U.S. Office of Personnel Management

Office of the Inspector General

Office of Audits

Final Audit Report

Audit of Coordination of Benefits with Medicare at Select Blue Cross Blue Shield Plans For the Period 2019 through 2020

Report Number 1A-99-00-21-019

January 3, 2022

Executive Summary

Audit of Coordination of Benefits with Medicare at Select Blue Cross Blue Shield Plans for the Period 2019 through 2020

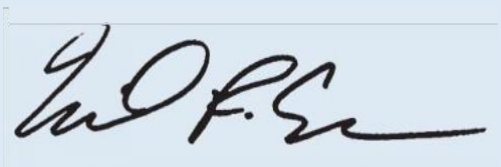
Report No. 1A-99-00-21-019 **January 3, 2022**

Why Did We Conduct the Audit?

The objective of our audit was to determine whether the select Blue Cross and Blue Shield (BCBS) plans charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to FEHBP members in accordance with the terms of the BCBS Association's (Association) contract with the U.S. Office of Personnel Management. Specifically, our objective was to determine whether the select BCBS plans complied with contract provisions relative to coordination of benefits (COB) with Medicare.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the FEHBP operations at select BCBS plans (excluding BCBS plans where other audits covered COB for the scope of this audit). We identified and audited claims that were reimbursed during contract years 2019 and 2020, and were potentially not coordinated with Medicare. Our audit work was remotely conducted by staff in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.



Michael R. Esser
Assistant Inspector General for Audits

What Did We Find?

Overall, the results of this audit indicate to us that the local BCBS plans are continuing to improve their performance in processing COB claims. This audit identified 80 claim lines totaling $107,108 in overcharges to the FEHBP. We note that all these claim lines were initially processed correctly based on the Medicare enrollment information that was available at the time the claims were paid. It was not until retroactive Medicare enrollment information was received that these claim lines were then in need of adjustment. Consequently, this report does contain a recommendation related to the review of claims with retroactive Medicare enrollment changes.

Of the 80 claim lines questioned above, we also identified 23 claim lines where the select BCBS plans did not initiate recoveries of the overpayments until 91 or more days after the updated Medicare information was available to the Association. In fact, 15 were initiated more than one year after the updated information was available. Delays of this length could jeopardize the recovery process because claims received by Medicare more than one calendar year after the date of service could be denied due to being outside of its timely filing requirements.

Abbreviations

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
Association	**Blue Cross Blue Shield Association**
BCBS	**Blue Cross Blue Shield**
COB	**Coordination of Benefits**
Contract	**Contract CS1039 - the contract between the Association and OPM**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEPDirect	**BCBSA's nation-wide claims processing system**
HIO	**Healthcare and Insurance Office**
Med A	**Medicare Part A**
Med B	**Medicare Part B**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
RER	**Retroactive Enrollment Report**
SBP	**Service Benefit Plan**

Table of Contents

I. Background

This final report details the results of our performance audit of the Federal Employees Health Benefits Program (FEHBP) claims processing and payment operations, as it relates to the coordination of benefits (COB) with Medicare, at select Blue Cross Blue Shield (BCBS) plans for contract years 2019 and 2020. The audit was remotely conducted in the Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida areas.

The audit was conducted pursuant to the provisions of contract CS 1039 (Contract) between the U.S. Office of Personnel Management (OPM) and the BCBS Association (Association); Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits Act (Act), Public Law 86-382, enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office (HIO) has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the HIO contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the Act are implemented by OPM through regulations codified in 5 CFR 890.

The Association, on behalf of participating BCBS plans, has entered into a Government-wide Service Benefit Plan (SBP) contract with OPM to provide a health benefit plan authorized by the Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers.

The Association has established a Federal Employee Program (FEP[1]) Director's Office in Washington, D.C. to provide centralized management for the SBP. The FEP Director's Office coordinates the administration of the Contract with the Association, member BCBS plans, and OPM.

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

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

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

The most recent audit report focusing on COB with Medicare at all BCBS plans was Report No. 1A-99-00-19-001 (dated September 19, 2019) and covered the period October 1, 2017, through June 30, 2018. All recommendations from this previous audit have been satisfactorily resolved and closed.

The results of our audit were discussed with Association officials throughout the audit and via an email (in lieu of an exit conference) on July 29, 2021. We issued a draft report, dated August 5, 2021, to solicit the Association's comments to the findings and recommendations. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an appendix to this report.

II. Objectives, Scope, and Methodology

Objectives

The objectives of our audit were to determine whether the select BCBS plans charged costs to the FEHBP and provided services to the FEHBP members in accordance with the terms of the Contract. Specifically, our objective was to determine whether the select BCBS plans complied with the Contract provisions relative to COB with Medicare.

Scope and Methodology

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The focus of this performance audit was to identify any FEHBP claims not properly coordinated with Medicare by select local BCBS plans for the period January 1, 2019, through December 31, 2020. Our audit fieldwork was remotely performed by staff located near our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from March 31, 2021, through August 5, 2021.

In planning and conducting our audit, we obtained an understanding of the Association's internal control structure to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Association'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 Association's system of internal controls taken as a whole.

We also conducted tests to determine whether the select BCBS plans and Association had complied with the Contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP as they relate to claim payments. With the exception of those areas noted in the "Audit Findings and Recommendations" section of this audit report, we found that the select BCBS plans and the Association were in compliance with the health benefit provisions of the Contract. With respect to any areas not tested, nothing came to our attention that caused us to believe that the select BCBS plans and the Association 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 BCBS plans. Through the performance of audits and an in-house claims data reconciliation process, we verified the reliability of the BCBS claims data in our data warehouse, which is used to identify claims

potentially not coordinated with Medicare and to select our samples. The BCBS claims data is provided to the OPM OIG monthly by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

As part of our review, we separated the uncoordinated claims into six categories based on the place of service and whether Medicare Part A (Med A) or Part B (Med B) should have been the primary payer, as follows:

- Categories A and B consist of inpatient claims that should have been coordinated with Med A. If the BCBS plans indicated that Med A benefits were exhausted, we reviewed the claims to determine whether there were any inpatient services that were payable by Med B.

  For these categories Med A pays all covered costs (except for deductibles and coinsurance) for inpatient care in hospitals, skilled nursing facilities, and hospice care. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories, we reduced the amount paid using the applicable Medicare deductible and/or copayment.

- Categories C and D include inpatient claims with ancillary items that should have been coordinated with Med B. If the BCBS plans indicated that members had Med B only, we reviewed the claims to determine whether there were any inpatient services that were payable by Med B.

  For these categories, Med B covers a portion of inpatient facility charges for ancillary services such as medical supplies, diagnostic tests, and clinical laboratory services, and pays 80 percent for these services after the calendar year deductible has been met. Based on our experience, ancillary items account for approximately 30 percent of the total inpatient claim payment. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories we estimated a 25 percent overcharge for the inpatient claim lines (0.30 x 0.80 = 0.24 – 25 percent).

- Categories E and F include outpatient facility and professional claims where Med B should have been the primary payer.

  For these categories, Med B pays 80 percent of most outpatient charges and professional claims after the calendar year deductible has been met. Consequently, in determining potential overcharges for the claim lines improperly paid in these categories we used 80 percent of the amount paid as the amount overcharged.

We selected the following sample of health benefit claims to assess if the Association complied with the Contract's requirements as they relate to COB with Medicare. For BCBS plan sites with error rates of three percent or more (11 plan sites) from our last audit (Report No. 1A-99-00-19-001), we queried our claims data warehouse to identify all claim payments reimbursed

from January 1, 2019, through December 31, 2020, that potentially were not coordinated with Medicare and had potential overpayments greater than $250. This search identified 5,068 claims, totaling $7,282,024 in potential COB overcharges.

From this universe, we selected all claims identified in categories A, B and C for review. For categories E and F, we calculated a total expected sample size of 200 per category which was based on the results of our prior COB audit. Simple random sampling was then utilized to select the samples from those categories. Based on materiality, we did not select any claims from category D as part of this audit. In total, we selected 395 claims, with potential overcharges of $775,707, for review to determine whether the claims were properly coordinated with Medicare.

During our review, we utilized the Contract, the 2019 and 2020 SBP brochures, the Association's FEP Procedures Administrative Manual, and various manuals and other documents available from the Center for Medicare and Medicaid Services that explain Medicare benefits to determine the amounts questioned. The samples selected and reviewed were not statistically based. Consequently, the results were not projected to their respective universes since it is unlikely that the results are representative of the universes taken as a whole.

III. Audit Findings and Recommendations

Overall, the results of this audit indicate to us that the local BCBS plans are continuing to improve their performance in processing COB claims. However, as shown below, this report does contain a recommendation related to their review of claims with retroactive Medicare enrollment changes.

1. Coordination of Benefits with Medicare Review $107,108

Our review determined that the plans incorrectly paid 80 claim lines, resulting in overcharges to the FEHBP of $107,108. Additionally, we identified 23 claim lines where the local plans did not initiate recoveries of the overpayments until 91 or more days after the updated Medicare information was available to the Association.

Section 3.2(a)(4)(b)(1) of the Contract states that "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

Section 2.3(g) of the Contract states, "It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program." And "If the Carrier 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."

Additionally, Section 2.6 of the Contract states, "(a) The Carrier shall coordinate the payment of benefits under this contract with the payment of benefits under Medicare . . . (b) The Carrier shall not pay benefits under this contract until it has determined whether it is the primary carrier - ."

Finally, the 2020 BCBS SBP brochure Primary Payer Chart illustrates whether Medicare or the Plan should be the primary payer (based on employment status and other factors determined by Medicare). Additionally, the SBP brochure states that for those persons with Medicare, the Plan will limit its "payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays."

Uncoordinated Claims Due to Retroactive Enrollment Changes

We reviewed a sample of claim lines where the patients had Medicare coverage, but the claims did not appear to be coordinated with Medicare. We provided the samples to the Association and asked it to review them and provide a determination. We then reviewed their responses to determine if the claims were properly coordinated.

Our review identified 80 claim lines, with FEHBP overcharges totaling $107,108, that were not coordinated with Medicare due to retroactive enrollment changes (where the patient's Medicare enrollment information was updated within the Association's nation-wide claims processing system (FEPDirect) after the claim was processed).

Recommendation 1:

We recommend that the contracting officer disallow $107,108 for claim overpayments and verify that all amounts recovered are returned to the FEHBP. To date, $101,025 in overpayments has been recovered, leaving a remaining amount of $6,083 due to the FEHBP.

Association's Response:

The Association provided documentation supporting the recovery of $101,025 and stated that the remaining $6,083 was written off as uncollectible.

Untimely Initiation of Recoveries

We reviewed all 80 questioned claim lines to determine the timeliness of the plans' recovery efforts. Timeliness, in this regard, is of utmost importance because claims received by Medicare more than one calendar year after the date of service could be denied due to being outside of its timely filing requirement.

The select BCBS plans did not review claims appearing on the RER in a timely fashion. Preventable delays on the part of the local plans could lead to claims not being recoverable.

Section 2.3.(g)(8)(i) of the Contract states that the carrier may only charge erroneous payments to the FEHBP for which it can document that it made a prompt and diligent effort to recover the overpayment.

The Association and its FEP Operations Center generates a Retroactive Enrollment Report (RER) daily. The RER lists paid claims that may need adjustment due to changes in member enrollment or other new information (including new/updated Medicare information). According to the Association's FEP Administrative Procedures Manual and Benefits Policy Manual for Medicare Enrollment Information, local plans are responsible for researching the listed claims as a part of their daily operations to determine if refunds are due to the FEHBP.

For the 80 claim lines not properly coordinated due to retroactive enrollment changes, recoveries were initiated within the timelines noted in Table 1.

Table 1

Recovery Initiated Within	Count
0-30 Days	55
31-90 Days	2
91-360 Days	8
360+ Days	15
Totals	**80**

As the Association's procedures assume that the local plans will research the RER as part of their daily duties, we would assume that once updated Medicare information was available on FEPDirect that the claims would be researched, and recoveries initiated quickly. From what we can see, it does appear that the Association's procedures are generally working, as recovery efforts on 57 claim lines (71 percent) were initiated within 90 days of Medicare information being updated in FEPDirect. Included in these 57 claim lines are

the claim lines (totaling $6,083) that the Association deemed as uncollectible in its response above.

However, there is still room for improvement, as the recovery process on 23 (29 percent) of the claim lines identified was not initiated until 91 days or more after the Medicare information was updated in FEPDirect. Of that number, recovery efforts for 15 claim lines (19 percent) were initiated more than a year after the Medicare information was available to the Association. Typically, Medicare will not allow providers to submit claims a year after the date of service. That, coupled with the fact that the Medicare "clock" has already begun when the Association becomes aware of it, makes the timeliness of the RER process vital. Therefore, it is of great importance that the local plans shore up their internal procedures to ensure that they research the claims on the RER as quickly as possible. Any monies unrecovered due to extensive delays (i.e., delays of more than 90 days) by the local plans' initiating recoveries should be returned to the FEHBP regardless of the plans' ability to recover because the unrecovered amounts do not meet the Contract's requirements for prompt and diligent efforts to make recoveries. The fact that the local plans receive the RER daily and it is intended to be part of their daily workload makes any extended delays in initiating review and recovery unacceptable.

Recommendation 2:

We recommend that the contracting officer direct the Association to strengthen its policies, procedures, and oversight of the RER process to ensure that all claim lines identified are researched quickly and that any necessary recoveries are initiated within 90 days of the claims appearing on the RER.

Association's Response:

The Association agrees and states that the local "Plans initiated recovery on the questioned claim lines either when received on the RER or once it was determined that overpayments occurred. Further, all claim lines were recovered. [Except for the $6,083 determined to be uncollectible.] In evaluating the identified claim lines, BCBSA identified opportunities for improvement in ensuring that Plans:

- **Review the member history to identify all affected claims when a member is included on the RER or the CAMT Uncoordinated Medicare application.**
- **Respond correctly to questioned claims during an OIG audit.**
- **Review claims on the RER correctly.**
- **Override the Medicare FPW edits appropriately.**

BCBSA will provide Plan training to address the opportunities for improvement listed above."

OIG Comments:

The OIG acknowledges and thanks the Association for recognizing that there is continued room for improvement regarding COB claims with retroactivity. However, in the claim errors pointed out in this section of the finding, the local plans did not fulfill their requisite due diligence when reviewing the RER. As the Association points out, the local plans failed to fully review, respond correctly, review correctly, and apply overrides appropriately to the claim lines we identified. We feel that the RER is a great internal control feature that the Association has implemented, but it is only as good as its application.

In instances where the local plan's failure to review the RER timely and/or correctly delays the identification of and initiation of a recovery beyond any timeliness standard (be it a Medicare requirement or a contractual requirement with a provider), any overpayments resulting from said failures should not be considered good faith errors in accordance with the Contract and should be reimbursable to the FEHBP independent of recovery.

Appendix

BlueCross BlueShield Association

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September 2, 2021

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

Reference: OPM Draft Audit Report
Audit of Coordination of Benefits (COB) with Medicare Claim Payments
Audit Report Number 1A-99-00-21-019
Issued August 5, 2021

Dear Ms. Oliver:

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

Recommendation 1

We recommend that the contracting officer disallow $143,271 for claim overpayments and verify that all amounts recovered are returned to the FEHBP. To date, $6,211 in overpayments have been recovered, leaving a remaining amount of $137,060 due to the FEHBP.

BCBSA Response:

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

Of the 78 claim lines totaling $141,916 identified as overpayments, BCBSA determined the following:

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

- For the 59 questioned claim lines were reported by Plans as fully recovered and two claims were reported as partially recovered, for a total recovered amount of $94,814.

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

- Six questioned claim lines totaling $6,083 were determined by Plans to be uncollectible.

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

Recommendation 2

We recommend that the contracting officer direct the Association to strengthen its policies, procedures, and oversight of the Retroactive Enrollment Report (RER) process to ensure that all claim lines identified are researched quickly and that any necessary recoveries are initiated within 90 days of the claims appearing on the RER.

BCBSA Response:

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

In summary, BCBSA determined that Plans initiated recovery on the questioned claim lines either when received on the RER or once it was determined that overpayments occurred. Further, all claim lines were recovered. In evaluating the identified claim lines, BCBSA identified opportunities for improvement in ensuring that Plans:

- Review the member history to identify all affected claims when a member is included on the RER or the CAMT Uncoordinated Medicare application.
- Respond correctly to questioned claims during an OIG audit.
- Review claims on the RER correctly.
- Override the Medicare FPW edits appropriately.

BCBSA will provide Plan training to address the opportunities for improvement listed above.

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

Sincerely,

[redacted]

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