



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

Final Audit Report

Subject:

AUDIT OF FLORIDA BLUE JACKSONVILLE, FLORIDA

Report No. 1A-10-41-12-050

Date: September 10, 2013

--CAUTION--

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AUDIT REPORT

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

Florida Blue
Plan Codes 90/590
Jacksonville, Florida

REPORT NO. 1A-10-41-12-050 DATE: September 10, 2013



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Assistant Inspector General
for Audits

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EXECUTIVE SUMMARY

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

Florida Blue
Plan Codes 90/590
Jacksonville, Florida

REPORT NO. 1A-10-41-12-050 DATE: September 10, 2013

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at Florida Blue (Plan), located in Jacksonville, Florida, questions \$1,768,338 in health benefit charges and administrative expenses. The report also includes a procedural finding regarding the Plan's Fraud and Abuse (F&A) Program. The BlueCross BlueShield Association (Association) agreed (**A**) with \$383,983 and disagreed (**D**) with \$1,384,355 of the questioned charges, and generally disagreed (**D**) with the procedural finding regarding the Plan's F&A Program.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered miscellaneous health benefit payments and credits from 2010 through February 29, 2012, as well as administrative expenses from 2009 through 2011 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management activities and practices related to FEHBP funds and the Plan's F&A Program from 2010 through February 29, 2012.

The audit results are summarized as follows:

MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

- **Health Benefit Refunds and Recoveries (A)** **\$70,787**

In three instances, the Plan had not returned health benefit refunds, totaling \$264,900, to the FEHBP. The Plan also inadvertently returned two health benefit refunds, totaling \$158,693, and one subrogation recovery, totaling \$35,420, to the FEHBP twice. As a result of this finding, the Plan returned \$70,787 (net) to the FEHBP for the questioned health benefit refunds and subrogation recovery.

ADMINISTRATIVE EXPENSES

- **Post-Retirement Benefit Costs** **\$1,623,435**

The Plan overcharged the FEHBP \$1,623,435 for post-retirement benefit costs from 2009 through 2011. The Association agreed with \$239,080 (A) and disagreed with \$1,384,355 (D) of the questioned charges.

- **Unallowable and/ or Unallocable Expenses (A)** **\$74,116**

The Plan charged the FEHBP \$74,116 for unallowable and/or unallocable administrative expenses in 2009.

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 audit 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, the FEHBP Carrier Letters issued by the Office of Personnel Management (OPM), and guidance provided by the Association’s Federal Employee Program Director’s Office, which are related to F&A Programs and notifying OPM’s Office of the Inspector General of fraud and abuse cases in the FEHBP. As a result of the Plan’s non-compliance, fraud and abuse may go undetected and unreported within the FEHBP, and the overall effectiveness of the Plan’s F&A Program cannot be accurately measured.

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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 Florida Blue (Plan). The Plan is located in Jacksonville, Florida.

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 (FEP¹) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member 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-10-41-10-012, dated May 12, 2011) for contract years 2006 through 2009 have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft report, dated March 1, 2013. The Association's comments offered in response to this draft report were considered in preparing our final report and are included as an Appendix to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the 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 codes 90 and 590 for contract years 2009 through 2012. During this period, the Plan paid approximately \$3.6 billion in health benefit charges and \$168 million in administrative expenses (See Figure 1 and Schedule A).

Specifically, we reviewed miscellaneous health benefit payments and credits (e.g., refunds, subrogation recoveries, provider audit recoveries, medical drug rebates and fraud recoveries), cash management activities, and the Plan's F&A Program for 2010 through February 29, 2012. We also reviewed administrative expenses for 2009 through 2011.

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 control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

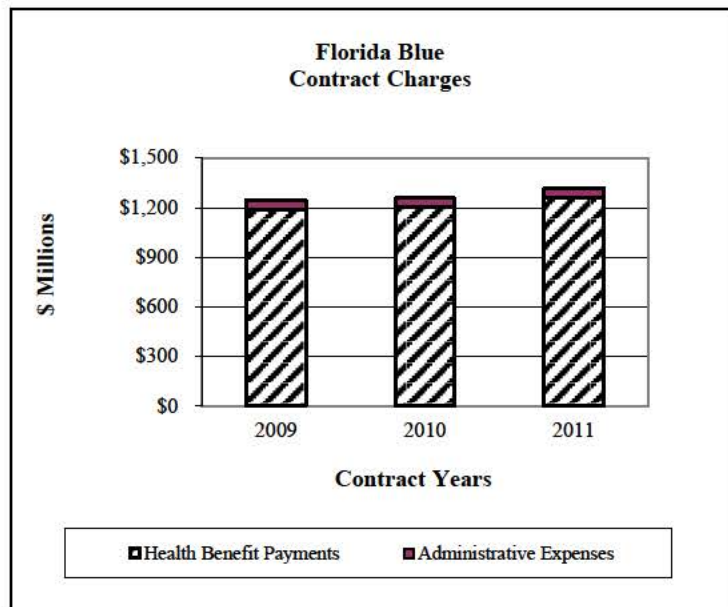


Figure 1 - Contract Charges

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 Jacksonville, Florida from October 1, 2012 through December 12, 2012. Audit fieldwork was also performed at our offices in Jacksonville, Florida; Cranberry Township, Pennsylvania; and Washington, D.C.

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 156 health benefit refunds and adjustments, totaling \$10,698,037 (from a universe of 188,010 refunds and adjustments, totaling \$73,730,038); 106 provider audit recoveries, totaling \$8,097,048 (from a universe of 16,266 recoveries, totaling \$27,642,826); 28 subrogation recoveries, totaling \$1,517,543 (from a universe of 1,448 recoveries, totaling \$5,717,387); 25 fraud recoveries, totaling \$25,106, (from a universe of 70 recoveries, totaling \$31,100); 19 special plan invoices (SPI), totaling \$3,766,059 in net FEP credits (from a universe of 349 SPI's, totaling \$6,192,412 in net FEP credits); and all FEP drug rebate amounts, totaling \$196,404, 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 2009 through 2011. 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, non-recurring projects, gains and losses, intercompany profits, and the 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 activities and 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 sample of health benefit refunds and adjustments included the following: 81 refunds, totaling \$10,795,935, representing all refunds of \$75,000 or more; 60 randomly selected refunds, totaling \$427,147, from the stratification of \$74,999.99 or less; and 15 adjustments, totaling \$525,045 in reductions to the refund universe, representing the five highest dollar adjustments from each year in the audit scope. The sample of provider audit recoveries included the following: 66 recoveries, totaling \$7,176,155, representing all recoveries of \$50,000 or more; 20 randomly selected recoveries, totaling \$738,837, from the stratification of \$25,000 to \$49,999.99; and 20 randomly selected recoveries, totaling \$182,056, from the stratification of \$5,000 to \$24,999.99. For subrogation recoveries, the sample consisted of all recoveries of \$30,000 or more. For fraud recoveries, the sample consisted of all recoveries of \$300 or more. For the SPI sample, we judgmentally selected 8 SPI's with miscellaneous FEP payments, totaling \$1,799,022, and 11 SPI's with miscellaneous FEP credits, totaling \$5,565,081.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Health Benefit Refunds and Recoveries **\$70,787**

In three instances, the Plan had not returned health benefit refunds, totaling \$264,900, to the FEHBP. The Plan also inadvertently returned two health benefit refunds, totaling \$158,693, and one subrogation recovery, totaling \$35,420, to the FEHBP twice. As a result of this finding, the Plan returned \$70,787 (net) to the FEHBP for the questioned health benefit refunds and subrogation recovery.

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 lost investment income (LII) will commence to be assessed.

Health Benefit Refunds and Adjustments

For the period January 1, 2010 through February 29, 2012, there were 188,010 health benefit refunds and adjustments, totaling \$73,730,038. From this universe, we selected and reviewed a judgmental sample of 156 health benefit refunds and adjustments, totaling \$10,698,037, for the purpose of determining if the Plan promptly returned these funds to the FEHBP. Our sample consisted of the following: 81 refunds, totaling \$10,795,935, representing all refunds of \$75,000 or more; 60 randomly selected refunds, totaling \$427,147, from the stratification of \$74,999.99 or less; and 15 adjustments, totaling \$525,045 in reductions to the refund universe, representing the Plan’s five highest dollar adjustments from each year in the audit scope. These adjustments to the refund universe were for refunds that the Plan stated were returned as a result of the prior OIG audit, and therefore, should not be included in the “current” universe.

Based on our review, we identified the following exceptions:

- The Plan had not returned three health benefit refunds, totaling \$264,900, to the FEHBP.
- The Plan inadvertently returned two health benefit refunds, totaling \$158,693, to the FEHBP twice.

In total, we are questioning \$106,207 (\$264,900 minus \$158,693) for health benefit refunds not returned to the FEHBP. We did not question LII on these funds since the estimated LII amount is considered immaterial. Additionally, the Plan makes a cash advance to the FEHBP letter of credit account (LOCA), which also covers the untimely return of health benefit refunds to the FEHBP.

Subrogation Recoveries

For the period January 1, 2010 through February 29, 2012, there were 1,448 subrogation recoveries totaling \$5,717,387. From this universe, we selected and reviewed a judgmental sample of 28 subrogation recoveries, totaling \$1,517,543, for the purpose of determining if the Plan promptly returned these recoveries to the FEHBP. Our sample included all subrogation recoveries of \$30,000 or more.

Based on our review, we identified the following exceptions in our sample:

- The Plan returned 22 subrogation recoveries, totaling \$727,689, to the LOCA during the audit scope, but deposited these funds untimely into the FEP investment account. Specifically, these recoveries were deposited into the FEP investment account from 3 to 211 days late. However, we verified that the Plan properly calculated and returned LII on these recoveries to the FEHBP.
- In one instance, the Plan returned a subrogation recovery of \$35,420 to the FEHBP twice. Therefore, the Plan should recover \$35,420 from the LOCA since these funds were credited to the FEHBP twice.

Provider Audit Recoveries

For the period January 1, 2010 through February 29, 2012, there were 16,266 provider audit recoveries totaling \$27,642,826. From this universe, we selected and reviewed a judgmental sample of 106 provider audit recoveries, totaling \$8,097,048, for the purpose of determining if the Plan promptly returned these recoveries to the FEHBP. Our sample consisted of the following: 66 recoveries, totaling \$7,176,155, representing all recoveries of \$50,000 or more; 20 randomly selected recoveries, totaling \$738,837, from the stratification of \$25,000 to \$49,999.99; and 20 randomly selected recoveries, totaling \$182,056, from the stratification of \$5,000 to \$24,999.99.

We identified five provider audit recoveries in our sample, totaling \$423,130, that were returned to the LOCA during the audit scope but were not deposited timely into the FEP investment account. Specifically, these recoveries were deposited into the FEP investment account from 1 to 39 days late. We did not question LII on these funds since the estimated LII amount is considered immaterial.

Fraud Recoveries

For the period January 1, 2010 through February 29, 2012, there were 70 FEP fraud recoveries totaling \$31,100. From this universe, we selected and reviewed a judgmental sample of 25 fraud recoveries, totaling \$25,106, for the purpose of determining if the Plan promptly returned these recoveries to the FEHBP. Our sample included all fraud recoveries of \$300 or more.

We identified 22 fraud recoveries in our sample, totaling \$6,447, that were returned to the LOCA during the audit scope but were not deposited timely into the FEP investment account. Specifically, these recoveries were deposited into the FEP investment account from 7 to 137 days late. We did not question LII on these funds since the estimated LII amount is considered immaterial.

Association Response:

The Association agrees with this finding. The Association states that the Plan returned \$70,787 (net) to the FEHBP for the questioned health benefit refunds and subrogation recovery.

OIG Comments:

The Association provided documentation supporting that the Plan wire transferred \$70,787 (net) for the questioned health benefit refunds and subrogation recovery into the Association's FEP joint operating account on February 12, 2013. The Association then wire transferred these funds to OPM on February 21, 2013.

Recommendation 1

Since we verified that the Plan returned \$70,787 (net) to the FEHBP for the questioned refunds and subrogation recovery, no further action is required for this amount.

B. ADMINISTRATIVE EXPENSES

1. Post-Retirement Benefit Costs \$1,623,435

The Plan overcharged the FEHBP \$1,623,435 for post-retirement benefit (PRB) costs from 2009 through 2011.

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(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 section."

Other post-retirement employee benefits (OPEB) include all benefits, other than cash or life insurance, that are paid by a pension plan and provided to employees and dependents after the employees' retirements. OPEB includes post-retirement health care, life insurance and other welfare services, such as day care provided after retirement. Only those OPEB provided in accordance with an established policy of the Plan are chargeable to the FEHBP.

During the period 2009 through 2011, the Plan used a "modified" version of Financial Accounting Standard (FAS) 715-60, formerly FAS 106, to calculate PRB expenses charged to the FEHBP. For our review, we limited FEP's allocable PRB costs to the lower of the FAS 106 amount or funded amount based on the Voluntary Employees' Beneficiary Association (VEBA) wire. Since the Plan funds the VEBA for retiree medical benefits only, we used the FAS 106 amount, which represented the retiree medical benefit costs. As a result, we determined that the FEHBP was overcharged \$1,384,355 (\$554,765 in 2009, \$350,620 in 2010, and \$478,970 in 2011) for unallocable PRB costs during the audit scope.

The Plan also identified that the FEHBP was overcharged \$239,080 in PRB costs due to an error in the allocation rate used to calculate FEP's share of PRB expenses recorded in "Cost Center 39 – Corporate Benefits" for 2009. Therefore, the FEHBP was overcharged a total of \$1,623,435 (\$1,384,355 plus \$239,080) for PRB costs from 2009 through 2011.

Association Response:

The Association agrees with \$239,080 and disagrees with \$1,384,355 of the questioned charges.

For the agree amount, the Association states, "On February 15, 2013, the Plan submitted Prior Period Adjustments in the amount of \$239,080, to return to the FEHBP the agreed upon portion of the questioned costs. However, Contract Year 2009 was an under-funded year for the Plan and the amount of the CY2009 unreimbursed costs exceeded the amount of the submitted credit Prior Period Adjustment. Because the Plan's total unreimbursed costs exceeded the amount of the credit Prior Period Adjustment, the result is that the Plan remains under-funded and the credit Prior Period Adjustment merely reduces the total amount of unfunded costs. . . .

Procedures have been updated, explaining that the allocation to FEP from the Post-Retirement Benefit (PRB) GL Account, 612025, in cost center 0039 (Corporate Benefits) should be used to calculate chargeable PRB expense."

For the disagree amount, the Association states, "The Plan continues to state that its cost accounting practices for its Post Retirement Benefit (PRB) plan complies in all material respects with FAR 31.205-6(o) Compensation/Post Retirement Benefits Other Than Pensions ('PRB'). 'Modified' FAS 106 calculations provided by the Plan's independent pension actuaries are reasonable because the differences between the PRB, for financial reporting and government cost accounting purposes, are due primarily to the different

starting points for the GAAP accrual accounting for financial reporting and the conversion to GAAP accrual accounting for government cost accounting (referred to as 'Modified' FAS 106). Additionally, cash contributions in excess of the current year's accrued cost are accounted for as prepayment credits that may be carried over to future periods up to the amount of the 'Modified' FAS 106 expense amount.”

OIG Comments:

Since the Plan’s total unreimbursed costs for 2009 exceed the uncontested questioned costs, we agree that the prior period adjustment should be netted against the Plan’s unfunded costs. Therefore, there is no impact on the amount charged to the FEHBP, which makes an LII calculation unnecessary for this finding.

In response to the contested amount, “modified” FAS 106 is not mentioned in the federal regulations covering PRB costs and is simply a “modified” method developed by the Plan. This method is not consistent with the government regulations covering PRB costs, and therefore unacceptable. Additionally, there is no authoritative source to support the Plan’s “modified” method. The Plan should be required to follow the applicable federal regulations and not be allowed to develop their own “modified” method for calculating PRB costs. The Plan’s “modified” method resulted in additional PRB cost allocations of \$1,384,355 to the FEP from 2009 through 2011.

Recommendation 2

We recommend that the contracting officer disallow \$1,384,355 for PRB cost overcharges from 2009 through 2011, as a result of the Plan’s “modified” method of calculating PRB expenses charged to the FEHBP.

Recommendation 3

We recommended that the contracting officer verify that the Plan submitted a prior period adjustment of \$239,080 to properly reduce the filed costs on the Plan’s annual cost submission for 2009. (Note: The Plan submitted this prior period adjustment as a result of an error in the allocation rate used to calculate FEP’s share of PRB expenses recorded in “Cost Center 39 – Corporate Benefits” for 2009.)

2. Unallowable and/or Unallocable Expenses **\$74,116**

The Plan charged the FEHBP \$74,116 for unallowable and/or unallocable expenses in 2009.

As previously stated under finding B1, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable.

48 CFR 31.201-4 states, “A cost is allocable if it is assignable or chargeable to one or more cost objectives on the basis of relative benefits received or other equitable relationship. Subject to the foregoing, a cost is allocable to a Government contract if it-

- a) Is incurred specifically for the contract;
- b) Benefits both the contract and other work, and can be distributed to them in reasonable proportion to the benefits received; or
- c) Is necessary to the overall operation of the business, although a direct relationship to any particular cost objective cannot be shown.”

For the period 2009 through 2011, we selected and reviewed a judgmental sample of 15 high dollar out-of-system adjustments (OSA), totaling \$3,965,921 in net credits (from a universe of 97 OSA’s, totaling \$6,544,411 in net credits), to determine if the adjustments were allowable, allocable and reasonable, as well as properly charged and/or credited to the FEHBP. We selected the OSA’s based on high dollar amounts and a nomenclature review.

During our review of the OSA’s for 2009, we found that the Plan overcharged the FEHBP \$74,116 for unallowable and/or unallocable project costs. Specifically, the Plan credited the FEHBP \$2,046,673 for unallowable and/or unallocable project costs through an OSA in 2009. In March 2010, the Plan performed a follow-up review of these project costs and determined that the FEHBP should have been credited a total of \$2,117,164 for unallowable and/or unallocable project costs, requiring an additional adjustment of \$70,491 (\$2,117,164 minus \$2,046,673) to the FEHBP. In June 2010, the Plan also found a mathematical error, requiring an adjustment of \$3,625 to the FEHBP.

Although the Plan identified these errors, the Plan did not make the necessary adjustments to FEP costs. Therefore, the FEHBP was overcharged a total of \$74,116 (\$70,491 plus \$3,625) for the unallowable and/or unallocable project costs in 2009.

Association Response:

The Association agrees with this finding. The Association states, “The Plan agreed with this finding and submitted a Prior Period Adjustment (PPA) to return the funds in the amount of \$74,116. However, as stated in OPM’s Draft Audit Report, Contract Year 2009 was an under-funded year for the Plan and the amount of the CY2009 unreimbursed costs exceeded the amount of the submitted credit Prior Period Adjustment. Because the Plan’s total unreimbursed costs exceeded the amount of the credit Prior Period Adjustment, the result is that the Plan remains under-funded and the credit Prior Period Adjustment merely reduces the total amount of unfunded costs.”

The Association also states, “Procedures have been updated with checks and balances to ensure the appropriate adjustment is being made. An out-of-balance will be a warning that there is an error in the excel spreadsheet.”

OIG Comments:

Since the Plan's total unreimbursed costs for 2009 exceed the questioned costs, we agree that the prior period adjustment should be netted against the Plan's unfunded costs. Therefore, there is no impact on the amount charged to the FEHBP, which makes an LII calculation unnecessary for this finding.

Recommendation 4

We recommend that the contracting officer verify that the Plan submitted a prior period adjustment for \$74,116 to properly reduce the filed costs on the Plan's cost submission.

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 audit findings pertaining to cash management noted in the "Miscellaneous Health Benefit Payments and Credit" section.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit

Procedural

The Plan's Fraud and Abuse (F&A) Program is not in compliance overall with contract CS 1039, and other guidance issued by OPM and the Association's FEP Director's Office (FEPDO), in relation to F&A Programs and notifying OPM's Office of the Inspector General (OIG) of fraud and abuse cases in the FEHBP. Specifically, we determined that the Plan did not report or timely report all potential FEP fraud and abuse cases to the FEPDO and/or OIG. Also, the Plan's reported recoveries and savings were inaccurate and/or incomplete. Furthermore, from the information provided, we could not determine if the FEHBP derived the full benefits from this Plan's F&A Program activities. Ultimately, the Plan's non-compliance is a result of the Plan's policies and procedures that do not specifically address the FEHBP, as well as the FEPDO's lack of oversight, direction, and guidance provided to the Plan. As a result of the Plan's non-compliance, fraud and abuse may go undetected and unreported within the FEHBP, and the overall effectiveness of the F&A Program cannot be accurately measured.

Incomplete and Untimely Reporting – FEHBP Fraud Cases

Our review of the Plan's Special Investigations Unit (SIU) revealed that the Plan did not report all potential FEP fraud and abuse cases to the FEPDO and the OIG and that many of the cases that were reported to the FEPDO were reported untimely. In addition, the FEPDO did not report to the OIG all of the cases that the Plan's SIU reported to the FEPDO that met specific contractual requirements and OPM Carrier Letter guidance. The Plan reported 116 cases to the FEPDO from January 2010 through February 2012, but only 14 of those cases were reported to the OIG. This lack of referrals and/or untimely reporting of investigations do not allow the OIG to investigate whether other

FEHBP carriers are exposed to the identified provider committing fraud against the FEHBP. It also does not allow the OIG's Administrative Sanctions Group to be notified timely. This may result in additional improper payments being made by other FEHBP carriers to these unscrupulous providers.

Contract CS 1039 Section 1.9(a) requires the Plan to "operate a system designed to detect and eliminate fraud and abuse . . . by providers providing goods or services to FEHB Members, and by individual FEHB Members."

Carrier Letter (CL) Number 2007-12 states "All carriers must send a written notification/referral to the OPM-OIG within 30 days of becoming aware of any cases involving suspected false, fictitious, fraudulent, or misleading insurance claims . . ." which meet a specific potential claims exposure threshold of \$20,000 or more for providers and \$10,000 or more for FEHB Members.

CL Number 2011-13, effective June 17, 2011, states that all Carriers "are required to submit a written notification to the OPM OIG . . . within 30 working days of becoming aware of a fraud, waste or abuse issue where there is a reasonable suspicion that a fraud has occurred or is occurring against the Federal Employees Health Benefits (FEHB) Program." There is no dollar threshold for this CL requirement.

The primary vehicle for the local BCBS plan's anti-fraud unit to report potential FEP fraud and abuse cases and other anti-fraud activities to the FEPDO is 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 Association has charged the FEHBP more than \$1.5 million to build and implement this system.

The Plan did not enter all of its FEP potential fraud and abuse cases into FIMS as required. In order to test the Plan's compliance with the reporting requirements in OPM's Carrier Letters and applicable FEPDO guidance, we requested the Plan's provider and pharmacy related fraud complaints and cases, as well as FEP subscriber complaints and cases, for the period January 1, 2010 through February 29, 2012. The Plan's SIU stated that they had a total of 2,551 complaints/cases in its own case tracking system for that time period. We actually identified a total of 2,967 complaints/cases from the information provided by the Plan. Of these complaints/cases, 1,834 had unique Tax Identification Numbers (TIN). We entered the 1,834 complaints/cases into the FEHBP data warehouse and identified matches for 1,151 of these complaints/cases. We added 51 cases that were provided to us as open investigations during the audit scope, but were not found in the 2,967 complaints/cases obtained from the Plan's tracking system. We removed all duplicate items, resulting in a final total of 1,032 complaints/cases. All but 4 of the 1,032 complaints/cases had FEHBP exposure of \$1 or more and therefore should have been entered into FIMS. In addition, we determined that 670 of these fraud and abuse complaints/cases contained FEHBP exposure greater than \$20,000. An additional

84 complaints/cases were initiated after June 17, 2011.³ As such, all 754 of these complaints/cases should have been entered into FIMS and reported to OPM and the OIG (based on CL 2011-13). As previously stated, only 14 cases were reported to the OIG during the audit scope.

The FIMS Plan SIU User Guide (FIMS Guide) states that the FEPDO SIU expects the local BCBS plans' 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** (Emphasis added). The FIMS Guide further advises to not wait until the investigation is complete and/or until fraud is proven before entering it into the tracking system. Lastly, FIMS Guide, Section 3.3.1, 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."

Our review of the FIMS cases entered by the Plan showed that the Plan's SIU reported a total of 120 cases to the FEPDO via FIMS. We found 4 duplicate FIMS cases that were entered under the same case name, reducing the total number of unique cases entered in FIMS to 116. Of the 116 unique cases that the Plan entered into FIMS, the cases were entered, on average, approximately 195 days **after the case was initiated**. In addition, for the 14 cases that were actually reported to the OIG during the audit scope, the FEPDO's SIU took an additional 71 days, on average, to submit these cases to the OIG.

Our analysis also revealed that 82 of the 116 FIMS entered cases met CL 2007-12 and CL 2011-13 requirements for notification/referral to the OIG based on the FEP exposure provided in FIMS. We also identified an additional nine cases entered into FIMS by the Plan that met the financial threshold based on our review of the OPM data warehouse. These nine cases either did not list any FEP exposure or the exposure provided by the Plan did not meet the CL 2007-12 financial thresholds. Thus, at a minimum, 91 of the 116 cases entered into FIMS met the financial threshold of CL 2007-12 or were entered after CL 2011-13 became effective and should have triggered an OIG case notification and/or referral. As previously stated, the FEPDO and/or Plan only submitted 14 cases to the OIG.

We also judgmentally selected four of the Plan's SIU investigation files to review. We noted that the Plan's SIU provides a complete, well documented, and thorough report of investigation. Two types of reports were included, "Investigative Summary Report" and "Plan of Action Closing Report". Both were professionally written and well documented. These reports are not included but would be an excellent supplement to a case notification or referral provided by the FEPDO to the OIG.

Further review of the Plan's structure revealed that the Plan's SIU only performs fraud related investigations. Waste and abuse related issues are reviewed by the Plan's Healthcare Provider Audit (HPA) group. HPA defined waste as any overpayment resulting from an error made by the Plan and abuse as any overpayment resulting from an

³ OPM issued Carrier Letter 2011-13 (dated June 17, 2011) requiring Carriers to report all potential FEHBP fraud cases, regardless of dollar amount, to the OIG.

error made by the provider. We do not agree with these broad definitions. Many overpayments (as well as underpayments) are made for various reasons, such as coding and keying errors. We do not believe that these scenarios meet the requirements of either waste or abuse. However, we do acknowledge that neither OPM nor the OIG has provided definitions for waste and abuse that the local BCBS plans must comply with.

We reviewed the Plan SIU's annual reports for 2010 and 2011 and noted that the SIU made 33 internal referrals to HPA. Our analysis found that 8 of these 33 complaints/cases (internal referrals) were entered into FIMS, but only 2 of them were reported to the OIG. Although some of the HPA cases involved billing errors, there were also allegations of inappropriate use of modifiers, abuse of evaluation and management codes, billing anomalies, diagnosis abuse, cloning of records, no signature authentication, insufficient documentation, and possible overutilization.

We can appreciate that some of the cases the SIU referred to HPA were billing errors and isolated overpayments that were not fraud and abuse related issues and were appropriately referred outside the SIU. However, the noted allegations of abusive billing practices and ineligible members referred by the SIU (internally) to HPA are all potential fraud and abuse cases/issues that should have been entered into FIMS. Based on our analysis, we determined that at a minimum 13 of the 33 HPA-referred cases should have been entered into FIMS, but we found that only 5 were. Also, only 4 of these 13 HPA cases were referred by the SIU after the effective date of CL 2011-13, of which only 1 of these 4 cases was entered into FIMS.

As a result, the Plan is not in compliance with the FEHBP contract, CL 2007-12, and CL 2011-13 for reporting potential fraud and abuse cases and/or reporting potential fraud and abuse cases timely to the OIG.

In part, the Plan's incomplete and untimely reporting is due to a lack of FEHBP-specific policies and procedures. In the two SIU policy manuals we reviewed, we found no references made to any actual FEHB fraud and abuse program contract requirement or FEHBP fraud and abuse case reporting requirements. In addition, the Plan's SIU policy manuals made no reference to the FEPDO's roles and responsibilities related to FEHBP fraud and abuse activities, including the FIMS User Guide and the FEP Standards Manual for Prevention, Detection and Investigation. Without references in the Plan's policy and procedure manuals to the relevant standards and requirements, it is uncertain how the Plan's fraud and abuse activities address the FEHBP effectively.

The Plan's incomplete and untimely reporting is also a result of the FEPDO's lack of oversight and proper guidance. The Plan stated that during the audit period of January 1, 2010 thru February 29, 2012, the Plan's SIU and a FEPDO case worker met on numerous occasions to discuss several topics, such as FIMS training, FIMS entries, case work/collaboration, on-site investigations, and SIU performance. Again, it is unclear what guidelines the FEPDO is utilizing or what oversight the FEPDO is providing when only 116 of 1,032 initiated complaints/cases were actually entered into FIMS.

Furthermore, the FEPDO provided no written guidance or presented no written notification to the Plan's FEP Executives related to non-compliance with contract CS 1039 or CL requirements. This is in clear contrast to the FEPDO's own policies and procedures, and is not in compliance with contract CS 1039. Therefore, we cannot determine what criteria the FEPDO used to determine the Plan's compliance with contract CS 1039.

Ultimately, the Plan's untimely reporting to the FEPDO, the FEPDO's lack of oversight of the Plan, and the lack of reporting to the OIG, has caused an unknown amount of financial damage to the FEHBP. At least 102 cases were entered into FIMS and not reported to the OIG. Of these, 91 cases met either the dollar threshold or other criteria for reporting to the OIG and 11 cases were for providers that were related to allegations of health care fraud. As a result, there could be providers who received health benefit payments from other FEHBP carriers without the benefit of a preliminary review (by the OIG and other FEHBP carriers) to determine whether benefits were being applied appropriately. As a result of the non-reporting of these potential fraud and abuse cases, improper payments may have been made by other FEHBP carriers.

Incomplete and/or Inaccurate Reporting - FEHBP Fraud and Abuse Recoveries

Our review of the Plan's reporting of FEHBP fraud and abuse recoveries, savings, and dollar loss was incomplete since the Plan's HPA performed reviews and audits of cases that were deemed as abuse issues. The Plan's SIU only reported recoveries and savings in FIMS for fraud related cases.

Contract CS 1039, Section 1.9(a) requires the Plan to submit reports to OPM annually that identify dollars as lost and recovered, as well as actual and projected savings related to fraud and abuse.

In response to our request for total FEP actual fraud and abuse related recoveries, the Plan stated that their SIU only performs fraud related investigations. Abuse related issues are reviewed by the Plan's HPA. Recoveries related to HPA were reported to OPM in another area outside of the SIU's reporting of recoveries. However, within the Plan's SIU annual reports for 2010 and 2011, we noted the SIU made 33 total internal referrals to HPA. Based on our analysis of these referrals, we identified two financial recoveries directly related to two FEP ineligible member cases that should have been reported in FIMS, accounting for \$11,046 in potential fraud and abuse recoveries. Although these funds were reported to OPM as recoveries under the Plan's HPA, these recoveries were not reported in FIMS as fraud and abuse related recoveries, and as such, the annual report provided to OPM by the FEPDO is an inaccurate representation of actual fraud and abuse recoveries.

Although we did not request additional information from the Plan, we noted that the SIU made a total of 340 internal referrals to other departments within the Plan in 2010 and 2011. We believe this process and tracking to be a best practice, revealing the SIU's ability to work with other internal partners and follow through with the completion of all

allegations, regardless of the outcome. The Plan's other internal departments include legal, compliance, network, provider credentialing, pharmacy, and other departments with noted acronyms that we could not decipher. It is unclear how many of the 340 cases may have included an element of fraud and abuse that went unreported in FIMS by the Plan.

As a result of the Plan separating its fraud and abuse functions into two separate departments, SIU and HPA, it is unclear how the FEPDO's required annual fraud and abuse reporting to OPM can be accurate and authenticated. Our analysis clearly showed that more than a third of the cases referred by the SIU to HPA were related to potential fraud and abuse issues and most of those cases were not even entered into FIMS.

Costs and Benefits of Plan's Fraud and Abuse Activities

We could not determine if the FEHBP is deriving the full benefit from the Plan's fraud and abuse activities. Based on the information provided by the Plan, the return on investment (ROI) for the Plan's F&A Program was between a positive \$1.29 and a negative \$8.88 per dollar spent.

Contract CS 1039 requires that the "Carrier must submit to OPM an annual analysis of the costs and benefits of its fraud and abuse program."

From January 1, 2010 through December 31, 2011, the Plan charged the FEHBP a minimum of \$235,993 to perform activities related to its FEP F&A Program. Although we found additional costs beyond the Plan's SIU, the Plan was unable to provide accurate total costs related to its total F&A Program.

The Plan's SIU only performs actual fraud investigations, but has responsibility for the Plan's complete corporate-wide fraud, waste and abuse program. The FEHBP was charged \$235,993 for the SIU. All of these charges were related to the Plan's F&A Program.

Other Plan departments, including HPA, Legal Affairs, and Clinical Operations also have responsibility for parts of the Plan's fraud and abuse activities. We could not determine and/or the Plan could not provide the costs for Legal Affairs and Clinical Operations. However, the Plan provided total allocated costs for HPA of \$2,476,815 to the FEHBP during the audit scope. We recognize that not all costs allocated from HPA were for fraud and abuse activities. However, despite guidance within the FEP Standards Manual to budget in all departments for fraud and abuse activities, the Plan could not provide documentation or determine what portion of the \$2,476,815 in HPA's allocated costs were associated with the Plan's F&A Program activities. Therefore, we determined the total range of costs to be between \$235,993 and \$2,712,808 for fraud and abuse activities.

The Plan's SIU personnel also gave a demonstration of their proactive fraud detection tools. The SIU uses two systems, the first known as the Fraud and Abuse Data System (FADS), and the second known as the Fraud and Abuse Management System (FAMS).

The FADS system extracts claims from the Plan's data warehouse and exports the results, based on set criteria (such as an allegation), directly to an SIU investigator or analyst. SIU staff reviews and manipulates the data looking for patterns and clues of potential fraud and abuse billing. The FAMS system analyzes data using behavior analytics to identify healthcare providers exhibiting suspicious actions or billing patterns to uncover fraud, waste and abuse schemes. FAMS contains integrated data mining, business logic, interactive data visualization reports and can display these reports in different fashions, such as spreadsheets, graphs and scatter plots, for presentation and referral purposes.

The Plan's demonstration of these tools indicated that the SIU personnel were well versed in the use and operation of these tools. We believe that the proper use of these proactive fraud detection tools, such as FAMS and FADS, provides a benefit to the Plan's overall F&A Program. However, we could not determine what costs for these systems are actually being charged to the FEHBP and whether the FEHBP benefits from the Plan's use of these tools.

Next, we identified total recoveries and actual savings for the FEHBP based on the Plan's information. According to the Plan, the actual recoveries and actual savings related to fraud totaled \$305,157 in 2010 and 2011. This consists of actual FEHBP fraud recoveries of \$30,293 as well as \$274,864 in actual savings for the FEHBP, all of which could be tracked to an SIU fraud and abuse activity or case. Finally, the Plan's SIU defined projected savings as follows: "Projected savings, cost avoidance, and/or prevented loss are calculated as the amount of claims that would probably have been billed and paid for one year had the anti-fraud unit not intervened and stopped the fraudulent behavior." The Plan reported projected savings of \$1,253,368 in 2010 and 2011. However, based on our review, we noted that the Plan only reported a total of \$305,157 in total recoveries and actual savings in 2010 and 2011. We would expect this total of recoveries and actual savings to be higher based on the Plan's projected savings.

Based on the Plan's reported information related to costs, recoveries, and actual savings, the ROI was between a positive \$1.29 and a negative \$8.88 per dollar spent. Although the calculation includes a potential positive ROI, the Plan could not provide all costs for the fraud and abuse activities. Therefore, the FEHBP does not appear to be deriving a benefit from the Plan's current structure and fraud and abuse activities as they relate to the FEHBP.

Association's Response:

The Association states, "The Plan continues to disagree with the statement of non-compliance with contract CS 1039 and other guidance issues by OPM and the FEPDO, and whether FEHBP is deriving the full benefits of the plan's fraud and abuse activities. The FEPDO and the Plan have created a system of controls to monitor, identify, investigate and recover fraudulent and abusive payments of FEHBP funds and is substantially in compliance with the requirements of CS 1039. The Plan's FEP Fraud and Abuse Program is designed to protect patient safety and the health care assets of Federal beneficiaries.

The Plan disagrees with the statement noted within the draft report, ‘As a result of the Plan’s non-compliance, fraud and abuse may go undetected and unreported within the FEHBP . . .’ During the audit scope of 2010 and 2011, the Plan’s fraud & abuse program activities resulted in over \$7.7 million dollars of actual recoveries and savings, ensuing in a positive return on investment (ROI) between \$1.29 and \$6.19. However, the goal of the Fraud and Abuse Program is focused on the proactive prevention and detection of fraud on a national basis, i.e., to prevent fraudulent claims from being paid at the outset.

Additionally, the plan disagrees with the statement noted within the draft report, ‘Plan’s reported recoveries and savings were inaccurate’. No evidence was provided by the auditors as a result of this audit to reflect that recoveries and savings that were reported were inaccurate.”

In response to the finding for incomplete and untimely reporting of FEHBP fraud cases, the Plan disagrees that it did not enter all of its cases into FIMS, as required by OPM and FEPDO guidance. The Plan believes that the OIG uses an overly broad definition of exposure that results in the inputting of complaints in which a preliminary review has not been completed to determine whether there is reasonable suspicion that a fraud has occurred. The Plan does not believe that the 754 cases noted in the OIG report should have been submitted into FIMS. It believes that of the 314 cases that were opened, the cases potentially affecting the FEHBP were entered into FIMS in accordance with the Association’s defined criteria.

The Plan also disagrees that the 33 internal complaints/cases referred to HPA should have been entered into FIMS. The Plan believes that only the 12 actual cases should have been entered into FIMS. Of those 12 cases, the Plan entered 9 cases into FIMS. According to the Plan, one of the cases did not meet the defined criteria and the remaining two cases should have been entered into FIMS but were not.

Furthermore, the Association states, “The Plan maintains a local database in which we record all related complaint and 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. that is investigated. It is the intent of the FEPDO that the Plans only enter case information once they have confirmed that there is FEP exposure to the original accusation, complaint, billing error, or fraudulent activity.”

The Plan also disagrees with the statement that the OIG could find no reference to the FEHBP F&A Program in either of the two policy manuals provided by the Plan. The Association states, “The Plan’s SIU manuals do contain references to the actual FEHB fraud and abuse program; however, the Plan did not receive an information request to obtain SIU manuals from the OIG auditors.”

The Association does agree, however, that FEPDO policies and procedures can be further refined regarding the specific criteria that BCBS plans should use to report cases. Accordingly, the FEPDO updated its policies and procedures as of December 31, 2012.

The Plan will receive training at the upcoming BCBS conferences. Furthermore, the Plan stated it would reference the FEHBP fraud and abuse program within the corporate wide policy and ensure that current infrastructure can accommodate the updates.

Regarding the finding of incomplete and/or inaccurate reporting of FEHBP fraud and abuse recoveries, the Association states that “the Plan agrees in part and disagrees in part. Per CS 1039, the FEPDO must provide reporting to OPM annually. The Plan acknowledges that 2 cases were not reported per the defined FEPDO criteria; however, no evidence was provided that cases were reported inaccurately. The Plan agrees the Plan is only reporting recoveries and savings from fraud related cases in FIMS as required by FEPDO criteria.

As the draft audit report results noted, the OIG auditors acknowledged that neither OPM nor the OPM OIG has provided definitions for waste and abuse applicable to Plan reporting. The Plan will change its reporting processes, as necessary, consistent with revised direction to report defined abuse cases, e.g., using the updated criteria provided by FEPDO as of December 28, 2012.”

Regarding the costs and benefits of the Plan’s fraud and abuse activities, the Association states, “The Plan disagrees with OIG’s position that the FEHBP is not deriving the full benefit from the Plan’s fraud and abuse program. The FEP Fraud Control Program is designed to protect patient safety and the health care assets of Federal beneficiaries and the Federal Government. The goal of the Program is primarily on the proactive prevention and detection of fraud on a national basis, *i.e.*, to prevent fraudulent claims from being paid at the outset. This goal is accomplished by various methods, including utilizing anti-fraud software; by reviewing tips, leads and referrals from different sources; and by coordinating efforts and sharing information on current schemes and industry trends with other Plans, law enforcement, prosecutorial agencies, industry associations, medical/licensing boards and other health insurance carriers.

The Plan’s SIU is focused on fraud prevention, in part, due to the difficulty of recovering program’s funds through restitution. Therefore, the Plan would encourage reviewing OPM’s benefit of each plan’s fraud and abuse activities by also taking into account projected medical savings, which is projected savings calculated as the amount of claims that would have been billed had the SIU not intervened and stopped the fraudulent behavior, an industry accepted metric.

As stated above, the Plan disagrees with the accuracy of the Return on Investment (ROI) calculation by OIG for the Program . . . BCBSA provides an overall ROI calculation for the entire SIU program to OPM, in order for OPM to determine whether [they are] deriving full benefit. However, if Florida Blue were to calculate a ROI it would be between a positive \$1.29 and \$6.19.

The OIG’s ROI calculation incorrectly included the entire costs for HPA . . . and did not consider HPA recoveries . . . HPA reviews both waste and abuse related cases, therefore the ROI calculation provided above excluded costs and recoveries associated with waste

and cases not identified as ‘Provider Billing error’ categories. The calculation provided by the Plan is conservative and may be understated, due to HPA cases [that] were not classified as ‘abuse’ or ‘waste’ for the entire audit period reviewed.”

In summary, the Association states that “the Plan disagrees with specific assertions in the draft audit report and the general assertion that the FEHBP is not deriving the full benefit from the Plan’s fraud and abuse activities. It is the Plan’s belief that some of the reasons for the findings are a result of ambiguous terminology being used in relation to reporting SIU activities and the Plan looks forward to remedying this matter in coordination with the OIG, as appropriate, and the FEPDO. Additionally, the Plan seeks to continuously improve its program and will work with the FEPDO to make appropriate adjustments to processes.”

OIG Comments:

The Association states that they have created a system of controls and processes that monitor, identify and recover fraudulent and abusive payments of FEP funds. We disagree. The FEPDO has failed to provide any specific details as to what oversight function they perform of this Plan, including the timely reporting of cases in FIMS and the reporting of financial impacts in FIMS.

The Association disagrees with the OIG’s position that all complaints should be entered into FIMS. However, we continue to believe that the Plan did not input all applicable complaints and cases into FIMS. As the FEPDO guidance states, FEP claims should be included in all reviews and Plans should report all cases involving FEP timely, regardless of outcome and/or dollar threshold. In addition, the FIMS user guide clearly advises the local BCBS plan to not wait until the investigation is complete and/or until fraud is proven before entering it (cases, complaints, etc.) into the tracking system. Anything reported in the Plan’s data entry system should be reported concurrently in FIMS. The Plan should not be investigating cases through to the end and then determining if FEP dollars are involved. Furthermore, the criteria for reporting potential fraud and abuse cases to the OIG are included in CL 2007-12 and CL 2011-13. These Carrier Letters require **all** plans to report potential fraud and abuse cases when there is a reasonable suspicion that fraud has occurred against the FEHBP. Nowhere in these Carriers Letters does it state that the fraudulent activity must be confirmed. Therefore, we continue to believe that the 754 cases we found that had FEHBP exposure should have been reported into FIMS, not the 116 cases that were entered into FIMS by the Plan. Moreover, at least 91 of the 116 cases entered into FIMS met the financial threshold of CL 2007-12 or were entered after CL 2011-13 became effective and should have triggered an OIG case notification and/or referral. As stated in the report, we found only 14 cases that were submitted to us either by the Plan or the FEPDO. The Plan did not comment on these issues or our finding regarding the untimely FIMS submissions. Therefore, we do not know the Plan’s positions on those findings.

Regarding the Plan’s SIU policy manuals, the Plan states that the manuals do contain references to the FEHBP F&A Program and that the auditors did not request these manuals through a formal information request. Whether the manuals were obtained

through a formal information request is irrelevant. The Plan provided the manuals while we were on-site conducting our audit. So they were fully aware that we were reviewing the manuals. Moreover, we stand by our original statement that the two policy manuals did not contain any reference to actual FEHBP contract requirements or fraud and abuse case reporting requirements. If these manuals are the primary source of information for an SIU staff person performing investigations, they should contain the requirements of the FEHBP. Overall, the Plan disagrees with the OIG's interpretation of what information should be submitted into FIMS. However, the Plan will integrate revised criteria for reporting the cases into FIMS.

The Plan also disagrees that it provided inaccurate information on its annual fraud and abuse reports submitted to OPM. The Plan does acknowledge that two cases were not included using the FEPDO criteria. We continue to assert that the reports were inaccurate because the FEPDO could not support the numbers during the audit that were submitted on the annual OPM reports. Furthermore, the FEPDO could not link the numbers it provided either at the time of the audit or on the annual reports to any actual investigative activity. We continue to acknowledge that work needs to be done to provide better definitions and instructions to carriers on how to properly complete the annual fraud and abuse reports. We look forward to working with the Association and OPM's contracting officers on this continuing endeavor.

Regarding the benefit this Plan is providing the FEHBP, we continue to believe that the FEHBP is not receiving the full benefit of this Plan's SIU anti-fraud program. We agree that fraud prevention is an important component of any anti-fraud program. However, the Plan should not focus solely on this one avenue to achieve a truly effective F&A Program. Moreover, it would be impossible for a Plan's SIU to provide the full benefits of its F&A Program to the FEHBP with the level of non-compliance discussed in this report. However, we applaud the Plan's willingness to change its policies and procedures and to work with the Association and OPM to develop a more effective SIU in addressing the FEHBP.

Lastly, the Plan disagrees with our ROI calculation. The Plan states that the OIG incorrectly included the entire costs for HPA but did not consider all of the HPA recoveries. The Plan is correct. We only included recoveries it could identify as being part of the Plan's anti-fraud program activities as it related to the SIU referrals made to HPA. In addition, not all HPA recoveries were related to fraud and abuse issues. We also did not include all of the costs associated with this Plan's anti-fraud program because the Plan did not capture those costs even though that is a requirement of the FEHBP contract. We acknowledged in the report that the ROI calculation is not perfect and that is why a range is provided. Furthermore, we look forward to working with the Association and OPM's contracting officers in developing an ROI calculation that all parties can agree to.

Even though the Association and/or Plan generally disagreed with most of the findings in this section, we are pleased to note that the Association is taking steps to improve the FEP and local Plan's F&A Programs, and is currently working with OPM to achieve consistency in BCBS and OPM guidance.

Recommendation 5

We recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the Plan has implemented a policy to review and investigate all FEHBP potential exposure upon the initiation of any and all fraud, waste, and abuse allegations and/or issues within the SIU. 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 applicable FEHBP Carrier Letters.

Association's Response:

The Association disagrees that all cases with potential FEP exposure should be included in FIMS. It states that the policy is for Plans to enter a case into FIMS after they complete their initial assessment and confirm that evidence exists to support the allegation. The Local Plans maintain a database for all case activity. The Association states, "It would be duplicative and an inefficient use of FEP funds for Plans to maintain case information in their local databases and FIMS for every case or allegation they investigate."

However, the Association agrees that the guidelines for reporting fraud, waste, and abuse activity into FIMS may not have been clear enough to ensure full compliance with the applicable Carrier Letters. The Association has developed a corrective action plan which includes a revised FEP Fraud, Waste and Abuse Program Standards Manual that includes enhanced definitions and clearer FEP requirements and FIMS training for the Plan's staff.

In addition, "The Plan currently has a policy in place to review and investigate all FEHBP potential exposure upon the initiation of any and all fraud, waste and abuse allegations and/or issues within the SIU. The Plan will timely report all fraud, waste and abuse allegations and/or issues in FIMS as defined within FEPDO's FEP Standards Manual for Fraud, Waste & Abuse."

OIG Comments:

As stated earlier, Carrier Letters 2007-12 and 2011-13 require all plans to report fraud and abuse cases where there is a reasonable suspicion that a fraud has occurred or is occurring against the FEHBP. Nowhere in these letters does it state that the Plan must confirm the initial complaint of fraudulent activity.

We are pleased that the Association has developed a corrective action plan and a revised manual to train the plans' staff on when to enter complaints/cases into FIMS. However,

we do not agree with all of the items in these documents. We agree to work with the Association, the FEPDO, and OPM's contracting officers to develop agreed-upon definitions and clearer guidance regarding the reporting of fraud and abuse cases to the OIG.

We are also pleased that the Plan's SIU has developed a policy to investigate and report all complaints with FEHBP exposure into FIMS in accordance with the FEPDO's updated FEP Standards Manual for Fraud, Waste, and Abuse. However, as noted above, we do not necessarily agree with all FEP manual updates, especially those that redefine when complaints/cases are to be reported to OPM and the OIG.

Recommendation 6

We recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the Plan has implemented a process to track all instances of SIU-initiated recoveries, claim denials and cost avoidance. The process should include linking the recoveries, actual savings, and cost avoidance to the initiated cases and/or investigations in order to accurately report FEP recoveries and actual and/or projected savings to the Association and OPM annually, as required by Carrier Letter 2003-25 (Revised FEHB Quality Assurance and Fraud and Abuse Reports).

Association's Response:

The Association agrees with this recommendation.

The Association states, "BCBSA staff has initiated a revised Local Plan monitoring approach, which will ensure that there is appropriate focus with responsible staff at every Plan, and where appropriate, implement additional BCBSA monitoring activities. This enhanced monitoring activity is scheduled to be fully implemented by June 30, 2013.

The Plan currently has a process in place to track all instances of SIU initiated recoveries, claim denials and cost avoidance and link the recoveries, actual savings and cost avoidance to the initiated cases and/or investigations in FIMS in order to accurately report FEP related recoveries, actual and/or projected savings to BCBSA."

Recommendation 7

We recommend that the contracting officer instruct the Association and Plan to update their F&A policy and procedure manuals 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 (Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General).

Association's Response:

The Association agrees with this recommendation. The Association has updated its fraud, waste and abuse manual and distributed this revised manual to all BCBS plans on December 28, 2012. The Association states, "The revised manual makes FEP requirements clearer and should result in greater adherence to requirements for case input.

The Plan has updated its F&A policy and procedure manual to accurately reflect the requirements of the FEHBP as reflected within the FEPDO's FEP Standards Manual for Fraud, Waste and Abuse."

OIG Comments:

We are pleased that the Association has proactively updated and distributed its revised manual related to FEP fraud, waste and abuse. However, we do not necessarily agree with all of the updates that were made to the manual. We look forward to working with OPM's contracting officers, as well as the Association, in developing guidance all parties agree on.

Recommendation 8

We recommend that the contracting officer direct the Association to provide OPM and the OIG full access to FIMS and the BCBSA National Anti-Fraud Advisory Board (NAAB) meetings.

Association's Response:

The Association partially disagrees with this recommendation to provide full access to FIMS and NAAB meetings.

The Association states that "unlimited access by the OIG to the system at this time would result in potential inefficiencies for FEP. However, in order to provide the OPM OIG investigators with efficient, effective and faster access to cases, BCBSA will submit alternative processes for sharing relevant case information with OPM OIG on an established and timely basis.

In addition, because of the detailed operational nature of the agenda, the NAAB meetings are task oriented sessions for Local Plan and BCBSA members only. However, we will invite the OPM OIG to participate in select portions of the agenda regarding case sharing and items specific to FEP for each NAAB meeting. This was already initiated with the recently completed January 2013 NAAB meeting, which included an OPM OIG representative."

OIG Comments:

We continue to recommend that the contracting office direct the Association to provide OPM and the OIG with full access to FIMS, a program fully paid for by OPM with FEHBP funds. Full access is necessary for OPM and the OIG to monitor the Association's fraud and abuse activity and the FEPDO's oversight, and will allow the OIG to make inquiries when we notice non-compliance by a BCBS plan such as untimely reporting. In addition, it will provide necessary information for analysis purposes prior to future OIG audits. This alone will save time and money for the local BCBS plans and the FEPDO.

The analysis of this Plan's FIMS entries showed that only 14 of the 116 unique cases entered by the Plan were reported to the OIG. It also showed that the Plan's entries into FIMS had significant timeliness issues. If the OIG had full access to FIMS, those 116 cases would have been reviewed and investigated by us. Also, we would have notified the Plan and FEPDO of the untimely reporting issue in real time and resolved the issue much earlier.

We are pleased that the Association has agreed to have an OIG representative participate in the NAAB meetings. We agree that our participation should be limited to the FEHBP portion of those meetings.

Recommendation 9

We recommend that the contracting officer direct the Association to provide OPM and the OIG an annual report of their oversight activities related to the FEHBP's F&A Program activities. The report should discuss all compliance issues, as well as the corrective actions that the Association has implemented with the local BCBS plans to correct all deficiencies (i.e., areas of non-compliance).

Association's Response:

The Association partially agrees with this recommendation. The Association states, "BCBSA will design and prepare an annual compliance oversight report by September 30, 2013 with the goal of submitting the final report to the Contracting Officer on or about March 31, 2014 to reflect on the 2013 calendar year results."

OIG Comments:

We are pleased that the Association has agreed to prepare an oversight report for its 2013 calendar year results. However, we continue to recommend that the contracting officer require these reports to be submitted on an annual basis. We are available to work with the contracting officer and the Association to determine exactly what information should be included in these reports.

Recommendation 10

We recommend the contracting officer direct the Association to provide OPM an annual report identifying and detailing all costs associated with the Association's FEP F&A Program. These costs should be identified by department (e.g., legal, compliance, claims utilization, and provider audits).

Association's Response:

The Association partially agrees with this recommendation. The Association states, "In most situations, it is not possible to distinguish the FEP vs. Non-FEP anti-fraud related costs system wide . . . given the variety of allocation and tracking methodologies that may be used and in some cases the small amount of the charge. As a result, tracking any and all costs associated with the Association's FEHB fraud and abuse program is likely not possible in many instances. However, BCBSA is committed to developing an acceptable format to report readily definable and available relevant costs. We expect to complete the report for submission with the 2013 Fraud and Abuse Report."

OIG Comments:

The Association's FEHBP contract with OPM requires them to capture and report all costs associated with their anti-fraud and abuse activities, so we expect the Association to do a better job of this in the future. We are pleased that the Association is developing a format to include more relevant costs and look forward to working with them and OPM's contracting officer in determining an acceptable methodology and procedures for capturing these costs.

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).

Association's Response:

The Association disagrees with this recommendation. The Association states that the FEHBP contract only requires the Association, as the Carrier, to calculate and report an aggregate ROI to OPM. The Association will calculate ROI for the 2012 contract year for all local BCBS plans using the following standard:

$$\frac{\text{Recoveries} + \text{Claims Denied} + \text{Investigative Expenses Recovered}}{\text{Actual Fraud Expenses incurred}}$$

The Association also states, "For the 2013 contract year, BCBSA will work with all Local Plans to identify a standard methodology for reporting SIU initiated fraud, waste

and abuse cases, recoveries, savings and related costs, including those handled by other departments outside the SIU at the direction of the SIU.”

OIG Comments:

We disagree that the FEHBP contract states that the Carrier must provide “an aggregate ROI to OPM.” The contract states that the Carrier must submit to OPM an annual analysis of the costs and benefits of its F&A Program. Therefore, we continue to recommend that the contracting officer require the Association to provide the methodology and a measure of performance to ensure its fraud, waste, and abuse program is a benefit to the FEHBP. We believe it is imperative that the Plan be able to track and provide all costs associated with its fraud, waste, and abuse program and that those costs be provided on the annual fraud and abuse report.

We accept the Association’s ROI formula/calculation as long as the amounts used in the calculation are easily traceable and supportable to specific complaints, cases, investigations, and/or claims.

Recommendation 12

To ensure that all FEHBP Carriers are reporting statistics to OPM based on the same definitions, we recommend that the contracting officers prepare and distribute to all Carriers the definitions for the terms “fraud”, “waste”, and “abuse”.

Association’s Response:

The Association agrees with this recommendation and will also propose definitions to OPM by September 30, 2013.

Recommendation 13

We recommend that the contracting officer direct the Association to perform a study to determine how many local BCBS plans actually utilize proactive fraud detection software; determine what systems are being utilized; provide descriptions of the systems’ capabilities; and determine the total costs and benefits of these systems to the FEHBP. The results of this analysis should be provided to the contracting officer.

Association’s Response:

The Association agrees with this recommendation and will evaluate the feasibility of obtaining all of this information. The Association will provide the results of the study to the contracting officer by December 31, 2013.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

██████████, Lead Auditor

██████████, Auditor

██████████, Auditor

██████████, Auditor

██████████, Auditor

██████████, Chief ██████████

██████████, Senior Team Leader

Office of Investigations

██████████, Special Agent-In-Charge

██████████, Special Agent-In-Charge

██████████, Senior Audit Advisor to the Assistant Inspector General for Investigations

V. SCHEDULES

FLORIDA BLUE
JACKSONVILLE, FLORIDA

CONTRACT CHARGES

CONTRACT CHARGES*	2009	2010	2011	TOTAL
A. HEALTH BENEFIT CHARGES				
PLAN CODE 90	\$616,844,084	\$637,742,834	\$682,942,668	\$1,937,529,586
MISCELLANEOUS PAYMENTS AND CREDITS	2,107,205	501,088	(2,004,401)	603,892
PLAN CODE 590	566,320,418	564,237,987	578,302,946	1,708,861,351
MISCELLANEOUS PAYMENTS AND CREDITS	0	0	0	0
TOTAL HEALTH BENEFIT CHARGES	\$1,185,271,707	\$1,202,481,909	\$1,259,241,213	\$3,646,994,829
B. ADMINISTRATIVE EXPENSES				
PLAN CODE 90	\$60,774,604	\$54,597,931	\$55,796,509	\$171,169,044
PRIOR PERIOD ADJUSTMENTS	(\$1,000)	(\$216,808)	\$709,315	\$491,507
BUDGET SETTLEMENT	(\$2,096,719)	(\$1,475,612)	\$0	(\$3,572,331)
TOTAL ADMINISTRATIVE EXPENSES	\$58,676,885	\$52,905,511	\$56,505,824	\$168,088,220
TOTAL CONTRACT CHARGES	\$1,243,948,592	\$1,255,387,420	\$1,315,747,037	\$3,815,083,049

* This audit covered miscellaneous health benefit payments and credits and cash management activities from January 1, 2010 through February 29, 2012, as well as administrative expenses from 2009 through 2011.

SCHEDULE B

**FLORIDA BLUE
JACKSONVILLE, FLORIDA**

QUESTIONED CHARGES

AUDIT FINDINGS	2009	2010	2011	TOTAL
A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS*				
1. Health Benefit Refunds and Recoveries	\$0	\$70,787	\$0	\$70,787
TOTAL MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS	\$0	\$70,787	\$0	\$70,787
B. ADMINISTRATIVE EXPENSES				
1. Post-Retirement Benefit Costs	\$793,845	\$350,620	\$478,970	\$1,623,435
2. Unallowable and/or Unallocable Expenses	74,116	0	0	74,116
TOTAL ADMINISTRATIVE EXPENSES	\$867,961	\$350,620	\$478,970	\$1,697,551
C. CASH MANAGEMENT	\$0	\$0	\$0	\$0
D. FRAUD AND ABUSE PROGRAM				
1. Special Investigations Unit (Procedural)	\$0	\$0	\$0	\$0
TOTAL FRAUD AND ABUSE PROGRAM	\$0	\$0	\$0	\$0
TOTAL QUESTIONED CHARGES	\$867,961	\$421,407	\$478,970	\$1,768,338

April 16, 2013



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

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**Reference: OPM DRAFT AUDIT REPORT
BlueCross BlueShield of Florida
Audit Report Number 1A-10-41-12-050
(Dated March 1, 2013 and Received March 1, 2013)**

Dear [REDACTED]:

This is Blue Cross and Blue Shield of Florida, Inc.'s (Plan) response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP). The Blue Cross and Blue Shield Association (BCBSA) and the Plan are committed to enhancing existing procedures on issues identified by OPM. Please consider this feedback when updating the OPM Final Audit Report.

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

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Health Benefit Refunds \$70,787

OPM questioned \$70,787 in health benefit refunds that had not been returned to the FEHBP. The Plan agreed with this finding and, on February 13, 2013, returned the entire amount to the FEHBP. Documentation that supported the return of these funds was forwarded to the OPM OIG for their review and confirmation.

B. ADMINISTRATIVE EXPENSES

1. Post Retirement Benefit Costs \$1,623,435

OPM questioned \$1,623,435 in Post Retirement Benefit costs charged to the FEHBP during the period 2009 – 2011. The Plan agreed that, during this period, the FEHBP

was overcharged by \$239,080, due to an allocation error but disagrees with \$1,384,355 due to the method used by the OIG in its calculation of the Post Retirement Benefit costs charged to the FEHBP. The Plan continues to state that its cost accounting practices for its Post Retirement Benefit (PRB) plan complies in all material respects with FAR 31.205-6(o) Compensation/Post Retirement Benefits Other Than Pensions ("PRB"). "Modified" FAS 106 calculations provided by the Plan's independent pension actuaries are reasonable because the differences between the PRB, for financial reporting and government cost accounting purposes, are due primarily to the different starting points for the GAAP accrual accounting for financial reporting and the conversion to GAAP accrual accounting for government cost accounting (referred to as "Modified" FAS 106). Additionally, cash contributions in excess of the current year's accrued cost are accounted for as prepayment credits that may be carried over to future periods up to the amount of the "Modified" FAS 106 expense amount. FAR 31.205-6(o) (2)(iii)(F). The OIG stated that it was in the process of further reviewing the Plan's response in the draft report.

On February 15, 2013, the Plan submitted Prior Period Adjustments in the amount of \$239,080, to return to the FEHBP the agreed upon portion of the questioned costs. However, Contract Year 2009 was an under-funded year for the Plan and the amount of the CY2009 unreimbursed costs exceeded the amount of the submitted credit Prior Period Adjustment. Because the Plan's total unreimbursed costs exceeded the amount of the credit Prior Period Adjustment, the result is that the Plan remains under-funded and the credit Prior Period Adjustment merely reduces the total amount of unfunded costs. (Please see Attachment A)

Procedures have been updated, explaining that the allocation to FEP from the Post-Retirement Benefit (PRB) GL Account, 612025, in cost center 0039 (Corporate Benefits) should be used to calculate chargeable PRB expense.

2. Unallowable and/or Unallocable Costs \$74,116

OPM questioned \$74,116 in unallowable/unallocable project costs charged in error to the FEHBP in 2009. The Plan agreed with this finding and submitted a Prior Period Adjustment (PPA) to return the funds in the amount of \$74,116. However, as stated in OPM's Draft Audit Report, Contract Year 2009 was an under-funded year for the Plan and the amount of the CY2009 unreimbursed costs exceeded the amount of the submitted credit Prior Period Adjustment. Because the Plan's total unreimbursed costs exceeded the amount of the credit Prior Period Adjustment, the result is that the Plan remains under-funded and the credit Prior Period

Adjustment merely reduces the total amount of unfunded costs. (Please see Attachment A).

Procedures have been updated with checks and balances to ensure the appropriate adjustment is being made. An out-of-balance will be a warning that there is an error in the excel spreadsheet.

C. CASH MANAGEMENT – No findings

D. FRAUD AND ABUSE PROGRAM

1. Fraud and Abuse Program

Procedural

The Plan continues to disagree with the statement of non-compliance with contract CS 1039 and other guidance issues by OPM and the FEPDO, and whether FEHBP is deriving the full benefits of the plan's fraud and abuse activities. The FEPDO and the Plan have created a system of controls to monitor, identify, investigate and recover fraudulent and abusive payments of FEHBP funds and is substantially in compliance with the requirements of CS 1039. The Plan's FEP Fraud and Abuse Program is designed to protect patient safety and the health care assets of Federal beneficiaries.

The Plan disagrees with the statement noted within the draft report, "As a result of the Plan's non-compliance, fraud and abuse may go undetected and unreported within the FEHBP..." During the audit scope of 2010 and 2011, the Plan's fraud & abuse program activities resulted in over \$7.7 million dollars of actual recoveries and savings, ensuing in a positive return on investment (ROI) between \$1.29 and \$6.19. However, the goal of the Fraud and Abuse Program is focused on the proactive prevention and detection of fraud on a national basis, *i.e.*, to prevent fraudulent claims from being paid at the outset.

Additionally, the plan disagrees with the statement noted within the draft report, "Plan's reported recoveries and savings were inaccurate". No evidence was provided by the auditors as a result of this audit to reflect that recoveries and savings that were reported were inaccurate.

Incomplete and Untimely Reporting – FEHBP Fraud Cases

The draft audit report results include statements purporting to direct what information should be included in the FIMS system. In response, the Plan disagrees with OIG's interpretation of FEPDO's internal policies and procedures regarding the criteria for reporting of the Plan's complaints and cases into FIMS. Based on the finding, the OIG interprets the FEP policy as requiring Plans to enter all complaints and cases in which FEP may have exposure into FIMS, regardless of whether that exposure is related to the initial allegation, compliance, billing error, or fraudulent activity. The OIG is determining exposure simply as a dollar of Program funds paid to a provider in question. However, this definition of exposure is overly broad and would result in the inputting of a substantial number of complaints in which a preliminary review has not been completed in order to determine whether there is **reasonable suspicion** that a **fraud** has occurred or is occurring.

Carrier Letter Number 2011-13 effective June 17, 2011, states that all Carriers "are required to submit a written notification to the OPM OIG ("OIG") within 30 working days of becoming aware of a fraud, waste or abuse issue where there is a **reasonable suspicion** (emphasis added) that a **fraud** (emphasis added) has occurred or is occurring against the Federal Employees Health Benefits (FEHB) Program."

Therefore, the Plan disagrees with the statement noted in the audit results of "2551 cases/complaints were provided." As requested by the OIG auditors, the data file provided consisted of complaints during the audit period, in which 314 cases were opened. Further, the Plan disagrees with the Draft Report statement "754 of those cases should have been entered into FIMS and reported to OPM and OIG" due to the fact that these were complaints and a **reasonable suspicion** that a fraud had occurred or was occurring against the FEHBP had not been established. To the best of our ability, the Plan believes that of the 314 cases that were opened, the cases potentially affecting FEBHP were entered into FIMS using the BCBSA's defined criteria. The remaining complaints did not meet the standards that would have required reporting under the FEHBP guidelines.

Furthermore, the Plan disagrees with the accuracy of the Draft Report regarding the internal referrals to Healthcare Provider Audit (HPA), specifically the statement "Our analysis of these 33 complaints/cases [referred to HPA] found that 8 of the 33 cases were entered in FIMS, and 2 of the 8 cases entered in FIMS were reported to the OIG." The Plan noted out of the 33 referrals to HPA, 12 were identified as cases and 21 were identified as complaints. The Plan disagrees that complaints should be entered into FIMS due to the lack of a reasonable suspicion that a fraud has occurred or is occurring

against the FEHBP. Of the 12 cases that were referred over to HPA, 9 cases were entered into FIMS, and 1 case did not fit the criteria as defined by the FEPDO. The Plan agrees that 2 of the cases should have been entered into FIMS based on the criteria defined by the FEPDO.

The intent of the FEPDO's policy is not for the Plan to enter every complaint or case 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 details of the initial complaint occurred, 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 (used for the scope of this audit), "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. It also states that FIMS serves as the primary vehicle to report FEP Fraud related cases. Cases in which a Plan confirms that there is not a fraud issue or that the issue is unrelated to FEP are not required to be entered into FIMS.

The Plan maintains a local database in which we record all related complaint and 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. that is investigated. It is the intent of the FEPDO that the Plans only enter case information once they have confirmed that there is FEP exposure to the original accusation, complaint, billing error, or fraudulent activity.

The Plan disagrees with the accuracy regarding the statement "In the two policy manuals we reviewed provided by the Plan, we found no references made to any actual FEHB fraud and abuse program contract requirement or FEHBP fraud and abuse case reporting requirements." The Plan's SIU manuals do contain references to the actual FEHB fraud and abuse program; however, the Plan did not receive an information request to obtain SIU manuals from the OIG auditors.

However, based on the findings, we do agree that FEPDO policies and procedures can be further refined regarding the specific criteria Plans should use to report cases and, accordingly, the FEPDO has updated policies and procedures as of December 31, 2012. The Plan will receive training regarding the updated policies and procedures through written communications from the FEPDO and at Blue Cross Blue Shield conferences. Additionally, the Plan will reference the FEHBP fraud and abuse program

within the corporate wide policy and ensure current infrastructure can support the updates.

In summary, although the Plan disagrees with OIG's interpretation of the criteria used to input data into FIMS, the Plan will integrate revised criteria for reporting more specifically defined cases into FIMS.

Incomplete and/or Inaccurate Reporting - FEHBP Fraud and Abuse Recoveries

The draft audit report results states the Plan is providing incomplete and/or inaccurate reporting per the Contract, which requires the Plan to submit reports to OPM annually that identify dollars as lost and recovered, as well as, actual and projected savings related to fraud and abuse.

In response, the Plan agrees in part and disagrees in part. Per CS 1039, the FEPDO must provide reporting to OPM annually. The Plan acknowledges that 2 cases were not reported per the defined FEPDO criteria; however, no evidence was provided that cases were reported inaccurately. The Plan agrees the Plan is only reporting recoveries and savings from fraud related cases in FIMS as required by FEPDO criteria.

As the draft audit report results noted, the OIG auditors acknowledged that neither OPM nor the OPM OIG has provided definitions for waste and abuse applicable to Plan reporting. The Plan will change its reporting processes, as necessary, consistent with revised direction to report defined abuse cases, e.g., using the updated criteria provided by FEPDO as of December 28, 2012.

Costs and Benefits of Plan's Fraud and Abuse Activities

The draft audit report results include statements purporting that the FEHBP does not appear to be deriving the full benefit from the Plan's fraud and abuse activities.

The Plan disagrees with OIG's position that the FEHBP is not deriving the full benefit from the Plan's fraud and abuse program. The FEP Fraud Control Program is designed to protect patient safety and the health care assets of Federal beneficiaries and the Federal Government. The goal of the Program is primarily on the proactive prevention and detection of fraud on a national basis, i.e., to prevent fraudulent claims from being paid at the outset. This goal is accomplished by various methods, including utilizing anti-fraud software; by reviewing tips, leads and referrals from different sources; and by coordinating efforts and sharing information on current schemes and industry trends with other Plans, law enforcement, prosecutorial agencies, industry associations, medical/licensing boards and other health insurance carriers.

The Plan's SIU is focused on fraud prevention, in part, due to the difficulty of recovering program's funds through restitution. Therefore, the Plan would encourage reviewing OPM's benefit of each plan's fraud and abuse activities by also taking into account projected medical savings, which is projected savings calculated as the amount of claims that would have been billed had the SIU not intervened and stopped the fraudulent behavior, an industry accepted metric.

As stated above, the Plan disagrees with the accuracy of the Return on Investment (ROI) calculation by OIG for the Program was between a positive \$1.29 and a negative (\$8.88). BCBSA provides an overall ROI calculation for the entire SIU program to OPM, in order for OPM to determine whether deriving full benefit. However, if Florida Blue were to calculate a ROI it would be between a positive \$1.29 and \$6.19.

The OIG's ROI calculation incorrectly included the entire costs for HPA of \$2,476,815 and did not consider HPA recoveries of \$18,168,722 for 2010 & 2011. As mentioned within the Draft Report, HPA reviews both waste and abuse related cases, therefore the ROI calculation provided above excluded costs and recoveries associated with waste and cases not identified as "Provider Billing error" categories. The calculation provided by the Plan is conservative and may be understated, due to HPA cases were not classified as "abuse" or "waste" for the entire audit period reviewed.

As described in the Plan's response above, the Plan disagrees with specific assertions in the draft audit report and the general assertion that the FEHBP is not deriving the full benefit from the Plan's fraud and abuse activities. It is the Plan's belief that some of the reasons for the findings are a result of ambiguous terminology being used in relation to reporting SIU activities and the Plan looks forward to remedying this matter in coordination with the OIG, as appropriate, and the FEPDO. Additionally, the Plan seeks to continuously improve its program and will work with the FEPDO to make appropriate adjustments to processes.

Please see responses to the following recommendations:

Recommendation 4:

We recommend that the contracting officer have the Association verify that the Plan implements a policy to review and investigate all FEHBP potential exposure upon the initiation of any and all fraud, waste, and abuse allegations and/or issues within the SIU. 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 (Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General).

In response, BCBSA disagrees with the OIG's recommendation to include all cases with potential exposure in FIMS. The intent of FIMS is not that Local BCBS Plans enter every case or project they record with potential FEP exposure as defined by OPM OIG into FIMS, but for Plans to enter a case into FIMS once they have completed their initial assessment of the issue and confirmed that the claims or other evidence supports the allegation and/or raises a reasonable suspicion that fraud, waste or abuse is involved. Cases in which a Local Plan confirms that there is no reasonable suspicion to believe that there is a fraud issue, or where the issue is unrelated to FEP are not required to be entered into FIMS.

Additionally, Local 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 FEP funds for Plans to maintain case information in their local databases and FIMS for every case or allegation they investigate. It is the intent of BCBSA that Local Plans only enter case information once they have confirmed that there is exposure to the original accusation, complaint, or fraudulent activity.

However, BCBSA agrees that the guidelines for reporting fraud, waste and abuse activity into FIMS may not have been clear enough to fully ensure compliance with the relevant Carrier letters. As a corrective action plan:

- BCBSA conducted a thorough examination of available industry definitions of Fraud, Waste and Abuse. The resulting enhanced definitions were included in the Revised FEP Fraud, Waste and Abuse Program Standards Manual that was issued to Plan SIU departments on December 28, 2012. The revised manual was also issued to Persons with Primary FEP Responsibility and Primary Internal Audit Responsibility on February 15, 2013. The revised manuals make FEP requirements clearer and should result in greater adherence to requirements for case input. BCBSA will also continue to evaluate the FEP Fraud, Waste and Abuse Program Standards Manual to determine if any additional guidance is required on how Local Plans should report fraud, waste and abuse cases in FIMS.
- BCBSA has updated its policy to require Plan staff to attend training that is specific to FIMS reporting or other contractually mandated requirements. Roll-out scheduled completion date is June 30, 2013.

The Plan currently has a policy in place to review and investigate all FEHBP potential exposure upon the initiation of any and all fraud, waste and abuse allegations and/or issues within the SIU. The Plan will timely report all fraud, waste and abuse allegations and/or issues in FIMS as defined within FEPDO's FEP Standards Manual for Fraud, Waste & Abuse.

Recommendation 5:

We recommend that the contracting officer have the Association verify that the Plan implements a process to track all instances of SIU initiated recoveries, claim denials and cost avoidance, and link the recoveries, actual savings, and cost avoidance to the initiated cases and/or investigations in FIMS 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).

In response, BCBSA agrees with the recommendation to enhance monitoring of Local Plan initiated recoveries, claim denials and cost avoidance activities, and link the activities to the initiated cases and/or investigations.

BCBSA staff has initiated a revised Local Plan monitoring approach, which will ensure that there is appropriate focus with responsible staff at every Plan, and where appropriate, implement additional BCBSA monitoring activities. This enhanced monitoring activity is scheduled to be fully implemented by June 30, 2013.

The Plan currently has a process in place to track all instances of SIU initiated recoveries, claim denials and cost avoidance and link the recoveries, actual savings and cost avoidance to the initiated cases and/or investigations in FIMS in order to accurately report FEP related recoveries, actual and/or projected savings to BCBSA.

Recommendation 6:

We recommend that the contracting officer instruct the Association and 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 (Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General).

In response, BCBSA agrees with the recommendation to update its fraud, waste and abuse policy and procedure manual to consistently reflect the requirements of the FEHBP and updated its manual and distributed the revised manual to all Plans on December 28, 2012. The revised manual was also issued to Persons with Primary FEP Responsibility and Primary Internal Audit Responsibility on February 15, 2013. The revised manual makes FEP requirements clearer and should result in greater adherence to requirements for case input.

The Plan has updated its F&A policy and procedure manual to accurately reflect the requirements of the FEHBP as reflected within the FEPDO's FEP Standards Manual for Fraud, Waste and Abuse.

Recommendation 7:

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.

In response, BCBSA partially disagrees with the recommendation to provide full access to FIMS and NAAB meetings. FIMS is an internal management reporting system used by BCBSA and Local Plans to report Fraud, Waste and Abuse cases. Before cases can be accepted into FIMS, they must be reviewed and evaluated by BCBSA consultants, who then work with Local Plans to ensure the proper data elements are entered. As such, unlimited access by the OIG to the system at this time would result in potential inefficiencies for FEP. However, in order to provide the OPM OIG investigators with efficient, effective and faster access to cases, BCBSA will submit alternative processes for sharing relevant case information with OPM OIG on an established and timely basis.

In addition, because of the detailed operational nature of the agenda, the NAAB meetings are task oriented sessions for Local Plan and BCBSA members only. However, we will invite the OPM OIG to participate in select portions of the agenda regarding case sharing and items specific to FEP for each NAAB meeting. This was already initiated with the recently completed January 2013 NAAB meeting, which included an OPM OIG representative.

Recommendation 8:

We recommend that the contracting officer direct the Association to provide OPM and OPM OIG an annual report of their oversight activities related to the FEHB fraud and

abuse program. The report should discuss any and all compliance issues, as well as, the action plan the Association implemented with the local Plan to correct all deficiencies (*i.e.* areas of non-compliance).

In response, BCBSA partially agrees with this recommendation. BCBSA will design and prepare an annual compliance oversight report by September 30, 2013 with the goal of submitting the final report to the Contracting Officer on or about March 31, 2014 to reflect on the 2013 calendar year results.

Recommendation 9:

We recommend the contracting officer direct the Association to provide OPM an annual report identifying and detailing any and all costs associated with the Association's FEHB fraud and abuse program. These costs should be identified by department (*i.e.* legal, compliance, claims utilization, provider audit, etc.).

In response, BCBSA partially agrees with this recommendation. In most situations, it is not possible to distinguish the FEP vs. Non-FEP anti-fraud related costs system wide for other, peripheral departments, (*e.g.* Legal, Claims Utilization, Provider Audit etc.), given the variety of allocation and tracking methodologies that may be used and in some cases the small amount of the charge. As a result, tracking any and all costs associated with the Association's FEHB fraud and abuse program is likely not possible in many instances. However, BCBSA is committed to developing an acceptable format to report readily definable and available relevant costs. We expect to complete the report for submission with the 2013 Fraud and Abuse Report.

Recommendation 10:

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).

In response, there are no industry standards currently; therefore, BCBSA disagrees with the recommendation to require the BCBSFL Plan to provide a methodology and measure for determining the benefits of the Plan's fraud program based on industry standards. CS 1039 Section 1.9(a) states that the Carrier must submit to OPM an annual analysis of the costs and benefits of its fraud and abuse program. For this reference, the Carrier is the Blue Cross Blue Shield Association. To ensure that an appropriate, industry standard based ROI is reported, FEP will calculate ROI for the 2012 contract year for all Local Plans as follows:

Recoveries + Claims Denied + Investigative Expenses Recovered / Actual Fraud Expenses incurred.

For the 2013 contract year, BCBSA will work with all Local Plans to identify a standard methodology for reporting SIU initiated fraud waste and abuse cases, recoveries, savings and related costs, including those handled by other departments outside the SIU at the direction of the SIU.

Recommendation 11:

We recommend that the contracting office develop and distribute to all FEHBP Carriers definitions for the terms “fraud”, “waste” and “abuse” so that all Carriers are reporting statistics to OPM based on the same definitions.

In response, BCBSA agrees with this recommendation and will prepare proposed definitions and provide our recommendations to the Contracting Officer by September 30, 2013.

Recommendation 12:

We recommend that the contracting officer direct the Association to perform a study to determine how many local plans utilize proactive fraud detection software; determine what system is being utilized; provide a description of the systems capabilities; and determine the total costs and benefit of these systems to the FEHBP.

In response, BCBSA agrees with this recommendation and will evaluate the feasibility of obtaining all of the requested information by June 30, 2013. We will provide the results of the study to the Contracting Officer by December 31, 2013.

[REDACTED]
April 16, 2013
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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]

[REDACTED]

Director, Program Assurance

[REDACTED]

cc: [REDACTED], Contracting Officer, OPM
[REDACTED], Vice President, FEP
[REDACTED], FEP
[REDACTED], BCBSFL