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

Final Audit Report

Subject:

AUDIT OF
BLUECROSS BLUESHIELD ASSOCIATION
WASHINGTON, D.C. AND CHICAGO, ILLINOIS

Report No. 1A-10-91-11-030

Date: March 6, 2012

--CAUTION--

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10

BlueCross BlueShield Association
Washington, D.C. and Chicago, Illinois

REPORT NO. 1A-10-91-11-030 DATE: 3/6/12

Michael R. Esser
Assistant Inspector General
for Audits

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
Plan Code 10

BlueCross BlueShield Association
Washington, D.C. and Chicago, Illinois

REPORT NO. 1A-10-91-11-030 DATE: 3/6/12

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at the BlueCross BlueShield Association (Association), located in Washington, D.C. and Chicago, Illinois, questions $103,525 in health benefit charges, administrative expenses, and lost investment income (LII), and includes a procedural finding regarding the Association's Fraud and Abuse (F&A) Program. The Association agreed ***(A)*** with $101,447 and disagreed ***(D)*** with $2,078 of this questioned amount and generally disagreed with the procedural finding. Additional LII on the questioned charges amounts to $2,473.

Our audit was conducted in accordance with Government Auditing Standards. The audit covered administrative expenses for 2005 through 2009, as well as the Association's cash management practices related to FEHBP funds for 2005 through 2010. In addition, the audit covered health benefit charges for Plan codes 496 (Disease Management – [redacted], 497 (Overseas Provider Network – [redacted]), and 498 (Demand Management – [redacted] for 2005 through 2010 as reported in the Annual Accounting Statements. We also reviewed the Association's F&A Program.

The audit results are summarized as follows:

HEALTH BENEFIT CHARGES

- **Miscellaneous Payments for Plan Codes 496, 497, and 498 *(A)*** **$24,712**

  In one instance, the Association charged the FEHBP for a disease management invoice that was billed incorrectly, resulting in an overcharge of $20,522 to the FEHBP. As a result of this finding, the FEHBP was credited $24,712, consisting of $20,522 for the overcharge and $4,190 for LII.

ADMINISTRATIVE EXPENSES

- **Administrative Expense Adjustments *(A)*** **$65,384**

  The Association identified non-chargeable administrative expenses that were charged to the FEHBP from 2005 through 2009, totaling $1,200,638, and appropriately returned these funds to the FEHBP. However, the Association did not calculate and return LII, totaling $64,465, to the FEHBP related to these adjustments. In addition, the FEHBP was charged $919 for unallowable travel expenses due to a calculation error made on one of these adjustments. As a result, we are questioning $65,384, consisting of $64,465 for LII and $919 for unallowable travel expenses.

- **Post-Retirement Benefit Costs *(A)*** **$6,314**

  The Association overcharged the FEHBP $6,314 (net) for post-retirement benefit costs from 2005 through 2009.

- **Gains and Losses on Assets *(A)*** **$4,899**

  In 2008, the Association allocated to the Federal Employee Program a $14,707 loss incurred for missing computer equipment. The Association partially corrected this error in January 2010 by returning $10,380 to the FEHBP. However, no adjustment was made for the remaining loss amount of $4,327. In addition, the Association did not return LII of $572 with the partial credit adjustment in January 2010. As a result, we are questioning $4,899, consisting of $4,327 for the loss amount not adjusted and $572 for LII not returned with the partial credit adjustment.

- **Unsupported or Unallowable General Ledger Transactions** **$2,216**

  The Association did not provide adequate supporting documentation for six general ledger transactions, totaling $1,664. Therefore, we could not determine if these expenses were allowable charges to the FEHBP. In addition, the Association charged $552 to the FEHBP for three unallowable transactions. As a result, the FEHBP was charged $2,216 for these nine unsupported or unallowable general ledger transactions. The Association agreed with $138 ***(A)*** and disagreed with $2,078 ***(D)*** of these questioned charges.

CASH MANAGEMENT

Overall, we concluded that the Association handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the findings pertaining to cash management noted in the "Health Benefit Charges" and "Administrative Expenses" sections.

FRAUD AND ABUSE PROGRAM

- **Special Investigations Unit *(D)*** **Procedural**

The Association's FEP Special Investigations Unit (SIU) is not in compliance with Contract CS 1039 and the FEHBP Carrier Letters issued by the Office of Personnel Management (OPM) related to F&A Programs and notifying OPM's Office of the Inspector General of F&A cases in the FEHBP. This non-compliance exists because the organizational structure and systems created by the Association do not provide for the consistent communication and coordination of fraud activities between the local BlueCross and BlueShield plans and the Association's FEP SIU.

LOST INVESTMENT INCOME ON AUDIT FINDINGS

The Association calculated and returned LII of $2,252 to the FEHBP for audit findings B2, B3, and B4 in this report. However, the FEHBP is still due LII of $221, calculated from January 1, 2009 through December 31, 2011 on audit findings B1 and B4. In total, we are questioning **$2,473** for LII on audit findings presented in this audit report.

CONTENTS

PAGE

EXECUTIVE SUMMARY i

I. INTRODUCTION AND BACKGROUND 1

II. OBJECTIVES, SCOPE, AND METHODOLOGY 3

III. AUDIT FINDINGS AND RECOMMENDATIONS 6

A. HEALTH BENEFIT CHARGES 6

1. Miscellaneous Payments for Plan Codes 496, 497, and 498 6

B. ADMINISTRATIVE EXPENSES 7

1. Administrative Expense Adjustments 7
2. Post-Retirement Benefit Costs 8
3. Gains and Losses on Assets 10
4. Unsupported or Unallowable General Ledger Transactions 11

C. CASH MANAGEMENT 13

D. FRAUD AND ABUSE PROGRAM 13

1. Special Investigations Unit 13

E. LOST INVESTMENT INCOME ON AUDIT FINDINGS 26

IV. MAJOR CONTRIBUTORS TO THIS REPORT 28

V. SCHEDULES

A. CONTRACT CHARGES
B. QUESTIONED CHARGES
C. LOST INVESTMENT INCOME CALCULATION

APPENDIX (BlueCross BlueShield Association reply, dated December 12, 2011, to the draft audit report)

I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our audit of the Federal Employees Health Benefits Program (FEHBP) operations at the BlueCross BlueShield Association (Association). The Association is located in Washington, D.C. and Chicago, Illinois.

The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

BACKGROUND

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

The Association, on behalf of participating BlueCross and BlueShield 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 BlueCross and BlueShield plans throughout the United States to process the health benefit claims of its federal subscribers. There are approximately 63 local BlueCross and BlueShield plans participating in the FEHBP.

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

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

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

All findings from our previous audit of the Association (Report No. 1A-10-91-03-032, dated February 27, 2007) for contract years 1999 through 2002 have been resolved.

The results of this audit were provided to the Association in written audit inquiries; were discussed with Association officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated October 27, 2011. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as the Appendix to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Association charged costs to the FEHBP and handled FEHBP funds in accordance with the terms of the contract. Specifically, our objectives were as follows:

Health Benefit Charges

- To determine whether miscellaneous payments charged to the FEHBP for Plan codes 496 (Disease Management – [redacted]), 497 (Overseas Provider Network – [redacted]), and 498 (Demand Management – [redacted]) were in compliance with the terms of the contract.

Administrative Expenses

- To determine whether administrative expenses charged to the contract were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable regulations.

Cash Management

- To determine whether the Association handled FEHBP funds in accordance with applicable laws and regulations concerning cash management in the FEHBP.

- To determine whether the Association properly returned FEP funds (e.g., wire transfers by BlueCross and BlueShield plans for health benefit refunds, letter of credit drawdown errors, prior period adjustments, and uncontested audit findings), fraud recoveries, pharmacy drug rebates, and interest to the FEHBP in a timely manner.

Fraud and Abuse Program

- To determine if the Association operates an effective Fraud and Abuse Program for the prevention, detection, and/or recovery of fraudulent claims as required by the FEHBP contract.

SCOPE

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

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to the Association's FEP administrative expenses for 2005 through 2009, as well as the Association's cash management activities for 2005 through 2010. In addition, we reviewed the health benefit payments charged to the FEHBP under Plan codes 496 (Disease Management – [redacted]), 497 (Overseas Provider Network – [redacted]), and 498 (Demand Management – [redacted]) for 2005 through 2010. We also reviewed the Association's Fraud and Abuse program. During the period 2005 through 2010, the Association charged approximately $444 million in administrative expenses to the FEHBP and paid approximately $177 million in health benefit payments for Plan codes 496, 497, and 498 (See Schedule A).

In planning and conducting our audit, we obtained an understanding of the Association's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Association's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Association's system of internal controls taken as a whole.

We also conducted tests to determine whether the Association had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations (FAR) and Federal Employees Health Benefits Acquisition Regulations (FEHBAR), as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Association did not comply with all provisions of the contract and federal procurement regulations. Exceptions noted in the areas reviewed are set forth 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 Association had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the Association and various BlueCross and BlueShield plans. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during our audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

The audit was performed at the Association's offices in Washington, D.C. and Chicago, Illinois on various dates from March 28 through June 17, 2011. Audit fieldwork was also performed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania.

METHODOLOGY

We obtained an understanding of the internal controls over the Association's financial, cost accounting, and cash management systems by inquiry and interview of Association officials.

We interviewed Association personnel and reviewed the Association's policies, procedures, and accounting records during our audit of miscellaneous health benefit payments. We also judgmentally selected and reviewed 54 high dollar special plan invoices, totaling $45,023,492 in net payments (from a universe of 444 special plan invoices, totaling $177,438,145 in net payments), for plan codes 496 (Disease Management – [redacted]), 497 (Overseas Provider Network – [redacted]), and 498 (Demand Management – [redacted]), to determine if miscellaneous payments were properly charged to the FEHBP. The results of this sample were not projected to the universe of miscellaneous health benefit payments for Plan codes 496, 497, and 498.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2005 through 2009. Specifically, we reviewed administrative expenses relating to responsibility centers, natural accounts, out-of-system adjustments, prior period adjustments, pension, employee health benefits, post-retirement, executive compensation, non-recurring projects, benefit plan brochures, gains and losses, subcontracts, return on investment, and lobbying. We used the FEHBP contract, the FAR, and the FEHBAR to determine the allowability, allocability, and reasonableness of charges.

We reviewed the Association's cash management practices to determine whether the Association handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations. We judgmentally selected and reviewed 106 letter of credit drawdowns, totaling $4,884,746,579 (from a universe of 1,378 letter of credit drawdowns, totaling $38,099,231,056). As part of our audit of cash management activities, we also judgmentally selected and reviewed 115 pharmacy drug rebates and other refunds, totaling $413,107,838 (from a universe of 780 pharmacy drug rebates and other refunds, totaling $565,985,069); 16 high dollar [redacted], totaling $26,039,221 in net credits (from a universe of 28 settlements, totaling $4,253,992 in net payments); 12 prior period adjustment (PPA) credits, totaling $7,821,552 (from a universe of 439 PPA credits, totaling $24,900,233); and two fraud recoveries, totaling $1,630 (from a universe of six fraud recoveries, totaling $9,771), to determine if FEP funds were promptly returned to the FEHBP and payments were properly charged to the FEHBP. The results of these samples were not projected to the applicable universes.

We also interviewed the Association's Special Investigations Unit regarding the effectiveness of the Fraud and Abuse Program, as well as reviewed various local BlueCross and BlueShield plans' cases, the Association's pharmacy cases, and the Association's case recoveries to test compliance with Contract CS 1039 and the FEHBP Carrier Letters.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT CHARGES

1. Miscellaneous Payments for Plan Codes 496, 497, and 498 $24,712

In one instance, the Association charged the FEHBP for a disease management invoice that was billed incorrectly, resulting in an overcharge of $20,522 to the FEHBP. As a result of this finding, the FEHBP was credited $24,712, consisting of $20,522 for the overcharge and $4,190 for lost investment income (LII).

Contract CS 1039, Part III, section 3.2(b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

FAR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

For the period 2005 through 2010, we identified 444 special plan invoices for Plan codes 496 (Disease Management – [redacted]), 497 (Overseas Provider Network – [redacted], and 498 (Demand Management – [redacted]) totaling $177,438,145 in net payments. From this universe, we selected and reviewed a judgmental sample of 54 invoices, totaling $45,023,492 in net payments, to determine whether charges for these Plan codes were based on actual expenses incurred and whether credits were applied correctly. The sample included the three highest payments for each year and all credits over $100.

Based on our review, we noted that an incorrect rate was applied to a disease management invoice dated October 2006. Consequently, the FEHBP was overcharged $20,522. As a result of this finding, the Association coordinated with [redacted] to offset an April 2011 invoice to return the overcharge of $20,522 and applicable LII of $4,190 to the FEHBP. In total, we verified that the charge on this April 2011 invoice was reduced by $24,712 ($20,522 plus $4,190) to correct the 2006 billing error.

Association's Response:

The Association agrees with this finding.

Recommendation 1

Since we verified that the Association returned $20,522 to the FEHBP for disease management cost overcharges, no further action is required for this questioned amount.

Recommendation 2

Since we verified that the Association returned $4,190 to the FEHBP for LII on the disease management cost overcharges, no further action is required for this questioned LII amount.

B. ADMINISTRATIVE EXPENSES

1. Administrative Expense Adjustments $65,384

The Association identified non-chargeable administrative expenses that were charged to the FEHBP from 2005 through 2009, totaling $1,200,638, and appropriately returned these funds to the FEHBP. However, the Association did not calculate and return LII, totaling $64,465, to the FEHBP related to these adjustments. In addition, the FEHBP was charged $919 for unallowable travel expenses due to a calculation error made on one of these adjustments. As a result, we are questioning $65,384, consisting of $64,465 for LII and $919 for unallowable travel expenses.

Contract CS 1039, Part III, section 3.2(b)(1) states, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

FAR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

While reviewing prior period adjustments, post-retirement benefit costs, and refunds received from BlueCross and BlueShield plans, we identified that the Association did not calculate and return LII when returning unallowable and/or unallocable charges to the FEHBP. As a result, we calculated LII of $64,465 on these charges, covering various dates from January 1, 2006 through October 27, 2010. Specifically, we identified the following exceptions:

- The Association returned $754,852 to the FEHBP for unallowable legal defense costs incurred from 2005 through 2008, but did not calculate and return LII to the FEHBP. As a result, we calculated LII of $36,917 on these unallowable costs.

- The Association returned $153,177 to the FEHBP for unallowable travel expenses [redacted] invoice review) incurred from 2005 through 2009, but did not calculate and return LII to the FEHBP. As a result, we calculated LII of $14,293 on these unallowable expenses. In addition, the Association did not correctly calculate the 2008 estimated over per diem amount, resulting in unallowable travel charges of $919 to the FEHBP.

- The Association returned $92,905 to the FEHBP for unallocable post-retirement benefit costs for active key employees (officers) that were charged to the FEHBP for 2005 through 2009. However, the Association did not calculate and return LII to the FEHBP. As a result, we calculated LII of $8,152 on these unallocable costs.

- The Association returned $160,785 to the FEHBP for monthly expense allowances provided to a plan that were in excess of the plan's 2009 incurred expenses. However, the Association but did not calculate and return LII to the FEHBP. As a result, we calculated LII of $2,999 on these excess funds.

- The Association returned $38,919 to the FEHBP for unallowable travel expenses [redacted] invoice review) incurred from 2007 through 2009, but did not calculate and return LII to the FEHBP. As a result, we calculated LII of $2,104 on these unallowable expenses.

Association's Response:

The Association agrees with this finding. The Association wire transferred $65,384 to OPM on October 12, 2011 to return the questioned amounts to the FEHBP.

OIG Comments:

We verified that the Association returned $65,384 to the FEHBP, consisting of $64,465 for LII and $919 for unallowable travel charges. We calculated LII on the unallowable travel charges of $919 in Schedule C of this report.

Recommendation 3

Since we verified that the Association returned $64,465 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Recommendation 4

Since we verified that the Association returned $919 to the FEHBP for the unallowable travel charges, no further action is required for this questioned amount.

2. Post-Retirement Benefit Costs $6,314

The Association overcharged the FEHBP $6,314 (net) for post-retirement benefit (PRB) costs from 2005 through 2009.

As previously cited from contract CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable.

48 CFR 31.205-6(o)(2) states, "To be allowable, PRB costs must be reasonable and incurred pursuant to law, employer-employee agreement, or an established policy of the contractor. In addition, to be allowable, PRB costs must also be calculated in accordance with paragraphs (o)(2)(i), (ii), or (iii) of this subsection."

For the period 2005 through 2009, the Association charged $3,525,806 to the FEHBP for PRB costs. The Association used both cash (pay as you go) and accrual accounting to charge PRB costs to the FEHBP. We reviewed the Association's calculations of PRB costs chargeable to the FEHBP and determined if these costs were calculated in accordance with 48 CFR 31.205-6(o).

Based on our review, we determined that the Association overcharged the FEHBP $6,314 (net) for PRB costs. Specifically, we determined that PRB costs were understated by $9,362 in 2005 and 2006 ($6,695 in 2005 and $2,667 in 2006) and overstated by $15,676 in 2007, 2008, and 2009 ($5,936 in 2007, $6,129 in 2008, and $3,611 in 2009). These errors were caused by the Association not limiting FEHBP charges to the actual PRB payments made for retired key employees (officers).

Association's Response:

The Association agrees with this finding. The Association made an adjustment to the administrative expenses in September 2011 to return $6,314 to the FEHBP. The Association also wire transferred $1,779 to OPM on November 17, 2011 for LII.

The Association also states, "To mitigate this in the future BCBSA's actuary will provide an annual actuarial disclosure with the information on expenses for active and retired key employees. The annual disclosure will be the basis for the adjustments to limit such charges to FEP."

OIG Comments:

We verified that the Association returned $6,314 (net) to the FEHBP for the questioned PRB charges. In addition, we addressed the Association's calculated LII amount of $1,779 in Section E of this report.

Recommendation 5

Since we verified that the Association returned $6,314 (net) to the FEHBP for the questioned PRB charges, no further action is required for this amount.

3. Gains and Losses on Assets **$4,899**

In 2008, the Association allocated to the FEP a $14,707 loss incurred for missing computer equipment. The Association partially corrected this error in January 2010 by returning $10,380 to the FEHBP. However, no adjustment was made for the remaining loss amount of $4,327. In addition, the Association did not return LII of $572 with the partial credit adjustment in January 2010. As a result, we are questioning $4,899, consisting of $4,327 for the loss amount not adjusted and $572 for LII not returned with the partial credit adjustment.

As previously cited from contract CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable.

FAR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

For the period of January 1, 2005 through December 31, 2009, the Association incurred a net loss of $861,522 for the retirement or disposal of assets. The FEP was allocated $273,976 for this loss. We reviewed this loss amount to determine if these costs were properly charged to the FEHBP.

Based on our review, we determined that the Association allocated $14,707 to FEP in 2008 for losses related to missing computer equipment, which included laptops, monitors, printers, and computer towers. The Association stated that they wrote-off the missing computer equipment to agree the general ledger asset balance to the physical inventory of assets on hand. In January 2010, the Association partially credited the FEHBP $10,380 to reverse out this unallowable charge. However, no adjustment was made to reverse out the remaining $4,327 loss on missing computer equipment. In addition, the Association did not return LII of $572 to the FEHBP with the partial credit adjustment in January 2010. In total, we are questioning $4,899, consisting of $4,327 for the loss amount not adjusted and $572 for LII not returned with the partial credit adjustment.

Association's Response:

The Association agrees with this finding. The Association made an adjustment to the administrative expenses in September 2011 to return $4,899 to the FEHBP. The Association also wire transferred $462 to OPM on October 12, 2011 for LII on the $4,327 loss amount returned to the FEHBP in September 2011.

The Association states, "To mitigate asset losses in the future, Information Technology Service department and Finance have worked collaboratively for the past year and have

implemented a number of process improvements to bridge the process gaps and strengthen the asset management processes, which include processes in asset procurement, asset receiving, asset deployment, asset disposal, and asset returns.

In addition to the above process improvement and procedures, beginning immediately, BCBSA will charge all losses related to missing or unidentified computer equipment, including laptops, monitors, printers, and computer towers to a cost center that does not allocate to FEP."

OIG Comments:

We verified that the Association returned $4,899 to the FEHBP, consisting of $4,327 for the write-off charge in 2008 and $572 for LII on the partial credit adjustment in 2010.

In addition, we addressed the Association's calculated LII amount of $462 in Section E of this report. The Association calculated this LII amount on the questioned write-off charge of $4,327, which was subsequently returned to the FEHBP in September 2011.

Recommendation 6

Since we verified that the Association returned $4,327 to the FEHBP for the unallowable write-off charge in 2008, no further action is required for this questioned amount.

Recommendation 7

Since we verified that the Association returned $572 to the FEHBP for LII on the partial credit adjustment in 2010, no further action is required for this questioned LII amount.

4. Unsupported or Unallowable General Ledger Transactions $2,216

The Association did not provide adequate supporting documentation for six general ledger transactions, totaling $1,664. Therefore, we could not determine if these expenses were allowable charges to the FEHBP. In addition, the Association charged $552 to the FEHBP for three unallowable transactions. As a result, the FEHBP was charged $2,216 for these nine unsupported or unallowable general ledger transactions.

As previously cited from contract CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable.

Contract CS 1039, Part III, section 3.8 states, "the carrier will retain and make available all records applicable to a contract term . . . ."

In addition to the above criteria, the Association's internal procedures require receipts for the following: air travel, hotel, car rental, out-of-pocket expenses ($25 or greater), and overtime expenses (all receipts).

48 CFR 31.205-14 states, "Costs of membership in social, dining, or country clubs or other organizations having the same purposes are also unallowable, regardless of whether the cost is reported as taxable income to the employees."

48 CFR 31.205-46(a)(2) states that, "costs incurred for lodging, meals, and incidental expenses . . . shall be considered to be reasonable and allowable only to the extent that they do not exceed on a daily basis the maximum per diem rates in effect at the time of travel as set forth in the . . . Federal Travel Regulation, prescribed by the General Services Administration . . . ."

In 2009, the Association allocated administrative expenses of $84,978,573 (excluding out-of-system adjustments) to the FEHBP. From this universe, we selected a judgmental sample of 150 general ledger transactions to review, totaling $11,931,748 in expenses, from the 10 highest-dollar responsibility centers charged to the FEHBP. We reviewed these general ledger transactions for allowability, allocability, and reasonableness.

Based on our review, we determined that nine transactions, totaling $2,216, were unallowable or not fully supported. The following summarizes the exceptions noted:

- The Association did not provide documentation for six travel transactions totaling $1,664. Therefore, we could not determine if these travel expenses were allowable charges to the FEHBP.

- In one instance, the Association charged $400 to the FEHBP for a membership to an airline club. According to 48 CFR 31.205-14, membership costs to this type of club are unallowable charges.

- The Association charged two transactions, totaling $152, to the FEHBP that contained hotel and meal costs above the maximum federal per diem rates. 48 CFR 31.205-46 (a)(2) limits the amount of travel costs for lodging and meals that may be charged to a government contract to the maximum federal per diem rates on a daily basis.

Association's Response:

The Association states, "We do agree that $138 is an unallowable charge . . . This amount is the difference between a hotel charge and the applicable per diem limit and meal charges that were over the per diem limit and should not have been charged to the Program. The Association made an adjustment to our Administrative Expenses in September 2011 to return $138 to the FEHBP . . . The Association also wired to OPM $11 in Lost Investment Income on October 12, 2011 for this unallowable charge."

The Association disagrees that the remaining general ledger transactions were not supported and states that they provided documentation to support their position.

OIG Comments:

Based on our review of the Association's response and additional documentation provided, we revised the amount questioned from the draft report to $2,216. The Association agreed with $138 and disagreed with $2,078 of this revised questioned amount.

We verified that the Association returned the uncontested amount of $138 to the FEHBP. However, the Association did not provide adequate documentation for us to verify that the contested charges were allowable costs to the FEHBP.

We calculated LII on the contested amount of $2,078 in Schedule C of this report. We also addressed the Association's calculated LII amount of $11 in Section E of this report.

Recommendation 8

We recommend that the contracting officer disallow $2,078 for unsupported or unallowable general ledger transactions.

Recommendation 9

Since we verified that the Association returned $138 to the FEHBP for unallowable charges, no further action is required for this questioned amount.

C. CASH MANAGEMENT

Overall, we concluded that the Association handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the findings pertaining to cash management noted in the "Health Benefit Charges" and "Administrative Expenses" sections.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit — Procedural

The Association's FEP Special Investigations Unit (SIU) is not in compliance with Contract CS 1039 and the FEHBP Carrier Letters issued by OPM related to Fraud and Abuse (F&A) Programs and notifying OPM's OIG of F&A cases in the FEHBP. This non-compliance exists because the organizational structure and systems created by the Association do not provide for the consistent communication and coordination of fraud activities between the local BlueCross and BlueShield (BCBS) plans and the FEP SIU.

The Association has the primary responsibility of ensuring local BCBS plan compliance with OPM contracts and managing the prescription drug program for both retail and mail order pharmacies. The FEP SIU is in charge of developing and maintaining a comprehensive anti-fraud program for the FEP. The FEP SIU's responsibilities related to

FEP anti-fraud activities include, but are not limited to, overseeing each local BCBS plan's FEP anti-fraud activities; ensuring local BCBS plan compliance related to fraud and abuse within the FEP; managing anti-fraud activity within the prescription benefit manager for both retail and mail-order prescription drug claims; coordinating investigations among local BCBS plans, Federal and local law enforcement, and other entities; and tracking and reporting all anti-fraud activity relating to the FEP.

According to the Association's FEP Director's Office (FEPDO), their anti-fraud mission is accomplished in conjunction with over 500 investigators at 53 local BCBS anti-fraud units contained within the 39 BCBS companies throughout the United States, the dedicated fraud units within their pharmacy benefit vendors (CVS Caremark and Medco), and the 12 FEPDO staff and consultants. The cost of the FEPDO anti-fraud activities during the audit period January 1, 2005 through December 31, 2009 totaled $55,429,355. These costs included all administrative related expenses, including salaries, benefits, consultants, rent, local BCBS SIU plan allowances, retail Pharmacy Benefit Manager's (PBM) fraud units, and applicable Fraud Information Management System (FIMS) expenses reported by FEPDO during the audit period noted above. However, additional costs existed that should also be included in the anti-fraud activities that the FEPDO either did not provide or they were unable to provide, including but not limited to debarment activities at the FEP CareFirst Operations Center, hospital bill audit vendors, and their 2005 through 2007 mail order PBM vendor, Medco.

The local BCBS plans are a party to Contract CS 1039, which requires the local plans to "conduct a program to assess its vulnerability to fraud and abuse and shall operate a system designed to detect and eliminate fraud and abuse internally by Carrier employees and subcontractors, by providers providing goods or services to FEHBP Members, and by individual FEHB Members. The program must specify provisions in place for cost avoidance, not just fraud detection, along with criteria for follow-up actions" via the BCBS FEP Plan Participation Agreement (Agreement). The FEP SIU stated that all local BCBS plans participate in the Agreement and each has agreed to "Comply with the policies, practices, procedures adopted by the Association for the administration and provision of benefits under FEP . . . ."

The FEP Standards for Fraud Identification, Prevention and Report Manual states that all "Local Plans are required to notify the FEP SIU of potential fraud cases, regardless of dollar amount, at the time the case is initiated." FIMS, a multi-user web-based case tracking database developed by the FEP SIU, is the reporting tool for the local BCBS plan SIU's and contracted PBM's to report their anti-fraud activities on behalf of the FEP. FIMS is also used to track data requests and member complaints sent to the FEP SIU by OPM. FIMS is the only tool available to capture this information. FIMS was completed and began being utilized in January 2007 by all local BCBS plan anti-fraud units. The total cost of FIMS since inception in 2002 is $1,520,303.

In addition, the *FIMS Plan SIU User Guide* states that the FEP SIU expects the local BCBS plan SIU's to include FEP claims in all investigations/reviews and to report

investigations/reviews that involve FEP timely, regardless of the outcome and/or dollar threshold. According to the *FIMS Plan SIU User Guide*, the FEP SIU "reviews all data entered [into FIMS] to ensure Plan compliance with the OPM contract and to assess Plan SIU performance."

The FEP SIU uses FIMS to monitor each FEP fraud investigation that is initiated by a local BCBS plan and the progress of the investigation. In addition, the FEP SIU monitors local BCBS plans' activities through the fraud cases entered into FIMS to identify local plans that may require follow-up actions.

We used the FEHBP contract, the FEHBP Carrier Letters, the Association's FEP administrative manual, the Agreement, and the local BCBS plans' policies and procedures to determine if the Association's FEP F&A Program is in compliance with Contract CS 1039 and other applicable regulations.

To test the Assocation and BCBS plans' compliance with contract CS 1039 and the FEHBP Carrier Letters, we reviewed local BCBS plans' cases and the Association's pharmacy cases and case recoveries.

Association's Response:

The Association states, "BCBSA FEP and the Local BCBS Plans have created a system of controls to monitor, identify, investigate and recover fraudulent and abusive payments of Program funds. Our goal is to protect Program funds from waste, fraud and abuse. During the audit scope, FEP processed a total of $118 billion in health benefit payments, had $323 million in fraud recoveries and savings, and Plans reported 3,955 cases to BCBSA FEP. OIG identified reporting issues with 22 cases during this audit. We disagree and believe there are only six cases with reporting issues. If we utilize OIG's number of 22 cases unreported, that would be a 0.55 percent error rate in reporting during the scope of the audit. While BCBSA believes our system of controls is in compliance with the requirements of CS 1039, we do agree that our policies and procedures can be enhanced as we strive for excellence."

OIG Comments:

We disagree that the Association's FEPDO and the local BCBS plans have created a system of effective controls to monitor, identify, investigate, and recover fraudulent and abusive payments of FEP funds. Of the $323 million in fraud savings and recoveries, approximately $311.6 million were projected savings and only $11.4 million were actual dollars recovered (approximately $2.2 million a year during the audit scope), of which the Association's FEP SIU was directly responsible for $71,466. Since Contract CS 1039 does not define what fraud and abuse savings and recoveries constitute, it is impossible to actually determine how much of the $323 million in reported savings and recoveries related to anti-fraud activities.

In addition, we disagree with the Association's assertion of a 0.55 percent error rate in reporting cases. The error rate should be calculated using the total number of cases from March 30, 2007 through December 31, 2009 that met the Carrier Letter 2007-12 F&A reporting requirements of more than $20,000, not the total amount of cases local BCBS plan SIU's reported to the FEPDO. During the above time frame, we identified 27 cases that met the 2007-12 Carrier Letter guidelines and 22, or 81 percent, of these cases were not reported as required to OPM and OPM's OIG (See "Recovery Review" on pages 21 through 23 for specific details of this issue).

The Association provided no additional documentation to support their response(s); therefore, our conclusions remain as stated in this audit finding. However, we acknowledge the corrective actions that the Association is planning to take in regards to improving existing policies and procedures.

Local BCBS Plan Fraud and Abuse Case Review

To test local BCBS plans' compliance, we judgmentally selected 7 of the 53 local BCBS plan anti-fraud units contained within the 39 BCBS companies. We requested the applicable local BCBS plan to provide all cases (opened and closed) and the associated name, address, social security number, national provider identifier, and/or tax identification number of each provider being investigated by the local BCBS plan from March 2007 through December 2009 that were received, reviewed, worked on, tracked, and entered into their own investigative tracking system, regardless of whether or not they were entered into FIMS or had FEP exposure. The local BCBS plans were asked to exclude all non-FEP member related commercial cases, including ineligible dependent type cases and identity theft cases.

In addition, we requested the Association to provide all cases that were entered into FIMS, which were received and reviewed by the FEP SIU from March 2007 through December 2009 for the same 7 local BCBS plan anti-fraud units.

For each of these years that case information was provided, we determined potential FEP exposure by running a query into a database that contained BCBS claims data for a scope of two years from the year the case was either opened or closed by the local BCBS plan. The query of information was based on the tax identification number, a number required on all claims submitted by a billing provider, requested to be provided by the local BCBS plan that they identified as being associated with the subject of the investigation. The case development tools that are used by the local BCBS plans and the FEP SIU to aid in fraud detection contain at least two years of readily available claims data. These cases were then reviewed to determine if they were entered into FIMS and met the Association's criteria for entry into FIMS, so that they could be reviewed to ensure compliance with Contract CS 1039 and FEHBP Carrier Letters.

After reviewing the cases for the period March 2007 through December 2009, we determined that the local BCBS plans opened or closed a total of 10,395 cases. However,

we could not determine FEP exposure for 8,869 of these cases. For the remaining 1,526 cases, we determined that 369 did not contain FEP exposure and 1,157 contained FEP exposure of $1 or more. Of these 1,157 cases that contained FEP exposure, 508 were not entered in FIMS and contained FEP exposure of less than $20,000, and 432 were not entered into FIMS and contained FEHBP exposure of more than $20,000. Based on the policy, all of these cases potentially met the requirement to be entered into FIMS. In total, only 291 of the 10,395 cases were reported in FIMS.

Although we could not determine the entire or exact amount of FEP exposure for the fraudulent activities identified by the local BCBS plans without having complete case information, the requirement, as previously stated, is to enter a potential fraud case into FIMS as soon as the case is initiated or there is reason to believe that fraud may exist. Regardless of the dollar amount, the case should be entered in FIMS, so that fraud activities related to the FEHBP can be reviewed, tracked, and coordinated by the Association.

For 8,869 of the cases, we could not determine the potential FEP exposure because the tax identification numbers were not provided by the local BCBS plans or due to timeliness issues related to the receipt of the request for information. Since we do not have access to the BCBS Provider File, we could not confirm the tax identification numbers that the local BCBS plans have associated with the providers or practices. In addition, we did not have a complete universe of cases because not all of the local BCBS plans provided all information requested for all years. According to the Agreement, local BCBS plans are committed by the contract to "Conform to all reasonable requests of the Association in connection with the administration of the FEP, including providing OPM and the Association access to all of the Plan's records and other information relating to FEP."

According to the Association, all cases that contain FEP exposure and have been referred to OPM's OIG are tracked in FIMS. Therefore, we can assume that cases identified as having the potential of meeting the reporting requirements during the review of the local BCBS plan cases and those that did not contain a FIMS submission date were not reviewed by the Association nor were these cases reported to us by the Association. As a result, potential fraudulent activities against the FEHBP were not detected, investigated, and/or prevented, as well as unreported.

Since we determined that there were multiple cases with at least $1 of FEP exposure that were not entered into FIMS, this shows that the local BCBS plans are not adhering to the requirement that cases must be entered into FIMS, regardless of dollar exposure upon initiation of a case. Also, in instances where cases were initiated by a local BCBS plan and then closed due to the determination that fraudulent activities did not exist, or the allegations were unsubstantiated, the cases should have still been entered into FIMS and then closed in FIMS concurrently with the local BCBS plan according to the Association's policy. The determination of the lack of fraud does not absolve a local BCBS plan from entering the case into FIMS.

Furthermore, the Association simply being aware that a local BCBS plan and OPM's OIG have a case open does not absolve the Association's FEP SIU from entering the case into FIMS. In addition, the FEHBP Carrier Letter 2003-23 ("Industry Standards for Fraud & Abuse (F&A) Programs") requires Carriers to "Establish written policies and procedures to be followed by all personnel for the deterrence and detection of fraud."

The determinations that cases may potentially meet the requirement for review by the FEP SIU are not being reported into FIMS. This reporting tool established by the Association for analyzing the local BCBS plans' anti-fraud efforts and performance, such as cases initiated, dispositions, value to program, member demographics, and budget requests, is not being utilized in accordance with Association policies and procedures. This illustrates that the Association is not in compliance with contract CS 1039 and the FEHBP Carrier Letters.

In addition to the cases not being reported into FIMS, we found no policies or procedures related to what should be reported into FIMS (to the Association) by the local BCBS plans, so that the Association can ensure compliance with the FEHBP Carrier Letter 2007-12 requirement of what to include in a referral.

The Association's FEP SIU utilizes the total number of commercial and non-commercial fraud cases reported by the local BCBS plan to the Association to compare to the total number of reported FEP fraud cases by the local BCBS plan in FIMS to evaluate local BCBS plan performance. In order to identify local BCBS plans that may require performance improvement activities and follow-up actions, the local BCBS plans must be willing to provide the information in FIMS and to the Association.

If a local BCBS plan is unwilling to utilize FIMS as required, or provide fraud case identifying information to the Association, the FEP SIU is unable to properly oversee the local plan's FEP anti-fraud activities, ensure local plan compliance related to fraud and abuse within the FEP, and track and report all anti-fraud activity relating to the FEP. As a result, the Association's evaluation of a local BCBS plan's anti-fraud unit, which is based on reviewing, monitoring and analyzing data entered in FIMS, would be inaccurate.

Furthermore, in addition to the reporting of non-compliance to FEP managers and executives, the Association must implement an action plan and/or identify follow-up actions to address a local BCBS plan's anti-fraud unit's lack of prompt notification of a case into FIMS. As a result, without the Association performing and/or implementing a follow-up action plan, the Association is left unable to coordinate an investigation, involving the same provider, among other local BCBS Plan's and truly have an F&A Program that identifies, investigates and prevents fraud and abuse perpetrated against the FEP and to be in compliance with Contract CS 1039.

Association's Response:

"We disagree with the OIG's interpretation of our policies and procedures regarding the criteria for Local Plans' case input into FIMS. Based on the finding, the OIG interprets the FEP policy as requiring Plans to enter all cases in which FEP may have exposure into FIMS, regardless of whether that exposure is related to the initial accusation, compliance, billing error, or fraudulent activity. The OIG is determining exposure simply as a dollar of Program funds paid to a provider in question. Further the OIG finding states:

> 'instances where a case was initiated by a local BCBS Plan and then closed due to the determination that a fraudulent activity did not exist or the allegation was unsubstantiated . . . should have still been entered into FIMS and then closed in FIMS concurrently with the local BCBS plan according to BCBSA FEPDO policy'.

The intent of our policy is not that Local BCBS plans enter every case or project they initiate with potential FEP exposure as defined by OPM OIG, but for Plans to enter a case into FIMS once they have completed their initial review of the issue and confirmed the initial complaint, billing error, or fraudulent activity. BCBSA defines exposure as a dollar amount paid in which a confirmed issue exists. Page 22 of the FEP Fraud Prevention and Reporting Manual states, 'Local Plans are required to notify the FEP SIU of potential fraud cases' however it refers the reader to Section 3.3 of the FEP FIMS manual for further clarification. Section 3.3 (Page 11) of the FIMS manual states that FIMS is a system for reporting **FEP fraud cases**. (Emphasis added). It also states that FIMS serves as the primary vehicle to report FEP Fraud related cases. Cases in which a Plan confirms there is no fraud issue, or that the issue is unrelated to FEP are not required to be entered into FIMS.

Additionally, Plans maintain a local case or project database in which they record all the related case activity. It would be duplicative and an inefficient use of Program funds for Plans to maintain case information in their local databases and FIMS for every case, allegation, billing error, etc. they investigate. It is the intent of BCBSA that Plans only enter case information once they have confirmed that there is FEP exposure to the original accusation, complaint, billing error, or fraudulent activity.

Lastly, BCBSA relies on the Plans to perform the initial investigation for determination of fraud, billing error, etc. before reporting to the BCBSA FEP Special Investigations Unit (SIU). The BCBSA FEP SIU does not make that determination based on initial leads. The Local Plans are the most familiar with the providers and market in question and are in a better position to determine the extent of the issue. The BCBSA FEP SIU monitors Plans' anti-fraud efforts by comparing the number of reported cases against total case volumes reported by Plans, performing site visits of Plans, and educating Plan personnel at Blue conferences and meetings. When improvement opportunities are noted, the BCBSA FEP SIU works with the Plan to improve their policies and procedures. The BCBSA FEP SIU will also work with other areas of the Plan and FEP Director's Office

to correct Plan issues if needed. The effectiveness of this process was recently demonstrated by a turn-around for one multi-Plan organization that recently added anti-fraud staff in order to improve their FEP investigations and reporting.

The OIG also notes that for 8,869 cases they were unable to determine potential FEHBP exposure because the tax ID was not provided or due to timeliness issues related to the receipt of the response for the request for information. The OIG notes that the Plan Participation Agreement with Plans requires Plans to: 'conform to all reasonable requests of the Association in connection with the administration of the FEP, including providing OPM and the Association access to all of the Plan's records and other information **relating to FEP**.' (Emphasis added). BCBSA would like to note that not all Plans maintain the tax ID in their fraud reporting systems; tax ID numbers were provided where available. Further, the Plan Participation Agreement, as quoted above, requires that data be provided that relates to FEP. The OIG requested Plan-specific fraud cases for their non-FEP business, which do not relate to FEP, and are not part of the requirement to provide data. BCBSA would like to note that the Plans did supply the requested Local Plan data for the OIG to perform their testing.

We do agree that our policies and procedures can be further refined regarding the specific criteria Plans should use to report cases. Therefore, we will update our policies and procedures by 1st Quarter 2012. We will also provide training to Plans regarding the updated policies and procedures through Plan written communications and at Blue Cross Blue Shield conferences."

OIG Comments:

We found no indication or guidance describing the "intent" (Emphasis added) of the FEPDO policy posted anywhere in their FEP Fraud Prevention and Reporting Manual, FIMS User Manuel, Intranet or Internet web-site. In addition, the Association did not include their own entire policy sentence in the draft report response, which states that "Local Plans are required to notify the FEP SIU of potential fraud cases" and continues by stating "regardless of dollar amount and at the time the case is initiated (Emphasis added)".

Furthermore, the FEP FIMS User Manual, Section 3.3, page 6 (General Expectations What to Report & When) states: "expected that all plan SIUs reviews/investigations include FEP claims; . . . Report timely. Do not wait until investigation is complete. Do not wait until fraud is proven. You are to enter the review/investigation regardless of outcome; . . . There is no dollar threshold; if the case involves FEP dollars, report it."

FIMS was created to be used as an aide to report cases to the OPM and OPM's OIG, and after the FEHBP paid for the system, it is expected to be used by all local BCBS plans as the main reporting tool to the FEPDO for all cases potentially related to the FEHBP. The FIMS User Manual states in Section 3.3.1 (What to report – Cases), page 7: "Anything reported in a Plans data entry system should be reported concurrently in FIMS [in] order

to comply with OPM's contract with BCBSA." Again, nowhere does the Association state their "intent" in any written policy or procedure that was provided within the scope of the audit.

We also disagree that we requested non-FEP related data. All medical provider, physician, hospital, outpatient facility, and pharmacy (hereto referred to as "provider") related cases have the "potential" for FEP exposure. Therefore, the case data we requested is related to the FEP. We only asked for all provider related cases that the local BCBS plan SIUs reviewed/investigated to determine if in fact the local plans followed the FEPDO policies and procedures. Per the FEPDO and FIMS User Manual policy, any provider related case with FEP exposure should have been entered into FIMS at the initiation, regardless of dollar threshold and regardless if a proven fraud had occurred. We found 61 percent (940 of 1,526) of the local BCBS plan cases had met this criteria and were not entered into FIMS.

Recovery Review

We judgmentally selected and reviewed the Association's fraud recoveries from 2005 through 2009. Specifically, we reviewed all fraud recoveries that totaled more than $20,000 that were returned to the FEHBP after FEHBP Carrier Letter 2007-12 ("Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Case in the FEHBP") became effective on March 30, 2007 to determine compliance with the Carrier Letter. FEHBP Carrier Letter 2007-12 requires all Carriers to send a written notification/referral to OPM's OIG within 30 days of becoming aware of any cases involving ***suspected*** false, fictitious, fraudulent, or misleading insurance claims when certain conditions are met.

A review of the fraud recoveries determined that out of the 3,854 cases that returned recoveries to the FEHBP from January 1, 2005 to December 31, 2009, only 27 returned recoveries of more than $20,000 after FEHBP Carrier Letter 2007-12 became effective on March 30, 2007. Based on our review of the FIMS reports, only 5 of these 27 cases were referred to OPM's OIG prior to settlement.

The remaining 22 cases were reviewed by the Association, and they determined that 6 of these 22 cases should have been reported to OPM's OIG and were not. The reason the Association did not report those cases to OPM's OIG was because the cases were not reported to the Association by the local BCBS plans until after actions had been taken in the cases. Furthermore, the Association stated the remaining 16 cases did not warrant a notification to the OIG because FEHBP Carrier Letter 2007-12 "only requires notification of cases where false, fictitious or misleading claims are submitted" and the remaining 16 cases did not meet this criteria.

However, the determination by the Association that the recoveries related to the remaining 16 cases were based on claims submitted to the FEHBP for payment in relation to industry standard fraud indicators that included, but were not limited to, double billing,

overcharging, improper billing, miscoding and unlicensed lab tests shows the cases did in fact involve ***suspected*** false, fictitious, fraudulent, or misleading insurance claims. This validates that the remaining 16 cases reviewed by the Association should have resulted in a referral/notification to OPM's OIG.

All cases that returned a recovery of over $20,000 after FEHBP Carrier Letter 2007-12 became effective should have been documented in FIMS at the initiation of the case according to the Association's FEP SIU policy. If the local BCBS plans followed the FEP SIU policy, an accurate determination could have been made by the Association related to whether proper notification and referral procedures to the OIG were followed in accordance with FEHBP Carrier Letter 2007-12.

In addition, the Association's FEP SIU requires all proposed and actual settlements to be reported so that they can confer with OPM and OPM's OIG about whether or not to include the FEHBP in the settlement. FIMS is the designated FEP SIU reporting tool for the local BCBS plan SIU's to report their anti-fraud activities on behalf of the FEP. The proposed or actual settlement of a case that includes FEHBP funds should have been reported into FIMS promptly, and not after the recovery action occurred, so that the Association can ensure their compliance with OPM contracts and avoid discrepancies in reported recoveries.

Association's Response:

"Based on BCBSA's review of the 22 recoveries in question, we agree that 6 should have been reported to OPM OIG but were not. However, the OIG notes that all 22 should have been reported per Carrier Letter 2007-12, indicating a difference in BCBSA's and OPM's interpretations of Carrier Letter 2007-12. BCBSA will review our policies and procedures to determine if updates should be made to comply with OPM OIG's interpretation of what constitutes, 'suspected false, fictitious, fraudulent, or misleading insurance claims' per superseding Carrier Letter 2011-13 by 1st Quarter 2012. Further, corrective action was taken immediately regarding the 6 cases that were not reported to the OPM OIG. The actions included budget reductions to the Plans, onsite Plan visits by BCBSA FEP SIU staff for training and monitoring and the elevation of reporting issues to Plan Executive Management to address the issues. In addition, if the FEP SIU becomes aware of a case that was not reported properly in FIMS, we will notify the OIG immediately."

OIG Comments:

We disagree that only 6 of the 22 cases should have been reported. The remaining 16 cases included allegations of double billing, billing for undocumented services, allegations of billing for medically unnecessary and investigational services, billing for complex office visits when, in fact, simple billing codes should have been utilized, inappropriate billing, services billed for unlicensed lab technicians, and billing for missed appointments. The above noted descriptors are included in Carrier Letter 2003-25 as

basic red flags for providers submitting "suspected false, fictitious, fraudulent or misleading insurance claims".

Based on Carrier Letters 2003-25 and 2007-12, all 22 cases should have been reported.

Pharmacy Case Review

We requested a list of all current open cases, as well as other assignments investigated, for the period of March 1, 2007 to December 31, 2009 that were assigned to two of the Association's FEP SIU staff members. The two FEP SIU personnel primarily conduct FEHBP health care fraud investigations specializing in pharmacy fraud that include but are not limited to member fraud and provider shopping cases.

We reviewed the case referral status, case referred date, and final case dispositions for all cases that were opened after the effective date of FEHBP Carrier Letter 2007-12. In order to be in compliance with the FEHBP Carrier Letter 2007-12, the Carrier Letter requires that "all carriers must also send a prompt written notification/referral to their Contracting Officer and the OPM OIG for any cases, regardless of the dollar amount of claims paid, if there is an indication of patient harm, potential for significant media attention, or other exceptional circumstances."

FEHBP Carrier Letter 2003-23 ("Industry Standards for Fraud and Abuse Programs") aids in defining indicators of areas that contain patient harm or patient safety issues to include, but not be limited to: "(1) pharmaceuticals, such as altered prescriptions, illegal refills, prescription splitting, and abuse of controlled substances, (2) medical errors in both inpatient and outpatient care, resulting in unfavorable outcomes, and (3) improper settings for procedures and services that result in poor outcomes."

A review of the cases determined that a total of 94 cases related to pharmacy fraud and patient harm or patient safety issues were opened or assigned during the period March 30, 2007 through December 31, 2009. Out of these 94 cases, only 8 were referred to OPM's OIG; 40 were referred to local law enforcement or another Government agency; 16 were referred to a local BCBS plan and/or pharmacy benefit manager or another BCBS department; and 30 were not referred for reasons listed in the disposition, or are currently pending with no reasons noted. All 94 cases met the definition of including patient harm or safety issues.

During our review, we found no policy or procedure stating what methodology should be used to determine which pharmacy benefit cases, or other cases related to patient harm or safety issues, would result in a referral to OPM's OIG. The Association stated that "Historically, OPM OIG has not had the investigative resources to accept and investigate the hundreds of pharmacy benefit cases which are referred by the PBMs each year."

The Association's opinion that OPM's OIG has not had the resources to accept and investigate cases related to patient harm or safety issues and pharmacy benefits does not

absolve the Association from notifying or referring cases to the OIG that meet the requirements of the FEHBP Carrier Letters.

Furthermore, we found no requirement put in place by the Association for local BCBS plan SIU's to report pharmacy benefit cases they may have identified at the local BCBS plan level in FIMS. The local BCBS plans do not have access to the FEP Pharmacy Benefit Program claims information, so the local plans do not have the capability to determine if there is FEP claims exposure.

The Association stated that "Since the FEP Pharmacy Benefit Program is separate from the services provided to FEP by Blue Plans, FEP SIU is required to ensure we have investigative resources available to work these cases."

The Association has the responsibility to analyze and determine if pharmacy benefit cases identified by the local BCBS plans include FEP claims exposure related to fraud and abuse and require notification to OPM's OIG.

Based on our review, we determined that the Association has not fully adopted Carrier Letter 2007-12. By not notifying or referring potential patient harm or patient safety cases, regardless of monetary amounts, to OPM's OIG, issues related to pharmaceutical abuse, medical errors, etc. may have gone undetected, leading to fraud and abuse. Furthermore, by not requiring the local BCBS plans to refer, report, and/or enter all pharmacy related cases in FIMS, the Association is unable to incorporate a review process to determine if the fraud and abuse cases identified by the local BCBS plans relate to the FEHBP and if notification to the OIG is required.

Association's Response:

"Based on the finding, we have requested assistance from OIG Office of Investigations to develop an efficient method of reporting these cases. BCBSA would like to also note that Local BCBS Plans do report pharmacy-related cases to the BCBSA FEP SIU, contrary to what the OIG stated in the finding. We will update our policies and procedures to more clearly reflect this requirement and will update references in the policy by 1st Quarter 2012."

OIG Comments:

The local BCBS plans should report all cases per the applicable contract language and/or Carrier Letter guidelines.

The FIMS User Manual (Section 3.2) states that "plans can utilize FIMS to request (Emphasis added) pharmacy data related to their investigations." We found no policy that requires the local BCBS plans to report all pharmacy related cases to the FEP SIU at the initiation of the case, as the local plan SIU's do not have access to the Association's FEP contracted PBM pharmacy related data.

Return on Investment

OPM's contracting officer had concerns about the 20:1 return on investment (ROI) ratio provided by the Association's FEP SIU. This 20:1 ROI means for every dollar spent by the Association's FEP SIU, it recovered or saved $20. Specifically, the contracting officer wanted to know what is included in this ratio and whether the ROI was accurate. Based on our review of the calculation methodology, we determined that this ratio was high because it did not include all applicable costs in the calculation. Therefore, this ROI ratio is not a true reflection of the FEP SIU's effectiveness.

The Association's FEP SIU ROI calculation numerator includes the following savings and recoveries:

- Debarred provider savings;
- Utilization review savings (performed by local BCBS plans and the Service Benefit Plan's (SBP) FEP Operation Center (CareFirst BCBS);
- Hospital bill audit recoveries (performed by outside vendors such as [redacted] who charge 30 percent of all recoveries);
- PBM savings and recoveries (performed by Caremark/CVS and Medco); and,
- Local BCBS plan case savings and global recoveries.

The denominator in the ROI calculation includes only the following costs:

- FEP SIU costs
- Local BCBS plan anti-fraud costs

As shown above, the accounting in the ROI calculation did not include all costs associated with the applicable savings and recoveries, such as the costs incurred by the PBM's, CareFirst BCBS (SBP Operations Center) for the utilization reviews, the outside vendors for the hospital bill audits, and the local BCBS plans for the utilization and case reviews. As a result, the 20:1 ratio was inflated because the ROI calculation did not include the costs of these outside organizations.

To demonstrate how much this ROI may be inflated, the National Health Care Anti-Fraud Association's (NHCAA) Anti-Fraud Management Survey for calendar year 2007 (the most recent ROI we could locate for the NHCAA) shows an industry average ROI of 7.6:1. For every dollar entrusted to a private insurer's investigative unit, $7.60 is returned to the company through recoveries and prevented losses.

Association's Response:

"BCBSA supplied the return on investment (ROI) calculation as a measurement of the effectiveness of our special investigation efforts, even though this measurement is not required by CS 1039. We agree that the PBM costs and SBP Operations Center costs could be included in the denominator. However, the costs for utilization reviews and hospital bill audits are included in the Local Plan Anti-Fraud budgets in the denominator. To address OPM's concerns, going forward, BCBSA will only report based on the measurements required in CS 1039."

OIG Comments:

The Association should work with OPM's contracting officer to develop a mutually acceptable methodology for determining ROI for the Association's FEP SIU.

Recommendation 10

We recommend that the contracting officer verify that the Association implements current policies and procedures, develops and implements criteria for follow-up actions, and enforces the Agreement. This will ensure that the fraud activities identified by the local BCBS plans are effectively communicated and coordinated with the FEP SIU and appropriately reported to OPM and OPM's OIG, as required by the FEHBP Carrier Letters and Contract CS 1039.

Recommendation 11

We recommend that the contracting officer work with the Association to develop an acceptable methodology for determining ROI for the Association's FEP SIU.

E. LOST INVESTMENT INCOME ON AUDIT FINDINGS $2,473

The Association calculated and returned LII of $2,252 to the FEHBP for audit findings B2, B3, and B4 in this report. However, the FEHBP is still due LII of $221, calculated from January 1, 2009 through December 31, 2011, on audit findings B1 and B4. In total, we are questioning $2,473 for LII on audit findings presented in this audit report.

FAR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in Section 611 of the Contract Disputes Act of 1978 (Public Law 95-563), which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

The Association calculated and returned LII of $2,252 to the FEHBP for the following audit findings in this report:

- $1,779 in LII for "Post-Retirement Benefit Costs" (B2);
- $462 in LII for "Gains and Losses on Assets" (B3); and,
- $11 in LII for "Unsupported or Unallowable General Ledger Transactions" (B4).

For those audit findings, the Association calculated the LII amounts from January 1, 2008 through December 31, 2011 (see Schedule C).

In addition, we computed investment income that would have been earned using the semiannual rates specified by the Secretary of the Treasury. Our computations show that the FEHBP is still due LII of $221 from January 1, 2009 through December 31, 2011 on audit findings B1 and B4 (see Schedule C).

Association's Response:

The draft audit report did not include an audit finding for LII. Therefore, the Association did not specifically address this item in its reply. However, the Association did address LII when responding to the audit findings for "Post-Retirement Benefit Costs" (B2), "Gains and Losses on Assets" (B3), and "Unsupported or Unallowable General Ledger Transactions" (B4). The Association calculated and returned LII amounts, totaling $2,252, to the FEHBP for these audit findings.

OIG Comments:

We agree with the LII amounts calculated by the Association and verified these LII amounts, totaling $2,252, were returned to the FEHBP.

Recommendation 12

Since we verified that the Association returned $2,252 to the FEHBP for LII on audit findings B2, B3, and B4, no further action is required for this questioned LII amount.

Recommendation 13

We recommend that the contracting officer direct the Association to credit the Special Reserve an additional $221 for LII on audit findings.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted] Lead Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Chief [redacted]

[redacted], Senior Team Leader

Office of Investigations

[redacted], Special Agent-In-Charge

[redacted], Special Agent-In-Charge

[redacted], Special Agent

SCHEDULE A

V. SCHEDULES

BLUECROSS BLUESHIELD ASSOCIATION
WASHINGTON, D.C. AND CHICAGO, ILLINOIS

CONTRACT CHARGES

CONTRACT CHARGES	2005	2006	2007	2008	2009	2010	TOTAL
A. HEALTH BENEFIT CHARGES							
PLAN CODE 496:							
DISEASE MANAGEMENT - [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
PLAN CODE 497:							
OVERSEAS PROVIDER NETWORK - [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
PLAN CODE 498:							
DEMAND MANAGEMENT - [redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
TOTAL HEALTH BENEFIT CHARGES	$15,971,550	$19,378,411	$32,601,162	$37,661,752	$33,773,486	$38,051,741	$177,438,102
B. ADMINISTRATIVE EXPENSES*							
BLUECROSS BLUESHIELD ASSOCIATION	$47,496,717	$58,115,107	$76,011,808	$85,956,356	$85,602,154	$90,780,835	$443,962,977
TOTAL CONTRACT CHARGES	$63,468,267	$77,493,518	$108,612,970	$123,618,108	$119,375,640	$128,832,576	$621,401,079

*** We did not audit the administrative expenses for contract year 2010.**

SCHEDULE B

BLUECROSS BLUESHIELD ASSOCIATION
WASHINGTON, D.C. AND CHICAGO, ILLINOIS

QUESTIONED CHARGES

AUDIT FINDINGS*	2005	2006	2007	2008	2009	2010	2011	TOTAL
A. HEALTH BENEFIT CHARGES								
1. Miscellaneous Payments for Plan Codes 496, 497, and 498	$0	$20,522	$0	$0	$0	$4,190	$0	$24,712
B. ADMINISTRATIVE EXPENSES								
1. Administrative Expense Adjustments	$0	$872	$9,030	$23,191	$26,688	$5,603	$0	$65,384
2. Post-Retirement Benefit Costs	(6,695)	(2,667)	5,936	6,129	3,611	0	0	6,314
3. Gains and Losses on Assets	0	0	0	4,327	545	27	0	4,899
4. Unsupported or Unallowable General Ledger Transactions	0	0	0	0	2,216	0	0	2,216
TOTAL ADMINISTRATIVE EXPENSES	($6,695)	($1,795)	$14,966	$33,647	$33,060	$5,630	$0	$78,813
C. CASH MANAGEMENT	$0	$0	$0	$0	$0	$0	$0	$0
D. FRAUD AND ABUSE PROGRAM (Procedural)								
1. Special Investigations Unit	$0	$0	$0	$0	$0	$0	$0	$0
E. LOST INVESTMENT INCOME ON AUDIT FINDINGS	$0	$0	$0	$293	$909	$740	$531	$2,473
TOTAL QUESTIONED CHARGES	($6,695)	$18,727	$14,966	$33,940	$33,969	$10,560	$531	$105,998

*** We included lost investment income within audit findings A1 ($4,190), B1 ($64,465), and B3 ($572). We also calculated additional lost investment income in Schedule C for audit findings B1 through B4.**

SCHEDULE C

BLUECROSS BLUESHIELD ASSOCIATION
WASHINGTON, D.C. AND CHICAGO, ILLINOIS

LOST INVESTMENT INCOME CALCULATION

LOST INVESTMENT INCOME	2005	2006	2007	2008	2009	2010	2011	TOTAL
A. QUESTIONED CHARGES (Subject to Lost Investment Income)								
Administrative Expense Adjustments (B1)	$0	$0	$0	$919	$0	$0	$0	$919
Unuspported and Unallowable General Ledger Transactions (B4)	0	0	0	0	2,078	0	0	2,078
TOTAL	$0	$0	$0	$919	$2,078	$0	$0	$2,997
B. LOST INVESTMENT INCOME CALCULATION								
a. Prior Years Total Questioned (Principal)	$0	$0	$0	$0	$919	$2,078	$0	
b. Cumulative Total	0	0	0	0	0	919	2,997	
c. Total	$0	$0	$0	$0	$919	$2,997	$2,997	
d. Treasury Rate: January 1 - June 30	4.250%	5.125%	5.250%	4.750%	5.625%	3.250%	2.625%	
e. Interest (d * c)	$0	$0	$0	$0	$26	$49	$39	$114
f. Treasury Rate: July 1 - December 31	4.500%	5.750%	5.750%	5.125%	4.875%	3.125%	2.500%	
g. Interest (f * c)	$0	$0	$0	$0	$22	$47	$37	$107
Total Interest By Year (e + g)	$0	$0	$0	$0	$48	$96	$77	$221
C. LOST INVESTMENT INCOME ALREADY RETURNED BY BLUECROSS BLUESHIELD ASSOCIATION - Excluded from (B) Calculation	$0	$0	$0	$293	$861	$644	$454	$2,252
TOTAL QUESTIONED INTEREST (B + C)	$0	$0	$0	$293	$909	$740	$531	$2,473

*** The Association calculated and returned $2,252 to the FEHBP for lost investment income (LII) on audit findings: $1,779 in LII for "Post Retirement Benefit Costs" (B2); $462 in LII for "Gains and Losses on Assets" (B3); and, $11 in LII for "Unsupported or Unallowable General Ledger Transactions" (B4).**

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

December 12, 2011

[redacted] Group Chief
Experience-Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-1100

Reference: **OPM DRAFT AUDIT REPORT RESPONSE**
BlueCross BlueShield Association
Audit Report Number 1A-10-91-11-030
(Dated October 27, 2011 and Received October 27, 2011)

Dear [redacted]

This is our response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) concerning the BlueCross BlueShield Association (Association or BCBSA). Our comments concerning the findings in the report are as follows:

A. HEALTH BENEFIT CHARGES

1. Disease Management – [redacted] $24,712

We do not contest this finding. As noted in the finding, the vendor credited the April 2011 invoice to return the overpayment to the Program.

B. ADMINISTRATIVE EXPENSES

Deleted by the Office of Inspector General – Not Relevant to the Final Report

2. Administrative Expense Adjustments $65,384

We do not contest that $64,465 is due in lost investment income and $919 due to an error in a principal calculation for a total of $65,384. The Association wired $65,384 to OPM on October 12, 2011 to return these funds to the Program (Attachment I).

3. Post-Retirement Benefit Costs $6,314

We do not contest this finding. To mitigate this in the future BCBSA's actuary will provide an annual actuarial disclosure with the information on expenses for active and retired key employees. The annual disclosure will be the basis for the adjustments to limit such charges to FEP. The Association made an adjustment

to the Administrative Expenses in September 2011 to return $6,314 to the Program (Attachment II). The Association wired $1,779 to OPM on November 17, 2011 for Lost Investment Income (Attachment III).

4. Gains and Losses on Assets $4,899

We do not contest this finding. To mitigate asset losses in the future, Information Technology Service department and Finance have worked collaboratively for the past year and have implemented a number of process improvements to bridge the process gaps and strengthen the asset management processes, which include processes in asset procurement, asset receiving, asset deployment, asset disposal, and asset returns.

In addition to the above process improvement and procedures, beginning immediately, BCBSA will charge all losses related to missing or unidentified computer equipment, including laptops, monitors, printers, and computer towers to a cost center that does not allocate to FEP.

The Association adjusted the Administrative Expenses in September 2011 to return $4,899 to the Program (Attachment II). The Association also wired $462 in Lost Investment Income to OPM on October 12, 2011for the $4,327 loss amount not adjusted (Attachment I) to return funds back to the Program.

5. Unsupported General Ledger Transactions $4,473

We contest that General Ledger transactions are not supported. The expenses in question were all incurred on employees' corporate credit cards. The Association directly receives an electronic feed of employee expenses from the credit card vendor for employees' charges which are used to populate an employee's expense report. This feed includes the detail information that would be found on a traditional paper receipt and thus is an electronic receipt. The employee must then expense the charge on an expense report that is approved by his/her manager. Once approved, the Association pays the credit card vendor directly.

Electronic receipts and invoices are quickly becoming a best practice in invoicing and are commonly accepted by auditors as adequate documentation. Blue Cross and Blue Shield Plans pay billions of dollars in benefit payments on the

basis of electronic claims. These electronic records have been accepted by the OIG and other auditors as adequate documentation of the expense incurred.

During the audit, we provided the OIG with documentation from employees' expense reports, but we did not supply the original credit card data from American Express. Attached are the electronic receipts for the transactions (Attachment IV).

We do agree that $138 is an unallowable charge to the Program but not because it is unsupported. This amount is the difference between a hotel charge and the applicable per diem limit and meal charges that were over the per diem limit and should not have been charged to the Program. The Association made an adjustment to our Administrative Expenses in September 2011 to return $138 to the Program (Attachment II). The Association also wired to OPM $11 in Lost Investment Income on October 12, 2011 (Attachment I) for this unallowable charge.

C. CASH MANAGEMENT

The Association concurs with the OIG's conclusion that the Association handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the Administrative Expense Adjustment finding noted in the "Administrative Expense" section.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit — Procedural

BCBSA FEP and the Local BCBS Plans have created a system of controls to monitor, identify, investigate and recover fraudulent and abusive payments of Program funds. Our goal is to protect Program funds from waste, fraud and abuse. During the audit scope, FEP processed a total of $118 billion in health benefit payments, had $323 million in fraud recoveries and savings, and Plans reported 3,955 cases to BCBSA FEP. OIG identified reporting issues with 22 cases during this audit. We disagree and believe there are only six cases with reporting issues. If we utilize OIG's number of 22 cases unreported, that would be a 0.55 percent error rate in reporting during the scope of the audit. While BCBSA believes our system of controls is in compliance with the requirements of CS 1039, we do agree that our policies and procedures can be enhanced as we strive for excellence.

Local BCBS Plan Fraud and Abuse Case Review

We disagree with the OIG's interpretation of our policies and procedures regarding the criteria for Local Plans' case input into FIMS. Based on the finding, the OIG interprets the FEP policy as requiring Plans to enter all cases in which FEP may have exposure into FIMS, regardless of whether that exposure is related to the initial accusation, compliance, billing error, or fraudulent activity. The OIG is determining exposure simply as a dollar of Program funds paid to a provider in question. Further the OIG finding states:

> "instances where a case was initiated by a local BCBS Plan and then closed due to the determination that a fraudulent activity did not exist or the allegation was unsubstantiated

> the cases should have still been entered into FIMS and then closed in FIMS concurrently with the local BCBS plan according to BCBSA FEPDO policy".

The intent of our policy is not that Local BCBS plans enter every case or project they initiate with potential FEP exposure as defined by OPM OIG, but for Plans to enter a case into FIMS once they have completed their initial review of the issue and confirmed the initial complaint, billing error, or fraudulent activity. BCBSA defines exposure as a dollar amount paid in which a confirmed issue exists. Page 22 of the FEP Fraud Prevention and Reporting Manual states, "Local Plans are required to notify the FEP SIU of potential fraud cases" however it refers the reader to Section 3.3 of the FEP FIMS manual for further clarification. Section 3.3 (Page 11) of the FIMS manual states that FIMS is a system for reporting **FEP fraud cases**. (Emphasis added). It also states that FIMS serves as the primary vehicle to report FEP Fraud related cases. Cases in which a Plan confirms there is no fraud issue, or that the issue is unrelated to FEP are not required to be entered into FIMS.

Additionally, Plans maintain a local case or project database in which they record all the related case activity. It would be duplicative and an inefficient use of Program funds for Plans to maintain case information in their local databases and FIMS for every case, allegation, billing error, etc. they investigate. It is the intent of BCBSA that Plans only enter case information once they have confirmed that there is FEP exposure to the original accusation, complaint, billing error, or fraudulent activity.

Lastly, BCBSA relies on the Plans to perform the initial investigation for determination of fraud, billing error, etc. before reporting to the BCBSA FEP Special Investigations Unit (SIU). The BCBSA FEP SIU does not make that determination based on initial leads. The Local Plans are the most familiar with the providers and market in question and are in a better position to determine the extent of the issue. The BCBSA FEP SIU monitors Plans' anti-fraud efforts by comparing the number of reported cases against total case volumes reported by Plans, performing site visits of Plans, and educating Plan personnel at Blue conferences and meetings. When improvement opportunities are noted, the BCBSA FEP SIU works with the Plan to improve their policies and procedures. The BCBSA FEP SIU will also work with other areas of the Plan and FEP Director's Office to correct Plan issues if needed. The effectiveness of this process was recently demonstrated by a turn-around for one multi-Plan organization that recently added anti-fraud staff in order to improve their FEP investigations and reporting.

The OIG also notes that for 8,869 cases they were unable to determine potential FEHBP exposure because the tax ID was not provided or due to timeliness issues related to the receipt of the response for the request for information. The OIG notes that the Plan Participation Agreement with Plans requires Plans to: "conform to all reasonable requests of the Association in connection with the

administration of the FEP, including providing OPM and the Association access to all of the Plan's records and other information **relating to FEP**." (Emphasis added). BCBSA would like to note that not all Plans maintain the tax ID in their fraud reporting systems; tax ID numbers were provided where available. Further, the Plan Participation Agreement, as quoted above, requires that data be provided that relates to FEP. The OIG requested Plan-specific fraud cases for their non-FEP business, which do not relate to FEP, and are not part of the requirement to provide data. BCBSA would like to note that the Plans did supply the requested Local Plan data for the OIG to perform their testing.

We do agree that our policies and procedures can be further refined regarding the specific criteria Plans should use to report cases. Therefore, we will update our policies and procedures by 1st Quarter 2012. We will also provide training to Plans regarding the updated policies and procedures through Plan written communications and at Blue Cross Blue Shield conferences.

Recovery Review

Based on BCBSA's review of the 22 recoveries in question, we agree that 6 should have been reported to OPM OIG but were not. However, the OIG notes that all 22 should have been reported per Carrier Letter 2007-12, indicating a difference in BCBSA's and OPM's interpretations of Carrier Letter 2007-12. BCBSA will review our policies and procedures to determine if updates should be made to comply with OPM OIG's interpretation of what constitutes, "suspected false, fictitious, fraudulent, or misleading insurance claims" per superseding Carrier Letter 2011-13 by 1st Quarter 2012. Further, corrective action was taken immediately regarding the 6 cases that were not reported to the OPM OIG. The actions included budget reductions to the Plans, onsite Plan visits by BCBSA FEP SIU staff for training and monitoring and the elevation of reporting issues to Plan Executive Management to address the issues. In addition, if the FEP SIU becomes aware of a case that was not reported properly in FIMS, we will notify the OIG immediately.

Pharmacy Case Review

Based on the finding, we have requested assistance from OIG Office of Investigations to develop an efficient method of reporting these cases. BCBSA would like to also note that Local BCBS Plans do report pharmacy-related cases to the BCBSA FEP SIU, contrary to what the OIG stated in the finding. We will update our policies and procedures to more clearly reflect this requirement and will update references in the policy by 1st Quarter 2012.

Return on Investment

BCBSA supplied the return on investment (ROI) calculation as a measurement of the effectiveness of our special investigation efforts, even though this measurement is not required by CS 1039. We agree that the PBM costs and SBP Operations Center costs could be included in the denominator. However, the costs for utilization reviews and hospital bill audits are included in the Local Plan Anti-Fraud budgets in the denominator. To address OPM's concerns, going forward, BCBSA will only report based on the measurements required in CS 1039.

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.

Sincerely,

[redacted]

Executive Director
Program Integrity

Cc: [redacted] OPM
[redacted] OPM
[redacted] BCBSA
[redacted] BCBSA