overcharges to the FEHBP resulting from this claim system error.

Plan response:

The Plan reiterates what we've identified in the finding above and agrees with the finding. However, it goes on to state that the recommendation should be withdrawn because it has taken corrective action on the issue.

OIG Comments:

While the Plan has implemented changes to correct the issue identified, it was identified via audit and therefore it is our responsibility to report on both the issue and the overpayments identified which are still outstanding as of the date of this report.

Recommendation 2:

We recommend that the contracting officer ensure that the Plan continues its efforts to identify all claims paid incorrectly due to this error and initiate recovery of all FEHBP overpayments.

Plan Response:

The Plan stated that it has initiated efforts to identify each claim line affected and set up overpayment recovery efforts.

While correcting the system to ensure that claims are initially paid correctly would be optimal, the Plan determined that this approach would be too costly and burdensome to implement quickly. Instead, it has instituted procedures to produce a weekly report to identify and then manually rework each claim line affected by the error. As with Recommendation 1, because of the corrective actions already implemented, the Plan requested that this recommendation be withdrawn.

OIG Comments:

While the Plan has implemented changes in accordance with the recommendation, it was identified via audit and therefore it is our responsibility to report on the issue. As the issue causing the overpayments is not being addressed by the Plan, the process by which it must identify and recover the overpayments must continue.

B. Claims Paid after Member Termination

The Plan overcharged the FEHBP $33,622 for nine claim lines paid after a member's eligibility for coverage was terminated.

The Plan did not identify and adjust claims paid for a member after their coverage was terminated.

We initially identified two claim lines where the Plan determined that it incorrectly paid the claim after the member's coverage was terminated. This resulted in overcharges to the FEHBP of $6,318.

The Plan receives periodic member eligibility updates from the members' payroll offices. These updates include the addition of newly covered members and changes to a current member's coverage status. To keep abreast of these changes, the Plan runs a weekly report to identify members whose claims may have been affected by retroactive changes to their eligibility. It then works to identify all claims affected and begins collection efforts on any overpayments. Additionally, the Plan utilizes an outside vendor to perform a similar review to capture any claims that it may have missed. Unfortunately, in the case of these claim lines, neither the Plan's internal efforts, nor its outside vendor identified these claim lines as requiring retroactive adjustment until they were identified in our audit.

The Plan stated that the termination information for this member was received and updated in the claims system on November 10, 2020. It currently does not understand why the affected claim lines were not identified and adjusted prior to our audit.

Since the two claim lines identified pertain to the same individual, we requested the Plan to provide a list of all claims that were paid for this member after the enrollment termination became effective. From this list, we determined that an additional seven claim lines, totaling $27,304, were not retroactively adjusted.

In total, the Plan overcharged the FEHBP $33,622 for nine claim lines paid after the member's eligibility coverage was terminated. The Plan has initiated recoveries on these nine claim lines.

Recommendation 3:

We recommend the contracting office disallow $33,622 in overcharges to the FEHBP resulting from the Plan not identifying and adjusting claims paid after termination of coverage.

Plan Response:

The Plan agrees with this recommendation and states that it has initiated recovery of the overpayments. Because of the corrective actions initiated, it requested that the recommendation be withdrawn.

OIG Comments:

While the Plan has implemented changes in accordance with the recommendation, it was identified via audit and therefore it is our responsibility to report on the issue identified and the overcharges to be returned to the FEHBP, which are still outstanding as of the date of this report.

2. Debarred Claims Notification Process: Procedural

The Plan did not have procedures in place to notify the OPM OIG when claims are submitted by providers debarred from the FEHBP after the effective date of their debarment, as required by the OPM OIG's Guidelines.

Title 5 CFR section 890 Sub-Part J implements Title 5 USC section 8902a, which "establishes a system of administrative sanctions that OPM may, or in some cases, must apply to health care providers who have committed certain violations." 5 USC 8902a (j) gives OPM the authority to prescribe regulations regarding services or supplies furnished by debarred providers.

The Plan was unaware of the requirement to notify the OPM OIG of claims submitted by debarred providers after the effective date of their debarment.

The OPM OIG operates the administrative sanctions as applicable to the FEHBP under delegation from the OPM

Director. In March 2004, the Administrative Sanctions Group (ASG) issued Guidelines to supplement the regulations and to provide comprehensive instructions on all aspects of carriers' responsibilities.

According to 48 CFR 1609-7001(a), carriers are required to meet the requirements of 5 USC 89 and 5 CFR 890 upon which the Guidelines are based. Additionally, 48 CFR 1609-7001(b)(3) states that the carriers must comply with the terms of the FEHB contract, regulations, and statutes.

Chapter 2 Section E.6 of the Guidelines states, "If a suspended/debarred provider continues to submit claims for services rendered after the effective date of his/her suspension/debarment, you should furnish the OIG with documentation of all claims for services received after the effective date of the provider's suspension/debarment." This reporting is in addition to the reporting the Plan is already required to do as part of its Semi-Annual Report to ASG.

The Plan was unaware of this notification requirement. As a result, the OPM OIG was not made aware and was not given the opportunity to contact the providers to address the issue.

Recommendation 4:

We recommend that the contracting officer verify that the Plan's corrective action plan is in place and that it has begun to notify the OPM OIG when claims from debarred providers incurred after the effective date of the debarment are submitted to it.

Plan Response:

The Plan stated that it is currently modifying its reporting procedures to comply with the recommendation and will furnish OPM with documentation once completed.

Appendix

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Aetna Management Response to OPM OIG Draft Audit Report No. 1B-45-00-21-034

April 18, 2022

I. AUDIT FINDINGS AND RECOMMENDATIONS

1. Claim Payment Errors $598,819

Redacted by the OPM-OIG
Not relevant to the Final Report

A. Incorrect Non-Participating (Non-PAR) Drug Allowance Applied

Redacted by the OPM-OIG
Not relevant to the Final Report

Recommendation 1

We recommend that the contracting officer direct the Plan to correct its claim system logic to ensure that the proper Plan allowance is applied for drug claims provided by Non-PAR providers.

Aetna Response: As it advised the OPM OIG auditors during their field work, shortly after assuming responsibility for administering the MHBP pursuant to its 2013 acquisition of Coventry Healthcare, Aetna initiated the arduous and costly project of "migrating" the MHBP from Coventry's legacy IDX claims processing system onto Aetna's proprietary ACAS claims processing platform. Among countless other things, this project necessitated that Aetna: compare and contrast the MHBP's customized plan design (as enumerated in Section 5 ["Benefits"] of its FEHBA-mandated contract statement of benefits [or "brochure"]) against Aetna's standardized plan design programmed onto ACAS; identify every instance where an MHBP benefit deviated from the Aetna standard benefit, and in exactly what respect; prepare and submit an exceptions request for Aetna's IT department to program that MHBP benefit deviation onto ACAS to ensure that post-migration it would adjudicate consistent with the terms of MHBP brochure; and, after each processing exception was programmed onto ACAS, conduct testing to ensure that the programming had been performed correctly and the benefit would adjudicate correctly. It took Aetna more than four (4) years to plan and execute this migration project to completion, which resulted in the MHBP migrating onto the Aetna ACAS claims processing platform effective for claims incurred on or after January 1, 2018.[1]

[1] It bears noting in passing that this migration project included two (2) other FEHB plans (RCBP and FSBP) whose administration Aetna likewise assumed responsibility for pursuant to its 2013 acquisition of Coventry Healthcare. That project was at the time, and to this date remains, the single largest project of its type in Aetna's 150-plus year history.

As Aetna further advised the OPM OIG auditors during their field work, since 2014 the definition of the term "Plan allowance" that appears in the MHBP brochure has contained language limiting the MHBP's allowance "for drugs provided by Non-Network providers" to "80% of the Average Wholesale Price (AWP) of the drug (or its equivalent if AWP data is no longer published)." See, e.g., 2022 MHBP brochure, pp. 126-27. Simply stated, because that limiting language appears not in the Section 5 "Benefits" section of the MHBP brochure, but rather its Section 10 "Definitions of Terms We Use in This Brochure" section, it was inadvertently overlooked during the migration project outlined immediately above, which in turn resulted in the MHBP deviation from the Aetna standard resulting therefrom not being programmed onto ACAS. Accordingly, on MHBP claims incurred on or after the aforementioned January 1, 2018, migration date, claims containing those charges instead have been being adjudicated, and MHBP benefits paid, on the basis of billed charges in accordance with Aetna's standard benefit plan design, resulting in the benefit overpayments identified in the Draft Audit Report. It bears noting that the beneficiaries of these erroneous but good faith overpayments were the MHBP members whose out-of-pocket patient responsibility costs were reduced as a result thereof.

Promptly following the OPM OIG auditors' identification of this inadvertent system error during the course of its field work, Aetna initiated efforts to identify each and every MHBP claim line affected by it and set them up for overpayment recovery efforts in accordance with the requirements enumerated in Section 2.3(g) of OPM Contract No. CS 1146 establishing the MHBP. Aetna confirms that the overpaid claim line counts and dollar amounts identified in the Draft Audit Report are complete and accurate for the period January 1, 2018 through September 27, 2021, and its recovery efforts on those claim lines remains ongoing. In addition, beginning September 27, 2021, and continuing through the current date, Aetna has run reports on a weekly basis to identify and set up for rework each and every MHBP claim line (approximately 20 per week) that continues to adjudicate incorrectly due to that error. In lieu of making costly and burdensome modifications to its ACAS claims processing platform to implement this MHBP benefit deviation, however, Aetna intends to correct the error prospectively by deleting the "80% of AWP" limiting language that appears currently in the MHBP brochure's Section 10 "Plan allowance" definition effective with the 2023 Contract year. This necessarily will result in the correct payment of all MHBP claim lines of this type incurred on or after that date, without the need to make costly system modifications (which themselves may not even be completed on or before January 1, 2023). Furthermore, to ensure the ongoing appropriate administration of this benefit, Aetna will continue to run the weekly claims reports described immediately above throughout the remainder not only of 2022, but into 2023 in order to capture all 2022 charges not submitted for payment before the end of that calendar year.

For these reasons, Recommendation 1 should be withdrawn.

Recommendation 2

We recommend that the contracting officer direct the Plan continue monitoring claims containing drug procedure codes submitted by Non-PAR providers and manually review these claims until the system logic is enhanced and the edits have been tested for a reasonable period.

Aetna Response: See response to Recommendation 1 above. Because it has been implemented, Recommendation 2 should be withdrawn.

Recommendation 3

We recommend that the contracting officer direct the Plan to disallow $565,197 in overcharges to the FEHBP resulting from this claim system error.

Aetna Response: As indicated in Aetna's response to Recommendation 1 above, as required by Section 2.3(g) of the OPM Contract Aetna has initiated recovery efforts on the benefit overpayments made erroneously but in good faith resulting from this inadvertent system error pursuant to the terms of its internal Overpayment Recovery Guidelines, whose contents it shared with the OPM OIG auditors during their field work. For that reason, Recommendation 3 should be withdrawn.

B. Claims Paid After Member Termination

Redacted by the OPM-OIG
Not relevant to the Final Report

Recommendation 5

We recommend the contracting officer disallow $33,622 in overcharges to the FEHBP resulting from the Plan not identifying and adjusting claims paid after termination of coverage.

Aetna Response: Promptly upon the OPM OIG auditors' identification of this isolated instance and the erroneous but good faith overpayments resulting from it, Aetna initiated recovery efforts on them pursuant to the terms of its internal Overpayment Recovery Guidelines which ensure MHBP compliance with Section 2.3(g) of the OPM Contract. For that reason, Recommendation 5 should be withdrawn.

2. Debarred Claims Notification Process

Redacted by the OPM-OIG
Not relevant to the Final Report

Recommendation 6

We recommend that the contracting officer verify that the Plan's corrective action plan is in place and that it has begun to notify the OPM OIG when claims from debarred providers are submitted to it.

Aetna Response: Aetna currently is engaged in the process of modifying its reporting procedures to comply with Recommendation 6, and will furnish OPM with documentation to that effect once the necessary modifications have been implemented.

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