



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

Management Advisory Report

**FEHB Program Integrity Risks Due to Contractual
Vulnerabilities**

Report Number 4A-HI-00-18-026

April 1, 2021

EXECUTIVE SUMMARY

Management Advisory Report on FEHB Program Integrity Risks due to Contractual Vulnerabilities

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What is the Management Advisory?

The primary objective of this Management Advisory Report is to inform the U.S. Office of Personnel Management (OPM) of concerns that the Office of the Inspector General (OIG) has with various program administration vulnerabilities, as well as contractual vulnerabilities identified within the health benefit contracts between OPM and the participating Federal Employees Health Benefits Program (FEHBP) carriers.

Why Issue the Management Advisory?

A review of the standard language utilized in contracts between OPM and its participating FEHBP carriers identified several program integrity risks, which we believe require intervention. If OPM does not address these items, we are concerned that the risks could cause potential harm to program members, that the Government will not receive the best value in meeting its needs for the program, and that the Government could potentially overpay for the services provided.

What Did We Find?

Our review of the standard contract language identified the following integrity risks:

- **Data Issues** – The FEHBP contract documents do not sufficiently address OPM’s or the OIG’s access to claims data and data retention timeframes, which affects the ability to provide effective program oversight.
- **Fraud, Waste, and Abuse Efforts** – The FEHBP contract documents do not sufficiently address all components needed for a carrier to implement an effective fraud, waste, and abuse program, putting the FEHBP at risk of fraudulent payments, and, more importantly, putting program members at risk of potential harm.
- **OPM’s Fiduciary Responsibilities** – The FEHBP contract documents do not sufficiently address OPM’s fiduciary responsibility to ensure that taxpayer dollars are wisely and properly spent.
- **Other Contract Improvements** – The FEHBP contract documents include clauses that need to be removed because they are no longer relevant or amended based on the results of recent audits conducted. In addition, there are clauses that should be added to address vulnerabilities encountered in the performance of our oversight.



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ABBREVIATIONS

CL	Carrier Letter
CR HMO	Community-Rated Health Maintenance Organization
DOJ	U.S. Department of Justice
ER HMO	Experience-Rated Health Maintenance Organization
FCA	False Claims Act
FEHBP	Federal Employees Health Benefits Program
FFS	Fee-for-Service
FWA	Fraud, Waste, and Abuse
HHS	U.S. Department of Health and Human Services
HI	Healthcare and Insurance
HMO	Health Maintenance Organization
NFR	Notice of Findings and Recommendations
OGC	Office of General Counsel
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
PBM	Pharmacy Benefit Manager
PPA	Plan Performance Assessment
SIU	Special Investigations Unit

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I. BACKGROUND

The Federal Employees Health Benefits Program (FEHBP) was established by the Federal Employees Health Benefits Act, enacted on September 28, 1959.¹ The program provides health insurance benefits for Federal employees, annuitants, and dependents, and is administered by OPM's Healthcare and Insurance (HI) office. It is currently the largest employer-sponsored group health insurance program in the world, covering over 8 million Federal employees, retirees, and their family members. As of December 31, 2019, the FEHBP paid over \$58 billion dollars in healthcare premiums to approximately 190 participating carriers.

The FEHBP is a decentralized program in which OPM contracts with health care insurance carriers to provide health care benefit administration activities to FEHBP enrollees. Contracted FEHBP carriers process and pay claims, provide customer service and access to health care providers and hospitals, and deliver other related services and benefits. OPM administers three types of FEHBP carrier contracts: an experienced-rated Fee-for-Service (FFS) contract; an experienced-rated Health Maintenance Organization (ER HMO) contract; and a community-rated Health Maintenance Organization (CR HMO) contract.

OPM issues Carrier Letters (CL) to provide additional, binding guidance to carriers on various sections of the contract. For example, CL 2017-13 provides guidance related to the administration of carriers' fraud, waste, and abuse programs, including mandatory information sharing and the requirement to report fraud, waste, and abuse issues to the OIG.

As mentioned above, the FEHBP was established in 1959, which makes the program over 60-years old. Over those 60-plus years, the health care industry has undergone significant changes that have affected the way the OIG performs its audit and investigative activities and have also created new and more complex audit issues and investigative cases. To address the changes to our work necessitated by the changes in the health care industry, and to fulfill our mission of protecting the integrity of OPM services and programs through independent and objective oversight, we need to ensure that OPM has the program criteria in place to provide quality service to FEHBP members at a reasonable cost and to protect program assets from misuse. Consequently, during fiscal year 2018, the OIG created a working group tasked with performing a comprehensive review of the standard contracts OPM has with each of the three types of carriers. The objective of this review was to identify program vulnerabilities within the current contractual language and propose corrective actions to address the vulnerabilities. The results of this review and our proposed corrective actions are discussed in Section II of this report.

¹ Public Law 86-382.

II. FINDINGS AND RECOMMENDATIONS

A. DATA ISSUES

The FEHBP's contract documents do not sufficiently address data retention timeframes, which is impacting both OPM's and the OIG's ability to provide effective oversight of the program.

1. Data Retention Periods

The False Claims Act (FCA) applies to all contractors providing goods and services to the Federal Government and although the FCA can be used in almost every aspect of Government spending, one of the top sources annually for the recovery of Government funds has been in the medical arena. The FCA is one of the broadest, strongest, and most utilized tools available to recover the billions of dollars lost due to fraud, waste, and abuse (FWA). The OIG often pursues investigative cases under the FCA, which has a 10-year statute of limitations.² Currently however, FEHBP carriers are required to retain claims data for only six years. This incongruity can create problems during FCA investigations.

For example, a 2003 FCA case was settled for \$87 million when the carrier inflated claim payments in order to charge higher premiums. At the time, this case was the largest settlement related to FEHBP insurance contracts in OPM history. The investigation required the OPM OIG to audit and investigate over 10 years of claim payment data and other information related to premium calculations, which required an Inspector General subpoena to obtain the information because of the limits of the 6-year claims data requirement. Having to issue a subpoena to an FEHBP carrier for FEHBP information is counter to the Inspector General Act of 1978, as amended, which under Section 6 provides for timely access to all records, reports, audits, reviews, documents, papers, recommendations, or other materials relating to the programs and operations under that Inspector General's oversight responsibilities.

The OIG receives approximately 500 to 700 *qui tam* cases per year relating to health care fraud. These cases are often pursued under the FCA, and require claims data to assess potential FEHBP exposure related to the allegations. The statute of limitations for an FCA *qui tam* action is:

- (1) six years after the date on which the violation is committed, or
- (2) three years after the date when facts material to the right of action are known or reasonably should have been known by the official of the United States charged with

² 31 U.S.C.

responsibility to act in the circumstances, **but in no event more than 10 years after the date on which the violation is committed**, whichever occurs last.³

In determining which limitation period applies to *qui tam* actions, courts examine the time at which either the relator or the Government became aware or knew of the violation. If a relator files a *qui tam* lawsuit two years after he/she was aware of the conduct, under the current FEHBP contract the OIG would be able to obtain information from only four of the six years retained by the carrier. However, if the contract requirement is extended to 10 years, carriers could provide at least 8 of the relevant years in this case – thereby maximizing the amount of damages the FEHBP could recover. The OIG’s Office of Investigations frequently encounters this limitation when evaluating submitted *qui tams* where getting a subpoena for additional years would be time- and cost-prohibitive to our investigative resources.

Recommendation 1

We recommend that OPM modify FEHBP contract language for all applicable records retention clauses to require the retention and accessibility of claims for 10 years plus the current year in a manner of OPM/HI’s choosing.

OPM’s Response:

OPM does not agree with our recommendation and states, “Under Section 1.11 of the standard FEHB contract, OPM and OIG have the right to examine all books and records relating to the contract, including performance provisions. If FEHB funds are being fraudulently expended, that would be a performance issue for which OPM would insist that OIG be given the data necessary to prevent fraudulent loss of funds.”

Additionally, “Changing the record retention requirement in the contract would require HI to update Federal Employees Health Benefits Acquisitions Regulations (FEHBAR), 48 CFR 1652.204-70, which states that records will be maintained for six years after the end of the contract term. The clause is currently included in the contract as required by the FEHBAR.

Furthermore, this clause is required to be inserted in all subcontracts for underwriting and claim payments, administrative services, and, in experience-rated contracts, in Large Provider Agreements. It is the carrier’s responsibility to ensure that applicable

³ 31 U.S.C. 3731(b) (emphasis added).

contract clauses exist in their subcontracts to allow OPM to receive the information that is requested.”

In conclusion, “If a carrier is reluctant to provide information necessary for fraud investigations, OIG should reach out to the Contracting Office and we will address it.”

OIG Comments:

The OIG appreciates the Contracting Office’s willingness to mediate issues where carriers are reluctant to provide information necessary for fraud investigations. However, the current limitations of the data retention policy in the FEHBP contract can be outside the ability of the Contracting Office to provide assistance. The FCA’s statute of limitations extends beyond the six years of data the contract requires carriers to retain, which makes it more difficult for the OIG and the U.S. Department of Justice (DOJ) to evaluate and pursue the total fraud loss. We have experienced long delays waiting for FEHBP carriers to pull archived data from beyond the currently required six years of data retention; those delays have affected our ability to conduct timely and relevant investigative activities. OPM’s HI states the data retention policy is limited by the FEHBAR. While we understand that updating the FEHBAR to address our concerns will require some effort on OPM’s part, we still believe these changes are needed to assist our office in reducing fraud, waste, and abuse within the program and the return of improper payments back to the health care trust fund. That being said, we also understand that further discussion of the FEHBAR and the contract may ultimately be necessary in order to implement our recommended changes.

B. FRAUD, WASTE, AND ABUSE EFFORTS

The FEHBP contract documents do not sufficiently address all components needed for an effective FWA identification and prevention program, putting the FEHBP at risk of improper payments and, more importantly, putting program members at risk of potential harm.

1. Strengthening Language in Contract Section 1.9(a) Related to Fraud, Waste, and Abuse

The current language in all three contracts states the following regarding fraud, waste, and abuse:

“The Carrier shall conduct a program to assess its vulnerability to FWA to include but not limited to performing post-payment reviews and audits of providers identified either proactively or reactively. The Carrier shall operate a system designed to detect and eliminate FWA internally by Carrier employees and Subcontractors, by providers providing goods or services to FEHB Members, and by individual FEHB Members. In addition, FEHBP Carriers must demonstrate they have submitted written notification to

OPM-OIG within 30 business days of identifying potential FWA issues impacting the FEHB Program regardless of dollar value. The program must specify provisions in place for cost avoidance, not just fraud detection, along with criteria for follow-up actions. The Carrier must submit to OPM an annual analysis of the costs and benefits of its FWA program.”

The broad nature of this clause concerns the OIG because too much is open to interpretation by the carriers. While OPM has issued carrier letters (most specifically Carrier Letter (CL) 2017-13) to provide additional guidance regarding FWA programs and has stated in CL 2017-13 that the guidance supplements contract requirements, in at least one instance with one of the program’s largest carriers, the carrier considered this guidance to be extra-contractual and sub-regulatory, intended only to facilitate cooperation and coordination between the carriers and OPM. Because of this determination the carrier made a decision related to a settlement that conflicted with an open U.S. Department of Justice (DOJ) investigation.

This specific carrier’s Associate General Counsel wrote in defense of its decision that the CL’s guidance “does not supersede [the FEHBP contract] or expand the OIG’s statutory authority.” As such, while acknowledging the existence and a clear awareness of the CL guidelines, this carrier still made a judgement to keep a settlement confidential instead of notifying the OIG to discuss the issue, as required under CL 2017-13. This notification is necessary in order for the OIG to assess and determine if a settlement will interfere or conflict with an ongoing investigation. If the settlement is related to an ongoing investigation, we must advise the DOJ to determine the appropriate steps for the Government to take in order to decide whether to include or carve out FEHBP dollars.

If a large carrier in the FEHBP asserts that OPM CLs are sub-regulatory, and thus an un-enforceable part of the FEHBP contract, then other carriers may similarly start to disregard the CLs. Consequently, the OIG has concerns that the CLs are not sufficiently binding.

Recommendation 2

We recommend OPM modify or add language in Section 1.9 of all FEHBP contracts to include all relevant sections and attachments of CL 2017-13, or modify all FEHBP contracts to add relevant language stating that all CLs are an addendum to the contract language and enforceable as a contract requirement.

OPM's Response:

OPM does not concur with our recommendation and contends, “It is not appropriate to include CLs or their attachments in FEHB Program contracts as addendums. So long as they are reasonable, CLs are enforceable guidance under the contract per 48 CFR 1609.7001(b)(1) – ‘Minimum standards for health benefits carriers’ which includes ‘(1) Timely compliance with OPM instructions and directives.’ We currently have relevant provisions of CL 2017-13 in Section 1.9 of the contract.”

OIG Comments:

The agency's non-concurrence does not address that there have been issues, as cited, with FEHBP carriers considering CLs as unenforceable. We have experienced resistance from carriers that required the OIG to coordinate with HI's Contracting Office and delayed investigations. In the instance cited above, the OIG considered the issue to be a function of the CL and the contract carrying, in the eyes of the carrier, different weights. The OIG remains concerned that similar incidents may occur. We made this recommendation because, while the Contracting Office has been successful in resolving issues of this nature in the past, the incidents have and can still negatively affect investigations while a resolution is pursued. If there is a way of ensuring or reinforcing that carriers adequately respect and comply with the CLs without modifying the contract, the OIG is receptive to other ways OPM's HI might meet this goal.

2. Fraud and Abuse Recoveries

The OIG is concerned that FEHBP contract section 1.9(a) is unclear regarding the return of fraud-related recoveries to specific U.S. Treasury accounts. Fraud recoveries obtained from criminal, civil, or administrative cases investigated by the OIG are returned to OPM via the DOJ Financial Litigation Units. These funds, initially collected by DOJ as part of a judge's restitution order, civil settlement, or administrative recovery, are returned to OPM either by hard-copy check from the U.S. Treasury or via an Intra-Governmental Payment and Collection electronic fund transfer.

Currently, these funds are placed into the carriers' contingency reserve account where they remain available to help mitigate against future premium increases. However, Section 1.9 of the standard contract does not provide instructions to carriers as to where to return the fraud-related recoveries reported in carriers' annual fraud reports. Instead, these funds are often treated as erroneous payments and returned or credited to the Letter of Credit Account, which

means that they cannot be used to benefit enrollees by mitigating potential premium increases.

Recommendation 3

We recommend OPM modify or add language to the appropriate Section of the FFS and ER-HMO FEHBP contracts to state that all FWA-related recoveries must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP contingency reserve fund account within 60 days after receipt by the carrier.

OPM's Response:

OPM does not agree with our recommendation. They state that under its Letter of Credit System Guidelines, the amounts making up the working capital account are derived via a quarterly calculation. Placing recoveries into this account would, therefore, require a recalculation of the working capital account each time a recovery is deposited. Additionally, use of working capital accounts is not a program requirement, and thus, not all FEHB carriers use them. Furthermore, it is problematic to require carriers to submit payments for FWA recoveries since there are multiple methods to recover funds (e.g., use of offsets) that would not involve a physical return of funds. Operationally, requiring carriers to use a working capital account would necessitate extensive reprogramming and accounting reorganization on OPM's end, and it would also remove the administrative flexibilities that currently exist for the FEHB fee-for-service carriers. Finally, they state that OIG's recommendation that recoveries ultimately be returned to the carriers' respective contingency reserve funds is problematic as carriers do not have access to these funds to either deposit or remove funds. Consequently, addressing this recommendation would require significant changes to OPM's internal processes that we cannot undertake.

OIG Comments:

While OPM raises valid points in its response, the problem remains that FWA monies recovered as a result of carriers' annual fraud reports are not being handled in the same manner as fraud recoveries obtained from criminal, civil, or administrative cases investigated by the OIG. In both instances, actual monies returned should be placed in the carriers' contingency reserve accounts to benefit program enrollees. Understanding that FEHBP carriers do not have operational access to their contingency reserve funds does not change that underlying issue. There still needs to be a mechanism wherein FWA funds recovered via the annual fraud reports can be deposited in such a way that the monies will feed into their contingency reserve accounts. Consequently, our position is still that any FWA amounts

recovered from carriers' annual fraud reports ultimately should be deposited into their respective contingency reserve accounts. Requiring carriers to deposit FWA monies into contingency reserve accounts provides better insight into the effectiveness of each plan's ability to identify and recover improper payments associated with FWA activities.

3. Protecting the Integrity of OIG Investigations

Conflicts can emerge when carriers proceed without awareness or regard to ongoing OIG investigations. In the case discussed in Section B.1 above, the carrier appeared to use its knowledge of an ongoing OIG investigation to its advantage in a settlement. Also, carriers that do not follow the stated guidance of carrier letters, including not providing information related to settlements for the OIG to conduct due diligence reviews, may further impede investigations, even unknowingly. Therefore, adding language to the contract that explicitly safeguards information that is law enforcement sensitive is necessary.

Since OPM does not have a claims data warehouse and the OIG's claims data warehouse does not contain claims data for all participating FEHBP carriers, the OIG must instead communicate with and rely upon the carriers to gather data to facilitate criminal and civil prosecutions. This can be particularly difficult in *qui tam* and whistleblower cases where certain legal protections are afforded to the complainant. Carriers, inadvertently or otherwise, may interfere with DOJ and OIG actions and investigations. The OIG receives between 500 and 700 *qui tams* annually, and as the previous example demonstrates, safeguarding the integrity of OIG investigations is paramount to investigating allegations in an independent manner and in accordance with the law. Until OPM has its own source/repository of reliable claims data, the FEHBP contract needs to be amended to safeguard the integrity of the OIG's investigations.

Recommendation 4

We recommend that OPM add language to all FEHBP contracts requiring carriers to notify the OIG's Office of Investigations regarding their intention to share FEHBP fraudulent activity with outside parties, and obtain approval from OIG's Office of Investigations before sharing this information.

OPM's Response:

“OPM does not disagree that safeguarding investigations is important.” However, additional information and dialogue with the OIG will be necessary to obtain a complete understanding of this issue to assist us in drafting contract requirements, if deemed appropriate. Specifically, OIG will need to provide more detail regarding what communications are being shared, who they are being shared with, and how sharing of

communications is impeding OIG investigations in order for us to assess the issue and craft a potential solution.

Additionally during discussions with the OIG, OPM stated their concerns with carriers pursuing fraud cases for their other lines of business once they become aware of a potentially fraudulent provider in the FEHB program. While OPM understands this concern, they do not see any legal authority that would prohibit a carrier from using information gleaned from one line of business to benefit another line of business. To address our questions, OPM requests that OIG provide the legal justification that limits the sharing of communications between the carrier and OIG's Office of Investigations. OPM also remains open to further discussions with OIG in order to better understand the need and the potential options to address this issue, as appropriate.

OIG Comments:

We understand carriers' concerns and their desire to protect non-FEHBP lines of business when fraudulent activity is identified within but not exclusively contained to the FEHBP. However, there is still a potential impact to our investigations and DOJ prosecutions when information is shared beyond the OIG and its law enforcement partners. The OIG takes the position that information requests related to the FEHBP are investigative materials that should not be shared with other lines of business because they are law enforcement sensitive. In the specific instance mentioned above, our investigation was leveraged to enter into a settlement that interfered with an active DOJ-led criminal investigation. We are happy to again provide further information on this matter.

More importantly, the safety of our criminal investigators must be considered. The OIG's Office of Investigations not only conducts routine investigations that are privileged, confidential, and law enforcement sensitive, we also conduct investigations that can potentially produce dangerous situations for our law enforcement officers. Consequently, it is essential carriers do not share law enforcement sensitive information for the safety of our investigative staff and law enforcement partners, as well as to maintain the integrity of our investigations and prosecutions.

That being said, we appreciate OPM's willingness for further dialogue on this issue. To that end, we will work to provide them with the information requested so that they have a better understanding of our position.

4. Adding Language to FEHBP Contracts Requiring All Vendors and Large Provider Agreements to Adhere to OPM Anti-Fraud Requirements

The current FEHBP contract does not require all vendors and large providers to have an FWA program in place as is required for carriers under Section 1.9(a) and by CL 2017-13. Currently, pharmacy benefit payments make up approximately 27 percent⁴ of the annual costs associated with the FEHBP and most carriers utilize a Pharmacy Benefit Manager (PBM) to administer pharmacy benefits, so it is essential that these types of providers have FWA programs.

Similarly, behavioral health providers contracted by FEHBP carriers under large provider agreements to administer mental health benefits are also not bound by Contract Section 1.9(a) or CL 2017-13 requirements. Much like contracting with a PBM, most (if not all) FEHBP carriers provide behavioral health services through a contract with a separate entity/vendor that specializes in mental health and substance abuse treatments and services. As such, large provider agreements that include behavioral health pre-authorization, claims review, and claims payments should be required to have an FWA program that meets the minimum standards of OPM's contract Section 1.9(a) and CL 2017-13.

Finally, in reviewing two carriers' Special Investigative Units' (SIU) Process and Procedure Manuals, we identified concerns with the level of oversight provided by each carrier to ensure compliance with contract Section 1.9(a) and CL 2017-13. For example, one carrier's SIU manual did not address the performance of investigations to further develop potential FWA information provided by the contractor. A review of the second carrier's SIU manual indicated a complete reliance on its vendors, who are not currently subject to CL 2017-13's FWA requirements, for detection and investigation of FWA. This carrier's Fraud Control Unit also performs no investigative activities to further develop FWA issues. In addition to requiring references to Contract Section 1.9 and FWA guidelines in future SIU manuals (for all carriers), it should be clear to vendors and large providers that they must return all FWA recoveries to the carrier, and these recoveries should be subsequently earmarked for the carriers' contingency reserve funds.

Recommendation 5

We recommend that OPM modify or add language to all FFS and ER-HMO FEHBP contracts requiring PBMs or providers under a Large Provider Agreement, who provide

⁴ Carrier Letter 2019-01 (March. 14, 2019) stated that "In 2017, approximately 27 percent of total FEHB premium was attributed to prescription medications." at page 9.

services or supplies related to benefit administration, to have an FWA program that meets the OPM contract and CL 2017-13 requirements.

OPM's Response:

OPM stated that while they do not agree with the recommendation, they will consider whether modifications are warranted for including FWA standards for vendors, other than PBMs, that are under a Large Provider Agreement. PBMs' FWA programs should not have to meet all CL requirements because some elements may not be applicable to PBMs. In light of this, “

[REDACTED]

OIG Comments:

[REDACTED]

The OIG appreciates the deliberation required for making these types of amendments to the contract and will provide feedback or information as requested in HI's vetting process. We do, however, reiterate our recommendation that the same scrutiny be given to Large Provider Agreements more broadly, as contractors in areas such as mental health should have similar FWA reporting standards as PBMs or carriers in order to protect FEHBP beneficiaries and the integrity of the trust fund. Because subcontractors are beholden to the contract similarly to the FEHBP carriers, the OIG needs independent access to information held by PBMs and subcontractors to be able to provide effective oversight of the FEHBP.

Recommendation 6

We recommend that OPM modify the ER-HMO and FFS contracts to require that vendors under Large Provider Agreements return all FWA-related recoveries to the carrier within 30 days, whereby carriers must deposit these recoveries into their working capital or investment account within 30 days. Once deposited into one of these accounts, the carrier must return the recoveries to the contingency reserve fund.

OPM's Response:

As stated in response to recommendation 3 above, under our Letter of Credit System Guidelines, the amounts making up the working capital account are derived via a quarterly calculation. Placing recoveries into this account would, therefore, require a recalculation of the working capital account each time a recovery is deposited. Additionally, use of working capital accounts is not a program requirement, and thus, not all FEHB carriers use them. Furthermore, it is problematic to require carriers to submit payments for FWA recoveries since there are multiple methods to recover funds (e.g., use of offsets) that would not involve a physical return of funds. Operationally, requiring carriers to use a working capital account would necessitate extensive reprogramming and accounting reorganization on OPM's end, and it would also remove the administrative flexibilities that currently exist for the FEHB fee-for-service carriers. Moreover, it may not be feasible for Large Providers to return FWA recoveries within 30 days, as these recoveries are more complex and the exact amount due to the program is not determined for months after a settlement is agreed to or recovery made. Finally, OIG's recommendation that recoveries ultimately be returned to the carriers' respective contingency reserve funds is problematic as carriers do not have access to these funds to either deposit or remove funds. Consequently, addressing this recommendation would require significant changes to OPM's internal processes that we cannot undertake.

OIG Comments:

As stated in our previous comments to OPM's response above (*see* Recommendation 3), OPM raises valid points in its response, but the problem remains that FWA monies recovered by vendors under Large Provider Agreements are not being handled in the same manner as fraud recoveries obtained from criminal, civil, or administrative cases investigated by the OIG and DOJ. In both instances, actual monies returned should be placed in the carriers' contingency reserve accounts to benefit program enrollees. Consequently, it is still our position that any FWA amounts recovered from Large Providers ultimately should be deposited into their respective contingency reserve accounts, even if additional or intermediary mechanisms are necessary. HI's Contracting Office should have insight into both a plan's improper payments and the plan's ability to recover those improper payments.

C. OPM's ROLE

The FEHBP contract documents do not sufficiently address OPM's fiduciary responsibility to ensure that taxpayer dollars are spent wisely and properly.

1. The Erroneous Payments Clause

Contract Section 2.3(g) Erroneous Payments, as written, is too broad, does not require any type of routine recovery reporting, and may be costing the program for recovery efforts that could be handled in a more efficient manner.

The current contract language states, “It is the Carrier’s responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program.” The language also states, “the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments when the errors are egregious or repeated.” The terms “proactively,” “comprehensive, statistically valid reviews,” “a robust internal control program,” and “egregious” are not defined. Lacking explicit, contractual definition, the carriers seem able to define the terms as they see fit. For example, a carrier performing hospital diagnosis-related group audits to identify overpayments or underpayments may be part of an internal control program or it could be part of the anti-fraud program under Section 1.9(a). In order to ensure that erroneous payments are held to the minimal extent possible, it is crucial that carriers understand what is expected of them to identify these types of payments.

Additionally, while Section 2.3(g)(11) allows OPM to request evidence from carriers to show that appropriate steps were taken to promptly recover erroneous payments, there is currently no requirement to track and annually report to OPM the amount identified as erroneous payments, the amount actually collected or returned to the FEHBP, or the amount off-set or written off as uncollectible. Instead, Section 1.9, Plan Performance Measures, and Section (f)(3) (Recovery of Erroneous Payments), only require reporting on the average number of working days it takes for the carrier to begin collection action against an FEHBP provider or member following identification of an erroneous payment, for which the standard is no more than 30 working days from identification of the erroneous payment to the date it begins the collection action.

Moreover, paragraph (8)(i) of the clause specifically states, “the Carrier may charge the contract for benefit payments made erroneously but in good faith provided that it can document that it made a prompt and diligent effort to recover erroneous payments” Without a reporting requirement on collection efforts, it is not clear how OPM can determine that participating carriers are being prompt and diligent in their recovery efforts, that the program is seeing a return on investment for these efforts, or that efforts not meeting the prompt and diligent metrics are deemed unallowable program costs.

Furthermore, section 2.3(g)(8)(ii) states, “the Carrier may not charge the contract for the administrative costs to correct erroneous benefit payments . . . when the errors are egregious

or repeated.” This section of the contract goes on to state that payments resulting from egregious or repeated errors should be considered unreasonable and unallowable costs. However, the section does not provide any requirements to report these types of errors to OPM. The OIG’s Claim Audits and Analytics Group is responsible for auditing medical claims costs charged to the FEHBP by participating FFS and ER HMO carriers. Oftentimes, these audits identify similar claim payment errors committed by the same carrier from audit to audit. Based on the requirements currently in the contract, the erroneous payments caused by repeated errors would be considered unreasonable and unallowable costs that should be returned to the FEHBP in full. However, without any type of contractual reporting metric to inform OPM of the types of claim payment errors and how often they are occurring, OPM will not be in a position to determine whether these types of errors should be deemed unreasonable and unallowable costs.

Finally, while section 2.3(g)(1) through (5) lays out a recovery framework for erroneous payments, the OIG is concerned that this framework may unintentionally cost the program more than necessary due to the level of effort required. Specifically, section 2.3(g)(1) and (2) spell out the number of written notices that must be sent, a total of four over a 120-day period, before moving to the next steps in the recovery process. While 2.3(g)(3)(ii) allows carriers to set up benefit offsets to a provider prior to the expiration of the 120-day written notification requirement, the provision states that carriers “may” elect this option. It does not require them to do so. The OIG questions why OPM requires so many written notifications before additional steps are taken, as a benefit offset to the member or provider after the first notification would appear to be more cost efficient, provided benefit offsets are a viable alternative for that provider/member.

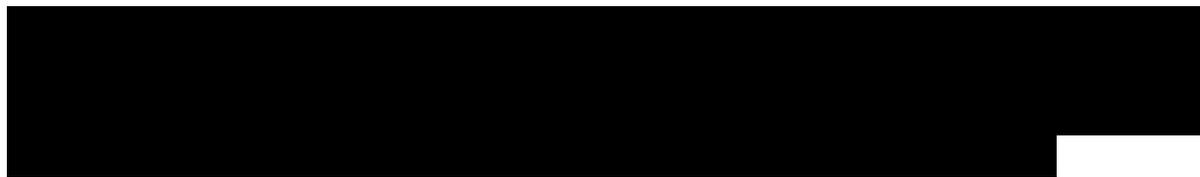
In drafting its response to this issue, OPM stated that its HI office is also in the process of responding to three other OIG reports. Each of these reports have similar recommendations that would potentially affect Section 2.3(g). As such, this creates a challenge for HI to respond to and resolve multiple recommendations raised in separate OIG engagements. Therefore, OPM used their responses to each of these engagements to form a backdrop from which it is basing its responses to recommendations 7 through 10 below.

Recommendation 7

We recommend that OPM modify Section 2.3(g) and 2.3(g)(ii) to provide expectations for how carriers are to proactively identify overpayments and to define what it means by egregious errors.

OPM's Response:

OPM stated that the language in this section of the contract is intentionally broad in order to provide carriers flexibility in their overpayment efforts. They expect carriers to have robust internal controls in place and be proactive and aggressive in preventing, identifying, recovering, and returning overpayments to the program. While OPM cannot commit to the modifications suggested in OIG's recommendation, they will initiate an information-gathering effort to obtain a greater familiarity with carriers' proactive efforts to identify overpayments. This effort will start with obtaining information from different types of participating carriers, which will be analyzed to determine any necessary next steps.



OIG Comments:

While we appreciate OPM's efforts to obtain a better understanding of carrier's efforts to identify overpayments and to evaluate the clause's current terminology to determine if modifications or clarifications are warranted, we maintain that the changes recommended are still necessary. As stated above, in order to ensure that erroneous payments are held to the minimal extent possible, it is crucial that carriers understand what is expected of them to identify these types of payments. Additionally, clarifying terms such as egregious errors is crucial in determining what costs can be and cannot be charged against the contract. It is hoped from the efforts OPM is undertaking, that they also come to understand the need for these changes.

Recommendation 8

We recommend that OPM modify Section 2.3(g) requiring carriers to report on their collection efforts, including how promptly the carrier initiated collection once the erroneous payment was identified and the causes of the claim payment errors.

OPM's Response:

OPM acknowledges that there is potential value in program-wide reporting as OIG is recommending. However, the value may be incremental, based on requirements carriers must already meet to identify, process, and return erroneous payments to the FEHBP. HI's Audit Resolution and Compliance (ARC) function works closely with

carriers to evaluate their compliance with Section 2.3(g)'s due diligence and good faith provisions. FEHB carriers are also contractually required to meet a claims payment accuracy benchmark of at least 95 percent and report their performance against this benchmark, as well as other targets in their Quality Assurance Reports.

OPM states that implementing this recommendation would require the completion of a significant set of activities over the course of months and, potentially years. It would also require a new, expanded or structurally-reorganized function within HI to receive, review, standardize, conduct quality assurance, reconcile, and externally report on carriers' collection efforts.



Finally, evaluation of any erroneous payments recommendations will require the coordination of any potential new requirements and guidance with other possible changes in Section 2.3(g) that may result from any of the other OIG engagements that include findings and/or recommendations related to erroneous payments.

OIG Comments:

While we concur that HI's Audit Resolution and Compliance group does work closely with FEHB carriers as part of the OIG audit resolution process, which includes assessing their contractual compliance, we maintain that modifying Section 2.3(g) to include provisions for reporting on carriers' erroneous payment collection efforts is necessary to assess the promptness and diligence of these efforts. As mentioned above, Section 2.3(g)(8)(i) specifically states, "the Carrier may charge the contract for benefit payments made erroneously but in good faith **provided that it can document that it made a prompt and diligent effort to recover erroneous payments ...** ." Currently, the only contract provision that covers collection efforts is in Section 1.9. However, this section only requires reporting on the average number of working days it takes for the carrier to begin collection action against an FEHBP provider or member following identification of an erroneous payment, for which the standard is no more than 30 working days from identification of the erroneous payment to the date it begins the collection action. Without any other reporting requirement, how can OPM assess and determine that FEHB carriers were prompt and diligent in their collection efforts?

Moreover, while OPM is correct in stating that FEHB carriers are contractually required to meet a claims accuracy benchmark of at least 95 percent and report on their performance in meeting this benchmark, this benchmark has nothing to do with how quickly an erroneous payment is recovered. Though we understand that implementing our recommendation will

require significant planning and work on OPM's end, we maintain that additional reporting metrics are necessary in order to determine future allowability of these payments.

Recommendation 9

We recommend that OPM review the current recovery process in Section 2.3(g)(1) through (5) and consider whether the use of benefit offsets, after the first written notification is sent, would be more cost efficient.

OPM's Response:

OPM concurs with this recommendation and will review the recovery process as part of its more comprehensive evaluation of the Contract language during FY 2021. [REDACTED]

[REDACTED]. **While benefit offsets are commonly used by some carriers, in some instances offsets cannot or should not be initiated.** [REDACTED]

D. OTHER CONTRACT IMPROVEMENTS

The FEHBP's contract documents do not sufficiently address the use of statistical sampling; contain clauses that are no longer relevant or that need to be amended based on the results of recent audits; and require the addition of clauses to address vulnerabilities encountered in the performance of OIG's oversight.

1. Use of Statistical Sampling

Frequently, the OIG, like other audit organizations, uses judgmental samples in its audits. Since 2012, however, the OIG has been utilizing statistical sampling for some of its health care claims audits. The reason for this is that it is impractical to individually review the hundreds of thousands of health care claims in the scope of a typical audit. Instead, like other agencies such as the U.S. Department of Health and Human Services (HHS), the OIG utilizes a statistical sample of a subset of claims to make population projections. It is important to note that statistical sampling is a widely accepted, scientifically based, and commonly used tool to identify instances of improper payments in Federal programs. Indeed, its use by Federal agencies in the improper payments context has repeatedly been

upheld by Federal courts.⁵ By using this tool, the OIG has identified almost \$15 million in additional FEHBP funds improperly paid in five reports issued over the last several years:

Audit Report	Time Period Covered	Questioned Amount
Global Coordination of Benefits 1A-99-00-14-046	September 1, 2013 – May 31, 2014	\$4,486,775
Global Enrollment 1A-99-00-15-008	January 1, 2012 – September 30, 2014	\$3,207,289
Global Coordination of Benefits 1A-99-00-15-060	October 3, 2014 – June 30, 2015	\$3,361,086
Global Coordination of Benefits 1A-99-00-16-062	December 1, 2015 – August 31, 2016	\$2,792,794
Global Coordination of Benefits 1A-99-00-19-001	October 1, 2017 – June 30, 2018	\$1,057,603
Total		\$14,905,547

Ubiquitous acceptance notwithstanding, OPM has declined to require FEHBP carriers to repay statistically projected improper payments identified by the OIG because it is not specifically provided for in the FEHBP carrier contracts. In addition, OPM has expressed the concern that statistically projected improper payments cannot be associated with specific claims, therefore making recovery impossible.

Even though OPM has expressed concerns about associating statistically projected improper payments with specific claims, there is already a precedent for such resolution activity.

OPM’s audit resolution group has proposed settlements of disallowed claims costs using

⁵ See, e.g., *Ratanasen v. State of Cal., Dep’t of Health Servs.*, 11 F.3d 1467, 1471 (9th Cir. 1993) (joining other circuits in “approving the use of sampling and extrapolation as part of [Medicare] audits . . . provided the aggrieved party has an opportunity to rebut such evidence”); *Chaves County Home Health Serv. v. Sullivan*, 931 F.2d 914, 919 (D.C. Cir. 1991) (observing that statistical sampling has been allowed in a wide range of contexts “to determine whether there has been a pattern of overpayments spanning a large number of claims where case-by-case review would be too costly”); *Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84, 89-90 (2d Cir. 1991) (upholding use of sampling to calculate Medicaid overpayment); *Mich. Dep’t of Educ. v. U.S. Dep’t of Educ.*, 875 F.2d 1196 (6th Cir. 1989) (involving an educational grant); *Ill. Physicians Union v. Miller*, 675 F.2d 151, 155 (7th Cir. 1982) (holding that “[t]he use of statistical samples to audit claims and arrive at a rebuttable initial decision was reasonable where the number of claims rendered a claim-by-claim review a practical impossibility”).

estimates that are not based on valid statistical sampling. For example, in a September 2019 audit resolution letter, OPM used a projection to settle the remaining amount questioned on an open recommendation. Specifically, OPM proposed to allow 85 percent of the amount owed, as 85 percent of a judgmental sample of claims reviewed had sufficient documentation, provided the auditee returned the remaining 15 percent of the amount due to the program.

It seems inconsistent with its own existing practices that OPM refuses to support the recovery of improperly paid claims based on valid statistical sampling, yet as demonstrated above, used unscientific judgmental sampling to resolve and recover outstanding monetary recommendations for unspecified claims. This concern is a prime example of where use of our audit results from statistical sampling could benefit OPM in resolving outstanding audit recommendations, especially when negotiating settlements with the carriers.

As stated above, the use of statistical sampling is a widely accepted, scientifically based, and commonly used tool to identify instances of improper payments in Federal programs. Provided our sampling universes are adequately defined, including criteria for its use in all FEHBP contracts would greatly assist OPM and the OIG in ensuring that improper payments are captured, especially when systemic errors are identified, and that taxpayer dollars are not being misspent on unallowable program charges.

Recommendation 10

We recommend that OPM modify FEHBP contracts to clarify the Agency's authority to recoup projected improper payments identified by statistical sampling.

OPM's Response:

"We do not concur with this recommendation."

OPM states that statistical estimations are also not appropriate for use in HI's improper payment reporting. In OIG audits where these types of costs were questioned, HI carefully reviewed these costs and several issues were noted and discussed with the OIG.

[REDACTED]

[REDACTED]

[REDACTED]

OIG Comments:

We disagree with OPM’s position. While FAR 31.109(a) does recommend use of advance agreements on the treatment of special or unusual costs and on statistical sampling methodologies, use of these agreements is not an absolute requirement. In fact, absence of this type of agreement on any cost will not, in itself, affect the reasonableness, allocability, or the allowability under subparts 31.2, 31.3, 31.6, and 31.7 of that cost. Furthermore, FAR 31.201(c)(2) states, “Statistical sampling is an acceptable practice for contractors to follow in accounting for and presenting unallowable costs provided: ... (i) The statistical sampling results in an unbiased sample that is a reasonable representation of the sampling universe. (ii) Any large dollar value or high risk transaction is separately reviewed for unallowable

costs and excluded from the sampling process. (iii) The statistical sampling permits audit verification.”

Also, while we do agree that, upon identification of an erroneous payment, Section 2.3(g)(1)(C) does request identifying information of the amount/s paid in error, this clause does not prohibit OPM’s or OIG’s use of statistical sampling to identify additional erroneous payments. Nor should Section 2.3(g) in its entirety be considered the exclusive means by which the contract addresses erroneous payments.

As to OPM’s assertion that sampling is not a “widely accepted” or commonly used tool for identifying disallowable health insurance claims cost, the HHS OIG, which oversees the Medicaid program – a program that as of July 2020 covered approximately 75 million people, published a toolkit document in September 2018 outlining the basics of statistical sampling for use by State Medicaid Fraud Control Units in calculating improper payment amounts. The toolkit document was designed to serve as a practical training guide to help the State Medicaid Fraud Control Units design effective statistical samples. Regarding statistical sampling, HHS OIG states within this document that **“Statistical sampling is a widely accepted methodology in an audit or other review of healthcare claims to identify improper payment amounts. When performed in a valid scientific manner, statistical sampling permits the Government to estimate overpayments in a universe of claims that may be too voluminous or complex to permit a claim-by-claim review. Statistical sampling saves the time and expense of reviewing the entire universe of claims by allowing a small sample of claims to be analyzed.”**

An additional argument raised by OPM is their concern that were the contract documents modified to accept statistical sampling for the purpose of identifying improper payments, the modifications would be strenuously contested and likely litigated by the participating carriers. These modifications could also result in carriers deciding to cease participation in the FEHBP, as allowing for statistical sampling to identify improper payments would, in essence, require 100 percent payment accuracy with an added mandate to return all funds estimated as improperly paid.

It is unrealistic to expect the participating FEHBP carriers to pay claims 100 percent correctly, and that is not the intent of our requested modification to the contract documents. The contract’s requirements that carriers have a robust internal control system; that carriers proactively identify overpayments through comprehensive, statistically valid reviews; and that carriers should make a prompt and diligent effort to recover erroneous payments should already go a long way in ensuring claims are paid correctly, although per our recommendation above, it would be helpful for OPM to provide expectations for how carriers are to proactively identify overpayments.

Our recommended contract modification allowing for the use of statistical sampling for the purpose of identifying overpayments is not to identify every possible overpayment. Instead, its use would be limited to when errors are identified to ensure all potential overpayments related to this error are recovered. As American taxpayers are contributing approximately 72 percent of the health care premium cost, it is important that when an error is identified in a sample, all related errors in the population are also identified and recovered.

Finally, OPM's assertion that our use of statistical sampling to identify improper overpayments, and its own use of judgmental sampling to reach settlement regarding recovery of overpayments, cannot be compared is simply wrong.

In our statistical sampling, we used analytic procedures to identify a known universe of potential improper payments. From that universe, we selected a statistically valid random sample, conducted a detailed audit of each item in the sample, developed an error rate, and projected that error to the universe from which the sample was drawn. There is a known point estimate, precision, and confidence level of the estimated improper payments. What is unknown is the specific items in the universe that were improperly paid.

In OPM's use of judgmental sampling to negotiate settlements with carriers regarding improper payments, there is a known universe of questioned claim payments. OPM reviews some of the actual claims in this universe and determines an error rate. This then becomes the basis for its proposed settlement for recovery of the remaining, unreviewed claims in the universe. When this occurs, OPM is clearly recovering improper payments based on sampling without being able to associate the recoveries with the specific claims that it did not review.

There is no substantial difference between OPM's own longstanding, unscientific practice for resolving audits and our statistically valid process that OPM rejects. In essence, OPM is rejecting science in favor of a politically expedient outcome while failing to recover improper payments on behalf of Federal employees and the American taxpayer.

It is for all of these reasons we maintain that our recommendation to clarify the Agency's authority to recoup projected improper payments identified by statistical sampling is warranted and will assist us greatly in ensuring that all claims related to an identified error are recovered.

2. Other Adjustments to Contract Clauses

The FEHBP contract documents should be updated for clauses that are no longer relevant, that need to be amended based on results of recent audits, or need to be added to address vulnerabilities encountered in the performance of our oversight.

We have previously provided a list of these clauses to OPM. Some examples of updates we are recommending include:

- a) Updates to Sections 1.5 and 2.1 of the CR HMO contract to direct carriers to obtain supporting documentation from payroll offices for overage dependents and/or allow carriers to deny member coverage until such documentation is either provided by the payroll office or the member.

OPM's Response:

OPM does not agree that these sections should be updated. HI has already and is currently taking significant steps to improve documentation that establishes family member eligibility. "Recently adopted regulations at 5 CFR 308(e) allow FEHBP Carriers to request from the enrollee or from the employing office supporting documentation that establishes family member eligibility, and to disenroll the family member if they do not receive the documentation in a timely fashion or the documentation is insufficient. These regulations also grant similar authority at 5 CFR 308(f) to OPM and to the employing offices to request from the enrollee the supporting documentation and to disenroll the family member."



OIG Comments:

The above mentioned steps being taken to improve eligibility verification of family members are positive first steps, and we appreciate OPM's efforts. As the above regulations have recently been issued, we have not yet had an opportunity to test their effectiveness. We concur that contract modifications to address verification of family member eligibility may not be necessary at this time. However, we reserve the right to revisit this issue should future oversight efforts raise additional concerns.

- b) For cases where a carrier does not retain or make available documentation needed to support an OIG audit, update Section 3.4 (CR HMO contract) and Section 3.8 (FFS and ER HMO contracts), Contractor Records Retention, to provide for a penalty or other consequences.

OPM's Response:

OPM does not concur with our suggested modification. It maintains that the failure of carriers to maintain records is already addressed under the Contract Oversight portion of OPM's Plan Performance Assessment. This portion of the assessment gives OPM the discretion to penalize carriers for failure to maintain records. Finally, adding express penalties in the contracts is not ideal as each carrier is different. As such, "it would be inappropriate to state a standard penalty without information specific to the compliance issue."

OIG Comments:

We concur that OPM's Plan Performance Assessment (PPA) does include a section called Contract Oversight that assesses, among other things, carrier compliance with providing requested documentation. In fact, CL 2014-28, Attachment II, issued on December 3, 2014, lays out specific components upon which carriers are assessed for the Contract Oversight portion of the PPA. However, we do have some concerns with OPM's assessment process.

As part of this process, carriers are scored on an annual basis in four domain areas. CL 2017-15, issued on December 14, 2017, defines these areas as Clinical Quality, Customer Service, Resource Use, and Contract Oversight. Per the carrier letter, the first three areas – Clinical Quality, Customer Service, and Resource Use make up what is known as the QCR framework, which is currently 65 percent of each carrier's overall performance score. The remaining area, Contract Oversight, is 35 percent of the overall performance score.

CL 2017-15 further segregates the Contract Oversight domain into four sub-domains – Contract Performance, Responsiveness to OPM, Contract Compliance, and Technology Management and Data Security, and each of these sub-domains is weighted in coming up with the overall Contract Oversight score. Carriers' responsibility to provide requested documentation falls under the Contract Performance sub-domain, which is given a 40 percent weight. This means that a low score in this sub-domain will only impact 14 percent (35 percent times 40 percent) of the carrier's overall performance score. However, carrier compliance with providing requested documentation is just one of many components that are assessed within the Contract Performance sub-domain, so a low score within that one component will likely have an even lower impact to the overall performance score.

As such, were OPM to penalize a carrier for non-compliance with providing requested documentation, the resulting penalty would represent a percentage of a percentage of a percentage of the overall score. Our concern with this scoring methodology is whether the monetary penalty would be sufficient to incentivize compliance. On top of this, CL 2017-15 also allows for a threshold to ensure carriers receive a minimum amount should their overall performance score result in a very low Service Charge or profit amount. So in essence, should a carrier receive low performance scores in Clinical Quality, Customer Service, Resource Use, and Contract Oversight, OPM still wants to ensure that the carrier receives a minimal amount of profit for their lack of performance.

Another concern we have with OPM's assessment process is the information considered in deriving each carrier's overall performance score. Each year, OPM issues a PPA Procedure Manual as part of the PPA carrier letters. CL 2019-12 issued on November 26, 2019, included the 2020 PPA Procedure Manual. In reviewing Section 3 of this manual – Contract Oversight Procedures, we discovered that OPM solicits carrier input to assist in scoring their performance for the Contract Oversight domain. While we do not, necessarily, have an issue with OPM soliciting carrier input, there are components within this domain where OIG could have input based on our oversight efforts. Yet, our input is not solicited by OPM in assessing carrier performance. Furthermore, once all information is provided, it would be helpful to understand how OPM arrives at the Contract Oversight's sub-domain scores, which are weighted to arrive at the Contract Oversight overall score. For example, aside from the score ranges outlined in the PPA Procedure Manual, are there other specific metrics used to arrive at these scores, or is the scoring more subjective?

Ultimately, while a contract modification may not currently be necessary to address consequences for carrier non-compliance with providing requested documentation, additional conversations/reviews of OPM's PPA process will likely be warranted to better understand how the process works and whether modifications to this process may be necessary.

- c) Modifying Section 2.6(g), in the amendment to the Coordination of Benefits section of the FFS contract to allow for the recovery of low dollar claims that result from claims system errors. Currently, this amendment excludes from recovery claims that are under \$100 and claims that are under \$50 where Medicare is the primary payer of benefits for those errors identified during global claims audits. As currently stated, this language precludes OPM from seeking reimbursement on low dollar claims that are tied to identified claims system errors.

OPM's Response:

OPM does not agree with our suggested modification, as attempted recovery efforts for claims amounts this low would not be cost-effective. “Additionally, given the scope and frequency of global audits, OPM does not have the manpower to review hundreds of thousands of claims under this threshold.” Finally, removing the threshold would increase Trust Fund costs, as it would require additional Plan resources to timely review all questioned claims resulting from a global audit.

OIG Comments:

We concur that recovery efforts for individual claims costing less than \$100 would likely not be cost effective to pursue. However, these low cost claims can quickly result in significant improper payment amounts should a system error be identified during an audit. In this situation, we contend that the entire improper payment amount resulting from the system error be returned to the program. However, as we stated above, the way the contract language is currently written, carriers would have a valid argument for excluding these lower cost claims from the recovery process. Consequently, we maintain that modifying Section 2.6(g) from the Coordination of Benefits amendment of the FFS contract is necessary to allow for the recovery of these claim payments when the improper payments are due to a system error.

Recommendation 11

We recommend modifying Section 2.6(g), in the amendment to the Coordination of Benefits section of the FFS contract, to allow for the recovery of low dollar claims that result from claims system errors.

As to the remaining list of contract clauses provided to OPM that are either no longer relevant, that need to be amended based on the results of recent audits, or need to be added to address vulnerabilities encountered in the performance of our oversight, OPM stated that it will continue to review our list as part of the audit resolution process to determine if future contract amendments are warranted.

APPENDIX



Healthcare and
Insurance

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
1900 E Street, NW, Washington, DC 20415

DATE: October 22, 2020

MEMORANDUM FOR: MICHAEL R. ESSER
Assistant Inspector General for Audits

FROM: LAURIE E. BODENHEIMER 
Acting Director, Healthcare and Insurance

SUBJECT: Response to Draft Management Advisory Report: Federal
Employees Health Benefit (FEHB) Program Integrity Risks
Due to Contractual Vulnerabilities Report Number
4A-HI-00-18-026

Thank you for the opportunity to respond to the Office of the Inspector General's (OIG) Draft Report on the Office of Personnel Management's (OPM) Management Advisory Report (MAR) to Federal Employees Health Benefits (FEHB) Program Integrity Risks Due to Contractual Vulnerabilities, Report Number 4A-HI-00-18-026.

The OIG reviewed the standard language utilized in contracts between OPM and its participating FEHB Carriers and has alleged several Program integrity risks, which it believes require immediate intervention. OIG has indicated its primary objective is "to inform OPM of concerns that the OIG has with various contractual vulnerabilities identified within the health benefit contracts between OPM and the participating FEHB Program carriers."

Our responses to the draft audit report include OPM's position on each recommendation as well as supporting comments to the report's narrative findings.

A. DATA ISSUES

Recommendation 1: We recommend OPM modify FEHBP contract language for all applicable records retention clauses to require the retention and accessibility of claims for 10 years plus the current year in a manner of OPM/HI's choosing.

OPM Response: Non Concur

OIG's concern appears to be that they were not given all requested information from FEHB carriers and subcontractors when it was requested pursuant to a fraud investigation that included time periods beyond 6 years. Under Section 1.11 of the standard FEHB contract, OPM and OIG

Report No. 4A-HI-00-18-026

have the right to examine all books and records relating to the contract, including performance provisions. If FEHB funds are being fraudulently expended, that would be a performance issue for which OPM would insist that OIG be given the data necessary to prevent fraudulent loss of funds.

Changing the record retention requirement in the contract would require HI to update Federal Employees Health Benefits Acquisitions Regulations (FEHBAR), 48 CFR 1652.204-70, which states that records will be maintained for six years after the end of the contract term. The clause is currently included in the contract as required by the FEHBAR.

Furthermore, this clause is required to be inserted in all subcontracts for underwriting and claim payments, administrative services, and, in experience-rated contracts, in Large Provider Agreements. It is the carrier's responsibility to ensure that applicable contract clauses exist in their subcontracts to allow OPM to receive the information that is requested. If a carrier is reluctant to provide information necessary for fraud investigations, OIG should reach out to the Contracting Office and we will address it.

B. FRAUD, WASTE AND ABUSE EFFORTS

Recommendation 2: We recommend OPM modify or add language in Section 1.9 of all FEHBP contracts to include all relevant sections and attachments of CL 2017-13, or modify all FEHBP contracts to add relevant language stating that all CLs are an addendum to the contract language and enforceable as a contract requirement.

OPM Response: Non Concur

It is not appropriate to include CLs or their attachments in FEHB Program contracts as addendums. So long as they are reasonable, CLs are enforceable guidance under the contract per 48 CFR 1609.7001(b)(1) – “Minimum standards for health benefits carriers” which includes “(1) Timely compliance with OPM instructions and directives.” We currently have relevant provisions of CL 2017-13 in Section 1.9 of the contract.

Recommendation 3: We recommend OPM modify or add language to the appropriate Section of the FFS and ER-HMO FEHBP contracts to state that all FWA-related recoveries must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP contingency reserve fund account within 60 days after receipt by the carrier.

OPM Response: Non Concur

Per OPM's Letter of Credit System Guidelines, the Working Capital (WC) account is determined by quarterly calculation. Therefore, it would be inappropriate to place recoveries in this account because it would render the quarterly calculation inaccurate and out of compliance with its own requirements. Depositing recoveries in this manner would require a recalculation of the working capital each time a recovery is deposited. Additionally, it is not appropriate to require carriers to deposit funds into a WC account because it is not a program requirement and, therefore, not all

FEHB Carriers use a WC account. Moreover, it is problematic to require carriers to submit payments for FWA recoveries because there are multiple methods to recover funds that do not involve a physical return of money. This may include an offset of payments to providers which would not result in a return of funds. Operationally, requiring carriers to use a WC account would necessitate extensive reprogramming and accounting reorganization and would remove the administrative flexibilities that currently exist for the FFS carriers.

Lastly, the OIG requests that once deposited into the working capital account, the carrier must return the recoveries to the contingency reserve fund. Carriers do not have direct access to the contingency reserve funds to either deposit funds or remove funds; this would require significant changes to OPM's internal processes that we cannot undertake.

Recommendation 4: We recommend that OPM add language to all FEHBP contracts requiring carriers to notify the OIG's Office of Investigations regarding their intention to share FEHBP fraudulent activity with outside parties, and obtain approval from OIG's Office of Investigations before sharing this information.

OPM Response: Non Concur

OPM does not disagree that safeguarding investigations is important. However, OPM will need additional information and dialogue with OIG to ensure a full understanding of this issue to draft contract requirements, if appropriate. We have asked OIG for more detail in order to assess the issue and craft a potential solution, if necessary, including what communications are being shared, who they are being shared with, and how sharing of communications is impeding OIG investigations. OIG has not yet provided this information.

In addition, OIG indicated in discussions that they want to prevent carriers from pursuing fraud cases for their other lines of business when OIG notifies them about a potentially fraudulent provider in the FEHB Program. We are unsure what legal authority OPM could use to prohibit carriers from using information gleaned from one line of business in another line of business. OPM has asked OIG's Office of Investigations to provide a legal justification for limiting sharing of communications. We have not yet received the requested legal justification from OIG but remain open to further discussion to better understand the need and the potential options to address the finding, as appropriate.

Recommendation 5: We recommend that OPM modify or add language to all FFS and ER-HMO FEHBP contracts requiring PBMs or providers under a Large Provider Agreement, who provide services or supplies related to benefit administration, to have an FWA program that meets the OPM contract and CL 2017-13 requirements.

OPM Response: Non Concur

We do not agree that the FWA program for PBMs must meet all Carrier Letter (CL) 2017-13 requirements since the CL includes FWA elements, reporting requirements, and timelines that, while applicable to the FEHB Carrier, may not be applicable to the PBM. [REDACTED]



We do not agree with the recommendation to modify or add language to all fee-for-service (FFS) and experience-rated health maintenance organization (HMO) FEHB Program contracts requiring providers under a Large Provider Agreement, who provide services or supplies related to benefit administration, to have a FWA program that meets the OPM contract and CL 2017-13 requirements. We will consider whether modifications are warranted for including FWA standards for vendors other than PBMs, where the Large Provider Agreements are applicable. Please see 48 CFR 1602.170-16 for the definition for Large Provider Agreements.

Recommendation 6: We recommend that OPM modify the ER-HMO and FFS contracts to require that vendors under Large Provider Agreements return all FWA-related recoveries to the carrier within 30 days, whereby carriers must deposit these recoveries into their working capital or investment account within 30 days. Once deposited into one of these accounts, the carrier must return the recoveries to the contingency reserve fund.

OPM Response: Non Concur

Per OPM's Letter of Credit System Guidelines, the Working Capital (WC) account is determined by quarterly calculation. Therefore, it would be inappropriate to place recoveries in this account because it would render the quarterly calculation inaccurate and out of compliance with its own requirements. Depositing recoveries in this manner would require a recalculation of the working capital each time a recovery is deposited. Additionally, it is not appropriate to require carriers to deposit funds into a WC account because it is not a program requirement and, therefore, not all FEHB carriers leverage a WC account. Moreover, it is problematic to require carriers to submit payments for FWA recoveries because there are multiple methods to recover funds that do not involve a physical return of money. This may include an offset of payments to providers which would not result in a return of funds. Operationally, requiring carriers to use a WC account would necessitate extensive reprogramming and accounting reorganization and would remove the administrative flexibilities that currently exist for the FFS carriers.

Additionally, it may not be feasible for Large Providers to return recoveries within 30 days. Fraud recoveries are often complex and the exact amount due to the FEHB Program is not determined for months after a settlement is agreed to or recovery is made. Further, OPM is unaware of any instances from OIG when a Large Provider has held recoveries for an unreasonable time.

Lastly, the OIG requests that once deposited into the working capital account, the carrier must return the recoveries to the contingency reserve fund. Carriers do not have direct access to the contingency reserve funds to either deposits funds or remove funds and this would require significant changes to OPM's internal processes that we cannot undertake.

C. OPM's ROLE

The paragraph that follows represents OPM's overarching concern in relation to our response to Recommendation 7, 8, 9 and 10.

As OPM responds to this draft audit report, **Deleted by the OIG – Not Relevant to the Final Report** we are also responding to three other OIG reports related to improper payments: **Deleted by the OIG – Not Relevant to the Final Report**.

Each of these independent efforts, initiated by different offices within OIG, with different timing, different approaches and similar recommendations, would all potentially impact the same FEHB standard contract provision, Section 2.3(g) *Erroneous Payments*. This creates a challenge for HI to respond and resolve multiple recommendations raised in separate engagements. These engagements include discussing and responding to final, draft and pre-draft reports, and are the backdrop from which we respond to the final four recommendations from this Draft MAR.

Recommendation 7: We recommend OPM modify Section 2.3(g) and 2.3(g)(ii) to provide expectations for how carriers are to proactively identify overpayments and to define what it means by egregious errors.

OPM Response: Partially Concur

HI reiterates that the language in this section of the contract is intentionally broad to provide carriers of all types and sizes flexibility in their overpayment efforts. As the contract states, we expect carriers to have robust internal controls in place and to be proactive and aggressive in preventing, identifying, recovering and returning overpayments to the FEHB Program. While OPM cannot commit to modifying section 2.3(g) and 2.3(g)(ii), per OIG's recommendation, we will initiate an information-gathering effort to gain greater familiarity with carriers' proactive efforts to identify overpayments. We will begin with obtaining information from different types of FEHB Carriers (community-rated and experience-rated HMOs and fee-for-service carriers.) in the Program and will analyze that data to determine next steps, if necessary.



Recommendation 8: We recommend OPM modify Section 2.3(g) requiring carriers to report on their collection efforts, including how promptly the carrier initiated collection once the erroneous payment was identified and the causes of the claim payment errors.

OPM Response: Non Concur

OPM acknowledges there is potential value in the program-wide reporting in OIG recommendations. However, that value may be incremental, based on the requirements carriers

must already meet to identify, process and return erroneous payments to the Program. HI's Audit Resolution and Compliance (ARC) function, acting as agents of the FEHB Program's Contracting Officers, work closely with carriers to evaluate compliance with Section 2.3(g)'s due diligence and good faith provisions. As noted in response to the NFR, FEHB Carriers are already contractually required to meet a claims payment accuracy benchmark of at least 95 percent and report their performance against this and other targets in their Quality Assurance Reports.

Implementing this recommendation, as we understand it, would require completion of a significant set of activities over the course of months, if not years, and would likely necessitate a new, expanded or structurally-reorganized function within HI to receive, review, standardize, conduct quality assurance, reconcile and externally report. [REDACTED]

To the extent feasible, OPM will evaluate carrier reporting as an extension of Recommendation 7. However, we cannot commit to modifying the contract to compel both carrier and OPM to implement global, standardized reporting of erroneous payment processing currently performed. If in the future we pursue this effort, the communications and corrective actions will need to be Program-wide, scalable to individual carrier size, type, percentage of FEHB business, systems, etc. Doing so, prior to completion of additional analysis would not be prudent.

Finally, evaluation of any recommendation pertaining to erroneous payments or ARC's resolution process will require the coordination of any potential new requirements and guidance with other possible changes in Section 2.3(g) that may result from any of the other audits, MARs or other engagements with erroneous payment findings or recommendations.

Recommendation 9: We recommend OPM review the current recovery process in Section 2.3(g)(1) through (5) and consider whether the use of benefit offsets, after the first written notification is sent, would be more cost efficient.

OPM Response: Concur

OPM will review the recovery process in Section 2.3(g)(1). As noted in the draft report, OPM is undertaking a review of Section 2.3(g). HI shared in its response to the NFR that benefit offsets are commonly used by carriers who need the ability to exercise discretion in using them, based on a variety of circumstances. We also know that in some instances, offsets cannot or should not be initiated.

[REDACTED]. OPM will evaluate Section 2.3(g)(1)-(5) with respect to carrier's requirement to demonstrate due diligence in its overpayment recovery efforts. [REDACTED]

D. OTHER CONTRACT IMPROVEMENTS

Recommendation 10: We recommend OPM modify FEHBP contracts to clarify the Agency’s authority to recoup projected improper payments identified by statistical sampling.

OPM Response: Non Concur

The OIG has asked that we clarify the Agency’s authority to recoup projected erroneous payments identified by statistical sampling. We do not concur with this recommendation. We previously presented our objections to OIG questioning costs and requiring carriers to return projected erroneous payments based on statistical sampling, as well as the legal challenges and contract limitations that make acceptance of this recommendation imprudent.

[REDACTED]

Statistical estimations (or projections) are not appropriate for use in HI’s improper payment reporting. In recent years OIG issued several audits which questioned costs that included both judgmental samples of actual claims as well as a separate cohort of randomly sampled claims which were then projected across the FEHB Program. Statistical projections were carefully reviewed by HI and several issues were noted and discussed with OIG. Further,

[REDACTED]

[REDACTED]




Other Adjustments to Contract Clauses

The OIG provided other adjustments they believe should be considered as amendments to the FEHB contracts.

(a) Updates to Sections 1.5 and 2.1 of the CR HMO contract to direct carriers to obtain supporting documentation from payroll offices for overage dependents and/or allow carriers to deny member coverage until such documentation is either provided by the payroll office or the member.

OPM Response: Non Concur

HI has already taken and is taking significant steps to improve documentation that establishes whether family members are eligible for FEHB coverage. Recently adopted regulations at 5 CFR 308(e) allow FEHB Carriers to request from the enrollee or from the employing office supporting documentation that establishes family member eligibility, and to disenroll the family member if they do not receive the documentation in a timely fashion or the documentation is insufficient. These regulations also grant similar authority at 5 CFR 308(f) to OPM and to the employing offices to request from the enrollee the supporting documentation and to disenroll the family member. HI is also taking steps to issue guidance that would require FEHB Carriers to collect documentation from the enrollee or the employing office when adding or changing a family member to existing Self Plus One or Self and Family enrollments. Employing offices would be required to verify family member eligibility documentation upon first enrollment and when enrollment is requested following a qualifying life event.

(b): Updating Section 3.4 (CR HMO contract) and Section 3.8 (FFS and ER HMO contracts), Contractor Records Retention, to provide for a penalty or other consequences if a carrier does not retain/make available documentation needed to support an OIG audit.

OPM Response: Non Concur

The failure of a carrier to maintain records is already addressed under the Contract Oversight part of OPM's Plan Performance Assessment. OPM already has the discretion under Contract Oversight to penalize a carrier for failure to maintain contract records. We do not put express penalties in our contract because each carrier is different, and it would be inappropriate to state a standard penalty without information specific to the compliance issue.

Deleted by the OIG – Not Relevant to the Final Report

(d): Removing Section 2.6(g), from the amendment to the Coordination of Benefits section of the FFS contract. This amendment excludes from recovery claims that are under \$100 and claims that are under \$50 where Medicare is the primary payer of benefits when errors are identified during global claims audits.

OPM Response: Non Concur

An attempt to recover funds under the stated threshold would not be cost-effective. Additionally, given the scope and frequency of global audits, OPM does not have the manpower to review hundreds of thousands of claims under this threshold. Removing the threshold would increase costs for the Trust Fund because it would require an increase in manpower from the Plan to timely review all claims resulting from global audits.

Conclusion

In conclusion, OPM welcomes collaboration with OIG, particularly the opportunity to proactively provide input into and shape potential audit findings and recommendations. HI is open to further dialogue, prior to the issuance of the Final Audit Report, and will continue to routinely engage OIG in the resolution of audit findings to achieve the most effective outcomes. If you have any questions regarding our response to Draft report number 4A-HI-00-18-026, please contact Lloyd Williams, Chief, Audit Resolution & Compliance at [REDACTED].

cc:

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