



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

Final Audit Report

**GLOBAL AUDIT OF VETERANS AFFAIRS CLAIMS
FOR BLUE CROSS AND BLUE SHIELD PLANS**

Report Number 1A-99-00-16-021
February 28, 2018

OFFICE OF
PERSONNEL MANAGEMENT

EXECUTIVE SUMMARY

Global Audit of Veterans Affairs Claims

Report No. 1A-99-00-16-021

February 28, 2018

Why Did We Conduct the Audit?

The objectives of our audit were to determine whether the 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 BCBS plans complied with contract provisions with regard to claims paid to the U.S. Department of Veterans Affairs (VA).

What Did We Audit?

The Office of the Inspector General has completed a limited scope performance audit of the FEHBP operations at all BCBS plans. The audit covered claim payments from January 1, 2013, through October 31, 2015, as reported in the Association's Government-wide Service Benefit Plan Annual Accounting Statements. Specifically, we identified claims from this period that were made to VA medical providers where the amount paid to the provider was greater than or equal to the amount billed by the provider.



Michael R. Esser
*Assistant Inspector General
for Audits*

What Did We Find?

Veterans that are also enrolled in the FEHBP may use their FEHBP benefits at VA medical service providers (e.g., a VA hospital). Our audit identified claim payment errors that we believe are indicative of systemic problems with the Association's administrative procedures for the processing of FEHBP claims paid to VA medical providers. We are recommending several system and policy enhancements that would result in significant cost savings to the FEHBP.

Our audit concludes that the overall processing of FEHBP VA claims by the BCBS plans does not appear to comply with the terms of its contract with the U.S. Office of Personnel Management and the Federal Acquisition Regulation. The Association and the BCBS plans lack the necessary controls to ensure that reasonable rates are paid to VA providers on behalf of the FEHBP. We determined that the Association and/or plans paid 77 percent of the VA claims reviewed during our audit at or above the full amount billed by the provider - **even though they had the option to pay the claims at a lower rate.** Specifically, the BCBS plans could have paid these claims using the plan's local "usual, customary, and reasonable" rate or by negotiating a lower payment rate with the VA.

This report questions \$58,023,161 in health benefit charges, the majority of which relate to the BCBS plans unreasonably paying VA claims.

ABBREVIATIONS

APM	Administrative Procedures Manual
Association	Blue Cross Blue Shield Association
BCBS	Blue Cross Blue Shield
CFR	Code of Federal Regulations
FAM	Federal Employee Program Administrative Manual
FAR	Federal Acquisition Regulation
FEHB	Federal Employees Health Benefits
FEHBP	Federal Employees Health Benefits Program
FEP	Federal Employee Program
FEP Express	Association's nation-wide claims processing system
Non-Par	Providers that do not contract with BCBS
OBRA 90	Omnibus Budget Reconciliation Act of 1990
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plans	Blue Cross and Blue Shield Plan(s)
PPO	Preferred Provider Organization
UCR	Usual, Customary, and Reasonable
VA	U.S. Department of Veterans Affairs

TABLE OF CONTENTS

	<u>Page</u>
EXECUTIVE SUMMARY	i
ABBREVIATIONS	ii
I. BACKGROUND	1
II. OBJECTIVES, SCOPE, AND METHODOLOGY	3
III. AUDIT FINDINGS AND RECOMMENDATIONS	6
Veterans Affairs Claims Review	6
APPENDIX A: Blue Cross Blue Shield Association’s May 23, 2017, response to the Second Draft Audit Report, issued April 25, 2017.	
APPENDIX B: Blue Cross Blue Shield Association’s April 15, 2016, response to the Draft Audit Report, issued February 4, 2016.	
REPORT FRAUD, WASTE, AND MISMANAGEMENT	

I. BACKGROUND

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at all Blue Cross and/or Blue Shield (BCBS) plans. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations. Health insurance coverage is made available through contracts with various health insurance carriers.

The Blue Cross Blue Shield Association (Association), on behalf of participating BCBS plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. There are 36 BCBS companies participating in the FEHBP. The 36 companies are comprised of 64 local BCBS plans.

The Association has established a Federal Employee Program (FEP¹) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BCBS plans, and OPM.

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

¹ Throughout this report, when we refer to "FEP," we are referring to the Service Benefit Plan lines of business at the Plan(s). 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 each Plan's management. Also, management of each BCBS plan is responsible for establishing and maintaining a system of internal controls.

This is our first global audit of claims paid to the U.S. Department of Veterans Affairs (VA). Therefore, there were no previous findings to resolve.

Our sample selections and preliminary audit results of the potential claim errors paid to VA service providers were presented to the Association in a draft report, dated February 4, 2016. We issued a second draft audit report, dated April 25, 2017, to provide the Association and BCBS plans an additional opportunity to more directly address our concerns. The Association's comments offered in response to the draft reports were considered in preparing our final report and are included as Appendices to this report. Also, additional documentation provided by the Association and BCBS plans on various dates through July 7, 2017, was considered in preparing our final report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the BCBS plans charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions with regard to claims paid to the VA.

SCOPE

The audit covered health benefit payments from January 1, 2013, through October 31, 2015, as reported in the Blue Cross and Blue Shield Association's Government-wide Service Benefit Plan FEP Annual Accounting Statements. We performed a computer search on BCBS claims data to identify all claim payments made to VA medical providers where the amount paid to the provider was greater than or equal to the amount billed by the provider, and the potential overpayment² was \$500 or more. The overpayment threshold of \$500 was judgmentally selected; we did not calculate the total universe of claims paid to VA medical providers. We consider these claims as high risk for payment errors because paying a claim at or above the billed amount could indicate the FEP did not receive a discount during the pricing of that claim. We reviewed these claims to test each BCBS plan's compliance with the FEHBP health benefits provisions related to the processing and payment of claims paid to VA service providers. See Exhibit I for a summary of the scope of our VA claims review. The results of our review were not projected to the universe of potentially overpaid claims.

Exhibit I – Summary of Veterans Affairs Claims Review Sample Selection

VA Claims Review	Criteria	Total Claims	Total Amount Paid
Claim paid at or above billed charges.	Potential overpayment of \$500 or more.	9,098	\$105,371,534

METHODOLOGY

We selected a sample of claims (see Exhibit 1) and submitted them to each BCBS plan for review on December 17, 2015. Our analysis of the Association's and plans' responses determined that we were not provided with enough information to accurately calculate the claim overpayments for a final audit report. After reviewing the information provided in response to

² The potential overpayment amount was calculated by comparing the amount paid to the standard FEP non-participating provider rates.

the initial draft report, we issued a second draft audit report designed to allow the Association and plans an additional opportunity to more directly address our concerns. We considered our review of the Association's responses to both draft reports in preparing the specific audit findings and recommendations contained in this final report.

The determination of the questioned amount is based on the FEHBP contract, the 2013 through 2015 Service Benefit Plan brochures, the Association's FEP Administrative Procedures Manual (APM), and other documents, such as the BCBS plans' contracts and various manuals.

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

We did not consider each BCBS plan's internal control structure in planning and conducting our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Therefore, we do not express an opinion on each BCBS plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the BCBS plans had complied with the contract and the laws and regulations governing the FEHBP as they relate to the pricing of claims paid to VA service providers. The results of our tests indicate that, with respect to the items tested, the BCBS plans did not fully comply with the provisions of the contract with regard to VA claim payments. Exceptions noted are explained in detail in the "Audit Findings and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the BCBS plans 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 audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of potential VA claim payment errors. The BCBS claims data is provided to us on a monthly basis by the FEP Operation's Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the BCBS plans' local claims systems. 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.

Audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through July 2017.

III. AUDIT FINDINGS AND RECOMMENDATIONS

The sections below detail the results of our global audit of Veterans Affairs claim payments. As mentioned in the Scope section above, our review consisted of 9,098 claims, totaling \$105,371,534 in payments (see Exhibit I on page 3).

Veterans Affairs Claim Review

\$58,023,161

Our review determined that the BCBS plans incorrectly paid 6,989 claims, resulting in \$58,023,161 in overcharges to the FEHBP. See Exhibit II for a summary of questioned claims.

Exhibit II – Summary of Questioned Claims

Total Claims Questioned	Total Amount Paid	Total Overcharges
6,989	\$89,593,467	\$58,023,161

Detail of Claim Overcharges

These claim payment errors are comprised of the following (See Exhibit III for a summary of questioned costs by cause of error):

- 26 of the 64 BCBS plans entered into contracts with VA providers to pay FEP claims at rates that violated the “reasonableness” requirements of the Federal Acquisition Regulation³ (FAR) 31.201-3. With respect to these 26 plans, our review identified 4,361 claims paid using the VA’s full billed charges, indicating that the FEP did not receive a discount in the pricing of these claims. The plans had several cost-saving pricing options available to pay these VA providers, such as 1) market rates, 2) the plan’s preferred provider organization (PPO) rates, 3) usual, customary, and reasonable (UCR) rates, or 4) Medicare rates. In the conduct of competitive business, a financially responsible organization would reimburse the provider using the lowest obtainable rate. As a result of the unreasonable pricing methodology used by the plans, the FEHBP was overcharged \$35,224,974.

We submitted multiple requests asking the Association and/or plans to provide documentation indicating that these claim payments were compliant with FAR guidelines, as the FAR places the burden of demonstrating reasonableness

The BCBS Association failed to meet its burden to demonstrate that claim payments were reasonable.

³ The FAR is codified at Title 48, Chapter 1 of the Code of Federal Regulations (CFR). An analysis of the FAR reasonableness requirements is detailed starting on page 13 of this report.

with the government contractor. Of these 4,361 claims, the Association or BCBS plans did not provide any documentation for 4,195 claims demonstrating *why* the plans contracted using the VA facilities' billed charges, and/or whether the processing of FEP's claims was consistent with the treatment of the local plans' other lines of business.

- 5 of the 64 BCBS plans incorrectly paid 2,215 claims because the Association's FEP Express nation-wide claims processing system (FEP Express) automatically paid the full amount billed instead of appropriately applying the plans' local pricing allowance for similar services (e.g., a UCR or PPO rate). In most instances, the claims automatically paid at billed charges because the plans had failed to load a UCR or PPO rate to the FEP Express system, and therefore the claim did not defer for a manual review in order to obtain the proper rate prior to payment. As a result, the FEHBP was overcharged \$21,248,686.
- The BCBS plans incorrectly paid 154 claims due to various FEP Express system errors, resulting in overcharges of \$736,999. These system errors included, but were not limited to the following:
 - UCR allowances not properly identified by the system;
 - Pricing allowances required by the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) were not appropriately applied;
 - Payments made for non-covered services; and
 - Processing of duplicate claims.

In general, the FEP Express system contains automatic processes for these type of quality control reviews. However, the system is designed to allow VA claims to bypass these controls.

- 157 claims were paid incorrectly due to manual processing errors such as incorrect coding, overriding system edits, and using incorrect allowances or billed amounts, resulting in overcharges of \$581,227 to the FEHBP.
- 102 claims were paid incorrectly due to provider billing errors, resulting in overcharges of \$231,275 to the FEHBP. In these instances, the type of bill included on the claim was incorrectly coded as a hospital instead of a clinic. If these claims had been properly coded as clinics, it likely would have resulted in a lower payment.

Exhibit III – Questioned Cost by Cause of Error

Cause of Error	Total Claims	Total Amount Paid	Amount Questioned
Unreasonable Contracted Rates	4,361	\$53,540,555	\$35,224,974
Unreasonable Non-Par Rates⁴	2,215	\$32,557,088	\$21,248,686
FEP Express System Error - Various	154	\$1,159,628	\$736,999
Manual Processing	157	\$1,946,985	\$581,227
Provider Billing	102	\$389,211	\$231,275
Total	6,989	\$89,593,467	\$58,023,161

Further Discussion of Claims Paid in Violation of FAR Reasonableness Standards

Our review determined that 41 of the 64 BCBS plans are paying claims to VA service providers at rates that are considered unreasonable per the FAR. We acknowledge that a separate regulation related to VA claim payments (38 CFR 17.106) includes the word “reasonable” in its language, but assert that this regulation in no way overrides a government contractor’s obligation to adhere to the requirements of the FAR. 38 CFR 17.106 states that the “reasonable charges subject to recovery” are established by another VA-promulgated regulation - 38 CFR 17.101. That provision states that “[a] third-party payer liable under a health plan contract has the option [emphasis added] of paying either the billed charges . . . or the amount the health plan demonstrates is the amount it would pay for care or services furnished by providers . . . for the same care or services in the same geographic area. If the amount submitted by the health plan for payment is less than the amount billed, VA will accept the submission as payment, subject to verification at VA’s discretion in accordance with this section.”

BCBS plans unreasonably paid claims using the full amount billed by the provider instead of opting to use a lower available rate, as allowed by 38 CFR 17.101.

The Association and/or BCBS plans paid most of the claims questioned in this report using the full amount billed by the provider (a violation of FAR 48 CFR 31.201-3), instead of opting to use a lower available rate, such as the plan’s local UCR (which is expressly allowed by VA regulation 38 CFR 17.101).

⁴ Non-participating or “non-par” refers to providers that do not contract with BCBS.

Our review also determined that the Association and BCBS plans lack the necessary controls to obtain the most reasonable pricing rate for VA providers on behalf of the FEHBP. We identified the following control issues:

- The Association does not have oversight procedures in place to ensure that VA claims are being properly processed and paid. Although the Association has developed a policy to provide guidance on how the plans should price VA claims (i.e., the FEP Administrative Manual or FAM, Volume II, Chapter 24), the Association has no procedures or controls to monitor whether the BCBS plans actually operate in compliance with the FEP policy. Therefore, the Association is unable to produce any attestation that VA claims are being properly paid, as required by the FAR - which places the burden of proving reasonableness on the Government contractor.
- The BCBS plans that contracted with the VA service providers do not have oversight procedures to ensure that the VA providers comply with the plans' contracts. If the plans had such procedures in place, they could have identified cost savings such as obtaining lower rates or identifying provider billing errors.
- 48 CFR 31.201-3 states "No presumption of reasonableness shall be attached to the incurrence of costs by a contractor . . . the burden of proof shall be upon the contractor to establish that such cost is reasonable." In this case, the contractor has the burden to demonstrate *why* claims paid at billed charges should be considered reasonable. In an effort to gain an understanding as to why the BCBS plans considered the full billed charges to be reasonable, we issued a second draft report (see Appendix A) to obtain documentation (e.g., actuarial analysis or provider negotiation standards) demonstrating how the providers' allowances were determined. However, despite multiple requests, the Association and plans failed to provide any evidence that it was paying claims in a reasonable manner.

Due to the lack of oversight of the processing and payment of VA claims by the Association and BCBS plans, the Association is unable to offer any information indicating whether the claims cost is "actual, allowable, allocable, and reasonable." In conclusion, we determined that the Association did not make a good faith effort to pay these claims accurately, as required by contract CS 1039. Therefore, the FEHBP should be reimbursed for all of these claim overcharges, regardless of the plans' ability to collect the funds from the providers or members.

The lack of oversight of claim payments to the VA indicates that the BCBS Association has not made a good faith effort to pay these claims correctly.

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

- FAR 31.201-3 outlines four elements that government contractors must demonstrate when determining reasonableness, as follows: “Determining reasonableness. (a) A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business. Reasonableness of specific costs must be examined with particular care in connection with firms or their separate divisions that may not be subject to effective competitive restraints. No presumption of reasonableness shall be attached to the incurrence of costs by a contractor. If an initial review of the facts results in a challenge of a specific cost by the contracting officer or the contracting officer’s representative, the burden of proof shall be upon the contractor to establish that such cost is reasonable. (b) What is reasonable depends upon a variety of considerations and circumstances, including - (1) Whether it is the type of cost generally recognized as ordinary and necessary for the conduct of the contractor’s business or the contract performance; (2) Generally accepted sound business practices, arm’s length bargaining, and Federal and State laws and regulations; (3) The contractor’s responsibilities to the Government, other customers, the owners of the business, employees, and the public at large; and (4) Any significant deviations from the contractor’s established practices.”
- Contract CS 1039, Part III, section 3.2 (b)(1) states that “The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable.”
- Contract CS 1039, Part II, section 2.3(g) states, “[i]f the Carrier [or OPM] determines that a Member’s claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment . . . regardless of any time period limitations in the written agreement with the provider.”
- The Association’s FAM, Volume II, Chapter 12, states, “In processing . . . claims for services provided by Non-preferred VA facilities, the Local Plan should base its reimbursement on the lower of [for emphasis] . . . [t]he VA’s reasonable charge [or] [t]he Local Plan’s allowance for Preferred providers – if that allowance is the same as the amount the Plan would allow for the same care or services in the same geographic area furnished by Preferred providers other than the VA . . . if the Plan bases its payment on a [Preferred Provider Allowance] that is lower than the VA’s reasonable charge, the Plan must be prepared to provide documentation to the VA to support its action.”
- The 2015 BCBS Service Benefit Brochure provides general guidance on the FEP’s policy for pricing and paying claims to non-par providers.

Association Response:

In response to the draft audit report, which questioned \$66,114,167 in potential overpayments, the Association stated that the BCBS plans agreed that claim payments totaling \$13,193,965 were paid in error due to the following:

- *\$11,773,964 was paid in error due to a contract rate loading error.*
- *\$854,077 was paid in error due to manual processing errors.*
- *\$247,501 was paid in error because the Plan did not properly load a preferred provider indicator (into the FEP Express system)*
- *\$318,423 was due to other miscellaneous reasons.*

The plans stated that the remaining \$52,920,202 in claim payments were paid correctly and that recovery had been initiated on payment errors identified in accordance with CS1039 Section 2.3(g). As of May 19, 2017, \$1,614,271 in overpayments have been returned to the FEHBP.

Regarding corrective actions, the Association disagrees that improvements to prevent and detect claims paid in error to VA providers is necessary, because the BCBS plans:

- *“Have provider contracts with the VA where payment is based upon various reimbursement methodologies*
- *Have provider contracts with the VA where the payment is based upon charges and the contract is used to pay all lines of business, including FEP*
- *Do not have contracts with the VA, nor do they have an allowance that is paid for the same service in the geographic area, and as a result, pay the VA billed charges*
- *Pay billed charges for all lines of business, including FEP, when they do not have a provider contract with the VA*

All [four] of the above reimbursement methods result in reasonably priced VA claims payments.”

The Association also states, “Chapter 31 of Title 48 of the Code of Federal Regulations contains cost principles and procedures for the pricing of contracts and the determination, negotiation or allowance of costs when required by a contract clause. Pursuant to §201.3 of that chapter, costs must be reasonable to be reimbursed. Section 201.3 provides that a “cost is reasonable, if in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business”. Section 201 goes on to state that what is reasonable depends on a variety of considerations and circumstances, including:

- (1) Whether it is the type of cost generally recognized as ordinary and necessary for the conduct of the contractor's business or the contract performance;*
- (2) Generally accepted sound business practices, arm's length bargaining, and Federal and State laws and regulations;*
- (3) The contractor's responsibilities to the Government, other customers, the owners of the business, employees, and the public at large; and*
- (4) Any significant deviations from the contractor's established practices.”*

The BCBS plans believe that its provider contracts with VA providers, and the plans' procedures for allowing non-contracted providers to pay at billed charges, did in fact satisfy the criteria for determining reasonableness. . . . In regards to the OIG's recommendations to develop corrective actions to reduce claim payment errors paid to VA service providers the Association states, "The BCBSA [Association] will work with Plans to ensure that they continue to pay VA claims in good faith, in accordance with VA laws and regulations. In addition, BCBSA [Association] will work with the Contracting Officer to implement any changes required."

OIG Comments:

After reviewing the Association's response to the draft audit report, we revised the questioned charges to \$58,023,161. The documentation provided by the Association and/or BCBS plans indicate that the Association concurred with \$13,840,916 of the questioned overpayments, but it disagrees with the remaining questioned costs. Despite multiple requests, the Association has not provided evidence supporting its position that the remaining \$44,182,245 was paid correctly. The Association also disagrees with all of the OIG recommendations provided in the draft report.

In most instances, we used a conservative methodology for calculating overpayments by using the FEP non-par pricing allowances instead of an estimated percentage using the BCBS plans' PPO allowances. Since the Association failed to comply with our request to provide the PPO or UCR allowance for each plan, we were unable to calculate overpayments using these figures. If we had this information available, the questioned overpayment would have been a more accurate (and likely a significantly larger) number.

Lack of Oversight of Program Funds

Before outlining the specific reasons we continue to question the contested overcharges, we would like to address our concern regarding the Association's overall management of the BCBS plans' payments to VA service providers. The Association performs no audits or reviews of VA claim payments. Although the

The BCBS Association had minimal oversight over \$1.7 billion in claim payments made to VA service providers during the scope of this audit.

Association has guidance and procedures for the BCBS plans to follow, it has no controls in place to validate that these procedures are being followed or that they are effective for controlling costs charged to the FEHBP. Due to this lack of oversight, the FEHBP was overcharged a substantial amount for costs that could have been controlled. The Association's minimal oversight is particularly concerning when considering the enormous volume of claim payments made by the plans to VA service providers, which totaled approximately \$1.7 billion during the 34-month scope of this audit.

In response to our recommendations, the Association disagrees that it needs to implement corrective actions to prevent VA claims from being incorrectly priced and paid. The fact that the Association recognizes that over \$13 million was paid in error, yet does not think that corrective actions to prevent future VA claims from paying in error is necessary, is fundamentally concerning to the overall operation of the Association in providing services on behalf of the Federal Government. As of 2011, VA regulations no longer allow carriers to offset VA claim payment errors (i.e., recoveries) from future claim payments; therefore, we believe it is imperative that the Association and plans have functional controls in place to ensure that claims paid to VA service providers are paid correctly on the first submission of payment.

The Association is the organization that directly contracts with OPM, and it allows the individual BCBS plans to process claims on behalf of the FEHBP. The BCBS plans assume minimal risk while acting as third-party administrators for the FEHBP, meaning that all claims expenses and the associated administrative costs are drawn directly from the Federal FEHBP trust fund, as opposed to the plans' commercial funds. We do not believe that any competitive business would voluntarily pay unreasonable costs if the funds were paid exclusively from its own commercial lines of business, as opposed to Federal funds that the plans do not have the same vested interest in protecting. In the conduct of competitive business, a prudent business would perform due diligence to minimize cost and maximize savings. As previously stated, the plans had multiple pricing options to pay VA claims but elected to pay VA claims at the highest possible rate.

Unreasonable Rates Paid to Contracted VA Providers

This section specifically relates to the questioned claim payments made by plans that entered into contracts with the VA to pay claims at the full billed amount. The Association's response to our draft audit report outlines the cost principles from FAR 31.201-3 and states that ***"BCBS Plans believe that its provider contract with VA providers did in fact satisfy the criteria for determining reasonableness."*** The Association also states the OIG's standards and methodologies used in this audit do not comply with applicable regulations. The sections below address the Association's specific concerns and explain why we continue to question these overcharges:

1. The Association states, “[t]he VA Contracts were ordinary and necessary for the conduct of BCBS Plan business and performance.” We acknowledge that contracting with VA service providers or any other health care provider is a routine and accepted part of conducting business on behalf of the FEHBP. Our audit determined that multiple BCBS plans contracted with many VA service providers to pay claims at reasonable (i.e., lower than billed charges) rates. This report does not take issue with such claims; rather, the costs questioned in this report strictly relate to the inflated contract rates used by 26 BCBS plans. While reimbursing health care expenses is ordinary and necessary, doing so at a rate significantly higher than other available rates is not. The CFR expressly allows VA providers to enter into provider agreements with plans and allows the plans to pay lower rates. It is the OIG’s assertion that the VA collections regulation (38 CFR 17.106) in no way applies to nor overrules the reasonableness requirements outlined in the FAR (48 CFR 31.201-3) or the Association’s contract with the U.S. Office of Personnel Management – contract CS 1039.
2. The Association states, “Plan VA Contracts were established through an arm’s length transaction, complied with federal and state laws and regulations, and were the product of generally accepted business practices.” We recognize that the BCBS plans’ provider contract arrangements incorporate multiple factors in determining reimbursement rates, such as the type of member receiving the services, market conditions, and operational and administrative costs. However, like most medical providers, the VA bills for its services using inflated rates in an effort to maximize its revenue. The generally accepted business practice is for insurance companies to establish standard contract rates to avoid paying excessive and uncontrolled claims costs. As such, we disagree with the notion that the contracts to pay the full amount billed by a provider are a product of generally accepted business practices. Furthermore, the VA billed charge rate schedules include procedure bundling and special arrangement methodologies built into the service fees, which are not accounted for unless the BCBS plans make internal arrangements to properly recognize these standard pricing arrangements. Our review determined that the BCBS plans did not apply industry standard contractual arrangements with regards to the VA, including standard practices such as bundling services, applying special and multiple-procedure discounts, removing non-covered FEP services, and using one Diagnostic Related Grouper (DRG) per diem rate per episode of care.
3. The Association states that “[t]he BCBS Plan VA Contracts furthered Plans’ responsibilities to the Government, other customers, the owners of the business, employees, and the public at large” Our review determined that the Association’s practice of allowing plans to pay the VA at the highest possible rates is harmful to the Federal government as a whole. We agree that overpaying the VA at the expense of OPM’s FEHBP may result in a net wash for the Government as a whole. However, this practice also results

in the plans collecting additional administrative reimbursement fees from the FEHBP, as many of its administrative cost allocation methods are based on claims expense volume. Furthermore, the impact of increasing claims costs has a direct negative impact on premiums paid by FEP members (i.e., Federal employees, retirees, and their families), and also increases the coinsurances and deductibles paid by veterans that are enrolled in the FEHBP.

4. The Association states that ***“BCBS Plan contracts with VA Providers were for All Plans’ Lines of Business.”*** As part of the second draft report, we asked the plans to perform a cost analysis using all lines of business, places of service (i.e., inpatient, outpatient, and physician), and service types to determine what rates are reasonable for the FEHBP to pay VA facilities. However, the Association refused to provide this cost analysis. Additionally, after multiple requests, 17 plans did not provide any documentation to support why it contracted using the VA facilities’ billed charges and/or whether the processing of FEP’s claims were consistent with the local plan’s other lines of business.

Unreasonable Rates Paid to Non-Par Providers

This section specifically relates to the questioned claim payments made by plans that do not have a contractual agreement with the VA, but still paid claims at the full billed charge instead of a lower reasonable rate. With regards to these claims, the Association states that ***“Plan payment of VA billed charges where the Plan does not have provider contracts with the VA and does not have an allowance for the same service for the same geographic area are also reasonable.”*** In general, the Association states paying the claims at billed charges were:

- “1) Ordinary and necessary;***
- 2) Complied with federal laws and regulations;***
- 3) The Plans’ responsibilities to the Government;***
- 4) The same charge in the geographic area; and***
- 5) Consistent with all lines of business.”***

However, the plans’ policies of paying claims to these non-par providers at full billed charges is, in fact, a direct violation of FEP’s non-par pricing procedures. The Association’s procedures for paying non-par providers (per the APM) state that plans should price claims using the local plan’s UCR. However, the Association’s automatic claims processing system is not configured to adhere to these procedures. Had the non-par rates been automatically applied, there would have been significant savings to the FEHBP. The Association allowed these claims to pay at billed charges, but has not provided sufficient documentation to support *why* these payments should be considered reasonable in nature when compared to payments made to non-VA providers using the UCR rate, as required by the APM.

Summary

We recognize that Federal regulation prohibits third-party carriers from performing offset recoveries against VA facilities. However, we again emphasize the reasons why the BCBS plans should be accountable for their actions to both the VA and FEHBP:

- The plans that contracted with the VA to pay claims at full billed charges did so in violation of the FAR.
- The plans that did not have a contract with the VA did not appropriately pay claims at the UCR rate, as required by the APM.

For these reasons, we conclude that the plans did not make a “good faith” effort to reasonably pay claims to VA service providers on behalf of the FEHBP. Regardless of the plans’ ability to recover these overpayments from the VA, the plans should be responsible for returning these overpayments to the FEHBP, since costs determined to be unreasonable are not allowable charges to the contract. In addition, the contracting officer should ensure that all OIG recommendations are addressed and implemented in a timely manner. These recommendations are designed to prevent future waste of Federal funds, and should be implemented regardless of the Association’s opinions about the reasonableness of historical payments.

Recommendation 1

We recommend that the contracting officer disallow \$58,023,161 for claim overcharges and that all overcharges be returned to the FEHBP, regardless of the BCBS plans’ ability to collect the funds from the providers or members.

Recommendation 2

We recommend that the contracting officer ensure that the Association develops corrective actions for improving the prevention and detection of VA claims that are not reasonably priced and paid by the BCBS plans.

Recommendation 3

We recommend that the contracting officer require the BCBS plans to perform a cost analysis using all lines of business, places of service (i.e., inpatient, outpatient, and physician), and service types to determine what rates are reasonable for the FEHBP to pay VA facilities. Once this analysis is complete, we recommend that the contracting officer require the BCBS plans to

pay VA claims using the lower of the VA's reasonable charge or the local plan's allowance that it would pay for the same care or services in the same geographic area, for all VA providers.

Recommendation 4

We recommend that the contracting officer require the Association to enhance the FEP Express system to automatically defer VA claims when a local UCR or average market rate has not been provided for non-par VA claims. These system enhancements should ensure that standard quality control reviews for VA claims (i.e., duplicate edits, OBRA 90 pricing) are being properly applied during the pricing of the claim.

Recommendation 5

We recommend that the contracting officer require the Association to develop auditing and/or oversight procedures to monitor the processing of VA claims. These procedures should include ongoing monitoring of changes to the FEP Express system that impact VA claim pricing and ongoing claim cost rate analysis by VA regions and/or provider types.

APPENDIX A



BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
202.942.1000
Fax 202.942.1125

May 23, 2017

██████████
Senior Team Leader
Experience-Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

**Reference: OPM DRAFT AUDIT REPORT
Global Veteran's Administration Audit
Audit Report 1A- 99-00-16-021**

Dear ██████████:

This is in response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Veterans Administration (VA) Claim Payments Audit of the FEP Blue Cross Blue Shield Plans. Our comments concerning the recommendations in the report are as follows:

Recommendation 1

We recommend that the contracting officer disallow \$66,114,167 for VA claim payments and have the BCBS plans return all amounts recovered to the FEHBP.

BCBSA Response

After reviewing 8,880 VA claims totaling \$66,114,167 in questioned claims, BCBS Plans determined that \$13,193,965 was paid in error due to the following:

- \$11,773,964 was paid in error due to a contract rate loading error.
- \$854,077 was paid in error due to manual processing errors.
- \$247,501 was paid in error because the Plan did not properly load a preferred provider indicator (into the FEP Express system)
- \$318,423 was due to other miscellaneous reasons.

Questioned claims totaling \$52,920,202 were paid correctly. Recovery has been initiated on payment errors identified in accordance with CS1039 Section 2.3g. As of May 19, 2017, overpayments totaling \$1,614,271 have been returned to the Program. Any additional overpayments recovered will be returned to the Program.

Report No. 1A-99-00-16-021

Recommendation 2

We recommend that the contracting officer ensure that the Association develops corrective actions for improving the prevention and detection of VA claims that are not reasonably priced and paid by the BCBS plans

BCBSA Response

BCBSA disagrees with this recommendation. BCBS Plans responded that they:

- have provider contracts with the VA where payment is based upon various reimbursement methodologies
- have provider contracts with the VA where the payment is based upon charges and the contract is used to pay all lines of business, including FEP
- do not have contracts with the VA, nor do they have an allowance that is paid for the same service in the geographic area, and as a result, pay the VA billed charges
- pay billed charges for all lines of business, including FEP, when they do not have a provider contract with the VA

All three of the above reimbursement methods result in reasonably priced VA claims payments.

Chapter 31 of Title 48 of the Code of Federal Regulations contains cost principles and procedures for the pricing of contracts and the determination, negotiation or allowance of costs when required by a contract clause. Pursuant to §201.3 of that chapter, costs must be reasonable to be reimbursed. Section 201.3 provides that a “cost is reasonable, if in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business”. Section 201 goes on to state that what is reasonable depends on a variety of considerations and circumstances, including:

- (1) Whether it is the type of cost generally recognized as ordinary and necessary for the conduct of the contractor's business or the contract performance;
- (2) Generally accepted sound business practices, arm's length bargaining, and Federal and State laws and regulations;
- (3) The contractor's responsibilities to the Government, other customers, the owners of the business, employees, and the public at large; and
- (4) Any significant deviations from the contractor's established practices.

BCBS Plans believe that its provider contracts with VA providers did in fact satisfy the criteria for determining reasonableness, as supported below.

Plans with contracts to pay the VA at billed charges

(1) The VA Contracts were ordinary and necessary for the conduct of BCBS Plan business and performance.

BCBS Plans enter into contracts with providers in order to arrange for the provision of medical and behavioral health services for FEP members as encouraged in guidance. Contracting with medical and behavioral health providers is a normal part of the business of benefit administration for insurers and third party administrators. BCBS Plan contracts with VA providers were entered into in the ordinary course of business. Further, the rates the Plans paid the VA under their provider contracts were reasonable under the law and in done in the ordinary course of BCBS Plan business.

(2) Plan VA Contracts were established through an arm's length transaction, complied with federal and state laws and regulations, and were the product of generally accepted business practices.

Plan contracts with the VA are compliant with federal and state laws and regulations. Entering into such contracts is also the product of generally accepted business practices as insurers routinely enter into such contracts in the normal course of business.

The contracts were entered into in as a result of arm's length negotiations. BCBS Plans base its decision to contract with the VA facilities, and at the reimbursement terms set forth in the agreements based upon a number of factors, including the benefits to the members who receive services at such facilities, the market conditions and the operational and administrative issues relating to paying claims to those facilities as contracted providers versus non-contracted providers.

According to the applicable regulations for VA providers, the VA is authorized to set rates that it can bill for services that are paid by third party payors. 38 CFR 17.101. The preface to the applicable VA regulations notes that the rates to be charged by the VA ***are intended to be reasonable and are designed to replicate, as much as possible, the 80th percentile of the community charges for such services.*** 68 Fed. Reg. 56876. BCBS Plans have determined that based upon a review of the rates, the manner in which the rates were published and implemented by the federal government, and in accordance with the regulations thereunder, such rates were reasonable in nature for the marketplace, and Plans exercised its reasonable and prudent business decision to agree to the terms. BCBS Plans' business decision to contract with the VA facilities for reimbursement at billed charges is justified by the fact that federal regulations are in place to provide protections as to the reasonableness of such billed charges.

(3) The BCBS Plan VA Contracts furthered Plans' responsibilities to the Government, other customers, the owners of the business, employees, and the public at large and (4) BCBS Plan contracts with VA Providers were for All Plans' Lines of Business.

BCBS Plans seek to provide all of its customers and employer groups with access to affordable and quality healthcare. As such, BCBS Plans do not make it a normal business practice to contract with providers for a specific employer group, such as the FEHBP, but rather it enters into contracts with providers that cover all of commercial business for specific product lines such as PPO and HMO products. This is an important consideration since the rates negotiated in the contracts with the provider impact the rates that the Plans would charge to all of its customers and the general public for its insurance products. This is the case with the Plan VA facility contracts as they apply to all of Plan PPO insurance products and are not specific to FEHBP.

Plans without contracts with the VA

Plan payment of VA billed charges where the Plan does not have provider contracts with the VA and does not have an allowance for the same service for the same geographic area are also reasonable. The payments at billed charges were also reasonable because:

- (1) The VA payments were ordinary and necessary for the conduct of BCBS Plan business and performance
- (2) The VA payments were based on and complied with federal laws and regulations.
- (3) The VA payments furthered Plans' responsibilities to the Government, other customers, the owners of the business, employees, and the public at large and
- (4) The Plans pay billed charges for all lines of business where the Plan did not have a provider contract or an allowance for the same charge for the same geographic area
- (5) The Plans treated FEP consistent with all lines of business and paid the claims at billed charges

Recommendation 3

We recommend that the contracting officer require the plans to perform a cost analysis using all lines of business, places of services, (i.e., inpatient, outpatient, and physician) and service types to determine what rates are reasonable for the FEHBP to pay VA facilities. Once this analysis is complete, we recommend that the contracting office require the BCBS plans to pay VA claims using the lower of the VA's reasonable charge or the local plan's allowance that it would pay for the same care or services in the same geographic area, for all VA providers.

BCBSA Response

BCBSA will work with Plans to ensure that they continue to pay VA claims in good faith, in accordance with VA laws and regulations. In addition, BCBSA will work with the Contracting Officer to implement any changes required.

Recommendation 4

We recommend that the contracting officer require the Association to enhance the FEP Express system to automatically defer VA claims when a local UCR has not been provided for non-par VA claims. These system enhancements should ensure that standard quality control reviews for VA claims (i.e., duplicate edits, OBRA 90 pricing) are being properly applied during the pricing of the claim.

BCBSA Response

BCBSA will work with Plans to ensure that they continue to pay VA claims in good faith, in accordance with VA laws and regulations. In addition, BCBSA will work with the Contracting Officer to implement any changes required.

Recommendation 5

We recommend that the contracting officer require the Association to develop auditing and/or oversight procedures to monitor the processing of VA claims. These procedures should include ongoing monitoring of changes to the FEP Express system that impact VA claim pricing and ongoing claim cost rate analysis by VA regions and/or provider types.

BCBSA Response

BCBSA will work with the Contracting Officer to implement any changes required.

We appreciate the opportunity to provide our response to the finding and request that our comments be included in their entirety as part of the Final Audit Report.

Sincerely,


Managing Director, FEP Program Assurance
Attachment

APPENDIX B



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans
Federal Employee Program
1310 G. Street, NW
Washington, DC 20005
202.942.1000
Fax 202.942.1125

April 15, 2016

██████████
Senior Team Leader
Experience-Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

**Reference: OPM DRAFT AUDIT REPORT
Global Veteran's Administration Audit
Audit Report 1A- 99-00-16-021**

Dear ██████████:

This is in response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning the Global Veterans Administration (VA) Claim Payments Audit of the FEP Blue Cross Blue Shield Plans. Our comments concerning the recommendations in the report are as follows:

Recommendation 1:

We recommend that the contracting officer disallow \$65,596,157 for VA claim payments and have the BCBS plans return all amounts recovered to the FEHBP.

BCBSA Response

After reviewing 9,098 VA claims totaling \$105,371,534 BCBS Plans determined that \$1,919,894 was paid in error due to the following:

- \$932,000 was paid in error due to manual processing errors.
- \$403,000 was paid in error because the Plan did not properly load a preferred provider indicator (into the FEP Express system)
- \$584,894 was due to other miscellaneous reasons.

Report No. 1A-99-00-16-021

Questioned claims totaling \$66,946,356 were paid correctly. Recovery has been initiated on payment errors identified in accordance with CS1039 Section 2.3g. Any overpayments recovered will be returned to the Program.

Recommendation 2

We recommend that the contracting officer ensure that the Association develops corrective actions for improving the prevention and detection of VA claims that are not reasonably priced and paid by the BCBS plans

BCBSA Response

BCBSA disagrees with this recommendation. BCBS Plans responded that they:

- have provider contracts with the VA where payment is based upon various reimbursement methodologies
- have provider contracts with the VA where the payment is based upon charges
- do not have contracts with the VA, nor do they have an allowance that they pay for the same service in the geographic area, and as a result, pay the VA billed charges.

All three of the above reimbursement methods result in reasonably priced VA claims payments.

Chapter 31 of Title 48 of the Code of Federal Regulations contains cost principles and procedures for the pricing of contracts and the determination, negotiation or allowance of costs when required by a contract clause. Pursuant to §201.3 of that chapter, costs must be reasonable to be reimbursed. Section 201.3 provides that a “cost is reasonable, if in its nature and amount, it does not exceed that which would be incurred by a prudent person in the conduct of competitive business”. Section 201 goes on to state that what is reasonable depends on a variety of considerations and circumstances, including:

- (1) Whether it is the type of cost generally recognized as ordinary and necessary for the conduct of the contractor's business or the contract performance;
- (2) Generally accepted sound business practices, arm's length bargaining, and Federal and State laws and regulations;
- (3) The contractor's responsibilities to the Government, other customers, the owners of the business, employees, and the public at large; and
- (4) Any significant deviations from the contractor's established practices.

BCBS Plans believe that its provider contracts with VA providers did in fact satisfy the criteria for determining reasonableness, as supported below.

Plans with contracts with the VA to pay billed charges

(1) The VA Contracts were ordinary and necessary for the conduct of BCBS Plan business and performance.

BCBS Plans enter into contracts with providers in order to arrange for the provision of medical and behavioral health services for FEP members as encouraged in guidance. Contracting with medical and behavioral health providers is a normal part of the business of benefit administration for insurers and third party administrators. BCBS Plan contracts with VA providers were entered into in the ordinary course of business. Further, the rates the Plans paid the VA under their provider contracts were reasonable under the law and in done in the ordinary course of BCBS Plan business.

(2) Plan VA Contracts were established through an arm's length transaction, complied with federal and state laws and regulations, and were the product of generally accepted business practices.

Plan contracts with the VA are compliant with federal and state laws and regulations. Entering into such contracts is also the product of generally accepted business practices as insurers routinely enter into such contracts in the normal course of business.

The contracts were entered into in as a result of arm's length negotiations. BCBS Plans base its decision to contract with the VA facilities, and at the reimbursement terms set forth in the agreements based upon a number of factors, including the benefits to the members who receive services at such facilities, the market conditions and the operational and administrative issues relating to paying claims to those facilities as contracted providers versus non-contracted providers.

According to the applicable regulations for VA providers, the VA is authorized to set rates that it can bill for services that are paid by third party payors. 38 CFR 17.101. The preface to the applicable VA regulations notes that the rates to be charged by the VA ***are intended to be reasonable and are designed to replicate, as much as possible, the 80th percentile of the community charges for such services.*** 68 Fed. Reg. 56876. BCBS Plans have determined that based upon a review of the rates, the manner in which the rates were published and implemented by the federal government, and in accordance with the regulations thereunder, such rates were reasonable in nature for the marketplace, and Plans exercised its reasonable and prudent business decision to agree to the terms. BCBS Plans' business decision to contract with the VA facilities for reimbursement at billed charges is justified by the fact that federal regulations are in place to provide protections as to the reasonableness of such billed charges.

(3) The BCBS Plan VA Contracts furthered Plans' responsibilities to the Government, other customers, the owners of the business, employees, and the public at large and (4) BCBS Plan contracts with VA Providers were for All Plans' Lines of Business.

BCBS Plans seek to provide all of its customers and employer groups with access to affordable and quality healthcare. As such, BCBS Plans do not make it a normal business practice to contract with providers for a specific employer group, such as the FEHBP, but rather it enters into contracts with providers that cover all of commercial business for specific product lines such as PPO and HMO products. This is an important consideration since the rates negotiated in the contracts with the provider impact the rates that the Plans would charge to all of its customers and the general public for its insurance products. This is the case with the Plan VA facility contracts as they apply to all of Plan PPO insurance products and are not specific to FEHBP.

Plans without contracts with the VA

Plan payment of VA billed charges where the Plan does not have provider contracts with the VA and does not have an allowance for the same service for the same geographic area are also reasonable. The payments at billed charges were also reasonable because:

- (1) The VA payments were ordinary and necessary for the conduct of BCBS Plan business and performance.
- (2) The VA payments were based on and complied with federal laws and regulations.
- (3) The VA payments furthered Plans' responsibilities to the Government, other customers, the owners of the business, employees, and the public at large and
- (4) The Plans pay billed charges for all lines of business where the Plan did not have a provider contract or an allowance for the same charge for the same geographic area.


Further, FEP Benefit Policy Manual, Chapter 12, page 25, states, "In processing claims for services provided by non-preferred VA facilities, the local Plan should base its reimbursement on the lower of, the VA's reasonable charge or the local Plan's allowance for Preferred providers – if that allowance is the same as the amount the Plan would allow for the same care or services in the same geographic area furnished by Preferred providers other than the VA If the Plan bases its payment on a PPA allowance that is lower than the VA's reasonable charge, the Plan must be prepared to provide documentation to the VA to support its action."

The key phrase is "if the Plan has an allowance that is the same amount the Plan would allow for the same care or services in the same geographic area". In those cases where Plans did not have a provider contract with the VA, the Plans paid charges as stated above. As a result, these Plans could not have paid less than billed charges and been able to support that payment with the VA because it did not have a preferred provider allowance that could be applied. As such, these Plans correctly responded that they do not contract with the VA and paid billed charges as there was no alternative payment capable of meeting the requirements of the VA regulation. As a result,

payment of billed charges is consistent with the BPM requirement to pay the lesser of the billed charge, or pay the allowance, which in this case did not exist. And, as stated previously, paying the VA's Reasonable Charge would, per the VA payment regulation, be reasonable. Since the VA billed charge is set by OMB at a discount of the geographic average, Plans who do not contract with the VA and do not have an allowance that is paid for the same service in the same geographic area were, in paying the billed charge, and by virtue of the applicable federal regulation, automatically obtaining the regional discount and paying a reasonable reimbursement rate. As a result, no additional action plans are required.

We appreciate the opportunity to provide our response to the finding and request that our comments be included in their entirety as part of the Final Audit Report.

Sincerely,


Managing Director, Program Assurance
Federal Employee Program

Attachment



Report Fraud, Waste, and Mismanagement

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: <http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse>

By Phone: Toll Free Number: (877) 499-7295
Washington Metro Area: (202) 606-2423

By Mail: Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100