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

# Final Audit Report

**Subject:**

## AUDIT OF
## BLUESHIELD OF CALIFORNIA
## SAN FRANCISCO, CALIFORNIA

**Report No. 1A-10-67-12-004**

**Date:** January 10, 2013

**--CAUTION--**

# AUDIT REPORT

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

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BlueShield of California
Plan Code 542
San Francisco, California

REPORT NO. 1A-10-67-12-004 DATE: 01/10/13

Michael R. Esser
Assistant Inspector General
for Audits

**--CAUTION--**

# EXECUTIVE SUMMARY

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

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BlueShield of California
Plan Code 542
San Francisco, California

REPORT NO. 1A-10-67-12-004 DATE: 01/10/13

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at BlueShield of California (Plan), in San Francisco, California, questions $178,201 in health benefit charges and lost investment income (LII) and $41,516 in administrative expenses. The report also includes a procedural finding regarding the Plan's Fraud and Abuse (F&A) Program**.** The BlueCross BlueShield Association agreed ***(A)*** with the questioned charges and LII of $219,717, but generally disagreed ***(D)*** with the procedural finding regarding the Plan's F&A Program. Additional LII on the questioned charges amounts to $1,457, calculated from January 1, 2010 through May 30, 2012.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered miscellaneous health benefit payments and credits from 2006 through August 31, 2011, as well as administrative expenses from 2006 through 2010 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management practices related to FEHBP funds and the Plan's F&A Program from 2006 through August 31, 2011.

The audit results are summarized as follows:

## MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

- **[redacted] Drug Rebates *(A)*** **$174,158**

In four instances, the Plan had not returned quarterly drug rebates totaling $165,362 from the manufacturer of [redacted] to the FEHBP. In another instance, the Plan inadvertently returned a quarterly drug rebate amount of $29,737 twice to the FEHBP. The Plan also deposited 14 quarterly drug rebate amounts untimely into the Federal Employee Program (FEP) investment account. As a result of this finding, the Plan returned $152,586 (net) to the FEHBP, consisting of $135,625 (net) for the questioned drug rebates and $16,961 for LII on the drug rebates deposited untimely or not deposited into the FEP investment account.

In addition, the Plan returned a quarterly drug rebate amount of $21,572 to the FEHBP on February 15, 2012, more than a year after receipt. Since the Plan returned these funds to the FEHBP more than 60 days after receipt and after receiving our audit notification letter and standard audit request (dated September 2, 2011), we are questioning this amount as a monetary finding.

- **Fraud Recoveries *(A)*** **$4,043**

In one instance, the Plan had not returned a fraud recovery of $3,876 to the FEHBP. As a result of this finding, the Plan returned $4,043 to the FEHBP, consisting of $3,876 for the questioned fraud recovery and $167 for applicable LII.

## ADMINISTRATIVE EXPENSES

- **Pension Costs *(A)*** **$41,516**

The Plan overcharged the FEHBP $41,516 for pension costs in 2009 and 2010. As a result of this finding, the Plan returned these pension cost overcharges to the FEHBP.

## CASH MANAGEMENT

Overall, we concluded that the Plan 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 "Miscellaneous Health Benefit Payments and Credits" section.

## FRAUD AND ABUSE PROGRAM

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

The Plan's Special Investigations Unit is not in compliance with Contract CS 1039 and the FEHBP Carrier Letters, issued by the Office of Personnel Management (OPM), that are related to F&A Programs and notifying OPM's Office of the Inspector General of fraud and abuse cases in the FEHBP. The Plan is required to conduct a program to assess its vulnerability to fraud and abuse and demonstrate the benefits of its F&A Program.

## LOST INVESTMENT INCOME ON AUDIT FINDINGS

As a result of our audit findings presented in this audit report, the FEHBP is due LII of **$1,457**, calculated from January 1, 2010 through May 30, 2012.

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# I. INTRODUCTION AND BACKGROUND

## INTRODUCTION

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at BlueShield of California (Plan). The Plan is located in San Francisco, California.

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 BlueCross BlueShield Association (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. The Plan is one of approximately 64 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.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and Plan management. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

[1] Throughout this report, when we refer to "FEP", we are referring to the Service Benefit Plan lines of business at the Plan. When we refer to the "FEHBP", we are referring to the program that provides health benefits to federal employees.

All findings from our previous audit of the Plan (Report No. 1A-10-67-05-012, dated January 25, 2006) for contract years 2001 through 2003 have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with the Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated June 1, 2012. The Association's comments offered in response to the draft report were considered when preparing our final report and are included as an Appendix to this report. Also, additional documentation provided by the Association and Plan on various dates through August 1, 2012 was considered in preparing our final report.

# II. OBJECTIVES, SCOPE, AND METHODOLOGY

## OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objectives were as follows:

Miscellaneous Health Benefit Payments and Credits

- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.

- To determine whether credits and miscellaneous income relating to FEHBP benefit payments were returned promptly to the FEHBP.

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 Plan handled FEHBP funds in accordance with applicable laws and regulations concerning cash management in the FEHBP.

Fraud and Abuse Program

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

## SCOPE

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

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan code 542 for contract years 2006 through 2010. During the period, the Plan paid approximately $1.4 billion in health benefit charges and $166 million in administrative expenses (See Figure 1 and Schedule A).

Specifically, we reviewed the miscellaneous health benefit payments and credits (e.g., refunds, subrogation recoveries, drug rebates, and fraud recoveries), cash management activities, and the Plan's F&A Program for 2006 through August 31, 2011. We also reviewed administrative expenses for 2006 through 2010.

In planning and conducting our audit, we obtained an understanding of the Plan'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 Plan's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

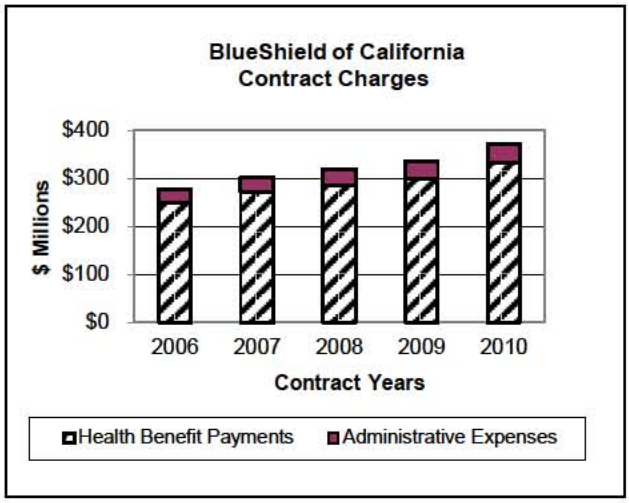


Figure 1 – Contract Charges

We also conducted tests to determine whether the Plan 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 Plan 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 Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office and the Plan. 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 Plan's office in San Francisco, California from February 7, 2012 through March 1, 2012. Audit fieldwork was also performed at our office in Jacksonville, Florida. Throughout the audit process, we encountered several instances where the Plan responded untimely, or initially provided incomplete responses, to various requests for supporting documentation. As a result, completion of our audit work and issuance of our draft and final reports were delayed.

## METHODOLOGY

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

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous health benefit payments and credits. We also judgmentally selected and reviewed 82 high dollar solicited health benefit refunds, totaling $1,431,821 (from a universe of 1,377 solicited refunds, totaling $8,216,562); 128 high dollar unsolicited health benefit refunds, totaling $744,380 (from a universe of 18,190 unsolicited refunds, totaling $3,831,295); 85 high dollar subrogation recoveries, totaling $856,499 (from a universe of 5,069 recoveries, totaling $4,980,402); all FEP drug rebate amounts, totaling $606,015; all FEP fraud recoveries, totaling $4,547; and 10 high dollar special plan invoices (SPI), totaling $1,936,880 in net FEP payments (from a universe of 143 SPI's, totaling $7,923,887 in net payments), to determine if refunds and recoveries were promptly returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP.[2] The results of these samples were not projected to the universe of miscellaneous health benefit payments and credits.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2006 through 2010. Specifically, we reviewed administrative expenses relating to cost centers, natural accounts, out-of-system adjustments, prior period adjustments, pension, post-retirement, employee health benefits, executive compensation, subcontracts, non-recurring projects, return on investment, and Health Insurance Portability and Accountability Act of 1996. We used the FEHBP contract, the FAR, and the FEHBAR to determine the allowability, allocability, and reasonableness of charges.

We reviewed the Plan's cash management practices to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations. We also interviewed the Plan's Special Investigations Unit regarding the effectiveness of the F&A Program, as well as reviewed case recoveries to test compliance with Contract CS 1039 and the FEHBP Carrier Letters.

[2] The samples of health benefit refunds included all solicited refunds greater than $10,000 and all unsolicited refunds greater than $3,000. For subrogation recoveries, the sample consisted of all recoveries greater than $6,000. For the SPI sample, we judgmentally selected 6 SPI's with high dollar miscellaneous payments totaling $2,234,938, as well as 4 SPI's with high dollar miscellaneous credits totaling $298,058.

# III. AUDIT FINDINGS AND RECOMMENDATIONS

## A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

### 1. [redacted] Drug Rebates $174,158

In four instances, the Plan had not returned quarterly drug rebates totaling $165,362 from the manufacturer of [redacted] to the FEHBP. In another instance, the Plan inadvertently returned a quarterly drug rebate amount of $29,737 twice to the FEHBP. The Plan also deposited 14 quarterly drug rebate amounts untimely into the Federal Employee Program (FEP) investment account. As a result of this finding, the Plan returned $152,586 (net) to the FEHBP, consisting of $135,625 (net) for the questioned drug rebates and $16,961 for LII on the drug rebates deposited untimely or not deposited into the FEP investment account.

In addition, the Plan returned a quarterly drug rebate amount of $21,572 to the FEHBP on February 15, 2012, more than a year after receipt. Since the Plan returned these funds to the FEHBP more than 60 days after receipt and after receiving our audit notification letter and standard audit request (dated September 2, 2011), we are questioning this amount as a monetary finding.

48 CFR 31.201-5 states, "The applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the contractor shall be credited to the Government either as a cost reduction or by cash refund."

Contract CS 1039, Part II, Section 2.3(i) states, "All health benefit refunds and recoveries, including erroneous payment recoveries, must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the FEHBP letter of credit account within 60 days after receipt by the Carrier." Also, based on an agreement between OPM and the Association, dated March 26, 1999, BlueCross and BlueShield plans have 30 days to return health benefit refunds and recoveries to the FEHBP before LII will commence to be assessed.

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 Plan participates in a drug rebate program with the manufacturer of the [redacted] drug. [redacted] drug rebates are received multiple times a year (usually on a quarterly basis) by the Plan and credited to the participating groups. For the period January 1, 2006 through August 31, 2011, there were 18 quarterly FEP drug rebate amounts totaling $606,015. We selected and reviewed all of these FEP drug rebate amounts for the purpose of determining if the Plan promptly returned these funds to the FEHBP.

The following summarizes the exceptions noted:

- In four instances, the Plan returned quarterly drug rebates of $165,362 to the letter of credit account (LOCA), but had not deposited these funds into the FEP investment account.[3] Since these drug rebates had not been deposited into the FEP investment account, we calculated LII of $12,140 on these funds. For these exceptions, we are questioning $165,362 for the drug rebate amounts not deposited into the FEP investment account and $12,140 for the applicable LII.

- In one instance, the Plan inadvertently returned a quarterly drug rebate amount of $29,737 twice to the FEHBP.

- The Plan returned 14 quarterly drug rebate amounts, totaling $440,654, to the LOCA, but deposited these funds untimely into the FEP investment account (i.e., from 10 to 445 days late). In one of these instances, the Plan returned the drug rebate amount of $21,572 to the FEHBP on February 15, 2012, more than a year after receipt (i.e., 380 days late). Since the Plan returned these funds to the FEHBP more than 60 days after receipt and after receiving our audit notification letter and standard audit request (dated September 2, 2011), we are questioning this amount as a monetary finding. For the remaining 13 drug rebate amounts, the Plan returned the funds to the FEHBP during the audit scope, so we did not question the principal amounts for these drug rebates. We noted that the Plan returned LII of $3,044 to the FEHBP on various dates during the audit scope for these exceptions. However, we calculated additional LII of $4,821 on these exceptions.

  In total for these 14 exceptions, we are questioning $21,572 for the drug rebate amount that was returned to the FEHBP more than 60 days after receipt and after our audit notification date, as well as $4,821 for additional LII on the drug rebate amounts that were deposited untimely into the FEP investment account.

In total, we are questioning $174,158, consisting of $157,197 ($165,362 plus $21,572 minus $29,737) for six drug rebate amounts and $16,961 ($12,140 plus $4,821) for applicable LII.

**Association Response**:

The Association agrees with this finding. The Association states that the Plan wire transferred $135,625 ($165,362 minus $29,737) into the FEP investment account on May 3, 2012, to make that account whole. The Plan also wire transferred $16,961 into the Association's FEP joint operating account on May 30, 2012, to resolve the questioned LII. The Association then returned this LII amount to OPM on June 6, 2012.

[3] The process of returning funds to the FEHBP requires the Plan to deposit the funds into the FEP investment account and adjust the LOCA for that amount.

The Association also states, "In order to ensure the timely return of drug rebates in the future, the Plan has initiated additional management review of all LOCA draw adjustment requests to ensure that pharmacy rebate draw adjustments are matched by offsetting transfer of funds into the segregated FEP bank accounts."

**OIG Comments**:

The Association provided documentation to support that the Plan deposited $135,625 (net) into the FEP investment account to complete the return process for five of the questioned drug rebate amounts. The Association also provided documentation to support that the questioned LII of $16,961 was returned to the FEHBP.

**Recommendation 1**

Since we verified that the Plan deposited $135,625 (net) into the FEP investment account to complete the return process for five of the questioned drug rebate amounts, no further action is required for this amount.

**Recommendation 2**

Since we verified that the Plan already returned $21,572 to the LOCA for the questioned drug rebate amount that was returned to the FEHBP more than a year after receipt and after receiving our audit notification letter and standard audit request, no further action is required for this amount.

**Recommendation 3**

Since we verified that the Plan returned $16,961 to the FEHBP for applicable LII on the drug rebate amounts deposited untimely or not deposited into the FEP investment account, no further action is required for this LII amount.

**2. Fraud Recoveries** **$4,043**

In one instance, the Plan had not returned a fraud recovery of $3,876 to the FEHBP. As a result of this finding, the Plan returned $4,043 to the FEHBP, consisting of $3,876 for the questioned fraud recovery and $167 for applicable LII.

As previously stated under audit finding A1, the Plan is required to promptly return fraud recoveries to the FEHBP with applicable LII.

For the period 2006 through August 31, 2011, there were only two FEP fraud recoveries totaling $4,547. We reviewed these two fraud recoveries to determine if the Plan promptly returned the funds to the FEHBP. In one instance, the Plan had not deposited a recovery of $3,876 into the FEP investment account nor returned these funds to the LOCA. Since this recovery had not been deposited into the FEP investment account, we also calculated LII of $167 on these funds.

**Association's Response:**

The Association agrees with this finding. The Association states that the Plan returned the questioned fraud recovery of $3,876 and applicable LII of $167 to the FEHBP via LOCA adjustment on March 13, 2012.

**OIG Comments:**

The Association provided documentation supporting that the Plan returned $4,043 to the FEHBP for the questioned fraud recovery and LII.

**Recommendation 4**

Since we verified that the Plan returned $3,876 to the FEHBP for the questioned fraud recovery, no further action is required for this amount.

**Recommendation 5**

Since we verified that the Plan returned $167 to the FEHBP for LII on the questioned fraud recovery, no further action is required for this LII amount.

## B. ADMINISTRATIVE EXPENSES

### 1. Pension Costs $41,516

The Plan incorrectly calculated the FEP pension costs in 2009 and 2010, resulting in overcharges of $41,516 to the FEHBP. As a result of this finding, the Plan returned these pension cost overcharges to the FEHBP.

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."

48 CFR 31.205-6(j)(2) states, "The cost of all defined-benefit pension plans shall be measured, allocated, and accounted for in compliance with the provisions of 48 CFR 9904.412, Cost accounting standard for composition and measurement of pension cost, and 48 CFR 9904.413, Adjustment and allocation of pension cost. The costs of all defined-contribution pension plans shall be measured, allocated, and accounted for in accordance with the provisions of 48 CFR 9904.412 and 48 CFR 9904.413. Pension costs are allowable subject to the referenced standards and the cost limitations and exclusions set forth in paragraph (j)(2)(i) and in paragraphs (j)(3) through (8) of this subsection."

FAR limits the amount of pension costs that may be charged to a government contract to the amount of any cash contribution to the pension fund trustee, or the amount of expense calculated in accordance with Cost Accounting Standards (CAS) 412 and 413, whichever is lower.

For the period 2006 through 2010, we reviewed the Plan's calculations of pension costs chargeable to the FEHBP. We found that in 2009 and 2010 the Plan did not use the correct base when calculating the appropriate allocation percentage used to compute FEP's allocable share of the pension costs. In determining FEP's percentage of the pension costs for each of these years, the Plan incorrectly calculated the FEP allocation percentage by using the funded amount as the base instead of the corporate payments from the cost system. As a result, the FEHBP was overcharged $1,490 in 2009 and $40,026 in 2010 for pension costs.

**Association's Response:**

The Assocation agrees with this finding. The Association states that the questioned pension costs of $41,516 were returned to the FEHBP. As a corrective action, the Association states that the Plan initiated a review process to ensure that pension costs are calculated based on the lower of CAS or funded amount.

**OIG Comments:**

We verified that the Plan returned $41,516 to the FEHBP for pension cost overcharges in 2009 and 2010. Specifically, the Plan wire transferred $41,516 to the Association's FEP joint operating account on May 30, 2012, and then the Association wire transferred these funds to OPM on June 12, 2012.

**Recommendation 6**

Since we verified that the Plan returned $41,516 to the FEHBP for pension cost overcharges, no further action is required for this questioned amount.

## C. CASH MANAGEMENT

Overall, we concluded that the Plan 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 "Miscellaneous Health Benefit Payments and Credits" section.

## D. FRAUD AND ABUSE PROGRAM

### 1. Special Investigations Unit — Procedural

The Plan's Special Investigations Unit (SIU) is not in compliance with Contract CS 1039 and the FEHBP Carrier Letters, issued by OPM, that are related to F&A Programs and notifying OPM's OIG of F&A cases in the FEHBP. The Plan is required to conduct a program to assess its vulnerability to fraud and abuse and demonstrate the benefits of its F&A Program.

From January 1, 2006 through August 2011, the FEHBP paid the Plan $228,911 to conduct anti-fraud activities. During this period, the Plan reported total recoveries of $4,547 to the FEP Director's Office (FEPDO). Based on this reported information, the return on investment was a negative $50 to $1. In other words, for every $50 the FEHBP provided to the Plan's fraud and abuse activities, the FEHBP received $1 in return.

Contract CS 1039 requires the Plan 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 FEHB 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." The Association's FEP Standards for Fraud Identification, Prevention and Reporting Manual (FEP Standards) states that local BCBS plans **are required** to notify the Association's FEP SIU of potential fraud cases, **regardless of dollar amount, at the time the case is initiated**.

The primary vehicle for the SIU at the local Plan to report potential FEP fraud cases and other anti-fraud activities to the FEPDO is via the Fraud Information Management System (FIMS). FIMS is a multi-user web based case tracking database, developed by the FEPDO, to facilitate and monitor FEP-related investigations. Local BCBS plans began using FIMS in January 2007, and since the inception of FIMS, the FEHBP has paid [redacted] to build and implement this system.

The FIMS Plan SIU User Guide (FIMS Guide) states that the Association's FEP SIU expects the local BCBS plans' SIU's to include FEP claims in all investigations and/or reviews and to timely report these investigations and/or reviews that involve FEP, regardless of the outcome and/or dollar threshold. The FIMS Guide also advises the BCBS plans not to wait until the investigation is complete and/or until fraud is proven before entering the information into the tracking system. Furthermore, Section 3.3.1 of the FIMS Guide states, "Anything reported in a Plan's data entry system should be reported concurrently in FIMS in order to comply with OPM's contract with BCBSA."

We found that the Plan is not entering all of the FEP fraud cases into FIMS. In our recent audit of the Association (Report No. 1A-10-91-11-030, dated March 6, 2012), we reviewed seven of the largest participating BCBS plans to determine their compliance with the Association's policies and procedures for reporting potential fraud and abuse cases. BlueShield of California was one of the seven plans we reviewed during that audit. As part of that review, we obtained the Plan's provider-related fraud cases for the period January 1, 2007 through December 31, 2008. The Plan's Special Investigations Department (SID) had documented a total of [redacted] cases from all lines of business in its own case tracking system. Our review of these [redacted] cases revealed that 155 of these cases, or [redacted] percent, had FEP exposure and should have been entered into FIMS. The Plan had only entered a total of eight cases into FIMS.

As part of our current audit, the Plan reported that they identified 23 potential fraudulent cases that impacted the FEP during the period January 1, 2009 through August 31, 2011,

but only 12 of those cases were reported in FIMS (2 of them were noted as part of the original 8 from the previous Association audit). Therefore, only 18 cases (8 from 2007 and 2008 and 10 from 2009 through August 2011) were entered into FIMS during the entire audit scope. In summary, the Plan identified at least [redacted] cases during the audit scope, of which 155 (2007 - 2008) plus an additional 23 (2009 - 2011), or 178 cases, potentially impacted the FEHBP. As of August 31, 2011, only 18 cases had been entered into FIMS.

The Association's FEP SIU staff met with the Plan's SID staff only four times during the audit scope for FEP and/or FIMS training sessions. The Association's Policies and Procedures Manual states, "Some Plans may require onsite visits for FEP and FIMS training, usually triggered by under reporting or new SIU staff at the Plan . . . A summary of the visit will be completed in a memo format and forwarded to FEP SIU management." Of the four training meetings held, the Plan could only provide a written memo for one of these meetings. That memo, dated December 8, 2010, related to a training session held on November 8 and November 9, 2010. According to this memo, many of the investigators acknowledged the need for additional FIMS training. One of the statements in the memo noted, "The omission of recorded financial exposure and recovery dollars were discussed." Another statement in the memo noted that the investigators generally identify FEP dollars at the close of a case. These statements clearly indicate that the SID staff did not understand how to properly use FIMS and were not aware of the requirements associated with the FEP account. Carrier Letter 2007-12 (Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHB Program) and various other OPM and Association guidance require that OPM and OPM's OIG are to be notified once there is a suspicion of fraud; not at the close of the case. Lastly, the memo states, "FIMS entries will be monitored to ensure they proceed in a proficient and timely fashion over the next 60 days. My expectation is that pertinent FIMS cases will begin to be accurately reported and recorded during this period." These statements demonstrate that the SID had not been accurately using FIMS to report all FEP exposure and recoveries. Moreover, the memo states that there will be some type of follow-up review in 60 days to determine if there has been improvement in the quality of FIMS reporting. We received no support that indicated a follow-up review was performed.

In addition, although the Plan's Senior Manager of the SID and the Association's Director of the FEP SIU both attended at least 18 quarterly meetings of the National Anti-Fraud Advisory Board (NAAB) during the audit period, neither the Plan nor the Association provided any information to support that issues related to compliance and/or non-compliance with reporting cases into FIMS, FEP oversight issues, or any other FEHBP-related requirements or training took place or were even discussed at these meetings. The FEHBP pays all of the FEPDO's travel expenses for these meetings, which have taken place in various locations, such as Honolulu, Hawaii; Chicago, Illinois; and New Orleans, Louisiana; because these meetings are supposed to benefit the FEHBP. Our review found no evidence that these meetings or training events had any effect on the FEHBP regarding the Plan's compliance with OPM and FEPDO guidance; the amount of recoveries or savings; or patient safety/health care outcomes.

After four training sessions between the Association's FEPDO and the Plan's SID on FIMS and FEP compliance, less than 10 percent of the Plan's fraud cases with potential FEP exposure were entered into FIMS. However, after only one brief meeting with the OIG's Office of Investigations during the audit, SID management stated that they would enter all potential fraud cases with FEP exposure into FIMS in the future.

In addition to not identifying and reporting potential FEP fraud cases, the Plan did not report any other FEP savings. Contract 1039, Carrier Letter 2003-25 (Revised FEHB Quality Assurance and Fraud and Abuse Reports), and Association guidance require the BCBS plans to report actual and potential savings from their fraud and abuse program activities. In their internal fraud policies, the Plan reported that their five investigators work to detect and prevent health care fraud and abuse, resulting in savings in excess of $6 million a year. It is unclear which line of business benefits from the efforts that resulted in savings in excess of $6 million a year. In response to our request for total FEP and corporate savings, the Plan stated that the SIU does not report to management a summary of the SIU's corporate progress. Again, this statement is inconsistent with the Plan's own policy statement that states that the SIU saves the company approximately $6 million a year.

The Plan provided a spreadsheet that included total recoveries/restitution of $[redacted] from all lines of business (including the $4,547 in FEP recoveries) during the audit scope. The recovery summary listed at least 100 cases and projects with no explanation whether the FEP was included, if the cases were a result of SID actions or anti-fraud activities, and/or whether the cases were even related to fraud and abuse activities. As an example, the report included recoveries for a "Duplicate Payment Project" with no FEP recoveries. We requested the Plan to provide a total listing of cases from all lines of business entered into their case tracking system from January 1, 2009 through August 31, 2011. However, the Plan only provided a listing of the 23 FEP-related cases previously provided.

The Plan has not been able to provide any documentation showing the SID's anti-fraud program activities resulted in any savings or cost avoidance for the FEHBP. The Plan's SID staff stated that their department only performs fraud detection and investigations, and does not perform any review and/or investigation of waste and abuse issues.

The Plan's SID anti-fraud program does not have a system in place to fully detect, prevent, and investigate fraud and abuse, as well as report to OPM and OPM's OIG all fraud and abuse activities. Furthermore, the Plan does not have a system in place to fully assess its vulnerability to fraud, waste and/or abuse issues within their SID or any other department. As a result, the Plan has not fully adopted the requirements of Contract CS 1039; Carrier Letter 2003-25 (Revised FEHB Quality Assurance and Fraud and Abuse Reports); Carrier Letter 2007-12 (Notifying OPM's Office of the Inspector General Concerning Fraud and Abuse Cases in the FEHB Program); Carrier Letter 2011-13 (Fraud and Abuse: Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General); and fraud and abuse reporting guidance issued by the Association. As a result, the FEHBP is not fully benefiting from the Plan's F&A Program and may be foregoing savings, case referrals and fraudulent recoveries.

**Association's Response:**

The Association states that the Plan is in compliance with Contract CS 1039. However, to be in full compliance with the contract, Carrier Letters, and the Association's requirements, they implemented additional processes for reporting recoveries, as well as savings, prevented loss, identified loss and court ordered restitutions. The Plan has also enhanced their FIMS training and has adopted procedures to immediately enter cases into FIMS whenever FEHBP exposure is identified.

The Association disagreed that the Plan was not in compliance with the requirements of the Association's FEP SIU manual. The Association states that the OIG omitted clarifying language from the FEP SIU Manual that limits what the local plan is required to report to the Association. According to the Association, the manual states, **"The potential fraud cases should be reported in FIMS. . . after a preliminary investigation has determined that the allegation merits a complete investigation (conformation [sic] of the complaint, billing error, or fraudulent activity) and that FEP claims are at risk. Investigations in which the Plan confirms there is no issue, or the allegation is unrelated to FEP are not required to be entered into FIMS."**

Regarding the 22 meetings for FIMS training and compliance issues, the Association states that 18 of the 22 meetings were with the BCBSA National Anti-Fraud Advisory Board (NAAB), a national anti-fraud task force consisting of about 15 local BCBS plans that meet regularly to address system-wide issues. The Association states, "These meetings were not meant to address training and compliance issues for BSC, but were meetings of the National Anti-Fraud Advisory Board. Any discussions about FEP specifically would have been incidental." With respect to the four visits to the Plan by the FEPDO staff members for FIMS instructions, the Association provided an example of an Association prepared meeting summary, which is required by the Association's Fraud Manual to document BCBS plan site visits.

The Association also disagreed with the OIG's calculation of a negative 50:1 ratio for return on investment. The Association states that the calculation is based on both incomplete and incorrect information. To properly calculate a return on investment to measure the impact of the government's funding of the Plan's anti-fraud efforts, the Plan based the calculation on the total savings and recovery efforts by the SID and operational efforts as a result of SID initiated reviews. The additional efforts include claim edits and audit codes that prompt the denial of claims due to SID investigative activities. The actual claim denials and savings generated as a result of SID activities for the audit period of January 1, 2006 to August 31, 2011 were 2,448 claim denials and $885,481 in savings. Therefore, according to the Association, the Plan's actual return on investment ratio is a positive 4.25:1.

The Association states that the Plan is unable to respond to the finding related to the [redacted] in total recoveries/restitution because the OIG did not provide the requested information on the 100 cases identified in the report.

The Plan is currently in the process of evaluating and restructuring its comprehensive fraud, waste and abuse initiatives, which currently encompass multiple departments within the Plan, to ensure greater cross-organizational structure and coordination. The Plan will continually work toward enhancing all reporting processes and workflows regarding fraud, waste and abuse.

**OIG Comments:**

We disagree that, during the audit scope, the Plan was in compliance with the FEHBP contract, OPM's Carrier Letters, and various other OPM and Association guidance. In addition, the Plan did not provide evidence that their F&A Program is a benefit to the FEHBP. However, we acknowledge that the Plan is implementing corrective actions to improve their existing policies and procedures.

The Association states that the OIG omitted clarifying language from the Association's FEP SIU Manual that limits what the Plan is required to submit into FIMS. The language quoted in the response is new language that the Association added to the revised "FEP Standards for Fraud Prevention, Detection and Investigation Manual" in December 2011. This language was developed after the audit scope and does not apply to the current audit. Furthermore, without a review by the OIG of the updated language, we can not determine if the updated language is compliant with Carrier Letter 2011-13, Fraud and Abuse: Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General**,** effective on June 17, 2011. This Carrier Letter requires Carriers to report all potential fraud cases when there is a reasonable suspicion that a fraud has and/or is occurring. Nowhere within Carrier Letter 2011-13 does it suggest that plans should only report cases where they have confirmation of the complaint, billing error, or fraudulent activity.

The Association states that 18 of the 22 meetings between the Association's FEP SIU and the Plan's SIU were for the BCBSA National Anti-Fraud Advisory Board (NAAB) and that any discussions about FEP specifically would have been incidental. Since the FEHBP pays all of the Association's travel expenses to attend these meetings, it is unfortunate and inefficient that any and all FEP discussions are incidental. The Plan provided a summary memo documenting one of the four training visits by the Association's FEP SIU to the Plan. The Plan did not provide any documentation of the other three training visits. From the results of the review, it is unclear what training actually took place during these visits.

We do not agree with the Plan's calculated return on investment of 4.25:1. The Plan has not shown or provided documentation that the savings of $885,481 were related to any type of fraud and abuse activity. We began requesting the actual savings from fraud and abuse activities in an audit information request, dated February 10, 2012. Also, the Plan has not provided the costs charged (and the corresponding cost centers) to the FEHBP for the anti-fraud activities that resulted in the savings being reported.

Furthermore, as cited by the Plan, "The SID works with a number of other BSC departments in its efforts to combat fraud, waste and abuse. These departments include

Claims, Customer Service, Corporate Finance, Medical Management, Pharmacy Services and Medicare Operations." Again, the Plan has not provided the roles, responsibilities and costs associated with the above-noted departments' anti-fraud activities. Thus, the Plan's ROI calculation does not include all factual information and is therefore incomplete.

Regarding the 100 cases, we obtained the listing of those cases in a spreadsheet that the Plan titled "Summary of Recoveries Report 01012009 – 08312011" and provided to the OIG on March 6, 2012 in response to an audit information request. This spreadsheet appeared to list approximately 100 cases and projects that were identified by the Plan with associated recoveries related to SID fraud and abuse activities. However, we noted that some of these 100 cases were not included in the Plan's local case tracking system (i.e., Duplicate Payment Project, Pharmacy Settlements, etc.) and it was unclear whether the Plan included the FEHBP in their review of these cases and projects where the Plan obtained recoveries. Since the Plan provided this listing to the OIG, the Plan should have all of the information needed to respond to this finding.

Lastly, we are pleased that the Plan is taking steps to enhance its compliance with the FEHBP contract, as well as the Carrier Letters and the Association's guidance and requirements. We agree with the majority of the improvements and process changes described in the Plan's response. However, we would like to remind the Plan that current OPM-approved guidance states that all fraud, waste, and abuse allegations and complaints should be timely reviewed, investigated and submitted into FIMS regardless of whether the complaint or allegation is substantiated and regardless of identified FEHBP exposure.

**Recommendation 7**

We recommend that the contracting officer have the Association verify that the Plan implements a policy to review and investigate all fraud, waste, and abuse allegations and/or issues within the SID. The Plan should timely report all fraud, waste, and abuse allegations and/or issues in FIMS, whether substantiated or not, based on the guidelines established by the Association's FEP SIU and required by OPM's Carrier Letter 2011-13 (Fraud and Abuse: Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General).

**Recommendation 8**

We recommend that the contracting officer have the Association verify that the Plan implements a process to track all instances of SID-initiated recoveries, claim denials and cost avoidance, and link the recoveries, actual savings, and cost avoidance to the initiated cases and/or investigations in order to accurately report FEP-related recoveries and actual and/or projected savings to the Association and OPM annually, as required in Carrier Letter 2003-25 (Revised FEHB Quality Assurance and Fraud and Abuse Reports).

**Recommendation 9**

We recommend that the contracting officer instruct the Plan to update its F&A policy and procedure manual to accurately reflect the requirements of the FEHBP, industry standards, case sharing and reporting guidelines, as well as the annual reporting requirements of Carrier Letters 2003-23 (Fraud and Abuse Industry Standards), 2003-25 (Revised FEHB Quality Assurance and Fraud and Abuse Reports), and 2011-13 (Fraud and Abuse: Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General). The Plan should also update this manual to accurately reflect the performance of the SID and F&A Program, the SID's duties and responsibilities, and all other duties and responsibilities of other Plan departments that relate to anti-fraud activities.

**Recommendation 10**

We recommend that the contracting officer direct the Association to provide OPM and OPM's OIG full access to FIMS. We also recommend that the contracting officer direct the Association to invite a staff member from OPM OIG's Office of Investigations to attend the BCBSA National Anti-Fraud Advisory Board meetings.

**Recommendation 11**

We recommend that the contracting officer require the Plan to provide the methodology and a measure of performance (based on industry standards) ensuring that the F&A Program is a benefit to the FEHBP, in accordance with Contract CS 1039, Section 1.9(a).

## E. LOST INVESTMENT INCOME ON AUDIT FINDINGS $1,457

As a result of the audit findings presented in this report, the FEHBP is due LII of $1,457 from January 1, 2010 through May 30, 2012.

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."

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 due LII of $1,457 from January 1, 2010 through May 30, 2012 on questioned costs for contract years 2009 through 2010 (see Schedule C).

**Association's Response**:

The draft audit report did not include an audit finding for LII. Therefore, the Association did not address this item in its reply.

**OIG Comments:**

The "[redacted] Drug Rebates" (A1) and "Fraud Recoveries (A2) audit findings already include the applicable LII, and therefore, are not subject to our LII calculation in Schedule C.

For the "Pension Costs" (B1) audit finding, the Plan wire transferred the questioned charges into the Association's FEP joint operating account on May 30, 2012. Accordingly, we calculated LII on this audit finding through the date when the Plan wire transferred the funds into the Association's FEP joint operating account. We noted that the Plan returned LII of $131 to the FEHBP on July 28, 2012 for this audit finding. However, based on our calculation, additional LII of $1,326 ($1,457 minus $131) is still due the FEHBP for this audit finding.

**Recommendation 12**

Since we verified that the Association returned $131 to the FEHBP for LII on audit finding B1, no further action is required for this questioned LII amount.

**Recommendation 13**

We recommend that the contracting officer direct the Plan to credit the Special Reserve an additional $1,326 for LII on audit finding B1.

# IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted], Lead Auditor

[redacted], Auditor

[redacted], Auditor

[redacted], Auditor

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[redacted], Chief ([redacted]

[redacted], Senior Team Leader

Office of Investigations

[redacted], Special Agent-In-Charge

[redacted] Special Agent-In-Charge

[redacted], Senior Audit Advisor to the Assistant Inspector General for Investigations

SCHEDULE A

## V. SCHEDULES

## BLUESHIELD OF CALIFORNIA
## SAN FRANCISCO, CALIFORNIA

## CONTRACT CHARGES

| CONTRACT CHARGES* | 2006 | 2007 | 2008 | 2009 | 2010 | TOTAL |
|---|---|---|---|---|---|---|
| **A. HEALTH BENEFIT CHARGES** | | | | | | |
| PLAN CODE 542 | $248,696,670 | $268,912,376 | $283,840,740 | $298,287,070 | $330,013,542 | $1,429,750,398 |
| MISCELLANEOUS PAYMENTS AND CREDITS | 1,407,080 | 1,410,621 | 1,363,304 | 1,009,189 | 1,681,350 | 6,871,544 |
| TOTAL HEALTH BENEFIT CHARGES | $250,103,750 | $270,322,997 | $285,204,044 | $299,296,259 | $331,694,892 | $1,436,621,942 |
| **B. ADMINISTRATIVE EXPENSES** | | | | | | |
| PLAN CODE 542 | $26,143,040 | $30,829,109 | $33,618,718 | $35,854,079 | $39,939,074 | $166,384,020 |
| PRIOR PERIOD ADJUSTMENTS | (11,069) | 0 | 0 | 16,855 | 0 | 5,786 |
| TOTAL ADMINISTRATIVE EXPENSES | $26,131,971 | $30,829,109 | $33,618,718 | $35,870,934 | $39,939,074 | $166,389,806 |
| TOTAL CONTRACT CHARGES | $276,235,721 | $301,152,106 | $318,822,762 | $335,167,193 | $371,633,966 | $1,603,011,748 |

* This audit covered miscellaneous health benefit payments and credits and cash management activities from January 1, 2006 through August 31, 2011, as well as administrative expenses from 2006 through 2010.

SCHEDULE B

**BLUESHIELD OF CALIFORNIA**
**SAN FRANCISCO, CALIFORNIA**

**QUESTIONED CHARGES**

| AUDIT FINDINGS | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | TOTAL |
|---|---|---|---|---|---|---|---|---|
| **A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS*** | | | | | | | | |
| 1. [redacted] Drug Rebates | $1,036 | $2,246 | $1,323 | $57,604 | $105,995 | $4,264 | $1,690 | $174,158 |
| 2. Fraud Recoveries | 0 | 0 | 0 | 0 | 3,906 | 99 | 38 | 4,043 |
| TOTAL MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS | $1,036 | $2,246 | $1,323 | $57,604 | $109,901 | $4,363 | $1,728 | $178,201 |
| **B. ADMINISTRATIVE EXPENSES** | | | | | | | | |
| 1. Pension Costs** | $0 | $0 | $0 | $1,490 | $40,026 | $0 | $0 | $41,516 |
| TOTAL ADMINISTRATIVE EXPENSES | $0 | $0 | $0 | $1,490 | $40,026 | $0 | $0 | $41,516 |
| **C. CASH MANAGEMENT** | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **D. FRAUD AND ABUSE PROGRAM** | | | | | | | | |
| 1. Special Investigations Unit (Procedural) | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| TOTAL FRAUD AND ABUSE PROGRAM | $0 | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **E. LOST INVESTMENT INCOME ON AUDIT FINDINGS** | $0 | $0 | $0 | $0 | $47 | $1,064 | $346 | $1,457 |
| **TOTAL QUESTIONED CHARGES** | $1,036 | $2,246 | $1,323 | $59,094 | $149,974 | $5,427 | $2,074 | $221,174 |

*** We included lost investment income (LII) within audit findings A1 ($16,961) and A2 ($167). Therefore, no additional LII is applicable for these audit findings.**
**** Audit finding is subject to LII calculation (See Schedule C).**

SCHEDULE C

**BLUESHIELD OF CALIFORNIA**
**SAN FRANCISCO, CALIFORNIA**

**LOST INVESTMENT INCOME CALCULATION**

| LOST INVESTMENT INCOME | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012** | TOTAL |
|---|---|---|---|---|---|---|---|---|
| **A. QUESTIONED CHARGES (Subject to Lost Investment Income)** | | | | | | | | |
| Administrative Expenses* | $0 | $0 | $0 | $1,490 | $40,026 | $0 | $0 | $41,516 |
| TOTAL | $0 | $0 | $0 | $1,490 | $40,026 | $0 | $0 | $41,516 |
| **B. LOST INVESTMENT INCOME CALCULATION** | | | | | | | | |
| a. Prior Years Total Questioned (Principal) | $0 | $0 | $0 | $0 | $1,490 | $40,026 | $0 | |
| b. Cumulative Total | 0 | 0 | 0 | 0 | 0 | 1,490 | 41,516 | |
| c. Total | $0 | $0 | $0 | $0 | $1,490 | $41,516 | $41,516 | |
| d. Treasury Rate: January 1 - June 30 | 5.125% | 5.250% | 4.750% | 5.625% | 3.250% | 2.625% | 2.000% | |
| e. Interest (d * c)** | $0 | $0 | $0 | $0 | $24 | $545 | $346 | $915 |
| f. Treasury Rate: July 1 - December 31 | 5.750% | 5.750% | 5.125% | 4.875% | 3.125% | 2.500% | | |
| g. Interest (f * c) | $0 | $0 | $0 | $0 | $23 | $519 | | $542 |
| Total Interest By Year (e + g) | $0 | $0 | $0 | $0 | $47 | $1,064 | $346 | $1,457 |

* Only the administrative expense overcharges on Schedule B are subject to lost investment income.

** We calculated lost investment income through May 30, 2012, which is the date when the Plan wire transferred the questioned charges into the Association's FEP joint operating account.

August 10, 2012

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BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G Street, N.W.
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202.942.1000
Fax 202.942.1125

**Reference:** **OPM DRAFT AUDIT REPORT RESPONSE**
**Blue Shield of California**
**Audit Report Number 1A-10-67-12-004**
**(Dated June 1, 2012 and Received June 1, 2012)**

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 Blue Shield of California. Our comments concerning the findings in the report are as follows:

## A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

### 1. [redacted] Drug Rebates $174,158

The amount of $174,158 is the net between $186,934 in rebates that had not been returned timely plus $16,961 in lost investment income minus $29,737 in rebates that the Plan returned twice to the Program. We acknowledge receipt of your Draft Audit Report, dated June 1, 2012, in which you confirmed the return of $21,572 in Rebates to the Program. OPM auditors also confirmed that the Plan had returned $135,325 to the Program by directly adjusting its Letter of Credit Account (LOCA) Drawdown instead of first transferring the funds to its FEP Investment Account. On May 3, 2012, the Plan transferred $135,325 from its corporate bank account to their FEP Investment Account in order to make that account whole. In addition, on May 30, 2012, the Plan wire transferred $16,961 to FEP's bank account to resolve lost investment income issue. These funds were returned to OPM on June 6, 2012.

In order to ensure the timely return of drug rebates in the future, the Plan has initiated additional management review of all LOCA draw adjustment requests to ensure that pharmacy rebate draw adjustments are matched by offsetting transfer of funds into the segregated FEP bank accounts.

**2. Fraud Recoveries** **$4,043**

The Plan agrees that $3,876 in fraud recoveries and $167 in lost investment income were not returned to the Program. The Plan provided documentation to support the return of these funds to the Program by way of an adjustment to its LOCA on March 13, 2012. In order to ensure the timely return of fraud recoveries in the future, the Plan initiated additional confirmation procedures to ensure that all FEP fraud recoveries are deposited directly into the segregated FEP bank accounts.

**3. Fraud and Abuse** **Procedural**

Despite having submitted fulsome responses that addressed many of OPM OIG's concerns, OPM OIG has not revised its initial findings other than to correct the amount paid to the Plan by FEHBP to conduct anti-fraud work. Further, despite requesting additional data and explanations from OPM OIG to enable the Plan to respond to the remainder of OPM OIG's initial findings, OPM OIG has not met the Plan's requests. The lack of data and explanation concerning certain of OPM OIG's findings that are now included in this Draft Audit Report prevent the Plan from providing as complete a response as it would like.

In responding to the draft report, the response has been divided into two sections. The first section addresses OPM OIG comments included in the report that are not associated with a specific recommendation. The second section addresses the Plan's response to recommendations 6-11.

**Section 1 – Draft Report Comments**

**Report Conclusion:** We disagree with the conclusion in the draft report that the Plan is not in compliance with contract CS1039, the FEHBP F&A Carrier Letters and guidance issued by the FEP Director's Office. The Plan's Special Investigation Division (SID) is in compliance with contract CS 1039 and has an effective program to combat fraud, waste and abuse. The SID is just one part of the Plan's overall fraud, waste and abuse program and focuses exclusively on investigating and pursuing recoveries from provider fraud. The SID researches, reviews and reports all allegations of fraud in all programs. Specific attention is given to the Federal

Employee Health Benefits Program due to the unique structure and reporting requirements of the program. The Plan also utilizes all available case recording and reporting tools in the investigation of substantiated fraud allegations, including the Federal Employee Program Special Investigations Manual, published by the Federal Employee Program Director's Office (FEPDO), and the Fraud Information Management System (FIMS) created by the FEPDO. The SID is tasked with the prevention, detection and investigation of health care fraud across all lines of business, including individual, small and large group products, Medicare and Federal Employee Health Benefits programs. The SID works with a number of other BSC departments in its efforts to combat fraud, waste and abuse. These departments include Claims, Customer Service, Corporate Finance, Medical Management, Pharmacy Services and Medicare Operations. Within Medical Management, the SID works specifically with the Provider Compliance Review (PCR) and Facility Compliance Review (FCR) departments. The PCR and FCR departments are tasked with reviewing medical care determined to be outside of normal practice, which can involve fraud, waste and abuse. Cases involving potential fraud are referred to the SID for investigation whereas cases involving potential waste and/or abuse are handled within the PCR and FCR. The PCR and FCR departments are each staffed with a fraud, waste and abuse coordinator. These coordinators triage fraud, waste and abuse complaints, refer potential fraud cases to the SID, and handle waste and abuse cases within the coordinators' respective departments. Likewise, when the SID determines, after research, that a case contains little or no evidence for the substantiation of a fraud investigation, a referral may be made to the departments handling potential waste and/or abuse. The SID is in continuous communication with these departments and participates in cross-organizational work groups such as the Medicare Compliance Committee and the Pharmacy Services Work Group. The purpose, in part, for these work groups is to discuss issues related to fraud, waste and abuse. The Plan is currently reviewing its comprehensive fraud, waste and abuse programs and will make improvements, as necessary, once the assessment is completed. We expect to implement recommendations that result from the assessment by 2nd quarter 2013.

In summary, although the Plan disagrees with the conclusion on its fraud and abuse activities, the Plan seeks to continuously improve its program and accordingly, agrees that some of the recommendations included in this report will enhance its current program.

**FEP SIU and FIMS Manual:** The draft report quotes the FEP SIU Manual as saying, "all local Plans are required to notify the FEP SIU of potential fraud cases

regardless of dollar amount and at the time the case is initiated" (Emphasis added in audit inquiry). While the quoted language is accurate, the FEPDO does not require local Plans to report fraud investigations regardless of the initial findings of the investigation. As the sentences that follow the quoted language in Section Six (Reporting) of the Manual clarify, a local Plan is required to report only potential fraud which merits investigation and which implicates FEP claims and finances: **"The potential fraud cases should be reported in FIMS. . . after a preliminary investigation has determined that the allegation merits a complete investigation (conformation [sic] of the complaint, billing error, or fraudulent activity) and that FEP claims are at risk. Investigations in which the Plan confirms there is no issue, or the allegation is unrelated to FEP are not required to be entered into FIMS.**

The draft report's claim that the local Plan must report all potential fraud cases is misleading. It marginalizes the overall intent of the manual instructions when taken out of context. We therefore respectfully request that this be removed from the draft report.

The draft report also includes numerous quotes from Section 3.3 of the FIMS Guide (General Expectations – What To Report & When):

> "It is expected that all plan SIUs [sic] 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." (Emphasis added in audit inquiry) "Anything reported in a Plan's data entry system should be reported concurrently in FIMS in order to comply with OPM's contract with BCBSA."

While these statements are accurately quoted, they too omit language in the FIMS Guide that provides essential context and that clarifies that only potential fraud which merits investigation and which implicates FEP claims and finances are to be reported: See first paragraph above for FEP reporting requirements.

**1/1/09 – 8/31/11 Potential Fraud Cases**: In its initial responses to the OPM OIG, the Plan disagreed with OPM OIG's finding about the potential fraudulent cases that impacted the FEP reported by the Plan from January 1, 2009 through August 31, 2011, and requested additional time to validate 20 of the OPM OIG reviewed cases

and review the list of 178 cases (of 302 cases) the BCBSA requested from the OPM OIG. While a report was provided by the OPM OIG to illustrate the finding, the SID was not provided with sufficient case by case detail of the analysis of the cases in question. Without the requested and necessary detail, the Plan would have to review all 302 cases to determine which cases the OIG is referring to. As a result, the Plan is unable to properly address the issues associated with this finding until the 178 of 302 cases are identified.

**22 Meetings with Plan:** The draft report also includes statements dealing with meetings between the FEPDO SIU and BSC which are not correct. BSC participates in the BCBSA National Anti-Fraud Advisory Board (NAAB), a national anti-fraud task force consisting of about 15 local Plans that meet regularly to address system-wide issues. By agreement, the locations of the meetings of the National Anti-Fraud Advisory Board rotate among the home cities of the participating Plans (and the hotel rates for such meetings are not the typical rates tourists pay when visiting the cities, but rather are rates negotiated by the home Plan that typically are consistent with the conference rates paid by Plans).

These meetings among the various Plans are an essential component of BCBSA's anti-fraud oversight role in that they allow BCBSA and the Plans to address national issues. These meetings were not meant to address training and compliance issues for BSC, but were meetings of the National Anti-Fraud Advisory Board. Any discussions about FEP specifically would have been incidental. Of the 22 meetings referenced by OPM OIG in the draft report, four were visits to the Plan by FEPDO staff members for FIMS instruction, relationship-building, training and presentations. The remaining 18 meetings were in conjunction with NAAB quarterly meetings.

Further, there were no expenses directly paid for by the FEHBP or costs directly charged to the FEHBP for any meetings or travel engaged in by the Plan related to the NAAB meetings. To suggest otherwise, without supporting empirical evidence, is irresponsible. See **Attachment 3** for Plan travel expenses charged to the Program.

With respect to the four visits to the Plan by the FEPDO staff members for FIMS instruction, see **Attachment 1** for an example of a BCBSA prepared meeting summary which is required by the FEPDO Fraud Manual to document Plan site visits.

**FEP Savings and ROI:** The OPM OIG's calculation of a negative 50:1 ratio for return on investment is incorrect. It is based on both incomplete and incorrect information.

To properly calculate a return on investment to measure the impact of the government's funding of the Plan's anti-fraud efforts, the Plan based the calculation on the total savings and recovery efforts by the Special Investigations Department ***and*** operational efforts as a result of SID initiated reviews. The additional efforts include claim edit and audit codes which prompt the denial of claims due to SID investigative activities. The following report shows actual claim denials and savings generated as a result of SID activities for the audit period of January 1, 2006 to August 31, 2011.

Refer to **Exhibit 1**, "FEP Operational Savings (SID Initiated" and "SID Cash Recoveries":

| FEP Operational Savings (SID Initiated) | | |
|---|---|---|
| **Year** | **Claim Count** | **Amount** |
| 2006 | [redacted] | [redacted] |
| 2007 | [redacted] | [redacted] |
| 2008 | [redacted] | [redacted] |
| 2009 | [redacted] | [redacted] |
| 2010 | [redacted] | [redacted] |
| 2011 | [redacted] | [redacted] |
| **Total** | [redacted] | [redacted] |

Source – Condition Code Analysis Reports – FEP Operations

| **SID Cash Recoveries** | | |
|---|---|---|

| Year | Subject Type | Amount |
|---|---|---|
| 2009 | [redacted] | [redacted] |
| 2010 | [redacted] | [redacted] |
| **Total** | | [redacted] |

Source –SIRS Reporting System - SID Special Investigations

These reports are based on FEP standards and industry best practices and are reported in Condition Code Analysis Reports. A Condition Code Analysis Report is a report of edit and audit codes which are utilized in the processing of claims. These codes, which are system generated, may prompt the suspension of claim processing for additional analysis and/or consideration, the reduction in payment or a denial of a claim due to an unusual circumstance. The output of the report includes the number of claims and dollars affected by these transactions, as well as number of categories which include eligibility, benefits and medical review. Accordingly, the proper and complete figure to use as a measure of the Plan's anti-fraud efforts includes an amount that reflects the Plan's anti-fraud recoveries ($4,547) and savings ($885,481.28).

When the Plan's anti-fraud generated recoveries and savings is compared to the actual costs incurred ($209,498.98 over the period under audit- refer to **Attachment 2** - "FEP Anti-Fraud Costs - 2006 - Aug YTD 2011"), the following ratio derived is as follows:

$890,028.56 (monies recovered and claim denials based on SID activities)/
$209,248.98 (five year budget allocation for Anti-Fraud Costs)

The return ratio over the audit period is calculated to be a **positive** return on investment (ROI) of **4.25:1**. As such, for every $1 the FEHBP provided to the Plan's fraud activities, the FEHBP received $4.25 in savings. We will continue to use the above calculation to determine the benefits of the Plan's fraud and abuse program is a benefit to the FEHBP.

**Total Recoveries/Restitution Calculation**: The Plan disagrees with OPM OIG's initial finding concerning the spreadsheet the Plan provided indicating total recoveries/restitution of [redacted] and requested that the list of the 100 cases and

projects identified as missing information or explanation be provided to the Plan. The OPM OIG has not responded to the Plan's request. Accordingly, the Plan is unable to respond to this finding that is now contained in the Draft Audit Report.

**Section II - Recommendations**

**Recommendation 6**

The OIG recommended that the Plan institute a complete fraud and abuse program that appropriately addresses the FEHBP. Further, the OIG states that this program should also be in compliance with the OPM contract CS 1039 and Carrier Letter (CL) 2003-23 Fraud and Abuse Industry Standards, CL 2003-25 Revised FEHB Quality Assurance and Fraud and Abuse Reports, and CL 2011-13 Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General.

**Plan's Response**

In compliance with Contract CS1039, the Plan has a complete fraud and abuse program, which includes FEHBP investigations. In recognition of the need for a distinct and separate set of processes for the investigation of FEHBP fraud, the Plan has made a number of enhancements. Prior to this particular audit engagement the Plan initiated the following:

Training: All Special Investigations Department (SID) team members have been trained on and are accountable for reporting cases in the FIMS (Fraud Information Management System). Each year all investigators will be required to complete refresher training.

Process: We have adopted Standard Operating Procedures in compliance with CS1039, FEPDO and OPM requirements, wherein any case in which FEHBP exposure is identified is immediately entered in the FIMS. A quarterly validation will be performed and each investigator will be responsible for monitoring their respective cases.

**Recommendation 7**

The OIG recommended that the Plan institute a policy of reviewing and investigating all fraud, waste and abuse allegations/issues within the SID. Report timely all such instances, whether substantiated or not, fraud, waste and abuse issues in FIMS per

the guidelines established by the BCBSA, FEPDO, FEP SIU and required by the OPM FEHBP Carrier Letter 2011-13 Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General.

**Plan's Response**

The Plan understands the importance of a strong infrastructure and the capacity to record and report issues and investigative results not only related to fraud, but waste and abuse as well. The Plan will continue and has implemented processes to capture and address, with the appropriate internal partners, issues of waste and abuse in all lines of business and those specific to the FEHBP and the Plan will continue to evaluate its procedures for future potential enhancements.

The Plan, by way of an established Fraud Plan and investigative processes, has a policy of investigating all allegations of fraud under all BlueShield of California programs, including the FEHBP, within the Special Investigations Department (SID). While the SID's primary focus is the prevention, detection and investigation of fraud, other Plan departments with which the SID closely works are responsible for waste and abuse. The Plan is currently in the process of evaluating and restructuring its comprehensive fraud, waste and abuse initiatives, which currently encompass multiple departments within the Plan, to ensure greater cross-organizational structure and coordination. The Plan does provide and report, in coordination with the appropriate departments, all issues where waste and abuse are components of the SID's investigative efforts. The Plan will continually work toward enhancing all reporting processes and workflows regarding fraud, waste and abuse.

**Recommendation 8**

The OIG recommended that the Plan institute a program to track all instances of SID initiated recoveries, claim denials and cost avoidance, and be able to link the recoveries, actual savings, and cost avoidance to a SID-initiated case/investigation, in order to accurately report FEP related recoveries, actual and projected savings to the FEPDO and OPM as required annually in Carrier Letter 2003-25 Revised FEHB Quality Assurance and Fraud and Abuse Reports.

**Plan's Response**

The Plan agrees with this recommendation. In compliance with "Carrier Letter 2003-25 Revised FEHB Quality Assurance and Fraud and Abuse Reports" and in following with national standards, the Plan implemented processes for reporting

Recoveries, as well as, Savings, Prevented Loss, Identified Loss and Court Ordered Restitutions.

We currently track and report, in FIMS, all cases where FEP dollars are identified as potential fraud on the front end of the investigation. The Plan will continue to evaluate and enhance reporting processes in compliance with "Carrier Letter 2003-25 Revised FEHB Quality Assurance and Fraud and Abuse Reports".

The Plan is in the process of converting to National Health Care Anti-Fraud Association (NHCAA) Standards for Return on Investment (final as of 2008), which should address the concerns identified in this recommendation. The general category descriptions are as follows:

- Recoveries – Actual monies received by the company for funds previously paid and as a direct result of actions taken by the Special Investigations Department (SID) shall be reported in the same period received. (**See Exhibit 1**).

- Savings – Actual or appropriately estimated payments associated with SID-directed pre-payment denial of a claim. These claims must have received their final determination and denial must be as a direct result of actions taken by the SID and shall be reported in the same period in which the claim received final adjudication.

- Prevented Loss – A quantifiable financial impact resulting from the direct action initiated by the SID. The quantifiable impact may be the result of: Change in Behavior – External, Claims Related and Process Improvement – Internal Impact.

- Identified Loss – A quantifiable financial impact that describes the loss determined by the SID at the completion of a case investigation.

- Court-ordered Restitution - Any order from a local, state or federal court, either criminal or civil, which directs a provider, corporation, facility or individual to repay money to a health insurance plan pursuant to a criminal or civil prosecution.

**Recommendation 9**

The OIG recommended that the Plan be required to provide the methodology and a measure of performance per industry standards that their fraud and abuse program is a benefit to the FEHBP per Contract CS 1039 Section 1.9(a).

**Plan's Response**

The Plan disagrees with the OIG recommendation. Please see the Plan's response under Section 1, Plan FEP SID Savings for further discussion.

**Recommendation 10**

The OIG recommended that the Plan update its fraud and abuse policy and procedure manual to accurately reflect the performance of the SID and fraud and abuse program, the SID's duties and responsibilities, and all other duties and responsibilities of other departments outside the SID related to anti-fraud activities.

**Plan's Response**

The Plan agrees with this recommendation. The Plan will document specific processes and references for handling of FEHBP investigations.

In following with the Plan's recognized duties and responsibilities and to ensure continual compliance with Contract CS 1039, the Plan has initiated the review and update of the Special Investigations Manual to incorporate references regarding the unique handling of FEHBP investigations. We expect to have the updated manual completed by the end of the first quarter of 2013.

**Recommendation 11**

The OIG recommended that the Plan update its fraud and abuse policy and procedure manual to accurately reflect requirements of the FEHB program, industry standards, case sharing and reporting guidelines, as well as its annual reporting requirements per Carrier Letter (CL) 2003-23 Fraud and Abuse Industry Standards, CL 2003-25 Revised FEHB Quality Assurance and Fraud and Abuse Reports, and CL 2011-13 Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General.

**Plan's Response**

Please refer to the response given for Recommendation 10.

## B. ADMINISTRATIVE EXPENSES

### 1. Pension Costs $41,516

The Plan agrees with the finding that costs were not calculated based on the lower of Cost Accounting Standards (CAS) or funded amount. On May 30, 2012, the Plan

wire transferred $41,516 to FEP's bank account. These funds were returned to OPM on June 7, 2012. As a corrective action plan, the Plan initiated a review process to ensure that pension costs are calculated based on the lower of CAS or funded amount.

**C. CASH MANAGEMENT**

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

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]
Director, Program Assurance

[redacted]

cc: [redacted], Contracting Officer, OPM
[redacted] Vice President- FEP
[redacted] Vice President – Internal Audit, BSC

**OIG Comment: This signature page is actually "Page 12 of 15" and Attachments 1 – 3 are pages 13, 14, and 15, respectively.**

# Memo

**ATTACHMENT 1**

**To:** [redacted]

**From:** [redacted]

**CC:** [redacted]

**Date:** December 8, 2010

**Re:** California Blue Shield Plan Visit

A Plan visit with the BSC SIU was scheduled for November 8-9, 2010 to review and discuss FEP reporting, FIMS entries and the status of FEP active cases. [redacted], SIU Senior Manager, was out of the office on a scheduled vacation. [redacted] coordinated the meeting to ensure all investigators were able to attend the presentation provided by FEPSIU Consultant, [redacted]. Attendees were [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted].

[redacted]

[redacted]

[redacted]

[redacted]

FEP Anti-Fraud Costs - 2006 - Aug YTD 2011

# Attachment 2

| Cost Center | Cost Center Name | 2006 FEP | 2007 FEP | 2008 FEP | 2009 FEP | 2010 FEP | 2011 FEP | Total | % of Total Costs allocated to FEP |
|---|---|---|---|---|---|---|---|---|---|
| [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | 5% |
| [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | 4% |
| Portion of | [redacted] | | | | | | | | |
| [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | | [redacted] | 3% |
| Portion of | [redacted] | [redacted] | [redacted] | | | | | | |
| Adjustments for disallowed charges/credits | | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | |
| Total Anti-Fraud Costs | | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | |

from SIR #18

| Year | CAC | Cost Center | Cost Center Name | Total FEP Charges | Total Corporate Charges | Allocation Method |
|---|---|---|---|---|---|---|
| 2006 | F51 | 2350H | SPECIAL INVESTIGATIONS DIVISION | 39,652.59 | [redacted] | Labor Dollars |
| 2007 | F51 | 2350H | SPECIAL INVESTIGATIONS DIVISION | 40,445.68 | [redacted] | Labor Dollars |
| 2008 | F51 | 2350H | SPECIAL INVESTIGATIONS DIVISION | 37,568.69 | [redacted] | Labor Dollars |
| 2009 | F51 | 2350H | SPECIAL INVESTIGATIONS DIVISION | 36,033.52 | [redacted] | Labor Dollars |
| 2010 | F51 | 2350H | SPECIAL INVESTIGATIONS DIVISION | 32,146.15 | [redacted] | Labor expenses |
| | | | | **185,846.63** | | |
| | | | 2011 partial | 23,402.35 | | |
| | | | | **209,248.98** | | |

**Anti-Fraud Charges by Natural Accounts**
**2009 - August 2011**

| Description | G/L Acct # | Anti-Fraud Charged to FEP 2009 | Anti-Fraud Charged to FEP 2010 | Anti-Fraud Charged to FEP Aug-11 YTD | ---Total Cost Center 2350H SIU--- 2009 | ---Total Cost Center 2350H SIU--- 2010 | ---Total Cost Center 2350H SIU--- Aug-11 YTD |
|---|---|---|---|---|---|---|---|
| CC 2350H - Total Labor | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | | [redacted] |
| *Percentage allocation to FEP* | | *5%* | *4%* | *4%* | | | |
| CC 2350H -Travel: | | | | | | | |
| Transportation | | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Lodging | | | | | | | |
| Other travel expense | | | | | | | |
| Mileage | | | | | | | |
| Car rental | | | | | | | |
| Travel meals | | | | | | | |
| **Total Travel** | | | | | | | |
| *Percentage allocation to FEP* | | *5%* | *4%* | *4%* | | | |
| CC 2350H -All other expenses, net of disallowed charges | | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] | [redacted] |
| Total cost center 2350H - SIU | | [redacted] | [redacted] | [redacted] | [redacted] | | [redacted] |
| Occupancy charges | | [redacted] | [redacted] | [redacted] | | | |
| **Total Anti-Fraud charged to FEP** | | **$38,795.52** | **$33,966.00** | **$23,924.00** | | | |

**Description:** Cost center 2350H SIU expenses are allocated to FEP based on headcount. There were no travel expenses charged directly to FEP for Anti-Fraud activities during the audit period. The only Anti-Fraud travel expenses were FEP's allocated share of total travel expenses within cost center 2350H.