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

Final Audit Report

Audit of Claims Processing and Payment Operations at all Blue Cross and Blue Shield Plans as Related to Provider Network Status for Contract Years 2019 through 2021

Report Number 2023-CAAG-009
February 15, 2024

EXECUTIVE SUMMARY

Audit of Claims Processing and Payment Operations at all Blue Cross and Blue Shield Plans as Related to Provider Network Status for Contract Years 2019 through 2021

Report No. 2023-CAAG-009 **February 15, 2024**

Why Did We Conduct the Audit?

The objective of our audit was to determine whether the health benefit costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to FEHBP members enrolled in plan codes 10, 11, and 13 were in accordance with the terms of the Blue Cross and Blue Shield (BCBS) Association's Contract CS 1039 with the U.S. Office of Personnel Management and the Service Benefit Plan brochures related to provider network status (PNS).

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the FEHBP claim operations at all BCBS plans. Specifically, we performed claim reviews to determine if the internal controls over the claims processing systems were sufficient to ensure that claims were processed at the correct PNS and paid accordingly by the local BCBS plans during contract years 2019 through 2021. Our audit work was remotely conducted by staff in our Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida offices.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

We identified $1,038,050 in net program overcharges ($1,083,534 in overpayments and $45,484 in underpayments) for 1,724 claims that were paid at the incorrect PNS.

The errors identified represent only 1.5 percent of the sample reviewed and 0.02 percent of the overall universe identified. Therefore, we believe that the local BCBS plan's internal controls over their claims processing systems, as related to PNS, were generally effective in ensuring that health care claims were properly processed and paid.

ABBREVIATIONS

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
Association	**Blue Cross and Blue Shield Association**
BCBS	**Blue Cross and Blue Shield**
Contract	**Contract CS 1039 – The contract between the Blue Cross Blue and Shield Association and the U.S. Office of Personnel Management**
CY	**Contract Year**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
ID	**Identification**
Non-Par	**Non-Participating**
OIG	**The Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
Par	**Preferred or Participating**
PNS	**Provider Network Status**
U.S.C.	**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 all Blue Cross and Blue Shield (BCBS) plans, as it relates to provider network status (PNS) (plan codes 10, 11, and 13) for contract years (CYs) 2019 through 2021.

The audit was conducted pursuant to the provisions of Contract CS 1039 (Contract) between the U.S. Office of Personnel Management (OPM) and the Blue Cross and Blue Shield Association (Association); Title 5, United States Code (U.S.C.), Chapter 89; and Title 5, Code of Federal Regulations, 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 (5 U.S.C. sections 401 through 424).

The FEHBP was established by the Federal Employee 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 Office of Healthcare and Insurance (HI) has overall responsibility for the administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, HI 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 Association, on behalf of participating local BCBS plans, has entered a Government-wide Service Benefit Plan Contract with OPM to provide a health benefit plan authorized by the Act. The Association delegates authority to member BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers.

The Association has established a Federal Employee Program (FEP[1]) 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. CareFirst BCBS, located in Owings Mills, Maryland, performs the activities of the FEP Operations Center. These activities include acting as fiscal intermediary between the Association and its member BCBS plans, verifying subscriber eligibility, approving, or denying the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

[1] Throughout this report, when we refer to FEP, we are referring to the Service Benefit Plan lines of business at the local BCBS plans. When we refer to the FEHBP, we are referring to the program that provides health benefits to Federal employees.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and its member plans. In addition, the Association and its member plans are responsible for establishing and maintaining a system of internal controls.

This is the first audit of claims processing and payment operations specifically related to PNS.

The results of our audit were discussed with the Association throughout the audit and at an exit conference on October 19, 2023. We issued a draft report on October 24, 2023, to solicit the Association's comments on the findings and recommendations. 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. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of our audit was to determine whether the health benefit costs charged to the FEHBP, and services provided to FEHBP members, were in accordance with the terms of the Contract and the Service Benefit Plan brochures, as related to PNS.

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 focused on a review of PNS claims. Specifically, we performed tests to determine if claims were paid in accordance with the provider's assigned network status during CYs 2019 through 2021.

Our audit fieldwork was remotely performed by OIG staff located in our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from March 22, 2023, through October 19, 2023.

In planning and conducting our audit, we obtained an understanding of the Association's internal control structure 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. Since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Association's system of internal controls taken as a whole.

We also conducted tests to determine whether the Association and its member plans 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. Except for the area noted in the "Findings and Recommendations" section of this audit report, we found that the Association and its member plans complied with the health benefit provisions of the Contract and the Service Benefit Plan brochures, as they relate to the processing and paying of claims related to PNS. With respect to any areas not tested, nothing came to our attention that caused us to believe that they 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 FEP Director's Office, the FEP Operations Center, the Association, and the local BCBS plans. Through the performance of audits and an in-house claims data reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify claims that were potentially paid with an incorrect PNS. The BCBS claims data is

provided to the OPM OIG monthly by the FEP Operations Center, 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.

Utilizing SAS software, we selected the following sample of claims to determine whether the local BCBS plans complied with the Contract's provisions relative to health benefit payments, specifically related to PNS. From CYs 2019 through 2021, we identified all claims paid where the local BCBS Plans were the primary payer, the claims were not dental claims, and where a health care provider (provider) was paid as both a preferred or participating (Par) and non-participating (Non-Par) provider during the scope of the audit. This resulted in a universe of 38,939 providers with 24,418,708 claim lines, totaling $4,097,772,721.

From this universe, we judgmentally selected 25 providers from the 10 plan sites with the highest total amount paid, 20 providers from the next 10 sites with the highest amount paid, and 15 providers from all other plan sites where the claims amount paid percentage of Par and Non-Par claims was 10 percent or more of the total amount paid respectively. In total, we selected 720 providers, with 449,277 claim lines, with payments totaling $71,007,254.

During our review, we utilized the Contract, the 2019 through 2021 Service Benefit Plan brochures, the Association's FEP Administrative Procedures and Benefit Policy Manual, and various manuals and other documents provided by the local BCBS plans and the Association to determine compliance with program requirements, as well as deriving any amounts questioned. The sample selected was not statistically based. Consequently, the results were not projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

III. FINDING AND RECOMMENDATIONS

The objective of our audit was to determine whether the health benefit costs charged to the FEHBP, and services provided to FEHBP members, were in accordance with the terms of the contract and the Service Benefit Plan brochures, related to PNS. The errors identified represent only 1.5 percent of the sample reviewed and 0.02 percent of the overall universe identified. Therefore, we believe that the local BCBS plan's internal controls over their claims processing systems, as related to PNS, were generally effective in ensuring that health care claims were properly processed and paid.

1. Provider Network Status Errors $1,038,050

Our review identified 1,724 claims paid incorrectly due to PNS errors. As a result, we identified net FEHBP overpayments totaling $1,038,050 (overpayments of $1,083,534 and underpayments of $45,484).

Due to provider network status errors, the FEHBP was overcharged $1,038,050 (net)

According to the Service Benefit Plan brochure, local plans enter into contracts with facilities and physician providers (often referred to as "preferred" or "participating" [Par] providers) to provide members with covered services at negotiated rates as payment in full. Facilities and physicians without contracts (Non-Par providers) may or may not accept Plan set allowances for covered services. If a Non-Par provider is utilized, the member is responsible not only for applicable copayment or coinsurance amounts, but also for any amount exceeding the Plan's allowance.

Therefore, amounts paid to Non-Par providers, both by the local plans and FEHBP members, often dramatically exceed the amounts paid to Par providers because of the local plans ability to negotiate allowances that are lower than the Non-Par provider's billing rate.

Generally, Par providers bill the BCBS local plans directly and the local plans pay the providers directly, while most often the members must file claims from Non-Par providers and the local plans pay the claim to the member. Therefore, when a claim is paid with the incorrect network status, often the original claim must be voided, and the claim reprocessed to pay the correct party, as well as a recovery issued to recover the funds from the original claim paid.

Section 3.2 (b) (1) of the Contract states that carriers may only charge costs to the Contract that are "actual, allowable, allocable, and reasonable."

Section 2.3 (g) of the Contract 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 … ; the recovery of any overpayment must be treated as an erroneous benefit payment, overpayment, or duplicate payment … ."

The Association's Federal Administrative Manual states that local BCBS plans must have processes in place to ensure that pricing systems are updated correctly and timely when any pricing change occurs and that the local plans should also validate provider pricing and contract

status in the pricing system following any updates to provider contracts or files that impact pricing. The Association's Federal Administrative Manual also states that this validation process should occur each time a change is made to a provider file that impacts pricing and should include all claims affected by the pricing and if any overpayments are identified, the local plan should initiate recovery on those claims.

Our review of the network status of providers who were identified as having claims paid as both a Par and Non-Par provider identified 1,724 claims paid improperly. Specifically, we identified the following:

- 802 claims that were overpaid $511,623 due to contract loading errors.

  - 798 claims were overpaid $511,121 due to provider identification (ID) numbers being loaded incorrectly when the provider contracts were entered into the local BCBS plan's system.

  - Four claims were overpaid $502 when the incorrect PNS was entered when adding a provider's contract information into the local BCBS plan's system.

- 747 claims were overpaid a net amount of $451,977 (overpayments of $496,183 and underpayments of $44,206) due to retroactive provider file updates. This occasionally happens when provider contract negotiations extend beyond the prior contract's termination, requiring the new contract to be backdated and not entered in the claim's system timely.

  When a retroactive provider file update is made, local BCBS plans typically submit an ad hoc report request to identify claims paid during the time affected by the retroactive update. When the report is returned, the local BCBS plans should compare the payment to the new contract terms to determine the correct amount to pay. If identified, overpaid claims are sent to the recovery department and underpaid claims are sent to adjustments.

  Three of the local BCBS plans indicated that they had letters of agreement with the providers to hold all claims during the negotiation/credentialing process and that some claims had been submitted anyway. If it is the local BCBS plan's policy to backdate the PNS to the date of the provider's application once negotiation/credentialing is complete, the local BCBS plan should still follow the Association's Federal Administrative Manual's guidance and identify any affected claims caused by the provider file update and initiate recovery or adjustments as necessary, including the recalculating of member liabilities owed.

- 69 claims were overpaid a net amount of $45,582 (overpayments of $46,170 and underpayments of $588), due to processor errors. Specifically:

  - 18 claims were overpaid $26,337 due to improper handling of edit codes. We found:

    - 15 claims overpaid $15,483 due to improper processing of Non-Par claims that defer for Basic Option members;

    - One claim overpaid $10,028 when a processor was not provided the specific guidance from the Unit Assistant to process the claim properly;

    - One claim overpaid $485 when the provider's billing PNS was changed in error when the claim deferred on FEPDirect (the Association's nation-wide claims processing system); and

    - One claim overpaid $341 because the claim was incorrectly processed with a default provider number.

  - 20 claims were overpaid $13,780 due to incorrect provider information being selected or entered. We found:

    - 17 claims were overpaid $11,550 because the processor entered/selected the incorrect performing or billing provider number; and

    - Three claims were overpaid $2,230 because the processer selected the wrong provider identification (ID) number (different ID numbers had been set-up for different dates of service) when a date of service grace period was in place after the provider's contract termination date.

  - 25 claims were overpaid a net amount of $3,613 (overpayments of $4,201 and underpayments of $588), due to a processor changing or selecting the PNS in error;

  - Four claims were overpaid $1,615 due to provider specialty errors. We found:

    - Three claims overpaid $358 due to processors failing to split the claims. Each claim contained multiple provider specialties (e.g., Physical Therapy, Chiropractic, Acupuncture) and should have been split into more than one claim, as the providers had separate PNSs for each service; and

    - One claim was overpaid $1,257 when the processor selected the wrong provider specialty on the claim.

- Two claims were overpaid a net amount of $237 due to processors entering the wrong dates of service.

- 98 claims were overpaid a net amount of $20,776 due to system errors. Specifically:

  - 92 claims were overpaid a net amount of $13,266 (overpayments of $13,909 and underpayments of $643), due to a system error. The error occurred because FEPBridge (a pre-processing claims system which prepares claims for final adjudication in FEPOC) was set up to exclude providers outside of the FEP service area and this provider's primary address was outside of the FEP service area. The provider's claims, therefore, paid as Non-Par. Updates were made resolving the issue for this provider and they now show as a preferred provider in FEPBridge;

  - Three claims were overpaid a net amount of $6,880 (overpayments of $6,927 and underpayments of $47), due to a submission logic error that occurred when the claims were sent to FEPDirect. An incident ticket has been created to provide an explanation of this error and corrective action plan to address it. To date, we have not received further information on the incident ticket; and

  - Three claims were overpaid $630 due to a system migration error. The local BCBS plan stated that during a system migration the provider was loaded with the incorrect PNS.

- Six claims were overpaid $4,214 due to billing provider submission errors. Specifically:

  - Four claims were overpaid $2,728 because charges were originally submitted and paid under the Non-Par performing provider. The provider resubmitted corrected claims under the Par billing provider identification number, which were also paid; and

  - Two claims were overpaid $1,486 because the billing provider submitted the claim in error. The hospital uses an all-inclusive case-rate and the provider charges were part of the facility claim.

- Two claims were overpaid $3,878 due to undetermined reasons. The local BCBS plans did not provide an explanation for why the errors occurred.

Due to the various errors identified above, the FEHBP was overcharged $1,038,050 (net).

Recommendation 1

We recommend that the Contracting Officer disallow $1,083,534 in FEHBP overcharges due to PNS errors. To date, $228,641 has been recovered and $854,893 remains due to the FEHBP.

<u>Auditee's Response</u>:

The Association stated that of the questioned amount:

- **A total of $314,446 was returned to the Program; and**
- **A total of $35,294 is contested; and**
- **The remaining amount has either been determined to be uncollectible or is still in recovery.**

It also stated it will continue to coordinate with plans to ensure the recovery and return of overpayments and that any claims deemed uncollectible will be supported with documentation in accordance with the Contract.

<u>OIG Comments</u>:

The Association did not state specifically whether it agreed or disagreed with the recommendation. Based on the Association's response, it appears to disagree with $35,293 (the spreadsheet provided by the Association as part of their draft response supports a contested amount of $35,293) of the questioned amount. We concur with $5,753 of the contested amount and that amount is reflected in our updated questioned amount.

In reviewing its draft response, we could only verify that $228,641 had been recovered to date. The plans did not provide support for the $85,805 difference between their amount and our amount.

For amounts deemed to be uncollectible by the Association, the Association must provide documentation to OPM's Office of Audit Resolution and Compliance to support its position and that it followed the Contract's due diligence provisions in its attempts to recover the overpayments.

<u>Recommendation 2</u>

We recommend that the Contracting Officer allow $45,484 in undercharges to the FEHBP due to PNS errors. To date $44,707 in adjustments to providers/members have been made and $777 remains to be issued.

<u>Auditee's Response</u>:

The Association stated that it has issued all underpayments to the provider/members.

OIG Comments:

The Association did not state specifically whether it agreed or disagreed with the recommendation. However, based on the Association's response, we conclude it does not dispute the undercharges that were made to the providers/members. The only remaining open item to be addressed is the amount that should still be returned to the providers/members, which will be addressed as part of the resolution process.

Recommendation 3

We recommend that the Contracting Officer direct the Association to instruct the local BCBS plans to review and update as needed, or institute policies and procedures, to identify all affected claims caused by an update to a provider file and to initiate any recoveries or adjustments warranted by the change in PNS.

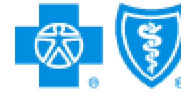
Auditee's Response:

The Association stated that it will work with the plans to review, update, or implement policies and procedures to identify all affected claims when a provider file update is made and to initiate recoveries and adjustments as warranted by the update.

OIG Comments:

The Association did not state specifically whether it agreed or disagreed with the recommendation. Based on the Association's response, we conclude that it concurs with our recommendation.

APPENDIX



BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

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December 1, 2023

Ms. Stephanie Oliver, Group Chief
Advanced Claims Analysis Team
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-11000

Reference: OPM DRAFT AUDIT REPORT
Audit of Provider Network Status
Audit Report Number 2023-CAAG-009
Issued October 24, 2023

Dear Ms. Oliver:

Below is the Blue Cross and Blue Shield Association (BCBSA) response to the recommendations included in the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report.

Recommendation 1

We recommend that the Contracting Officer disallow $1,111,168 in FEHBP overcharges due to provider network status errors. To date, $37,780 has been recovered and $1,073,388 remains due to the FEHBP. **(OIG Comment: All amounts in Recommendation 1 were updated in the final report)**

BCBSA Response

Of overcharges totaling $1,111,168 noted above, BCBSA determined the following:

- A total of $314,446 was returned to the Program (including the $37,780 reported above)
- A total of $35,294 is contested.
- A total of $301,159 has been determined to be uncollectible.
- A total of $460,269 is still in recovery.

BCBSA will continue to coordinate with Plans to ensure, where possible, that all recovered overpayments are returned to the Program and that all uncollectible claims are supported by due diligence recovery documentation in accordance with CS1039 Section 2.3g. The documentation to support the recovered, uncollectible, and contested claims is included with this response. Documentation to support the final disposition of claims still in the recovery process will be provided to OPM Audit Resolution and Compliance once the final report is received.

Recommendation 2

We recommend that the Contracting Officer allow $45,177 in undercharges to the FEHBP due to provider network status errors. To date $44,697 in adjustments to providers/members have been made and $480 remains to be issued. **(OIG Comment: All amounts in Recommendation 2 were updated in the final report)**

BCBSA Response

All undercharges totaling $45,177 due to provider network status errors have been issued to the providers/members.

Recommendation 3

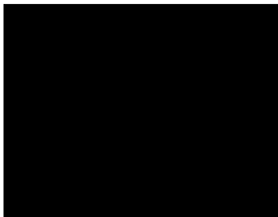
We recommend that the Contracting Officer direct the Association to instruct the local BCBS plans to review and update as needed, or institute policies and procedures to identify all affected claims caused by an update to a provider file and to initiate any recoveries or adjustments warranted by the change in PNS.

BCBSA Response

BCBSA will work with the Plans to review, update, or implement policies and procedures to identify all affected claims caused by an update to a provider file and to initiate any recoveries or adjustments warranted by the change in PNS.

Thank you for this opportunity to respond to the recommendations included in this Draft Report. If you have any questions, please contact me at [redacted] or [redacted] at [redacted]

Sincerely,



Managing Director, FEP Program Assurance

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