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

Final Audit Report

Audit of Blue Cross and Blue Shield of North Carolina

Report Number 1A-10-33-15-009
November 10, 2016

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EXECUTIVE SUMMARY

Audit of Blue Cross and Blue Shield of North Carolina

Report No. 1A-10-33-15-009 **November 10, 2016**

Why Did We Conduct the Audit?

The objectives of our audit were to determine whether Blue Cross and Blue Shield of North Carolina (Plan) charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to FEHBP members in accordance with the terms of its contract with the U.S. Office of Personnel Management (OPM). Specifically, our objective was to determine whether the Plan complied with contract provisions relative to claim payments.

What Did We Audit?

The Office of the Inspector General has completed a limited scope audit of the FEHBP operations of Blue Cross and Blue Shield of North Carolina. Specifically, this audit covered claim payments from January 1, 2011 through September 30, 2014, as reported in the Blue Cross Blue Shield Association's Federal Employee Program Government-wide Service Benefit Plan Annual Accounting Statements.

Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Our audit identified a major issue related to the Plan not negotiating reasonable pricing allowances with the U.S. Department of Veteran Affairs (VA), resulting in claim payments that were not paid in accordance with the terms of its contract with OPM. The report questions $18,648,497 in health benefit charges, the majority of which relate to the Plan unreasonably paying VA claims. The questioned health benefit charges are summarized as follows:

A. Veteran Affairs Claims Review
- The Plan incorrectly paid 10,622 claims to VA service providers, resulting in overcharges of $17,652,501 to the FEHBP.

B. Hospice Claims Review
- The Plan incorrectly paid 833 claims for Hospice services, resulting in overcharges of $964,834 to the FEHBP.

C. Indian Health Claims Review
- The Plan incorrectly paid 135 claims to Indian Health service providers, resulting in overcharges of $26,140 to the FEHBP.

D. System Pricing Review
- The Plan incorrectly paid two claims where the FEHBP paid as primary insurer, resulting in overcharges of $5,022 to the FEHBP.

ABBREVIATIONS

Association	Blue Cross Blue Shield Association
BCBS	Blue Cross Blue Shield
BCBSNC	Blue Cross and Blue Shield of North Carolina
CFR	Code of Federal Regulations
FEHB	Federal Employees Health Benefits
FEHBP	Federal Employees Health Benefits Program
FEP	Federal Employee Program
IPPS	Inpatient Payment Prospective System
LOB	Lines of Business
LOU	Letter of Understanding
OIG	Office of the Inspector General
OPPS	Outpatient Payment Prospective System Ambulatory Payment Classifications
OPM	U.S. Office of Personnel Management
Plan	Blue Cross and Blue Shield of North Carolina
VA	U.S. Department of Veteran Affairs

TABLE OF CONTENTS

Page

EXECUTIVE SUMMARY i

ABBREVIATIONS ii

I. **BACKGROUND** 1

II. **OBJECTIVES, SCOPE, AND METHODOLOGY** 3

III. **AUDIT FINDINGS AND RECOMMENDATIONS** 5

A. Veteran Affairs Claims Review 5

B. Hospice Claims Review 16

C. Indian Health Claims Review 17

D. System Pricing Review 18

IV. **MAJOR CONTRIBUTORS TO THIS REPORT** 20

APPENDIX: Blue Cross Blue Shield Association's April 7, 2016 response to the Draft Audit Report, issued January 28, 2016.

REPORT FRAUD, WASTE, AND MISMANAGEMENT

I. BACKGROUND

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at Blue Cross and Blue Shield of North Carolina (BCBSNC or Plan). The Plan is located in Durham, North Carolina. The audit was performed by the U.S. Office of Personnel Management's (OPM) 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 (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 Blue Cross Blue Shield Association (Association), on behalf of participating Blue Cross and Blue Shield (BCBS) plans, has entered into a Government-wide Service Benefit Plan 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. There are 64 BCBS plans participating in the FEHBP.

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. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving 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 Plan. 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 Plan management. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

The most recent audit report issued that covered claim payments for BCBS of North Carolina was Report No. 1A-10-33-11-023, dated January 25, 2012. All findings from that audit have been 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; and were presented in detail in the draft audit report, dated January 28, 2016. 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. Also, additional documentation provided by the Association and Plan on various dates through June 17, 2016, was considered in preparing our final 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 objective was to determine whether the Plan complied with contract provisions relative to health benefit payments.

Scope and Methodology

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 Blue Cross Blue Shield Association's Government-wide Service Benefit Plan FEP Annual Accounting Statements as they pertain to Plan codes 310 and 810 (BCBS of North Carolina) for contract years 2011 through 2014. During this period, the Plan paid approximately $2.5 billion in health benefit charges (See Figure 1). For the period of January 1, 2011 through September 30, 2014, we judgmentally selected various samples and reviewed 344 claims, totaling $2,983,098 in payments, for proper adjudication. Due to significant claim payment errors identified in our U. S. Department of Veteran Affairs, System Pricing, and Indian Health claim reviews, we performed expanded reviews in these areas covering an additional 15,914 claims, totaling $32.7 million in payments for the period of January 1, 2011 through April 30, 2015. We used the FEHBP contract, the 2011 through 2015 Service Benefit Plan brochures, the Plan's provider agreements, and the Association's FEP Administrative Procedures Manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

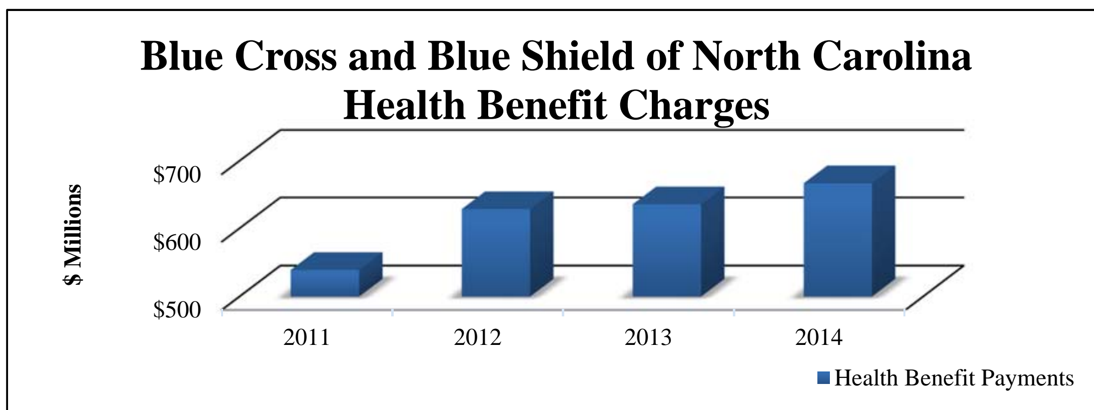


Figure 1 – Health Benefit Charges

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. 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 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 and the laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan did not fully comply with the provisions of the contract relative to claim payments. Exceptions noted are explained 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 FEP Director's Office, the FEP Operations Center, and the Plan. Through audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of claims for each type of review. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the Plan's local claims system. While utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

Audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through October 2015.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Veteran Affairs Claims Review **$17,652,501**

We reviewed a sample of claims where the amount paid to U.S. Department of Veterans Affairs (VA) service providers was greater than or equal to the amount billed by the provider. We consider these claims as high risk for payment errors because paying a claim at or above the billed amount could indicate that the FEHBP did not receive a discount in the pricing of that claim. See Exhibit I for a summary of the results of our VA claims review.

Exhibit I – Summary Results of Veterans Affairs Claims Review

Universe of Claims	Universe Dollar Total	Sampled Claims	Sampled Dollar Total	Claims Paid in Error	Total Claim Payment Errors
[redacted]	[redacted]	[redacted]	[redacted]	**10,622**	**$17,652,501**

Sample Selection Criteria
Our review included *all* claims paid to VA service providers between January 1, 2011 and April 30, 2015, with amounts paid of $500 or more, and where the amount paid was greater than or equal to the amount billed by the provider.

Cause of Errors
Our review determined that the contract pricing methodologies agreed upon in a Letter of Understanding (LOU) between BCBS of North Carolina and the VA service providers were unallowable and unreasonable in accordance with CS 1039. This LOU states that the Plan will pay VA inpatient and outpatient facility claims [redacted]
This contracting approach results in duplicate and excessive payments for claims that otherwise could be reduced by using reasonable [redacted]
[redacted], or even the FEP's discounted allowances used to pay providers that do not contract with Blue Cross Blue Shield (i.e., "non-par" rates).

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." The following sections explain why we believe these claim payments made at billed charges to be unallowable and/or unreasonable.

Unallowable Claims Payments

1) *Inconsistent pricing methodologies result in unallowable duplicate payments.*
   Prior to July 2011, the VA used average cost-based per diem rates for billing third-party payers, such as BCBSNC. In July 2011, the VA modified its inpatient and outpatient facility billing approach to reflect the methodology used by Medicare to bill third party payers: the

Inpatient Payment Prospective System (IPPS) and Outpatient Payment Prospective System Ambulatory Payment Classifications (OPPS). These billing methodologies bundle certain procedures and services, prorate professional and technical components, and include provider-based facility overhead into each individual charge. When these methodologies are used, it allows the facility provider to include physician services in the bill, and eliminates the need for the physician to bill separately for the same exact service.

BCBSNC's contracting approach results in duplicate and excessive claim payments.

After this July 2011 change in the VA's methodology for inpatient and outpatient facility services, the North Carolina VA service area and the Plan appropriately re-negotiated their payment structure in a LOU to pay physician services [redacted]. However, despite the fact that the 2011 billing methodology change also heavily impacted inpatient and outpatient facility claims, the Plan did not adjust the payment structure of these services, and continued [redacted]. The Plan's failure to consistently negotiate professional and facility rates with the VA caused the Plan to pay for physician services *twice*, once on the facility claim and again on the professional claim, and also caused the Plan to pay excessively for procedures and services that should have been subject to other discounts.

In general, providers submit bills that report all services rendered when requesting payment from third-party payers. However, these bills do not account for the pre-negotiated rates and payment structure, nor do they consider other factors that may reduce the payment such as bundling discounts, multiple procedure discounts, or the denial of non-covered services. It is the responsibility of the third party payer to account for these issues when adjudicating claims. However, our review determined that BCBSNC [redacted] without taking into consideration the concepts of the IPPS and OPPS pricing methodologies. This resulted in the various duplicate payment overcharges listed below:

a) Outpatient procedure payments were not properly limited to the outpatient technical component rates on outpatient facility claims;
b) Outpatient procedures for common diagnostic tests, anesthesia services, and other ancillary services were unbundled from the primary procedure code; and
c) The performing physician and the hosting facility were both paid for the same exact procedure.

2) *Claims processing system allows duplicate payments.*

BCBSNC sends all of its FEP claims directly to the Association's nation-wide FEP Express claims processing system. However, the FEP Express system is not designed to detect duplicate services that appear in corresponding VA facility and professional claims.

The 2014 BCBS Association FEP Administrative Procedures Manual states that "The VA's charges are submitted to the Local Plan using a UB-04 claim form for the facility services and a CMS-1500 claim form for the professional services. Local Plans should make sure that the facility claim does not include professional services fees that duplicate those reported on the professional claim." In other words, the Association requires the local plans to detect these duplicate services, but BCBSNC's claims adjudication process does not leverage a claims processing system that can detect these issues.

BCBSNC's claims adjudication process does not include controls to detect duplicate payments to VA service providers.

Unreasonable Claim Payments

3) *Unsupported contract rate increases.*

In an effort to evaluate the reasonableness of claim payments, we asked the Plan to provide documentation to support how it determined that the contracted rate increases for the FEHBP were cost effective and necessary. Despite numerous requests, the Plan provided no supporting documentation indicating why the Plan did not [redacted] [redacted]. The Plan did provide a statement indicating that "One of the reasons for doing this [contracting with the VA] was to avoid the administrative expenses and opportunity cost involved [redacted] [redacted] . . . ." However, our review determined that this statement was not accurate, as the Plan did, in fact [redacted] [redacted]. Therefore, the Plan has already subjected itself to the administrative expenses associated [redacted].

4) *Inequitable Treatment of the FEHBP Line of Business.*

According to the LOU between the Plan and the VA, BCBSNC contracted with the VA to [redacted] a different rate for members enrolled in the Plan's [redacted] [redacted]. Claims for these [redacted] are paid based on [redacted] [redacted], whereas facility claims for all other BCBSNC members (including FEHBP members) are [redacted]. The [redacted] are typically lower than [redacted], and therefore the Plan's [redacted] potentially incurred lower claims expenses than the products for "all other BCBSNC members."

In an effort to evaluate the impact of this on the FEHBP, we asked the Plan to provide documentation to support its assertion that contracted rates with the VA were equitably applied to all of its lines of business (LOB). In response, the Plan provided the following statement: "The fact that BCBSNC's [redacted] to the VA were twice as large as its [redacted] and [redacted], respectively] during this period further demonstrates that BCBSNC's agreement to the rates set forth in the LOU

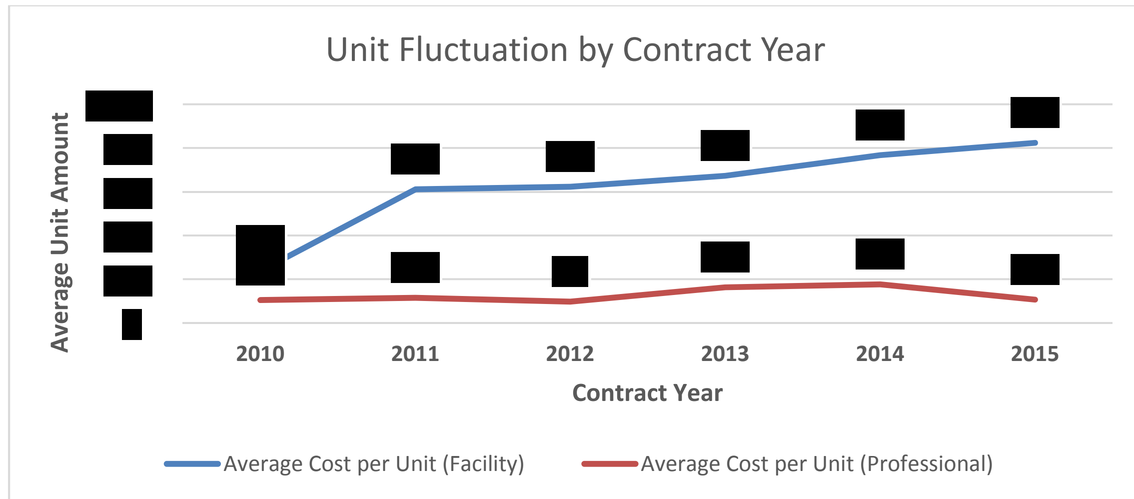
was driven by a rational business decision and is entirely consistent with sound business practice." However, the Plan has been unable to provide any claims expense evidence to support this statement. We attempted to validate the Plan's statement ourselves by querying historical data in our claims data warehouse, which reflects the amounts reported on the Blue Cross Blue Shield Association's Government-wide Service Benefit Plan Annual Accounting Statements. Our research determined that the Plan understated its FEHBP claims expenses by as much as $17 million. This fact, in combination with the fact that the Plan provided no evidence of its own to support its position, leads us to conclude its statements are not accurate or reliable.

Even if the Plan's statement were accurate, this response does not address our original request. The Plan simply states that it made greater net payments to the VA from its [redacted] than from [redacted] – it does not address the question of whether individual claim payments were being treated equitably between the various LOBs.

5) *FEHBP's claim expense substantially increased by* [redacted].
The 2011 rate changes [redacted] had a direct negative impact on FEHBP claims expenses for claims paid during the scope of this audit. Between 2010 and 2015, the average cost per FEP claim (unit) paid to the VA for inpatient and outpatient facility claims increased by [redacted] increase. The facility claims that were subject to this increase represent 86 percent of all FEP claim payments made by the Plan to the VA. During this same time period, the professional service cost per FEP claim unit increased at [redacted] (again, [redacted]). See Exhibit II below for the average rate increase per unit by contract year. Although it is not required for the Plan to obtain the lowest possible rate on behalf of the FEHBP, in the conduct of competitive business, a financially responsible organization would reimburse the provider using the lowest obtainable rate to maximize profit without sacrificing quality.

The average cost per claim paid to VA facility providers increased by [redacted] over a five-year period.

Exhibit II – Average Rate Fluctuation



6) *VA facility claims for FEHBP members* [redacted].
   The Plan reimburses its participating member providers at lower rates than it pays to the VA for similar outpatient and inpatient services. Specifically, we determined that on average the participating provider rates were [redacted] for outpatient and inpatient facility services, respectively. In fact, the Plan had [redacted] As previously stated, although it is not required for the Plan to obtain the lowest possible rate on behalf of the FEHBP, in the conduct of competitive business, a financially responsible organization would reimburse the provider using the lowest obtainable rate.

Summary of Unallowable and Unreasonable Paid Claims
BCBSNC's procedures for paying inpatient and outpatient facility claims results in duplicate payments for the same service, a practice that is expressly unallowable under contract CS 1039. In addition, the Plan has not demonstrated that these substantial cost increases for inpatient and outpatient facility claims were cost effective and/or necessary for the FEHBP; therefore, we determined that the additional costs associated with these payment increases are unreasonable charges to the FEHBP.

Calculation of the Costs Questioned in this Report
For many of the inpatient and outpatient facility claims in question there are one or more corresponding physician claims billed by the VA. Due to the complexity of the OPPS and IPPS pricing methodologies and the volume of claims the Plan paid to the VA, the OIG is unable to re-price all of the VA claims to determine which services were not properly bundled and/or identify all of the duplicate payments. We acknowledge that the VA hospital must receive some form of payment for allowing the provider to utilize its facility. However, due to the inconsistent pricing methodologies that the Plan used to contract for the FEP LOB, we are unable to determine a

reasonable amount the actual VA facility should receive for these overhead services. Therefore, we conservatively calculated the Plan's estimated overpayment amount for the claims we reviewed by using [redacted] Using this approach, our review determined the total overpayment of the sampled claims to be $17,652,501.

The following additional criteria supports our position that these claims were priced incorrectly and that the overcharges should be returned to the FEHBP:

- 48 CFR 31.201-3 states: "Determining reasonableness. (a) A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business. Reasonableness of specific costs must be examined with particular care in connection with firms or their separate divisions that may not be subject to effective competitive restraints. No presumption of reasonableness shall be attached to the incurrence of costs by a contractor. If an initial review of the facts results in a challenge of a specific cost by the contracting officer or the contracting officer's representative, the burden of proof shall be upon the contractor to establish that such cost is reasonable. (b) What is reasonable depends upon a variety of considerations and circumstances, including - (1) Whether it is the type of cost generally recognized as ordinary and necessary for the conduct of the contractor's business or the contract performance; (2) Generally accepted sound business practices, arm's length bargaining, and Federal and State laws and regulations; (3) The contractor's responsibilities to the Government, other customers, the owners of the business, employees, and the public at large; and (4) Any significant deviations from the contractor's established practices."

- 48 CFR 17.101-4 states that "(a) A third-party payer liable under a health plan contract has the **option** [emphasis added] of paying either the billed charges . . . or the amount the health plan demonstrates is the amount it would pay for care or services furnished by providers . . . for the same care or services in the same geographic area. If the amount submitted by the health plan for payment is less than the amount billed, VA will accept the submission as payment, subject to verification at VA's discretion in accordance with this section."

- Contract CS 1039, Part III, section 3.2 (b)(1) states that "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable." 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 . . . regardless of any time period limitations in the written agreement with the provider."

BCBSNC's Response (the full response is included in the Appendix):

In response to the questioned charges of $17,652,501, the Plan disagrees with the questioned charges in its entirety and states, "As set forth in more detail below, OIG performed this audit using standards and methodologies that are not supported by and do not comport with applicable law. As a result, the findings and conclusions that are set forth in the Veteran Affairs Claims Section of the Draft Audit Report ('VA Claims Review') have no foundation in governing law and this section should be removed from the final audit report in its entirety. . . .

I. OIG DID NOT USE THE PROPER LEGAL STANDARD TO ANALYZE THE 'REASONABLENESS' OF BCBSNC'S VA CLAIMS PAYMENTS. . . .
II. THE FAR DOES NOT REQUIRE GOVERNMENT CONTRACTORS TO INCUR COST USING THE 'LOWEST OBTAINABLE RATE.' . . .
III. THE VA CLAIMS PAYMENTS WERE 'REASONABLE' UNDER THE FAR . . . .
IV. THE
V. THE ALLEGED PAYMENT ERROR WAS CALCULATED USING AN INAPPROPRIATE AND UNSUPPORTED METHODOLOGY. . . .

As the foregoing demonstrates, the VA Claims Review was performed using analytical standards and methodologies that are not supported by – and do not comport with – applicable law, which fatally undermines the legal validity of the resulting findings and conclusion. As a result, the Plan disagrees with this section of the draft audit report, which should be removed in its entirety."

In response to the procedural recommendation that the contracting officer require the Plan to properly negotiate and/or contract reasonable rates with the North Carolina VA providers' service area on behalf of the FEHBP the Plan disagrees with this recommendation and states the following, "the rates that BCBSNC has agreed to use when pricing VA claims under the LOU are 'reasonable' for purposes of the FAR. As a result, the underlying premise of this recommendation is invalid, and this recommendation should be removed from the final audit report. The Plan further disagrees with this recommendation for the following two reasons.

I. OPM CANNOT MANDATE SPECIFIC PRICING TERMS FOR FEHBP CARRIERS' PROVIDER CONTRACTS. . . .
II. IS CONTRARY TO THE FISCAL INTEREST OF THE UNITED STATES . . . ."

OIG Comments:

After reviewing the Plan's response to the draft report, we continue to question $17,652,501 in claim payments. Although the Plan disagrees with this finding, the Plan has provided minimal

and insufficient documentation to support how contracting inpatient and outpatient facility services [redacted] could be considered a prudent business practice that was reasonable and allowable in accordance with CS 1039 and CFR. Also, we would like to emphasize that a portion of the questioned costs for these inpatient and outpatient facility services are reflective of duplicate overpayments, which are expressly unallowable costs under CS 1039.

Before outlining the specific reasons we continue to question the contested overcharges, we would like to address our concern regarding the Plan's overall management of VA providers in the North Carolina service area. It appears that the Plan entered into a contract with the VA that substantially increased direct costs for the Plan. We do not believe that any competitive business would unnecessarily solicit to pay claims at a higher rate if the funds were exclusively paid from its commercial lines of business, as opposed to Federal funds that it does not have the same vested interested in protecting.

BCBSNC is a third-party administrator for the FEHBP, meaning that all claim expenses and the associated administrative costs are drawn from the Federal FEHBP trust fund, as opposed to the Plan's commercial funds. The Plan assumes minimal risk while acting as a third-party administrator for the FEHBP. In fact, there is a direct correlation between the Plan's paid claim expenses and the administrative cost reimbursement that the Plan receives from the FEHBP. Using prior audit data, we determined that two of the five allocation methods used by the Plan are tied to claim volume and amounts paid.[2] In other words, if the Plan's claim expense is overstated, its administrative cost reimbursements would also be overstated. Following the amended VA LOU, the administrative cost expenses paid to the Plan from the FEHBP increased over 50 percent from 2013 to 2014, and another 31 percent from 2014 to 2015. However, since the scope of this audit did not include an administrative expenses review, we did not calculate the quantitative impact of the additional administrative costs incurred as a result of BCBSNC's VA claims overpayments.

The sections below address the specific concerns that the Plan outlined in its response to the draft report, and support why the OIG standards and methodologies used in this audit are in compliance with applicable regulations, and why we continue to question these overcharges in the final report:

1. The Plan states that "***OIG DID NOT USE THE PROPER LEGAL STANDARD TO ANALYZE THE 'REASONABLENESS' OF BCBSNC'S VA CLAIMS PAYMENTS . . ." and the criteria used should reflect the four standards of 48 CFR 31.201-3.*** The OIG's basis for evaluating "reasonableness" is not just limited to the rates being "cost effective and advantageous" to the FEHBP. Our analysis ties directly to various CFR criteria as follows:

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[2] Based on the OIG's most recent audit report issued that covered administrative costs for BCBS of North Carolina – Report No. 1A-10-33-12-020, dated December 27, 2012.

a) We recognize that claims expense is an integral part of the Plan conducting business on behalf of the FEHBP, but the costs in question are strictly related to the inflated contracted rates and not the legitimate claims expense for the services provided by the VA. *This ties to 48 CFR 31.201-3(b)(1) – costs are considered ordinary and necessary*.

b) We recognize that third party payers are Federally mandated to reimburse VA facilities, and that the actions of a Federal contractor should reflect a responsible attitude towards the Federal government. The Plan has clearly met its obligation to pay VA facilities, but has failed to show that its use of FEHBP funds to reimburse these claims complied with generally accepted sound business practices. The Plan has also failed to articulate what legal restrictions forced the Plan into these types of pricing arrangements. *This ties to 48 CFR 31.201-3(b)(2)(3) – costs are within generally accepted sound business practice and the public at large.*

c) The Plan has repeatedly informed the OIG through this audit that BCBSNC paid the FEHBP VA claims using the exact same rates that the Plan uses to pay its commercial LOB's including "those that are fully insured." However, the Plan has failed to provide documentation to demonstrate that its statements are true, and that FEHBP claims are being paid in accordance with established business practices. *This ties to 48 CFR 31.201-3(b)(4) – costs are within contractors established practices.*

2. The Plan states that**, *"THE FAR DO NOT REQUIRE GOVERNMENT CONTRACTORS TO INCUR COST USING 'THE LOWEST OBTAINABLE RATE.'"*** We acknowledge and agree that the Plan is not legally required to contract with providers to obtain the lowest obtainable rate – but the FAR in no way exempts the Plan from obtaining prices that are fair and reasonable. As previously cited, 86 percent of the FEP claims processed by the Plan for VA services were subject to a [redacted] during the scope of our audit. The Plan has not provided any documentation to support how these rate increases were fair and reasonable while its commercial LOB's received a lower rate.

3. The Plan states that [redacted] The Plan appears to be arguing that it is **required** to [redacted]. However, the CFR only impacts what the VA *bills* for services, and has no bearing whatsoever on what the VA can accept as *payment* from third party payers. In fact, the CFR clearly allows VA providers to enter into provider agreements with third party payers to accept lower payment rates. The fact that VA's billing practices are subject to regulation does not prevent or exempt the Plan from implementing controls that ensure VA claims are paid at competitive rates – just

BCBSNC has demonstrated its ability to negotiate lower rates with the VA for its [redacted], but failed to do so for facility services impacting the FEHBP.

as it would for any other medical provider. The fact that BCBSNC has already contracted lower rates with the VA for [redacted] and for professional services demonstrates that the Plan does, in fact, understand the true requirements and flexibilities of the CFR.

4. The Plan states that [redacted] allows the Plan to ***"avoid*** [redacted]***."*** This statement is entirely inaccurate and unsupported, as the Plan has already [redacted] for VA physician services for all of its lines of business. The Plan also contracted with the VA to pay a different rate for members enrolled in [redacted]. Therefore, the Plan has already accepted these risks associated with [redacted].

5. The Plan states that a ***"loss of FEHBP claims payment would be revenue neutral for the federal government, while the loss of $37 million in commercial revenue would be a net loss that would necessitate a $37 million increase in Congressional appropriations in order to maintain existing funding levels at the VA."*** The Plan is responsible to pay claims in accordance with its contract with the FEHBP and the CFR. The impact of its actions on Congressional appropriations to Federal government agencies is not the Plan's responsibility to address, nor does it exempt the Plan from these requirements.

6. The Plan states that, ***"the methodology used [by the OIG] to calculate the alleged resulting payment error is not consistent with governing law, which fatally undermines the legal validity of the results . . . [and the CFR] allows a third-party payer to reimburse VA claims using either (1) the rates set by the VA using the methodologies in the regulation, or (2) the contracted rates that the health plan would pay a non-VA facility in the same geographic area."*** The pricing methodology used by the OIG (i.e., comparing actual payments [redacted]) is a reasonable approach that is consistent with Federal law. As the Plan has acknowledged, the CFR allows [redacted] We agree that using [redacted] as a baseline to calculate the Plan's overpayments to the VA would be the most appropriate way to quantify this issue. However, the OIG does not have access to BCBSNC's proprietary participating provider fee schedules, and therefore we cannot use this approach. The use of [redacted] to calculate the Plan's overpayments is actually a significantly more conservative methodology, as the [redacted] is typically 14 percent higher than [redacted] In other words, the amount we are questioning in this report is lower than the amount that would be questioned if we used [redacted]

We do recognize the potential impact and risks associated with recovering any type of claim payment error from the VA. We also recognize that Federal regulation prohibits third-party carriers from performing offset recoveries against VA facilities. However, we again emphasize the reasons why the Plan should be accountable for its actions to both the VA and FEHBP:

- A majority of these claim overpayments were unallowable costs due to the Plan's failure to comply with CS 1039.
- The claims paid in error were unreasonably contracted by the Plan, which put the FEHBP at risk for millions of dollars in overpayments.
- The Plan relies on the Association's claims processing system to identify duplicate payments similar to those discussed in this report, but the Association's APM requires the Plans to monitor claims at the local level for duplicate payments related to VA claims. These conflicting actions between the two parties are indicative of negligence in providing proper oversight of the processing and payment of VA claims on behalf of the FEHBP.

For these reasons, we conclude the Plan did not make a "good faith" effort to reasonably pay these claims on behalf of the FEHBP. Regardless of the Plan's ability to recover these overpayments from the VA, the Plan should be responsible for returning these overpayments to the FEHBP.

Recommendation 1

We recommend that the contracting officer disallow $17,652,501 for claim overcharges and verify that the Plan returns all amounts to the FEHBP. Due to regulations, the contracting office should not allow the Plan to offset any recoveries against future payments, unless approved by a VA official.

Recommendation 2

We recommend that the contracting officer require the Plan to perform a cost analysis using all LOBs and types of services (i.e., inpatient, outpatient, and physician) to determine what rates are reasonable for the FEHBP to obtain and pay VA facilities. Based on this analysis, we recommend the contracting officer provide oversight that the Plan practices due diligence to ensure the Plan contracts equitably to pay VA claims on behalf of the FEHBP.

Recommendation 3

We recommend that the contracting officer require the Plan to perform an analysis to determine the extent that the Plan's administrative cost reimbursements were overstated as a result of the

overpayment of VA claims. The contracting officer should ensure that the Plan returns all excessive administrative cost reimbursements to the FEHBP.

B. Hospice Claims Review $964,834

Our system pricing review detected significant problems with claims paid by the Plan to hospice service providers. The full results of our system pricing review are detailed in section D below. Due to the substantial amount of pricing errors paid to hospice providers, we performed an expanded review of claims containing hospice services and separated this audit finding from the system pricing review for reporting purposes. See Exhibit II for a summary of the results of our Hospice Claims review.

Exhibit II – Summary Results of Hospice Claims Review

Universe of Claims	Universe Dollar Total	Sampled Claims	Sampled Dollar Total	Claims Paid in Error	Total Claim Payment Errors
[redacted]	[redacted]	[redacted]	[redacted]	**833**	**$964,834**

Sample Selection Criteria
Our review included *all* claims paid from January 1, 2012 through April 30, 2015, containing hospice services where the amount paid to the provider was greater than or equal to the amount billed by the provider.

Cause of Errors
The overpayments found in this review were due to the Plan's local processors overriding the Plan's local network pricing system. Although these claims were billed by in-network member providers, the processors incorrectly processed these claims at billed charges.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. Also, if a claim payment error is identified the Plan should make a prompt and diligent effort to recover the overpayment regardless of any provider contract time limitations. These criteria apply to all subsequent findings within this report.

<u>Plan Comments:</u>

***"The Plan agrees with the finding. The Plan has recovered $68,393 and deemed $822,662 as uncollectible due to provider contract limits. In addition, the Plan has initiated recovery on the latest sample of claims in the amount of $54,745. The Plan is contesting $19,034 due to contract fee schedule's that were not listed accurately at the time of the audit*."**

BCBSNC agrees with the audit finding, but states that the vast majority of funds are not recoverable.

Regarding corrective actions related to the pricing and payment of hospice claims on behalf of the FEHBP, the Plan states, ***"The Plan has updated the Standard Operating Procedures (SOP) and provided training to the staff."***

OIG Comment:

As part of the audit resolution process, we recommend that the Plan submit evidence that these overpayments have been properly adjusted and returned to the FEHBP. With regards to the overpayments that the Plan has determined uncollectible due to provider contract limitations, we recommend the Plan to attempt recovery on all overpayments to the FEHBP as required by CS 1039. These statements apply to all subsequent recommendations in this report where the Plan agrees to the audit finding.

For the contested overcharges of $19,034, the Plan did not provide sufficient documentation to support the correct payment rates or fee schedules for these providers. Therefore, we continue to question these additional costs as unsupported.

Recommendation 4

We recommend that the contracting officer disallow $964,834 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

C. Indian Health Claims Review $26,140

Our audit also detected significant problems with claims paid by the Plan to Indian Health service providers. See Exhibit III for a summary of the results of the Indian Health claims review.

Exhibit III – Summary Results of Indian Health Claims Review

Universe of Claims	Universe Dollar Total	Sampled Claims	Sampled Dollar Total	Claims Paid in Error	Total Claim Payment Errors
				135	$26,140

Sample Selection Criteria
Our review included claims paid from January 1, 2011 through September 30, 2014, where the amount paid to the provider was greater than or equal to the amount billed by the provider. We then selected the following from this group:

- All claim payments with potential overpayments of $100 or more; and
- A random selection of 30 claims

Cause of Errors

- For one provider network, the Plan loaded the incorrect contracted rates into its local pricing system. As a result, the Plan overcharged 134 claims, totaling $25,471, to the FEHBP.
- In one instance, the Plan's claims processors overrode the system's automated pricing, resulting in an overcharge of $669.

Plan Comments:

"The Plan agrees with the finding. The Plan has recovered $16,648 and deemed $9,492 as uncollectible due to provider contract limits. The Plan has updated the Standard Operating Procedures (SOP) and provided training to the staff."

Recommendation 5

We recommend that the contracting officer disallow $26,140 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

D. System Pricing Review $5,022

From a universe of claims reimbursed between July 1, 2012 and September 30, 2014, we reviewed a sample where the FEHBP paid as the primary insurer to verify that the local system properly processed and priced these claims in accordance with the Plan's provider contracts. See Exhibit IV for a summary of the results of our System Pricing Review.

Exhibit IV – Summary of System Pricing Review

Universe of Claim Lines	Universe Dollar Total	Sampled Claims	Sampled Dollar Total	Claims Paid in Error	Total Claim Payment Errors
				2	**$5,022**

Sample Selection Criteria

- We selected 74 claims that were stratified by place of service (e.g., a provider's office or an inpatient hospital), and payment category (e.g., $50 to $99). Our sample was judgmentally determined by number of sample items from each place of service stratum based on the stratum's total claim dollars paid.

Cause of Errors

- The Plan did not properly coordinate one claim with Medicare, resulting in an overcharge of $3,128 to the FEHBP.

- In one instance, the FEP Express national claims system allowed payment for a member whose FEHBP coverage was no longer effective (e.g., ineligible patient), resulting in an overcharge of $1,893 to the FEHBP.

Plan Comments:

"The Plan agrees with the finding. The Plan has recovered $3,128 and initiated recovery on the remaining $1,893. All four letters have been sent; however, the funds have not been recovered."

Recommendation 6

We recommend that the contracting officer disallow $5,022 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

<u>Information Systems Audits Group</u>

[redacted], Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Senior Team Leader

[redacted], Group Chief

APPENDIX

BlueCross BlueShield
Association

An Association of Independent
Blue Cross and Blue Shield Plans
Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
Phone # 202.942.1000
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April 7, 2016

[redacted]
Senior Team Leader
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Washington, D.C. 20415-1100

Reference: **OPM DRAFT AUDIT REPORT**
Blue Cross and Blue Shield of North Carolina
Audit Report Number 1A-10-33-15-009
(Dated and Received January 28, 2016)

Dear [redacted]:
This is our response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) for Blue Cross and Blue Shield of North Carolina (Plan). Our comments concerning the findings in this report are as follows:

HEALTH BENEFIT CHARGES

A. Veteran Affairs Claims Review **$17,652,501**

Recommendation 1

We recommend that the contracting officer disallow $17,652,501 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP. Due to the nature of this finding and the substantial amount questioned, we also recommend that the contracting officer contact the VA to discuss a practical approach for recovery of these claims. Based on regulations, the contracting office should not allow the Plan to offset these recoveries against future payments.

BCBSNC'S Response to Recommendation 1:

The Plan disagrees. As set forth in more detail below, OIG performed this audit using standards and methodologies that are not supported by and do not comport with applicable law. As a result, the findings and conclusions that are set forth in the Veteran Affairs Claims Section of the Draft Audit Report ("VA Claims Review") have no foundation in governing law and this section should be removed from the final audit report in its entirety. In the event that the VA Claims Review is maintained in the final audit report, BCBSNC's response should be included in the final report in its entirety.

I. OIG DID NOT USE THE PROPER LEGAL STANDARD TO ANALYZE THE "REASONABLENESS" OF BCBSNC'S VA CLAIMS PAYMENTS.

In the VA Claims Review, OIG asserts that the claims payments made by BCBSNC to the Department of Veteran's Affairs ("VA") were not "reasonable" under the Federal Acquisition Regulations ("FAR") because the pricing used for those claims was neither "cost effective" nor "advantageous to the FEHBP." *See* Draft Audit Report at 6. Although OIG asserts that this conclusion is grounded in the "reasonableness" standard set forth in 48 C.F.R. § 31.201-3, the actual analysis used in this audit does not support such contention. Specifically, by focusing exclusively on the relative "cost effective[ness]" and "advantageous[ness] to the FEHBP" of the pricing methodologies BCBSNC was contractually obligated to use under its Letter of Understanding with the VA (the "LOU"), OIG analyzed "reasonableness" using a legal standard that is materially different from the one mandated by the FAR. As a result, the analysis and conclusions set forth in the draft audit report do not have a proper legal foundation and are arbitrary and capricious.

Under the contract that governs BCBSNC's participation in the FEHBP ("CS 1039"), claims costs incurred by a carrier are allowable and can be properly charged to the FEHBP as long as they are, *inter alia,* "reasonable" under the FAR. *See* Section 3.2(b)(1) of 2013 Contract No. CS 1039 ("CS 1039"); 48 C.F.R. § 31.201-3. A cost is considered "reasonable" under the FAR when, "in its nature and amount, [such cost] does not exceed that which would be incurred by a prudent person in the conduct of competitive business." 48 C.F.R. § 31.201-3(a). This standard is designed to ensure that the costs paid by the federal government under a procurement contract are competitive and consistent with what a private party would pay in an open and competitive market. *See* Contract Pricing Reference Guide § 3.3.1 *available at* https://acc.dau.mil/CommunityBrowser.aspx?id=406579&lang=en-US ("the objective of cost analysis is to determine what the reasonable cost [for an item or service] would be if the offeror were operating in a competitive environment.").

The analysis used to determine whether a given cost is "reasonable" under 48 C.F.R. § 31.201-3(b) "depends on a variety of facts and circumstances," but focuses on the following four foundational factors:

(1) Whether it is the type of cost generally recognized as ordinary and necessary for the conduct of the contractor's business or the contract performance;

(2) Generally accepted sound business practices, arm's length bargaining, and Federal and State laws and regulations;

(3) The contractor's responsibilities to the Government, other customers, the owners of the business, employees, and the public at large; and

(4) Any significant deviations from the contractor's established practices.

48 C.F.R. § 31.201-3(b)(1)-(4); *see also* Contract Pricing Reference Guide § 3.3.1. Thus, these are the factors that should have been, but were not, applied here to determine whether the VA claims payments at issue were "reasonable" and allowable under CS 1039.

Instead, OIG performed an analysis that focused narrowly on whether the rates used to price the VA claims were "<u>cost effective and advantageous to the FEHBP.</u>" Draft Audit Report at 6 (emphasis in original). Rather than conducting a holistic examination of the VA rates in the context of BCBSNC's business, OIG simply compared the rates that were contractually mandated by the LOU to alternative rates that, in theory, could have been used if the operative facts of this audit had been completely different. Draft Audit Report at 6 (analyzing pricing that could have been used if the LOU did not exist[3] and if the VA had agreed to lower rates). As the discussion in the Draft Audit Report makes clear, the goal of this analysis was not to examine these rates in the context of the factors set forth in 48 C.F.R. § 31.201-3(b)(1) – (4), but, instead, simply to determine whether they represented what OIG believed to be the "lowest obtainable rate[s]." Draft Audit Report at 5-6. The dispositive question in this purely quantitative analysis was ultimately whether the claims could have been priced using rates that were more "cost effective and advantageous to the FEHBP" than the rates actually used. Draft Audit Report at 5-6. The FAR, however, do not define or determine "reasonableness" in such manner, *see* 48 C.F.R. § 31.201-3, and this analysis is not consistent with, comparable to, or a valid proxy for the actual standard mandated by the FAR, as the discussion in Section III below demonstrates. As a result, the analysis performed by OIG in this audit was not grounded in the governing law and was fundamentally incapable of producing results that could be enforced by OPM.

III. THE FAR DO NOT REQUIRE GOVERNMENT CONTRACTORS TO INCUR COSTS USING "THE LOWEST OBTAINABLE RATE."

The lack of legal foundation in the standard applied in this audit is confirmed by the holding in *United States ex rel. Thomas v. Siemens AG*, in which the court explicitly held that government contractors have no legal obligation to give their best or lowest prices to federal agencies under procurement contracts. 991 F. Supp. 2d 540, 547 (E.D. Pa 2014). In substance, OIG interprets "reasonableness" under the FAR to require contractors to sell to federal agencies at the best possible price or, put differently, to incur costs that will be charged to an agency using "the lowest obtainable rate." Draft Audit Report at 5. Thus, if an FEHB carrier contracted with a provider at a rate ***higher*** than

[3] The Draft Audit Report is incorrect in its assertion that BCBSNC could have priced VA claims using "the Association's non-participating provider rates" if the LOU did not exist. Draft Audit Report at 6. The Association's Administrative Procedures Manual clearly states that VA facilities must be paid at "Preferred benefit levels" when they are non-participating with a plan. APM § 12-27. This direction is consistent with 38 C.F.R. § 17.101, which gives health plans the option of either using the VA's "reasonable charges" or the contracted rates from a comparable facility in the same geography as the basis for the payment of VA claims.

what OIG considered "the lowest obtainable rate," any payments made thereunder would not – under the standard applied in this audit – be "reasonable" or allowable under the FAR. *See id.* The court's holding in *Siemens AG,* however, repudiates any notion that the "reasonableness" standard is a quantitative measure that operates in such manner.

In *Siemens AG,* a qui tam relator argued that the defendant had overcharged the federal government and violated the False Claims Act by selling medical equipment to the VA at prices substantially higher than the prices at which it sold the same equipment to commercial customers. 991 F. Supp. 2d at 563. The relator asserted that the defendant had a legal obligation to give the VA the lowest obtainable rate and sell the equipment at the lowest price that it offered to any of its customers. *Id.* Although the defendant readily admitted that the prices it gave to commercial customers were substantially lower than the prices it gave to the VA, the district court held that it no legal duty to do otherwise and that no overpayment had occurred as a result. *Id.* at 566. The court based this holding (which is irreconcilable with the "reasonableness" standard applied in this audit) on the fact that, under the FAR, "contracting officer[s are] ***not required to obtain the best price*** the vendor offers," *id.* at 547, and, instead, are simply required to obtain prices that are "fair and reasonable" under governing law, *id.* at 561.

Although *Siemens AG* involved a fixed-price contract in which "reasonableness" is determined prior to execution of the agreement(as opposed to a cost-reimbursement contract like CS 1039 where it is determined after performance has commenced[4]), 48 C.F.R. § 16.202-2, the opinion confirms that the analytical standard applied here is not consistent with governing law. The court's holding demonstrates that "reasonableness" under the FAR is not a quantitative measure under which a cost is only "reasonable" if it represents the "lowest obtainable rate" for the item or service at issue. Draft Audit Report at 5. If "reasonableness" actually depended on the government receiving the "lowest obtainable rate," the costs at issue in *Siemens AG* would not have satisfied such requirement given the contractor's forthright admission that it maintained one set of prices for the government and a separate set of much lower prices for commercial customers. However, there was no violation of this requirement on such basis there because, as the court correctly recognized, cost "reasonableness" under the FAR does not depend on the government receiving the "best price" or lowest obtainable rate. 991 F. Supp. 2d at 561 (holding that "a 'most-favored customer' or ***'best price' has no place in a contract governed by the FAR***, which sets a 'fair and reasonable' standard" (emphasis added)). Moreover, it is significant to note that the Office of Inspector General for the VA filed a declaration in *Siemens AG* confirming that "***there is no law, regulation, or contract provisions*** that requires vendors to offer [most-favored customer] pricing to [the] VA at the time of award or during the term of the contract." Declaration of Maureen Regan ¶ 5[5] (attached as Exhibit A).

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[4] In cost-reimbursement contracts like CS 1039, the "reasonableness" of the government's costs is determined after contract formation and during performance when those costs are submitted for reimbursement. 48 C.F.R. §§ 16.307(a)(1), 52.216-7.

[5] This declaration was filed in *Thomas v. Siemens AG*, Case No. 2:09-CV-04414-TJS (E.D. Pa.) and can be accessed directly through the PACER site for the United States District Court for the Eastern District of Pennsylvania at http://www.paed.uscourts.gov/

Because the FAR do not require contractors to give federal agencies their best pricing or "the lowest obtainable rate," the application in this audit of an analytical standard designed to measure "reasonableness" is such fashion is contrary to governing law.

III. THE VA CLAIMS PAYMENTS WERE "REASONABLE" UNDER THE FAR.

When the proper legal standard is applied to the VA claims payments at issue, the "reasonableness" and allowability of such costs is manifest. As stated above, 48 C.F.R. § 31.201-3(b)(1)-(4) establishes four foundational factors to be used in determining whether a given cost is "reasonable" under the FAR. Each of these four factors weighs in favor of "reasonableness" here.

1. Is the type of cost generally recognized as necessary in conducting business?

The first factor identified in 48 C.F.R. § 31.201(b)(1) weighs in favor of BCBSNC because the costs associated with reimbursing health care providers is a necessary and integral component of the business conducted by a health insurance carrier. Moreover, making such reimbursement payments on behalf of FEHB members is one of the core services that OPM contracted for carriers to provide under CS 1039. *See* Section 2.2 of CS 1039.

2. Is the cost consistent with sound business practice, law, and regulation, and are purchases conducted on an "arm's-length" basis?

The second factor also weighs in favor of "reasonableness" for the following four reasons. First, the costs at issue are consistent with governing law and regulation given that BCBSNC paid these claims in accordance with and using [redacted] Second, BCBSNC priced and paid these claims pursuant to the terms of an agreement with the VA that resulted from an arm's length negotiation. Clearly, following federal law and honoring contractual agreements with federal agencies are actions entirely consistent with sound business practice.

Third, [redacted] allowed BCBSNC to avoid the expense of and risks associated with [redacted]

Although OIG may discount or dismiss the value that a health plan places on avoiding the disruption, distraction, and expense of and the risk of , neither the FAR nor any other provision of federal law confer on OIG or OPM the legal authority to override or displace a health plan's judgment on such matters simply because that plan has contracted with OPM to serve as a carrier for the FEHBP.

Finally, the soundness of BCBSNC's decision to agree to the pricing methodologies in the LOU is clearly confirmed by the fact that BCBSNC, and not the FEHBP, paid a disproportionate share of VA claims received by BCBSNC during the relevant time period. Between 2011 and 2014, ***over two-thirds*** of the claims payments made by BCBSNC to the VA under the LOU were paid on behalf of members of BCBSNC's commercial (i.e., non-FEHBP) health plans. Declaration of ¶ 4 (stating that approximately 68% of BCBSNC's claims payments to the VA during the relevant period were paid on behalf of commercial members) (attached as Exhibit B). The fact that BCBSNC's commercial reimbursements to the VA were ***twice as large*** as its FEHBP reimbursements during this period further demonstrates that BCBSNC's agreement to the rates set forth in the LOU was driven by a rational business decision and is entirely consistent with sound business practice.

As the foregoing demonstrates, BCBSNC had ample business justification for agreeing to the pricing methodology set forth in the LOU and there is no legal or factual basis to support the suggestion in the Draft Audit Report that it is not a "prudent organization" for doing so.

3. Does the offeror's action reflect a responsible attitude toward the Government, other customers, the owners of the business, the employees, and the public-at-large?

The third factor also weighs in favor of "reasonableness." Because BCBSNC priced the VA claims in accordance with a contract ***with the federal government*** and then remitted payment ***to the federal government***, BCBSNC's actions reflect a responsible attitude towards the federal government. Indeed, the fact that BCBSNC paid these claims using prices that

There is absolutely no precedent that would support an

argument that a federal contractor acts irresponsibly for purposes of a "reasonableness" analysis when it acts in full and complete accordance with such laws and regulations.

4. Are the offeror's actions consistent with established practices?

The fourth and final "reasonableness" factor also clearly weighs in BCBSNC's favor. As BCBSNC repeatedly informed OIG throughout this audit and as the terms of the LOU confirm, BCBSNC paid the VA claims using the exact same rates that BCBSNC uses to pay VA claims for every other health plan that it administers, including those that BCBSNC fully insures. BCBSNC agreed to uniform pricing methodologies with the VA under the LOU and has consistently applied them across all lines of its business. As a result, the amounts paid on the FEHBP claims were identical to what BCBSNC pays when the same underlying services are supplied to members of its own fully-insured plans. In pricing and paying these claims, BCBSNC did not deviate in any way from its standard and established pricing practices for VA claims.

As the foregoing demonstrates, when the VA claims payments at issue are analyzed using the appropriate legal standard set forth in the FAR, each of the applicable factors supports the "reasonableness" – and, thus, the allowability – of the incurred costs. Although BCBSNC acknowledges that OIG could – given its mandate – have legitimate concerns regarding the impact on the FEHBP of the statutes and regulations that govern third-party reimbursement to the VA, such concerns represent an issue between two coordinate federal agencies within the Executive Branch that is appropriately addressed directly with the VA by OIG or OPM. Using claims audits such as this as a forum for addressing an inter-agency dispute of this type is not only inefficient insofar as FEHBP carriers have little to no ability to effectuate regulatory change at the VA, but also destructive to the stability of the program insofar as potential eight figure overpayment demands by one federal agency for payments that were made ***to another federal agency*** in full compliance with federal law would not only be unprecedented and grossly inequitable, but would also create a strong disincentive for carrier participation in the FEHBP.

IV. THE RATES AGREED TO IN THE LOU [REDACTED] AND, THEREFORE, ARE REASONABLE *PER SE*.

In addition to the foregoing, the "reasonableness" of the VA claims payments is established simply by virtue of the fact that [REDACTED] and, as a result, are deemed reasonable *per se* under the FAR. The federal government has adopted a variety of statutes and regulations to ensure that any prices agreed to by the federal government under a procurement contract are "reasonable." *See e.g.,* 10 U.S.C. § 2306a; 41 U.S.C. § 3502; 48 C.F.R. § 15.401 *et seq.* For example, Congress requires federal agencies to obtain "cost or pricing data" from prospective contractors under certain statutorily-specified circumstances in order to ensure that the prices being offered are "reasonable." 10 U.S.C. § 2306a(a); 41 U.S.C. § 3502(a), 48 C.F.R. §15.402(a).

Nevertheless, when enacting the controlling statutes, Congress identified certain instances in which the "reasonableness" of pricing is so clear and so beyond doubt that there is no need for agencies to expend resources obtaining or reviewing supporting data. *See e.g.,* 10 U.S.C. § 2306a(a)(7)(B)(1); 41 U.S.C. § 3503(a). Thus, federal agencies are not required to obtain such data when acquiring a "commercial item" because the competitive forces of the free market ensure that such items are reasonably priced. 41 U.S.C. § 3503(a)(1)(A). Similarly, agencies are not required to validate pricing that is established by adequate price competition, which ensures price reasonableness. 41 U.S.C. § 3503(a)(2). Most relevant for present purposes, Congress has mandated is sufficient – standing on its own – to validate its "reasonableness" for procurement purposes.

Given Congress's determination regarding the reliability and reasonableness of for purposes of the procurement process, there is no basis in law or fact for a federal agency to assert that such prices should be treated any differently for purposes of an allowability analysis during the performance phase of the resulting contract. Put simply, prices that are inherently "reasonable" during the procurement phase of the acquisition process do not change their character once performance begins and remain just as "reasonable" then as they were at the outset of the process.

IV. THE ALLEGED PAYMENT ERROR WAS CALCULATED USING AN INAPPROPRIATE AND UNSUPPORTED METHODOLOGY.

Even if the draft audit report were correct in its assertion that the VA claims payments at issue did not satisfy the "reasonableness" requirement of the FAR, the methodology used to calculate the alleged resulting payment error is not consistent with governing law, which fatally undermines the legal validity of the results. As OIG acknowledges in the draft audit report, 38 C.F.R. § 17.101(a)(4) allows a third-party payer to reimburse VA claims using either (1) the rates set by the VA using the methodologies in the regulation, or (2) the contracted rates that the health plan would pay a non-VA facility in the same geographic area. Draft Audit Report at 5. As the unambiguous text of this regulation makes plain, there is no third option; health plans are legally obligated to pay VA claims in accordance with one of the two specified pricing methodologies in the absence of a contract establishing a different rate structure. Thus, if OIG's analysis were correct and

Here, however, OIG selected an entirely separate set of rates (i.e., the FEP non-par pricing allowances) to use as the basis of its payment error analysis. Although OIG asserts that such rates are "comparable to [BCBSNC's] UCR rates," Draft Audit Report at 6, the fact that such rates are not one of the two pricing sources authorized by 38 C.F.R. § 17.101(a)(4) renders them fundamentally inappropriate for use as the basis of the payment error calculation that was performed here. Put simply, because the FEP non-par pricing allowances is not one of the two pricing methodologies permitted under 38 C.F.R. § 17.101(a)(4), OIG has no more legal basis to calculate an alleged payment error using such rates than BCBSNC would have to use when calculating VA claims payments in the first instance.

At bottom, OIG's use of a rate source that is not supported by any applicable law as the basis of its payment error analysis renders the results of such analysis legally invalid.

V. CONCLUSION REGARDING RECOMMENDATION 1

As the foregoing demonstrates, the VA Claims Review was performed using analytical standards and methodologies that are not supported by – and do not comport with – applicable law, which fatally undermines the legal validity of the resulting findings and conclusion. As a result, the Plan disagrees with this section of the draft audit report, which should be removed in its entirety.

Recommendation 2

We recommend that the contracting officer require the Plan to properly negotiate and/or contract reasonable rates with the North Carolina VA providers' service area on behalf of the FEHBP.

BCBSNC's Response to Recommendation 2:

The Plan disagrees. As discussed above, the rates that BCBSNC has agreed to use when pricing VA claims under the LOU are "reasonable" for purposes of the FAR. As a result, the underlying premise of this recommendation is invalid, and this recommendation should be removed from the final audit report. The Plan further disagrees with this recommendation for the following two reasons.

I. OPM CANNOT MANDATE SPECIFIC PRICING TERMS FOR FEHBP CARRIERS' PROVIDER CONTRACTS.

Recommendation 2 should also be removed because federal law does not confer on the contracting officer sufficient legal authority to interfere with an FEHBP carrier's provider contracts in the way recommended. In essence, OIG suggests that the contracting officer should compel the carrier to renegotiate the pricing terms of an existing provider contract in order to secure rates that would satisfy OIG's "cost effective and advantageous to the FEHBP" standard of "reasonableness." Putting aside the fact that

neither the contracting officer nor BCBSNC has any ability to force the VA to accept pricing that would meet this standard, there is no applicable federal law or regulation that displaces, preempts, or otherwise regulates BCBSNC's freedom to negotiate contractual pricing terms with the health care providers in its network simply because it has chosen to serve as an FEHBP carrier under CS 1039. Although the contracting officer has clear authority to determine whether a cost incurred by a carrier under a provider contract is allowable or not, *see* 48 C.F.R. §§ 31.201-2(d), 42.801(a), CS 1039 § 5.37, neither the statutes nor regulations that govern the FEHBP, nor the terms of CS 1039, confer any legal authority on OPM to dictate the pricing terms that a carrier must agree to with a provider in the first instance, or otherwise set a price cap for a carrier's provider contracts .

II. RECOMMENDATION 2 IS CONTRARY TO THE FISCAL INTERESTS OF THE UNITED STATES.

Recommendation 2 should also be removed because, if implemented by OPM, it would necessitate an increase in Congressional appropriations to the VA in order to offset the VA's loss of non-FEHBP revenue. Recommendation 2 seeks to have OPM force FEHBP carriers to negotiate contract pricing with the VA that meets OIG's standard of "reasonableness." Draft Audit Report at 5-6. Even if OPM had the legal authority to interfere in a carrier's provider relationships in this manner, doing so would be contrary to the fiscal interests of the United States.

Every reimbursement dollar that the VA collects from a health plan is deposited into the Medical Care Collections Fund ("MCCF"), 38 U.S.C. § 1729A(b)(6), and is used exclusively to fund the VA's mission of providing quality health care to our nation's veterans, 38 U.S.C. § 1729A(c)(2). As a result, Congress accounts for the funds available to the VA through the MCCF during the budgetary and appropriations process. *See e.g., Veterans' Medical Care FY2014 Appropriations,* Congressional Research Service Report #R43179 (August 14, 2013), *available at* https://www.fas.org/sgp/crs/misc/R43179.pdf. Thus, every dollar that the VA collects in third-party reimbursement is one less dollar Congress must appropriate to fund the VA's operations. Conversely, any reduction in the VA's collections reduces the funds available through the MCCF and necessitates additional appropriations from Congress in order to maintain existing levels of funding.

If the FEHBP were the only third-party health plan paying VA claims, any reduction in the rates used to reimburse the VA would be revenue neutral for the federal government because every dollar that the federal government did not collect through the VA from the FEHBP would represent a dollar that the federal government did not have to pay to the VA under the FEHBP. However, when an FEHBP carrier, such as the one at issue in this audit, pays nearly two-thirds of its VA claims for ***commercial members,*** any reduction in VA rates would result in a substantial loss of revenue for the federal government. For example, if BCBSNC had been able to price VA claims in accordance with the rates used by OIG in its payment error analysis here, the VA would have collected over $17 million less on FEHBP member claims and more than $37 million less on commercial member

claims.[6] Under such scenario, the loss of FEHBP claims payments would be revenue neutral for the federal government, while the loss of $37 million in commercial revenue would be a net loss that would necessitate a $37 million increase in Congressional appropriations in order to maintain existing funding levels at the VA.

As the foregoing demonstrates, even if OPM had the authority and ability to force FEHBP carriers to contract with the VA using the non-par FEP rates that OIG deems "reasonable," doing so would be clearly and materially contrary to the interests of the United States federal government.

B. Hospice Claims $964,834

Recommendation 3

We recommend that the contracting officer disallow $964,834 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

BCBSNC'S Response to Recommendation 3:

The Plan agrees with the finding. The Plan has recovered $68,393 and deemed $822,662 as uncollectible due to provider contract limits. In addition, the Plan has initiated recovery on the latest sample of claims in the amount of $54,745. The Plan is contesting $19,034 due to contract fee schedule's that were not listed accurately at the time of the audit.

Questioned Amt	Recovered Amt	Contested Amt	Uncollectible Amt	Initiated Recovery
$964,834	$68,393	$19,034	$822,662	$54,745

Recommendation 4

We recommend that the contracting officer require the Plan to perform training for its local processors to ensure they understand how to price and pay hospice claims on behalf of the FEHBP.

BCBSNC'S Response to Recommendation 4:

The Plan agrees with the finding. The Plan has updated the Standard Operating Procedures (SOP) and provided training to the staff.

[6] This estimation of the amount of non-FEHBP revenue the VA would have lost is based on the volume of non-FEHBP VA claims paid by BCBSNC between 2011 and 2014. If BCBSNC had paid the VA $17,652,501 less in FEHBP claims during this time period and FEHBP claims represented approximately 32% of BCBSNC's total VA claims volume, then application of the pricing that OIG promotes would have resulted in an overall reduction in VA payments of $55,164,065.63, which is arrived at by dividing $17,652,501 by 32%, and a reduction in commercial payments of $37,511,564.63, which is arrived at by multiplying $55,164,065.63 by 68%. *See* Exhibit B ¶ 4.

C. Indian Health Claims Review **$26,140**

Recommendation 5

We recommend that the contracting officer disallow $26,140 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

BCBSNC'S Response to Recommendation 5:

The Plan agrees with the finding. The Plan has recovered $16,648 and deemed $9,492 as uncollectible due to provider contract limits. The Plan has updated the Standard Operating Procedures (SOP) and provided training to the staff

D. System Pricing Review **$5,022**

Recommendation 6

We recommend that the contracting officer disallow $5,022 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

BCBSNC'S Response to Recommendation 6:

The Plan agrees with the finding. The Plan has recovered $3,128 and initiated recovery on the remaining $1,893. All four letters have been sent; however, the funds have not been recovered.

We appreciate the opportunity to provide our response to each of the findings in this report and request that our comments be included in their entirety and are made a part of the Final Audit Report. If you have any questions, please contact me at [redacted] or [redacted] at [redacted].

Sincerely,

[redacted], CISA
Managing Director, Program Assurance

cc: [redacted], BCBSNC
[redacted], FEP
[redacted], FEP

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