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

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# Final Audit Report

## MULTI-STATE PLAN PROGRAM OPERATIONS AT BLUE CROSS BLUE SHIELD OF TEXAS

Report Number 1M-0D-00-16-001  
September 28, 2016

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# EXECUTIVE SUMMARY

## *Multi-State Plan Program Operations at Blue Cross Blue Shield of Texas*

Report No. 1M 0D-00-16-001

September 28, 2016

### **Why Did We Conduct The Audit?**

The primary objective of our audit was to obtain reasonable assurance that Blue Cross Blue Shield of Texas (BCBSTX) complied with the provisions of Contract MSPP-2014 (Contract) and applicable Federal regulations for contract year 2014.

### **What Did We Audit?**

The Office of the Inspector General has completed a performance audit of the Multi-State Plan (MSP) Program operations at BCBSTX. Our audit of BCBSTX's compliance with the 2014 Contract and applicable regulations was conducted from November 9, 2015, through February, 9, 2016, at BCBSTX headquarters in Chicago, Illinois, and our offices in Cranberry Township, Pennsylvania, and Washington, D.C.

### **What Did We Find?**

Our audit of the 2014 MSP Program operations at BCBSTX disclosed six procedural findings pertaining to enrollment and contract quality assurance. Specifically, we identified the following:

- BCBSTX did not have formal termination policies and procedures in 2014.
- BCBSTX did not process the termination of enrollee coverage for 36 MSP members in accordance with the Contract and applicable regulations in 2014.
- BCBSTX did not process one enrollment fallout work item timely in 2014.
- BCBSTX did not adequately support one MSP Health Insurance Casework System case in 2014.
- BCBSTX did not meet the claims processing accuracy standard required by the Contract.
- BCBSTX did not meet the enrollment processing timeliness standard required by the Contract.

Finally, the audit recommends an area for program improvement to address concerns identified in the current benefit brochure language related to the termination of enrollee coverage.

Our audit did not disclose any findings related to rates and benefits or internal controls, except where internal control weaknesses are otherwise noted in the enrollment and contract quality assurance findings.



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**Michael R. Esser**  
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for Audits*

# ABBREVIATIONS

<b>Affordable Care Act</b>	<b>The Patient Protection and Affordable Care Act</b>
<b>APTC</b>	<b>Advanced Premium Tax Credit</b>
<b>Association</b>	<b>Blue Cross Blue Shield Association</b>
<b>BCBS</b>	<b>Blue Cross Blue Shield</b>
<b>BCBSTX</b>	<b>Blue Cross Blue Shield of Texas</b>
<b>CFR</b>	<b>Code of Federal Regulations</b>
<b>CMS</b>	<b>Centers for Medicare and Medicaid Services</b>
<b>Contract</b>	<b>Contract MSPP-2014</b>
<b>FFM</b>	<b>Federally Facilitated Marketplace</b>
<b>HICS</b>	<b>Healthcare Insurance Casework System</b>
<b>HHS</b>	<b>U.S. Department of Health and Human Services</b>
<b>MSP</b>	<b>Multi-State Plan</b>
<b>OIG</b>	<b>Office of the Inspector General</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>QAI</b>	<b>Quality Assessment Improvement</b>
<b>QHP</b>	<b>Qualified Health Plan</b>
<b>TDI</b>	<b>Texas Department of Insurance</b>

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Appendix (BCBSTX's June 16, 2016, response to the draft report)

**REPORT FRAUD, WASTE, AND MISMANAGEMENT**

# I. BACKGROUND

This final report details the results of our performance audit of the Multi-State Plan (MSP) Program operations at Blue Cross Blue Shield of Texas (BCBSTX). The audit covered contract year 2014. It was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

The audit was conducted pursuant to the provisions of Contract MSPP-2014 (Contract); the Patient Protection and Affordable Care Act (Affordable Care Act); Title 45 Code of Federal Regulations (CFR) Chapter VIII, Part 800; and other applicable Federal regulations. Compliance with the Contract as well as laws and regulations applicable to the MSP Program is the responsibility of the Blue Cross Blue Shield Association (Association) and BCBSTX's management. Additionally, BCBSTX's management is responsible for establishing and maintaining a system of internal controls and procedures. Due to inherent limitations in any system of internal controls, errors or irregularities may nevertheless occur and not be detected.

The MSP Program was established by Section 1334 of the Affordable Care Act. Under the Affordable Care Act, OPM was directed to contract with private health insurers to offer MSP products in each state and the District of Columbia. OPM negotiates contracts with MSP Program Issuers, including rates and benefits, in consultation with states and marketplaces. In addition, OPM will monitor the performance of MSP Program Issuers and oversee compliance with legal requirements and contractual terms. OPM's office of National Healthcare Operations has overall responsibility for program administration.

The Association, on behalf of participating Blue Cross Blue Shield (BCBS) plans, entered into a contract with OPM to participate in the MSP Program. Along with its participating licensees, the Association offers 154 MSP options in 30 states and the District of Columbia. BCBSTX was one of 35 BCBS plans, or State-Level Issuers, participating in the MSP Program in 2014.

The Association is a national federation of 37 independent, community-based and locally operated BCBS companies. The Association grants licenses to independent companies to use the trademarks and names in exclusive geographic areas. It operates and offers health care coverage in all 50 states, the District of Columbia, and Puerto Rico, covering nearly 105 million Americans. Nationally, the Association contracts directly with more than 96 percent of hospitals and 92 percent of professional providers.

Health Care Service Corporation is the largest customer-owned health insurance company in the United States and offers a variety of health insurance products through its operating divisions and subsidiaries, including BCBSTX. In addition to offering the MSP options on the Federal

marketplace, BCBSTX offers other individual and family health plans, dental plans, and Medicare supplement plans.

This is our first audit of BCBSTX's MSP Program. We selected BCBSTX to audit because Texas does not have an effective rate review program for plans offered on the Federally Facilitated Marketplace (FFM).

The preliminary results of this audit were discussed with BCBSTX and the Association officials at an exit conference and in subsequent correspondence. A draft report was also provided to the Association for review and comment. The Association's comments were considered in preparation of this report and are included as an Appendix to the report.

## II. OBJECTIVES, SCOPE, AND METHODOLOGY

### **Objective**

The primary objective of this performance audit was to obtain reasonable assurance that BCBSTX was in compliance with the provisions of its contract with OPM and applicable laws and regulations governing the MSP Program for contract year 2014. Specifically, we reviewed enrollment, rates and benefits, internal controls, and contract quality assurance.

### **Scope and Methodology**

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards required that we plan and perform the audit to obtain sufficient, 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 audit fieldwork was performed from November 9, 2015, through February 9, 2016, at BCBSTX's headquarters in Chicago, Illinois, and our offices in Cranberry Township, Pennsylvania, and Washington, D.C.

We obtained an understanding of BCBSTX's internal control structure and used this information to determine the nature, timing, and extent of our audit procedures. Our review of internal controls was limited to the procedures that BCBSTX had in place for claims processes; enrollment and billing processes; and ensuring compliance with requirements for prescription drug benefits.

Specifically, we interviewed BCBSTX personnel and reviewed the policies and procedures for manual claims processes to determine if controls were in place to mitigate the inherent risk of manual processes. We also interviewed BCBSTX personnel and reviewed information regarding system updates and corrective actions taken to increase controls over the enrollment, member maintenance, and billing processes. Finally, we tested a judgmental sample of MSP member invoices from August 2014 to determine if MSP members were billed accurately. The invoice universe, samples, and selection methodology are summarized in Exhibit A.

In addition, we reviewed documentation to ensure that the appropriate pharmacy benefits were covered.

We also interviewed BCBSTX personnel and reviewed the BCBSTX's policies and procedures related to enrollment processing and termination of enrollee coverage to evaluate compliance with the Contract. We reviewed judgmental samples of enrollment fallout work items, Health



Insurance Casework System (HICS) cases, and terminations of enrollee coverage transactions from 2014 to determine if these actions were processed timely and accurately. The enrollment transaction universes, samples, and selection methodologies are summarized in Exhibit B.

Finally, we interviewed BCBSTX personnel and reviewed supporting documentation related to the missed performance goals identified in the 2014 Contract Quality Assurance Report, specifically claims processing accuracy and enrollment processing timeliness, to determine the corrective actions put in place to address the issues with meeting these goals.

In conducting the audit, we relied to varying degrees on computer-generated data provided by BCBSTX and the Association. We did not verify the reliability of the data generated by the various information systems involved. However, nothing came to our attention during our audit utilizing the computer-generated data to cause us to doubt its reliability.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

## A. ENROLLMENT

### 1. Enrollment Termination Policies and Procedures

### Procedural

BCBSTX did not have formal enrollment termination policies and procedures in 2014. As such, it was not in compliance with the Contract and applicable regulations.

Contract Section 6.7(a) requires the issuer to “develop, operate and maintain viable systems, processes, and procedures for the timely, accurate and valid enrollment and termination of Enrollee coverage.”

Contract Section 6.8(a) further requires the issuer to “maintain standard operating procedures for the termination of coverage ... including due to non-payment of premiums.”

**A lack of formal policies and procedures could leave members vulnerable to errors in the termination of their coverage.**

Finally, 45 CFR §156.270(c)(1) requires the issuer to establish a standard policy for the termination of enrollee coverage for non-payment of premiums, which must include the grace period for recipients of the Advanced Premium Tax Credit (APTC).

During our review, BCBSTX provided narratives and flow charts describing the termination process for 2014 but was unable to provide formal documented policies or procedures. BCBSTX noted challenges to implementing the Affordable Care Act in 2014, including changing regulations that caused delays in the development of systems and processes. These challenges may have contributed to the lack of specific, defined policies and procedures for the termination of enrollee coverage. However, without defined policies and procedures, terminations of enrollee coverage may be performed incorrectly, potentially resulting in improper, inaccurate, or untimely terminations.

BCBSTX subsequently developed a formal policy on “Grace Periods for the Non-Payment of Premiums” in 2015. However, the policy is not sufficient to support full compliance with the Contract and 45 CFR §156.270. Specifically, the policy focuses only on termination of enrollee coverage in cases of non-payment of premiums and does not stipulate procedures for terminations of coverage for reasons other than non-payment of premiums. In addition, it does not address requirements to notify the U.S. Department of Health and Human Services (HHS) in the case of non-payment during the grace period of an APTC member. Finally, it does not define standard operating procedures to ensure the timely and accurate termination of enrollee coverage, nor the manner and timing in which it will notify enrollees of delinquency and termination. These weaknesses leave BCBSTX open to continued non-compliance issues and potential compliance actions as well as leaving members vulnerable to errors in termination of their coverage.

## **Issuer Response**

*BCBSTX agreed with the finding based on the 2014 contract year and noted that it has subsequently implemented corrective actions to improve and strengthen its policies, procedures, trainings, and technology related to the termination of enrollee coverage. BCBSTX also stated that formal training and re-training has been conducted relative to its procedures, and a quality assessment improvement (QAI) program was implemented to measure the accuracy and timeliness of manual activity for grace period administration. According to BCBSTX, the current QAI scores are at 99% for the department. Finally, BCBSTX reported that it implemented automation technology in September 2015, transitioning a number of previously manual activities (e.g., reminder notifications, grace period duration, coverage record termination, and record retention) into the core membership platform.*

## **OIG Comment**

Based on our review of supplemental information provided in response to the draft report, BCBSTX has developed several policies and procedures that address the 2014 deficiencies. However, we cannot determine whether the policies and procedures are relevant to MSPs. One of the policies specifically states that MSPs are not within the policy scope, and other policies and procedures reference Qualified Health Plans (QHPs) but do not specify whether or not MSPs are also included in the scope. Although we would typically consider any procedure that is applicable to QHPs relevant to MSPs as well, the separation and exclusion of MSPs from the scope of one policy raises questions as to whether this is a reasonable assumption.

In addition, while the QAI program, training, and technological enhancements reported by BCBSTX appear to address 2014 deficiencies and indicate improvement based on the descriptions provided, we cannot verify BCBSTX's statements. We will evaluate the effectiveness of these improvements and the policies and procedures during future audits.

## **Recommendation 1**

We recommend that the Contracting Officer verify that MSPs are included in the scope of BCBSTX's policies and procedures for the termination of enrollee coverage.

### **2. Enrollment Termination Processing**

### **Procedural**

BCBSTX did not terminate enrollee coverage for 36 members in accordance with the requirements in the contract and applicable regulations.

We reviewed a judgmental sample of 48 terminations of MSP enrollee coverage from 2014. Based on our review, we determined that 36, or 75 percent, of the termination transactions were processed untimely and/or inaccurately based on contractual and regulatory requirements. Most of the 36 transactions had multiple compliance issues across a variety of areas, including: termination of coverage and delinquency

notifications; grace periods for non-payment of premiums; effective dates of termination; and enrollment terminations processing. BCBSTX experienced a high volume of termination transactions in 2014, which involved the extensive use of manual processes to complete. However, BCBSTX did not have policies and procedures for the termination of enrollee coverage in 2014 to mitigate the risk of processor errors when performing these manual processes. The development of formal policies and procedures that align with requirements in the Contract and applicable regulations, as well as specific controls and processor training, could assist in preventing these errors and compliance issues in the future.

**36 of 48 termination transactions were processed untimely and/or inaccurately in 2014.**

Specifically, our review of this area uncovered the following issues:

- **Lack of Termination Notices** – BCBSTX did not provide 15 MSP members with termination notices in 2014. Coverage was terminated for three of these members due to non-payment and for one member due to discrepancies in the member’s data that the Centers for Medicare and Medicaid Services (CMS) was unable to resolve. When the issuer terminates coverage for members in accordance with 45 CFR §155.430(b)(2) because the members are no longer eligible for coverage through the Marketplace or because the applicable grace period for non-payment has been exhausted, 45 CFR §156.270(b)(1) requires issuers to “promptly and without undue delay,” provide a termination of coverage notice to include the termination effective date and reason for termination. However, BCBSTX did not comply with these regulations in the case of these four members. In addition, 11 of the 15 members who did not receive termination of coverage notices had requested the termination of coverage. Although not required by regulation to send a formal termination of coverage notice to these members, BCBSTX’s benefit brochures state that if coverage is “terminated for any reason, BCBSTX will provide ... a notice of termination of coverage that includes the reason for termination ....” As such, BCBSTX is not following its own process, as communicated to the members in the benefit brochures. Moreover, without appropriate notification, these members may unknowingly incur costs for benefits that are no longer covered and experience critical delays in seeking alternative healthcare coverage options.
- **Untimely Termination Notices** – BCBSTX provided untimely termination notices to two MSP members who were terminated for non-payment of premiums in 2014. As stated above, when the issuer terminates coverage for members in accordance with 45 CFR §155.430(b)(2) because the applicable grace period for non-payment has been exhausted, 45 CFR §156.270(b)(1) requires issuers to “promptly and without undue delay,” provide a termination of coverage notice. However, we determined that BCBSTX sent termination notices to these two members 45 and 98 days after the date BCBSTX terminated their coverage in its system. Without timely notification,

members may unknowingly incur costs for benefits that are no longer covered and experience critical delays in seeking alternative healthcare coverage options.

- **Incorrect Grace Period Application** – BCBSTX did not terminate coverage for 12 MSP members when their applicable grace periods expired, including 7 members who were receiving the APTC and 5 members who were not receiving the APTC.

45 CFR §156.270(g) requires issuers to terminate coverage for members who are receiving the APTC if they exhaust their three-month grace period without paying all outstanding premiums. In addition, CMS guidance dated July 22, 2013, reaffirms, “If an enrollee fails to pay in full his or her portion of the premium due prior to the end of the applicable grace period” the issuer is required to “send an 834 termination transaction to the Marketplace.” Finally, BCBSTX’s benefit brochures state that members will be terminated if the full amount of the premium is not received on time, subject to applicable grace periods. In spite of these requirements, however, our audit showed that seven APTC members received an additional grace period of one to four months after their original three-month grace period was exhausted.

While the regulations and guidance cited above are specific to APTC members, BCBSTX also granted a 31-day grace period to its non-APTC members per its benefit brochures and in accordance with the State of Texas Insurance Code §1201.209. However, our audit showed that BCBSTX gave 1 to 3 additional months of grace beyond the standard 31-day grace period to five non-APTC members before terminating their coverage in 2014.

By not complying with regulations or enforcing its own process, BCBSTX allows members to continue receiving health benefits coverage without paying their required premiums. As a result, members may expect that health benefits will continue to be covered even if they do not pay their premiums.

- **Inconsistent Delinquency Notifications** – BCBSTX did not provide 20 MSP members with delinquency notices that complied with 45 CFR §156.270(f). Specifically, 45 CFR §156.270(f) requires the issuer to provide a notice of delinquency when the enrollee is delinquent on premium payments. However, seven members did not receive any delinquency notification letters. In addition, 13 members received inconsistent delinquency notification letters. In some cases, these members received the letters in the first month of delinquency, but other members did not receive letters until the second or third months of delinquency, or even after the initial grace periods had been exhausted. Without timely and adequate notification of delinquency, the consequences of exhausting the grace period without paying the outstanding premiums in full are not communicated to the members. As a result, the members may be led to believe that the coverage will continue indefinitely, particularly since BCBSTX is not enforcing grace periods for non-payment of premiums, as noted above.

- **Incorrect Effective Dates of Termination** – Coverage for 14 MSP members was not terminated as of the effective dates per 45 CFR §155.430(d). Also, we were unable to determine if coverage for two additional members was terminated as of the correct effective date based on the documentation provided.

45 CFR §155.430(d)(2)(i) states that when the termination of coverage is initiated by the enrollee, the effective date of termination is the date specified by the enrollee. However, we determined that BCBSTX did not terminate coverage for two MSP members, who requested termination of coverage, as of the effective dates noted in the 834 termination transactions from the Marketplace.

In addition, when terminating coverage due to non-payment, 45 CFR §155.430(d)(4) states that the effective date of termination for APTC members is the last day of the first month of the three-month grace period. However, BCBSTX terminated coverage for 12 members who exhausted their applicable grace periods as of their respective “paid through dates” rather than the effective dates prescribed by regulation. BCBSTX asserted that benefits were still covered through the end of the grace period, which is communicated to members via the benefit brochures, yet the termination notices sent to the members contradicted this process by using the “paid through date” as the effective date of termination.

Finally, we could not determine the accuracy of the effective dates of termination for two additional members because BCBSTX did not provide adequate supporting documentation. Contract Sections 2.7 and 7.12 require the issuer to make available all records pertaining to contract compliance for a record retention period of 7 years. Without adequate supporting documentation, we were unable to verify that BCBSTX accurately terminated enrollee coverage for the affected members as of the appropriate effective date.

- **Untimely Enrollee-Initiated Terminations** – Four MSP member-initiated requests for termination of coverage were not processed timely. Contract Section 6.7(a) requires the issuer “develop, operate and maintain viable systems, processes, and procedures for the timely, accurate and valid enrollment and termination of Enrollee coverage.” However, we determined that BCBSTX did not process these four requests for termination of coverage from 28 to 106 days after the date of the request. Because the members were still carried on BCBSTX’s enrollment system, invoices would continue to be sent to the members, potentially causing confusion to members by eliciting payments for coverage the member was not using. The delays also resulted in complaints from at least two affected members.
- **Incorrect Termination Reason Codes** – BCBSTX processed termination of coverage for eight MSP members under an incorrect reason code in 2014. Contract Section 6.7(a) requires the issuer to operate systems, processes, and procedures for timely and accurate termination of coverage. Two members were processed under the wrong termination reason code. The processing errors may have been part of the

reason these members did not receive termination notices. In addition, six of the members were initially processed under the correct termination reason code, but BCBSTX subsequently altered the reason codes in its system. In most cases, these actions resulted in changing the effective dates of termination to dates earlier than originally requested by the member, which may have had an impact if the member had incurred claims after this date. BCBSTX did not provide support for the reason these termination transactions were altered.

### **Issuer Response**

*BCBSTX generally agreed with the finding based on the 2014 contract year but noted that it has subsequently implemented corrective actions to strengthen policies, procedures, trainings, and technology related to the terminations of enrollee coverage.*

*BCBSTX disagreed with the recommendation that it establish, implement, and document personnel training related to processing terminations of coverage. It stated that its Learning & Development department conducted personnel training in 2014 related to processing terminations of coverage.*

### **OIG Comment**

Based on our review of supplemental information provided in response to the draft report, BCBSTX has developed several policies and procedures that address the 2014 deficiencies, including processing member terminations, termination of coverage and delinquency notifications, and grace period and effective date application. The reported automation and implementation of procedures for quality audits also indicates controls have been put into place to improve termination of coverage processing as well as the ability to maintain and make available documentation to support actions that are taken. We will test the effectiveness of these improvements during future audits.

However, as previously noted in our comment to the Enrollment Termination Policies and Procedures finding, we cannot determine whether the policies and procedures for the termination of enrollee coverage are relevant to MSPs. Since this issue is already addressed under Recommendation 1, documentation provided to address the Enrollment Termination Policies and Procedures finding should also address this issue.

In addition, the policy and procedure updates do not fully address the issue of effective dates for APTC members whose coverage is terminated due to non-payment. Specifically, a September 2015 policy requires that the last day of coverage for APTC members would be the last day of the first month in the grace period, in accordance with 45 CFR §155.430(d)(4). However, BCBSTX's procedures do not support this, either noting that the effective date will be the paid-through-date for non-payment terminations or not specifying the precise effective date.

Finally, although BCBSTX performed training in 2014, the training specifically addressed cancellations at the members request and did not cover topics related to any of

the other issues identified in the finding. Moreover, the training did not occur until August and October of 2014. Given the timing and content of the training, it would not have been effective at deterring most of the errors identified in termination of coverage processing in 2014, nor would the content be effective at preventing errors in future years. We are unable to verify that BCBSTX made subsequent changes to its training curriculum.

### **Recommendation 2**

We recommend that the Contracting Officer direct BCBSTX to comply with guidance related to the effective dates for termination of coverage for APTC members as stated in 45 CFR §155.430(d)(4).

### **Recommendation 3**

We recommend that the Contracting Officer verify that BCBSTX implemented more relevant and timely personnel training related to processing terminations of coverage.

## **3. Enrollment Fallout Work Item Processing**

## **Procedural**

BCBSTX did not process one enrollment fallout work item timely in 2014.

Contract Section 6.7(a) requires the issuer to “develop, operate and maintain viable systems, processes, and procedures for the timely, accurate and valid enrollment and termination of Enrollee coverage.”

As part of BCBSTX’s enrollment processes, enrollment fallouts are triggered when the enrollment system is unable to process an enrollment application automatically. When the application fails any of the defined rules built into the enrollment system, the application is stopped, and a fallout work item is created for manual processing.

We reviewed a judgmental sample of 34 enrollment fallout work items from 2014. Based on our review, we determined that one fallout work item was not completed for 41 days, which was 17 days after the effective date of coverage. This work item may have been processed untimely due to the volume of enrollments requiring manual intervention in 2014. Although BCBSTX retroactively enrolled the member with the appropriate effective date, the delay in approving this enrollment may have negatively impacted the member’s ability to access coverage for necessary care. BCBSTX is currently engaged in system initiatives to improve enrollment system response times and accuracy, as well as decrease manual intervention, but we did not evaluate the effectiveness of these initiatives.



## **Issuer Response**

*BCBSTX agreed with the finding and stated that it established daily automated controls in 2015 to monitor and balance the transactions between systems and ensure that each transaction is appropriately dispositioned.*

## **OIG Comment**

Based on information provided in support of its response to the draft report, BCSBTX appears to have implemented daily enrollment control reporting and monitoring, with additional controls currently in process of implementation or development. We will review the effectiveness of these controls during future audits.

## **Recommendation 4**

Our draft report recommended that the Contracting Officer direct BCBSTX to review its controls over manual enrollment processes and update them as necessary to ensure the timely and accurate processing of enrollment fallout work items. However, the actions taken by the issuer in its response address the issues identified during the course of the audit, subject to future audits. As such, no further action is required at this time.

### **4. HICS Case Processing**

### **Procedural**

BCBSTX did not adequately support one MSP Healthcare Insurance Casework System (HICS) case in 2014. As a result, we were unable to verify that BCBSTX accurately processed the case.

Contract Sections 2.7(b)(1) and 7.12 require the issuer to maintain, and make available, all records pertaining to the Contract for purposes of compliance with the terms of the Contract for a record retention period of 7 years.

Additionally, Contract Section 6.7(a) requires the issuer to “develop, operate and maintain viable systems, processes, and procedures for the timely, accurate and valid enrollment and termination of Enrollee coverage.”

As part of BCBSTX’s enrollment processes, it is required to investigate and resolve complaints of dissatisfaction related to insurance offerings on the FFM. These complaints, or cases, are forwarded to BCBSTX by HHS through a case management system known as HICS.

We reviewed a judgmental sample of 40 HICS cases from 2014. Based on our review, we could not determine the accuracy of one case because BCBSTX did not provide sufficient documentation to support the actions taken to resolve the case. This case involved questions related to the affected member’s APTC. If this case was not accurately processed, then the affected member may not have had accurate billings and premium payments in 2014.

### **Issuer Response**

*BCBSTX agreed with the finding, noting that the documentation to support the case was unavailable. BCBSTX added that its HICS processes were subsequently modified to require that not only detailed documentation be maintained, but also clarifying comments be included in responses to CMS.*

### **OIG Comment**

We were unable to verify that BCBSTX made the cited modifications to its HICS processes. BCBSTX's policy and record retention schedule require enrollment records and data to be retained for at least 10 years after the event. In addition, member complaints and inquiries are required to be retained for 11 years. However, HICS cases are not specifically listed as a record category for these requirements. The policy and record retention schedule also do not indicate the level of detail required for the documentation to be maintained, nor does it include any direction regarding requirements for clarifying comments to CMS.

### **Recommendation 5**

We recommend that the Contracting Officer verify that BCBSTX made the appropriate procedural updates to maintain and make available appropriate documentation for HICS cases, in compliance with Contract MSPP-2014 Sections 2.7 and 7.12.

### **Recommendation 6**

We recommend that the Contracting Officer direct BCBSTX to determine if the affected member received accurate billings for premium payments in 2014, and take appropriate corrective actions if necessary.

## **B. RATES AND BENEFITS**

Based on our review, we concluded that BCBSTX is in compliance with the Contract and applicable criteria for pharmacy drug benefits.

## **C. INTERNAL CONTROLS**

Based on our review, we concluded that BCBSTX is in compliance with the Contract and applicable criteria for internal controls, except where otherwise noted in the enrollment and contract quality assurance findings disclosed in this report.

## D. CONTRACT QUALITY ASSURANCE

### 1. Claims Processing Accuracy Metric

### Procedural

BCBSTX processed 91.8 percent of MSP medical claims accurately in 2014, which is not in compliance with the claims processing accuracy standard required by the Contract.

Contract Section 2.1(f)(3)(i) requires the issuer to “process no less than 95 percent of MSP medical claims accurately” and to “report the number of MSP medical claims processed accurately, the total number of MSP medical claims processed, and the resulting percentage” to OPM on an annual basis.

BCBSTX reported to OPM that it processed 91.8 percent of claims accurately in 2014, based on a review of 122 randomly sampled claims. Of these 122 claims, BCBSTX identified 10 claims that were not processed correctly, preventing BCBSTX from meeting the 95 percent quality standard required by the Contract.

Two of the 10 claims were processed incorrectly because of system errors within the benefit coding that allowed copays to be misapplied. As a result of these system errors, providers were either overpaid or underpaid and the patient share was misapplied. According to BCBSTX, the benefit coding was updated in its system to ensure that benefits and copays paid properly. BCBSTX also adjusted the claims that were processed incorrectly, as applicable.

**Due to system/human errors, BCBSTX did not meet OPM’s claims processing standard of 95% in 2014.**

The remaining eight claims were processed incorrectly due to human errors made when manual intervention was required. In these cases, the claims processors did not appear to follow existing procedures and system prompts when manually processing the claims. This resulted in mistakes made to communications sent to providers; provider payments; claims denials; application of deductibles and patient-share amounts; and assignment of claims to members under a subscriber's policy. According to BCBSTX, it directed claims processors to review existing procedures and follow system prompts. In addition, it adjusted the claims that were processed incorrectly, as applicable.

Although BCBSTX took corrective actions to address these errors, controls that BCBSTX has in place may not be sufficient to mitigate the inherent risk of performing manual processes. As noted, BCBSTX did have procedures in place for manual claims processes, but the processors did not follow the existing guidance. This may be due in part to processors who were inexperienced in manual claims processing and did not receive the proper training or supervision. BCBSTX explained that the increased volume of claims requiring manual intervention in 2014 necessitated additional personnel to be given permission to perform manual calculations. However, BCBSTX indicated that training was an issue with the additional personnel. According to BCBSTX, training was performed only on an ad hoc basis and did not begin until July 2014. BCBSTX also

stated that supervisory review of manual calculations was not performed before claims were released for payment, with the exception of claims over \$50,000.

### **Issuer Response**

*BCBSTX agreed with the finding and stated that it has a process in place to continue monitoring and reporting BCBSTX's claims processing accuracy. BCBSTX also stated that it implemented additional action items in 2014 and 2015 to continuously improve quality results. These actions include increased sample sizes for monthly claims reviews; structured monthly meetings between the QAI team and the claims processing department to review and discuss performance; discussion of MSP Program trends in monthly Divisional Quality Council - Claims meetings; and use of designated operators for BCBSTX MSPP audits. In addition, BCBSTX stated that it formalized its training process, has supervisors discuss results of monthly QAI reviews with employees and take performance actions as needed, and performs monthly system updates.*

### **OIG Comment**

Because BCBSTX's response to the draft report was largely narrative, we cannot verify all of the corrective actions cited by BCBSTX. BCBSTX does appear to be actively monitoring and improving claims processing accuracy. Based on documentation provided in support of its response, BCBSTX updated the sampling strategy for its monthly claims reviews in 2016, based on 2015 performance. The strategy also indicates that QAI discusses MSP Program trends and results with MSP Program operations leadership. In addition, BCBSTX provided an example of a monthly tracking sheet that identifies the number of claims sampled, findings, and corrective actions taken. However, we cannot verify that BCBSTX has implemented formalized training, supervisory review, and system update initiatives.

### **Recommendation 7**

We recommend that the Contracting Officer continue to monitor BCBSTX's claims processing accuracy via its annual reports to OPM in order to verify that BCBSTX continues to improve and ultimately meet the accuracy metric.

### **Recommendation 8**

We recommend that the Contracting Officer verify that BCBSTX has formalized its training process for operators who are given access to manual claims processing, to include review of documented training policies and procedures.

**Recommendation 9**

We recommend that the Contracting Officer verify corrective actions that BCBSTX has put into place to address supervisory reviews of claims processors, to include documented policies and procedures for the actions taken.

**Recommendation 10**

We recommend that the Contracting Officer verify that BCBSTX made the appropriate system updates to address the system-related errors identified in 2014.

**2. Enrollment Processing Timeliness Metric**

**Procedural**

BCBSTX issued 88 percent of enrollment packages within 30 calendar days of the effective date of coverage in 2014, which is not in compliance with the enrollment processing timeliness standard required by the Contract.

Contract Section 2.1(f)(3)(ii)(B) and Appendix E 6 require no less than 99 percent of the ID cards and enrollment information packages to be issued to MSP Enrollees within 30 calendar days after the effective date of coverage.

BCBSTX reported to OPM that 88 percent of enrollment packages were issued within 30 days after the effective date of coverage. The report indicated that 3,113 enrollment information packages were issued untimely, preventing BCBSTX from meeting the 99 percent quality standard required by the Contract. Because these packages were issued untimely, affected enrollees may not have had important benefit coverage information when it was needed.

**Due to process delays/quality of data issues, 3,113 members did not receive important benefit coverage information on time.**

According to BCBSTX, enrollment packages, or fulfillment kits, were issued untimely due to problems with the quality of data from the Marketplace, which necessitated manual processes to complete enrollment transactions before the kits could be issued. BCBSTX also cited delays in the receipt of approvals from the Texas Department of Insurance (TDI) that were necessary to complete the packages. However, BCBSTX’s fulfillment kit production process also appears to have caused significant delays in providing the enrollment information to enrollees.

BCBSTX cannot issue health benefit policies, which are included in the fulfillment kits, until the policies have been approved by the TDI. As a result of updates to external review language mandated by OPM in an MSP Program Administration Letter dated November 27, 2013, the TDI had to review the updated policies with the revised external review language before BCBSTX could issue fulfillment kits for the affected policies. BCBSTX reported that it did not receive these approvals until December 16, 2013, at which point the production process was initiated. This process, which was not formally documented, consists of 12 steps requiring up to 10 weeks to complete, according to

BCBSTX. Based on information provided by BCBSTX, this delayed the release of fulfillment kits by 57 to 107 days after receiving the requisite approvals from the TDI.

BCBSTX indicated that it is currently taking corrective action to address timeliness issues through system initiatives and updates to controls and policies for enrollment processes, including fulfillment kits. In the 2014 Contract Quality Assurance Report provided to OPM, the Association also noted that the stabilizations of the regulatory environments have reduced regulatory delays with regards to the welcome kits. The Association further suggested that the online posting of welcome packages has reduced the delay in making the enrollment information available to enrollees. However, we did not verify that BCBSTX has posted this information to their website.

### **Issuer Response**

*BCBSTX agreed with the findings based on the 2014 contract year. BCBSTX stated that it will continue to monitor enrollment timeliness metrics on a monthly basis and take any action needed to ensure that the appropriate operational processes are in place to improve and ultimately meet the timeliness metric. In addition, BCBSTX stated that it has already implemented corrective actions by enhancing operational processes to improve enrollment timeliness results and validating that policy fulfillment kits have been and continue to be available to members on all plan websites.*

### **OIG Comment**

Because BCBSTX's response to the draft report was largely narrative, we cannot verify the corrective actions cited by BCBSTX. BCBSTX does appear to be actively working to improve enrollment processing timeliness, based on a matrix of improvements made to various new enrollee processes; however, we cannot verify the effectiveness of these improvements or if process updates were included in formal policies and procedures. We also cannot verify that the policy and benefit information from the fulfillment packages are posted to BCBSTX's website.

### **Recommendation 11**

We recommend that the Contracting Officer continue to monitor BCBSTX's enrollment processing timeliness via its annual reports to OPM to verify that BCBSTX continues to improve and ultimately meet the timeliness metric.

### **Recommendation 12**

We recommend that the Contracting Officer verify that BCBSTX updated controls and formal policies and procedures to streamline the fulfillment process and reduce production time.

### **Recommendation 13**

We recommend that the Contracting Officer verify that policy and benefit information from the fulfillment packages is posted to BCBSTX's website.

## **E. PROGRAM IMPROVEMENT AREA**

### **1. Termination of Enrollee Coverage Benefit Brochure Language                      Procedural**

BCBSTX did not provide notices for the termination of coverage to MSP members 30 days prior to the last day of coverage in 2014. Although not directly a violation of the Contract or applicable regulations, language in BCBSTX's benefit brochures may confuse the member by giving them false expectations in regards to the timing of these notices. As such, we identified this as an area of improvement and are recommending corrective action.

BCBSTX's benefit brochures, which are provided to the members, state that if coverage is terminated for any reason, BCBSTX will provide a notice of such termination at least 30 days prior to the last day of coverage.

Based on our review of 48 enrollment termination transactions, BCBSTX is not abiding by the timeframe for termination of coverage notices presented in its benefit brochures. However, in most cases, compliance with the timeframe would not have been feasible. Specifically, in cases when an enrollee requested termination of coverage, the effective date of termination could be as early as 14 days from the date of the request, per regulation. In addition, when coverage was terminated due to non-payment of premiums, the application of mandated regulatory grace periods meant that termination effective dates were retroactive. In these cases, BCBSTX could not notify members 30 days in advance of the last day of coverage. Therefore, the wording of the benefit brochures may inadvertently mislead members by indicating that they will receive a termination of coverage notice in advance of termination.

#### **Issuer Response**

***BCBSTX agreed with the finding based on the 2014 contract year. According to BCBSTX, it has updated the language for termination of coverage in the benefit booklets to accurately reflect the process and timing of these notices. BCBSTX stated that it is currently awaiting regulatory approval for the proposed modifications, which were sent to CMS and the TDI for review on May 11, 2016.***

#### **OIG Comment**

We verified that the new language adequately clarifies the nature and timing of the notices for termination of coverage based on a sample MSP benefit brochure.

**Recommendation 14**

We recommend that the Contracting Officer verify that BCBSTX implements the revised language for termination of coverage notices in its MSP benefit brochures after BCBSTX receives the requisite regulatory approvals.



# IV. MAJOR CONTRIBUTORS TO THIS REPORT

## COMMUNITY-RATED AUDITS GROUP

[REDACTED], Auditor-in-Charge

[REDACTED], Lead Auditor

[REDACTED], Auditor

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[REDACTED], Senior Team Leader

[REDACTED], Group Chief

# EXHIBIT A

## Invoice Review Sample Selection Criteria and Methodology

Review	Universe Criteria	Universe (Number)	Sample (Number)	Sample Selection Methodology	Sample Type	Results Projected to the Universe?
Internal Controls over MSP Member Invoices	MSP Member Invoices from August 2014	██████	44	Assigned a number to each MSP member invoice in the universe and used a random number generator from Random.org to select a cross-section of invoices as follows: 26 samples from the rating areas (1 invoice per rating area); 5 samples from invoices addressed to other states; 5 samples for which the invoice did not identify rating area/state; 3 samples based on group number from invoices for members who cancelled effectuated policies; and 5 samples based on group number from consolidated (multi-month) invoices.	Judgmental	No

# EXHIBIT B

## Enrollment Review Sample Selection Criteria and Methodology

Review	Universe Criteria	Universe (Number)	Sample (Number)	Sample Selection Methodology	Sample Type	Results Projected to the Universe?
Enrollment Fallout Work Items	2014 MSP Enrollment Fallout Work Items	█	34	Assigned a number to work items within specific fallout work types and used a random number generator from Random.org to select a cross-section of fallout work items as follows: 10 fallout work items for each work type with over 1,000 fallouts (10 samples); 5 fallout work items for each work type with 100 - 999 fallouts (20 samples); 1 fallout work item for each work type with 2-99 fallouts (4 samples).	Judgmental	No
HICS Cases	2014 MSP HICS Cases	█	40	Selected 10 cases (first case, then every 160 <sup>th</sup> case) from the HICS subcategory with the largest case volume. Selected 25 cases (first case, then every 9 <sup>th</sup> , 24 <sup>th</sup> , 31 <sup>st</sup> , 38 <sup>th</sup> , or 39 <sup>th</sup> case, defined by subcategory) from the 5 HICS subcategories with the next highest case volumes. Selected an additional 5 samples from HICS subcategories with less than 40 cases based on nomenclature (first case in the subcategory was selected).	Judgmental	No
Termination of Enrollee Coverage	2014 MSP Coverage Termination Transactions	█	48	Selected first transaction and then every 245 <sup>th</sup> transaction resulting in 36 samples. Selected an additional 12 samples based on nomenclature, including the first transaction from each of the termination reasons not represented within the original sample and the first four transactions for which the termination reason was not identified.	Judgmental	No

# APPENDIX



Federal Employee Program  
1310 G Street, N.W.  
Washington, D.C. 20005  
202.626.4800

June 17, 2016

[REDACTED], Senior Team Leader  
Community-Rated Audits Group  
U.S. Office of Personnel Management  
Office of the Inspector General  
800 Cranberry Woods Drive  
Suite 270  
Cranberry Township, Pennsylvania 16066

**Reference: OPM Draft Audit Report of the Multi-State Plan Program Operations  
Blue Cross Blue Shield of Texas Audit Report Number 1M-0D-00-16-  
001 (Dated and received April 7, 2016)**

Dear [REDACTED]:

This is the BCBSA response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Multi-State Plan Program operations at Healthcare Service Corporation (Texas).

Our comments concerning the findings in the report are as follows:

## **A. ENROLLMENT REVIEW**

### **1. Enrollment Termination Policies and Procedures**

**Procedural**

#### **Recommendation 1**

We recommend that the Contracting Officer direct BCBSTX to develop documented policies and procedures for the termination of enrollee coverage that more specifically align with requirements in the issuer's Contract with OPM and 45 CFR §156.270.

This includes standard operating procedures for termination of enrollee coverage for reasons other than non-payment; notifying HHS of non-payment for APTC members; the timely and accurate termination of enrollee coverage; and the manner and timing in which it will notify enrollees of delinquency and termination.

**Plan Response:**

The Plan agrees with the draft report's finding, which was based on the 2014 contract year. However, the Plan has implemented corrective actions to satisfy this recommendation which has improved and strengthened the Plans policies, procedures, trainings and technology related to the terminations of enrollee coverage due to non-payment of premium and notification of such.

In September 2015, the Plan created a formal enterprise policy documenting grace period management for non-payment of premium in accordance with all federal and applicable state requirements as they pertain to individual Plans sold both on and off exchange, "Grace Periods for Non-Payment of Premiums Policy #: 05.BIL.002" Attached. To address terminations of coverage for reasons other than non-payment of premiums, the Plan created formal enterprise policies, "Termination of Coverage – Retail, #05.MGS.001" and "Termination of Coverage – SHOP, #05.MGS.009" Attached. These policies document procedures for terminations of coverage initiated by the Federally-facilitated Marketplace, HCSC, the enrollee, and receipt of an 834 termination transaction. Along with these policies, the Plan also created corresponding standard operating procedures, two of which, "Retail Billing U65 Delinquency Automation.pdf" and "Retail Billing U65 ACA Delinquency Control Procedure.pdf"- Attached. These policies further document grace period management, including such details as: grace period duration, notification methods and timing, and timely/accurate termination of enrollee coverage.

Formal training and re-training has been conducted relative to these SOPs. In addition, a quality assessment improvement (QAI) Program was implemented to measure the accuracy and timeliness of manual activity within the grace period administration space. Current QAI scores are at 99% for the department. Finally, automation technology was implemented in September 2015 transitioning a number of previously manual activities (e.g. reminder notifications, grace period duration, coverage record termination, and record retention) into the core membership platform thus enhancing timeliness, accuracy, and auditability.

The following documents are produced in support of the Plan's response:

- Grace Periods for Non-Payment of Premiums Policy #: 05.BIL.002
- Termination\_Policy\_Draft\_v2RPO.pdf – Retail, #05.MGS.001
- Termination of Coverage – SHOP, #05.MGS.009

- RMO Processing On Exchange Member Request for an OFF Exchange Policy (Last updated 2014).pdf
- RMO Cancelling a Policy- Guideline (Last updated 2014).pdf
- RMO Cancelling an Account in VMS (Last updated 2014).pdf
- RMO Processing Reinstatements for Qualified Health Plans – Guideline (Last Updated 2014).pdf
- Retail Billing U65 Delinquency Automation.pdf
- Retail Billing U65 ACA Delinquency Control Procedure.pdf

## 2. Enrollment Termination Processing

**Procedural**

### **Recommendation 2**

We recommend that the Contracting Officer direct BCBSTX to develop and implement procedures and controls for the timely and accurate termination of enrollee coverage in compliance with the Contract and applicable regulations

#### **Plan Response:**

The Plan agrees with the draft report's finding, which was based on the 2014 contract year. However, the Plan has implemented corrective actions that satisfy this recommendation which has improved and strengthened the Plans policies, procedures, trainings and technology related to the terminations of enrollee coverage due to non-payment of premium and notification of such. See Plan response for recommendation 1

### **Recommendation 3**

We recommend that the Contracting Officer direct BCBSTX to send notification letters in compliance with 45 CFR §156.270(b) (1) and its own process as stated in the benefit brochures.

#### **Plan Response:**

The Plan has reviewed and modified its procedures to ensure compliance with 45 CFR §156.270(b) (1) and its own process as stated in the benefit brochures See additional documentation provided in response to recommendation

### **Recommendation 4**

We recommend that the Contracting Officer direct BCBSTX to enforce applicable grace periods in accordance with 45 CFR §156.270(g), CMS guidance, the State of Texas Insurance Code, and its own process as stated in the benefit brochures.

**Plan Response:**

Please reference the Plan's response to Recommendation 1 for enhancements to the enrollment process.

**Recommendation 5**

We recommend that the Contracting Officer direct BCBSTX to send consistent delinquency notifications in compliance with 45 CFR §156.270(f).

**Plan Response:**

Please reference the Plan's response to Recommendation 1 for enhancements to the enrollment process.

**DELETED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT**

**Recommendation 6**

We recommend that the Contracting Officer direct BCBSTX to comply with guidance related to the effective dates for termination of coverage as stated in 45 CFR §155.430(d).

**Plan Response:**

With respect to terminations initiated by members under 45 CFR §155.430(d) (2) (i), the Plan agrees with the draft report's findings, which were based on the 2014 contract year. However, the Plan has implemented corrective actions that satisfy this recommendation, which has improved and strengthened the Plans policies, procedures, trainings and technology related to the terminations of enrollee coverage due to non-payment of premium and notification of such.. See Plan response for recommendation 1 as well as the document RMO Finding the Status of ON Exchange Cancellations.pdf, Attached.

With respect to terminations of members who receive advance payment of premium tax credits ("APTC members") under 45 CFR §155.430(d) (4), The Plan agrees with the draft report's findings, which were based on the 2014 contract year. However, the Plan has implemented corrective actions that satisfy this recommendation, which has improved and strengthened the Plans policies, procedures, trainings and technology related to the terminations of enrollee coverage due to non-payment of premium and notification of such.. See Plan response for recommendation 1.

**DELETED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT**

## **Recommendation 7**

We recommend that the Contracting Officer direct BCBSTX to maintain and make available appropriate documentation for terminations of coverage, in compliance with the Contract Sections 2.7 and 7.12.

### **Plan Response:**

See Plan response to Recommendation 1, specifically the reference to updates to automation technology, as well as line 162 in the ERRS.pdf document, attached in support of the Plan's response.

## **Recommendation 8**

We recommend that the Contracting Officer verify that the effective dates for termination of coverage for two unsupported members were in accordance with 45 CFR §155.430(d).

### **Plan Response:**

The plan agrees with the finding that documentation for the two members is no longer available. However, BCBSTX has enhanced its policy for handling member terminations. In support of this policy, 14 procedures have been either created or updated to ensure that members are terminated timely, in accordance with applicable regulatory requirements and that sufficient documentation is retained in each instance. Please see the following documents provided in support of the Plan's response:

- RMO Cancelling Dental Coverage - Guideline.pdf
- RMO Changing a Termination Date or a Termination Reason in VUI.pdf
- RMO Correcting the Coverage Termination Date for a Dependent in VMS.pdf
- RMO Determining Letters for Transaction Type Cancellation of Policy.pdf
- RMO Processing HICS Cancellations.pdf
- RMO Processing Resolve MMT Cancel Term Exception Work Items.pdf
- RMO Processing Resolve MMT Exception Work Items.pdf
- RMO Terminating a Dependent From an Account in VMS.pdf
- RMO Terminating a Dependent in VUI.pdf
- RMO Terminating a Policy Guideline.pdf
- RMO Terminating a Single Line of Business (Dental or Medical) from an Account in VMS.pdf
- RMO Terminating an Account in VMS.pdf
- RMO Terminating Dental Policies in VUI.pdf
- RMO Terminating Policies and Accounts in VUI.pdf



- Termination of Coverage - Retail Policy.pdf
- Corporate Records & Information Management Policy No. 9.01.pdf

**Recommendation 9**

We recommend that the Contracting Officer verify the accuracy and appropriateness of termination transactions for six members whose termination reason codes were subsequently changed.

**Plan Response:**

The plan agrees with the finding that documentation for the six members is no longer available. However, BCBSTX has enhanced its policy for handling member terminations. In support of this policy, 14 procedures have been either created or updated to ensure that members are terminated timely, in accordance with applicable regulatory requirements and that sufficient documentation is retained in each instance. Please reference the documents provided in support of the Plan’s response to Recommendation 8.

**Recommendation 10**

We recommend that the Contracting Officer direct BCBSTX to establish, implement, and document personnel training related to processing terminations of coverage.

**Plan Response:**

The Plan disagrees. In 2014, BCBSTX Learning & Development department conducted personnel training related to processing terminations of coverage, titled Member Maintenance Transactions (“MMT”) Training. The MMT Training trained personnel on member maintenance transactions on the Vantage User Interface (“VUI”) system and wizards. The Plan has attached the document VUI Processing Wizard Transactions Leader Guide\_02072014.pdf as support. This is the facilitator guide that is used in the MMT Training

Respondent ID	Session ID	Training Topic	Type	Start	End
3484750393	SGUZ0825141	MMT Training	in-class	8/25/2014	9/26/2014
3598786516	SGUZ1027141	MMT Training	in-class	10/27/2014	11/21/2014

**3. Enrollment Fallout Work Item Processing**

**Procedural**

**DELETED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT**

**Recommendation 12**

We recommend that the Contracting Officer verify that the enrollment fallout work items, which were not adequately supported, were processed timely and accurately, as appropriate.

### **Plan Response**

#### **DELETED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT**

For Sample 32, the Plan **agrees** that the enrollment fallout work item was *not processed timely* and that *the member's enrollment was processed 17 days after the effective date*. The Plan also **agrees** that *there is no documentation to support whether the manual decision indicator was checked by the processor*.

#### **DELETED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT**

### **Recommendation 13**

We recommend that the Contracting Officer direct BCBSTX to review its controls over manual enrollment processes and update them as necessary to ensure the timely and accurate processing of enrollment fallout work items.

### **Plan Response**

The Plan has implemented corrective actions to satisfy this recommendation by establishing daily automated controls in mid-2015 that are monitored. These controls balance the transactions between systems to ensure that each transaction is appropriately dispositioned.

The following documents are attached in support of the Plan's response:

- Enrollment Control Monitoring Timeline\_v2.0.pdf, which is a summarized timeline of changes made.
- Enrollment Control Monitoring v7.205.11.2015.pdf, which captures the dashboard level instructions for enrollment control monitoring.

## **4. HICS CASE PROCESSING**

**Procedural**

### **Recommendation 14**

We recommend that the Contracting Officer direct BCBSTX to maintain and make available appropriate documentation for HICs cases, in compliance with Contract Sections 2.7 and 7.12.

### **Plan Response**

The Plan agrees with this recommendation. The Plan's HICS processes have been modified since the time that the cases cited by the OIG were processed.

The process now requires that detailed documentation be saved and clarifying comments are included in the Plan's response back to CMS.

Please reference the Plan's response to Recommendation 7, specifically line 162 in the document (ERRS.pdf) produced in support of the Plan's response.

### **Recommendation 15**

We recommend that the Contracting Officer verify that the two HICS cases were processed accurately.

### **Plan Response**

The Plan does not have the documentation to support the processing of HICS case E1400825468.

## **DELETED BY THE OIG – NOT RELEVANT TO THE FINAL REPORT**

### **B. RATES AND BENEFITS REVIEW**

No recommendations

### **C. INTERNAL CONTROLS**

No Recommendation

### **D. CONTRACT QUALITY ASSURANCE**

**Procedural**

#### **1. Claims Processing Accuracy Metric**

### **Recommendation 16**

We recommend that the Contracting Officer continue to monitor BCBSTX's claims processing accuracy via its annual reports to OPM in order to verify that BCBSTX continues to improve and ultimately meet the accuracy metric.

### **Plan Response**

The Plan agrees and has a process in place to continue to monitor and report BCBSTX's claims processing accuracy. During 2014 and into 2015 additional action items were implemented to continuously improve quality results. For example, the Plan's Quality Assessment and Improvement (QAI) team reviewed the Plan performance for 2014 and combined with the results of first quarter 2015, the sample size was increased from 10 randomly sampled claims to 20 randomly sampled claims per month. Additionally, QAI partnered with the claims processing department and scheduled structured monthly meetings to review and discuss performance. QAI included BCBSTX MSPP trending in the

monthly Divisional Quality Council - Claims meeting. It was also recommended by QAI that the claims processing department secure the work for BCBSTX MSPP audits to a designated group of operators; this was implemented in June 2015.

As a result of these improvements, in the first quarter of 2016, there were two findings cited from a sample of 124 claims and the accuracy rate was 98.39%.

The 2016 MSPP Sampling Methodology.pdf and Copy of April 2016.pdf. Documents are attached in support of the Plan's response.

### **Recommendation 17**

We recommend that the Contracting Officer direct BCBSTX to conduct more structured and regularly scheduled training with processors who perform manual claims processing.

### **Plan Response**

The Plan implemented corrective actions to satisfy this recommendation in 2015, by formalizing its training process. The Learning and Development team is engaged in facilitating these training sessions for operators who are given manual calculation access. After an operator receives this training, the claims processing department will perform focused audits on claims that have been manually calculated by employees newly trained on manual calculations for a defined period of time ("FYI Period"). The FYI period usually audits 15 sample claims. This FYI period allows for assessment of an operator's ability to consistently achieve quality claim outcomes. Small group meetings dedicated to discussing manual calculations have also been implemented. Additionally, there is a current initiative underway to have monthly meetings on manual calculations. Finally, supervisors meet individually with their team members to discuss any areas where additional education on this process would be beneficial.

### **Recommendation 18**

We recommend that the Contracting Officer direct BCBSTX to implement supervisory reviews of claims processed by inexperienced processors who perform manual claims processing.

### **Plan Response**

The Plan has implemented corrective actions to satisfy this recommendation as referenced in response to Recommendation 16. In addition to the collaboration with QAI as referenced in response to recommendation 16, claims supervisors meet individually with claim operators every month to discuss quality results. If

an operator incurred a finding related to manual claims processing, the supervisor makes sure the root cause of the error is understood so that a repeat mistake is not made. In addition to standard quality sample audits, any operator who has access to perform manual calculations will have four additional audits pulled each month by QAI. Formal performance management action is taken (including possible removal of this access) if an operator's manual calculation quality performance falls below the established threshold. An operator's supervisor maintains a scorecard that documents the supervisor's feedback and the operator's error findings, audit results, and other findings or issues related to the operator's quality and production results. Overall, these scorecards are used to document and substantiate any performance management actions.

### **Recommendation 19**

We recommend that the Contracting Officer verify that BCBSTX made the appropriate system updates to address the system related errors identified in 2014.

### **Plan Response**

The Plan agrees with the draft report's findings, which were based on the 2014 contract year. However, the Plan has already satisfied the recommendation by performing monthly system updates during 2014 and 2015 to address the system related errors. Corrections made to accurately apply benefits related to copay and coinsurance amounts have been completed.

The following documents are produced in support of the Plan's response:

- 2014 MSPP Error Detail Report.xlsx
- #19, Errors & system corrections.pdf

## **2. Enrollment Processing Timeliness Metric**

### **Recommendation 20**

We recommend that the Contracting Officer continue to monitor BCBSTX's enrollment processing timeliness via its annual reports to OPM to verify that BCBSTX continues to improve and ultimately meet the timeliness metric.

### **Plan Response**

BCBSTX will continue to monitor enrollment timeliness metrics on a monthly basis and take any action as needed to ensure that the appropriate operational processes are in place to improve and ultimately meet the timeliness metric.

## Recommendation 21

We recommend that the Contracting Officer verify that BCBSTX updates controls and policies to streamline the fulfillment process and reduce production time.

### Plan Response

The Plan agrees to continue monitoring enrollment timeliness metrics; however the Plan has already implemented corrective actions to satisfy this recommendation by implementing enhanced operational processes to improve enrollment timeliness results, as follows:

Doc Type	Improvement Made
PF Kits	<ul style="list-style-type: none"> <li>• Streamlined fulfillment kit compilation process.               <ul style="list-style-type: none"> <li>• Collaborated with Contract Admin to provide one combined PDF for all filed documents. This reduced the time needed for Open Enrollment testing to ensure timely kit delivery in production environment.</li> <li>• Partnered with Contract Admin to ensure all approved documents were print ready to reduce testing rework.</li> <li>• Created a team room to store approved documents ensuring document accuracy.</li> </ul> </li> <li>• Enhanced fulfillment system to further define PF kit errors to quickly identify and resolve issues.               <ul style="list-style-type: none"> <li>• Added new sub-statuses to allow users to easily identify errors.</li> <li>• Redefined error statuses and sub-statuses to allow accurate processing of fulfillment kits.</li> <li>• Added functionality to automatically cancel invalid requests such as requests on terminated policies.</li> <li>• Added new search criteria and the ability to control search results.</li> </ul> </li> <li>• Introduced process combining efforts from IT and Operations to review daily PF kit errors and resolve all issues timely.</li> <li>• Prioritized MSP products for PF Kit release strategy during Open Enrollment to ensure timely MSP kit delivery.</li> </ul>
Doc Type	Improvement Made
ID Cards	<ul style="list-style-type: none"> <li>• Enhanced fulfillment system to further define ID card errors to quickly identify and resolve issues.               <ul style="list-style-type: none"> <li>• Added new sub-statuses to allow users to easily identify errors.</li> <li>• Redefined error statuses and sub-statuses to allow accurate processing of ID cards.</li> <li>• Added functionality to automatically cancel invalid requests such as requests on terminated policies.</li> <li>• Added new search criteria and the ability to control search results.</li> </ul> </li> <li>• Introduced process combining efforts from IT and Operations to review daily ID card errors and resolve all issues timely.</li> </ul>
SBCs	<ul style="list-style-type: none"> <li>• Created manual reconciliation reporting process to ensure timely delivery of SBC's.</li> <li>• Introduced process combining efforts from IT and Operations to review and resolve SBC discrepancies timely.</li> </ul>

## **Recommendation 22**

We recommend that the Contracting Officer verify that policy and benefit information from the fulfillment packages are posted to BCBSTX's website.

### **Plan Response**

The Plan agrees with the draft report's finding, which was based on the 2014 contract year. However, the Plan has already implemented corrective actions to satisfy this recommendation by validating that policy fulfillment kits have been and continue to be available to members on all Plan websites.

## **E. PROGRAM IMPROVEMENT AREA**

### **1. Termination of Enrollee Coverage Benefit Brochure Language**

#### **Recommendation 23**

We recommend that the Contracting Officer advise BCBSTX to update the language for termination of coverage notices in its benefit brochures to accurately reflect the process and timing of these notices.

#### **Plan Response**

The Plan agrees with the draft report's finding which were based on the 2014 contract year. However, the Plan has already implemented corrective actions to satisfy this recommendation by updating the language for termination of coverage in the Benefit Booklets to accurately reflect the process and timing of these notices. Proposed modifications were sent to CMS and the Texas Department of Insurance for review on May 11, 2016 and the Plan is awaiting regulatory approval. Attached, please find a sample MSPP booklet which contains the new member termination language on the 57<sup>th</sup>, 58<sup>th</sup>, 131<sup>st</sup> and 132<sup>nd</sup> pages of the PDF attached and titled EOC-TX-I-HMO-MSPP-5-11-QHP.pdf.

We appreciate the opportunity to provide our response to this Draft Audit Report and request that our comments be included in their entirety as an amendment to the Final Audit Report.



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