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

Final Audit Report

AUDIT OF
BLUECROSS BLUESHIELD OF TENNESSEE
CHATTANOOGA, TENNESSEE

Report Number 1A-10-15-14-030
December 24, 2014

EXECUTIVE SUMMARY

Audit of BlueCross BlueShield of Tennessee

Report No. 1A-10-15-14-030 December 24, 2014

Why did we conduct the audit?

We conducted this limited scope audit to obtain reasonable assurance that BlueCross BlueShield of Tennessee (Plan) is complying with the provisions of the Federal Employees Health Benefits Act and regulations that are included, by reference, in the Federal Employees Health Benefits Program (FEHBP) contract. Specifically, the objectives of our audit were to determine if the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract.

What did we audit?

Our audit covered miscellaneous health benefit payments and credits from 2009 through September 30, 2013, as well as administrative expenses and statutory reserve payments from 2008 through 2012 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management activities and practices related to FEHBP funds from 2009 through September 30, 2013 and the Plan's Fraud and Abuse (F&A) Program for 2013.

Michael R. Esser
Assistant Inspector General for Audits

What did we find?

We questioned $5,824,432 in health benefit charges, administrative expenses, cash management activities, and lost investment income (LII). We also identified a procedural finding regarding the Plan's F&A Program. The BlueCross BlueShield Association (Association) and Plan agreed with the questioned amounts and generally disagreed with the procedural finding regarding the Plan's F&A Program. We noted that the Plan subsequently returned all of the questioned amounts to the FEHBP.

Our audit results are summarized as follows:

- Miscellaneous Health Benefit Payments and Credits – We questioned $17,181, consisting of $16,547 for a medical drug rebate amount that had not been returned to the FEHBP and $634 for applicable LII.

- Administrative Expenses – We questioned $31,022, consisting of $29,580 for overcharges that were related to out-of-system adjustments and Association dues as well as $1,442 for applicable LII.

- Statutory Reserve Payments – The audit disclosed no findings pertaining to statutory reserve payments.

- Cash Management – We determined that the Plan held excess FEHBP funds, totaling $5,776,229, in the Federal Employee Program investment account as of December 31, 2013.

- Fraud and Abuse Program – The Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases that are set forth in FEHBP Carrier Letter 2011-13.

ABBREVIATIONS

Association	**BlueCross BlueShield Association**
BCBS	**BlueCross BlueShield**
BCBSA	**BlueCross BlueShield Association**
BCBST	**BlueCross BlueShield of Tennessee**
CL	**Carrier Letter**
CFR	**Code of Federal Regulations**
EFT	**Electronic Funds Transfer**
FAR	**Federal Acquisition Regulations**
FEHB	**Federal Employees Health Benefits**
FEHBAR	**Federal Employees Health Benefits Acquisition Regulations**
FEHBP	**Federal Employees Health Benefits Program**
FEP	**Federal Employee Program**
FEPDO	**Federal Employee Program Director's Office**
F&A	**Fraud and Abuse**
FIMS	**Fraud Information Management System**
HIO	**Healthcare and Insurance Office**
LOCA	**Letter of Credit Account**
LII	**Lost Investment Income**
Manual	**FEP Fraud, Waste, and Abuse Program Standards Manual**
OIG	**Office of the Inspector General**
OMB	**U.S. Office of Management and Budget**
OPM	**U.S. Office of Personnel Management**
OSA	**Out-of-System Adjustment**
Plan	**BlueCross BlueShield of Tennessee**
SERP	**Supplemental Executive Retirement Plan**
SIU	**Special Investigations Unit**
SPI	**Special Plan Invoice**

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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 BlueCross BlueShield of Tennessee (Plan). The Plan is located in Chattanooga, Tennessee.

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

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 (BCBS) plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. This Plan is one of approximately 64 local BCBS plans participating in the FEHBP.

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

The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BCBS, 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

[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.

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.

All findings from our previous audit of the Plan (Report No. 1A-10-15-09-009, dated June 16, 2009) for contract years 2004 through 2007 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 July 15, 2014. The Association's comments offered in response to the 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.

Statutory Reserve Payments

- To determine whether the Plan charged statutory reserve payments to the FEHBP in accordance with the contract and applicable laws and 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 whether the Plan's communication and reporting of fraud and abuse cases were in compliance with the terms of Contract CS 1039 and the applicable FEHBP Carrier Letters.

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 390 and 890 for contract years 2008 through 2012. During this period, the Plan processed approximately $1.8 billion in FEHBP health benefit payments and charged the FEHBP $81 million in administrative expenses (See Figure 1 and Schedule A). The Plan also paid approximately $36 million in statutory reserve payments (See Schedule A).

Specifically, we reviewed miscellaneous health benefit payments and credits (e.g., refunds, provider audit recoveries, and drug rebates) and cash management activities from 2009 through September 30, 2013, as well as administrative expenses and statutory reserve payments from 2008 through 2012. We also reviewed the Plan's Fraud and Abuse (F&A) Program for 2013.

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.

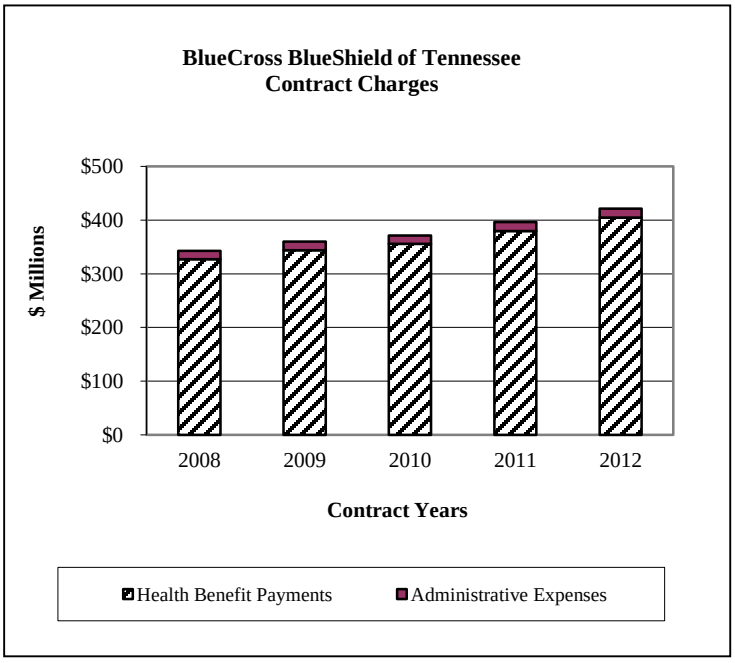


Figure 1 - Contract Charges

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 Chattanooga, Tennessee on various dates from March 11, 2014 through April 18, 2014. Audit fieldwork was also performed at our office in Cranberry Township, Pennsylvania.

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. For the period 2009 through September 30, 2013, we also judgmentally selected and reviewed 96 high dollar health benefit refunds, totaling $4,758,740 (from a universe of 48,473 refunds, totaling $18,419,733); 42 high dollar provider audit recoveries, totaling $1,158,144 (from a universe of 20,289 recoveries, totaling $7,166,538); 36 high dollar hospital credit balance audit recoveries, totaling $715,114 (from a universe of 1,104 recoveries, totaling $1,757,128); all FEP medical drug rebate amounts, totaling $145,756; 6 high dollar fraud and abuse recoveries, totaling $76,274 (from a universe of 19 recoveries, totaling $91,165); and 25 special plan invoices (SPI), totaling $7,855,741 in net FEP payments (from a universe of 500 SPI's, totaling $42,940,883 in net FEP payments), to determine if refunds and recoveries were promptly returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP.[2] The results of these samples were not projected to the universe of miscellaneous health benefit payments and credits.

[2] The sample of health benefit refunds included all refunds of $20,000 or more. For the sample of provider audit recoveries, we selected all recoveries of $20,000 or more from the Plan's "Exact" software listings and $5,000 or more from the Plan's "CAS" software listings. For the sample of hospital credit balance audit recoveries, we selected all recoveries of $10,000 or more. For the sample of fraud and abuse recoveries, we selected all recoveries of $5,000 or more. For the SPI sample, we selected three SPI's with the highest miscellaneous payment amounts and three SPI's with the highest miscellaneous credit amounts, if applicable, from each year in the audit scope.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2008 through 2012. Specifically, we reviewed administrative expenses relating to cost centers, natural accounts, out-of-system adjustments, pension, post-retirement, employee health benefits, Association dues, non-recurring projects, and subcontracts. We also reviewed the statutory reserve payments charged to the FEHBP for contract years 2008 through 2012. 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. Specifically, we reviewed letter of credit account (LOCA) drawdowns, working capital calculations, adjustments and/or balances, and interest income transactions from 2009 through September 30, 2013, as well as the Plan's dedicated FEP investment account balances as of September 30, 2013 and December 31, 2013.

We also interviewed the Plan's Special Investigations Unit regarding the effectiveness of the F&A Program, as well as reviewed the Plan's communication and reporting of fraud and abuse cases to test compliance with Contract CS 1039 and the applicable FEHBP Carrier Letters.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Medical Drug Rebates $17,181

In one instance, the Plan had not returned a medical drug rebate amount to the FEHBP. As a result of this finding, the Plan returned $17,181 to the FEHBP, consisting of $16,547 for the questioned medical drug rebate amount and $634 for applicable lost investment income (LII).

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

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

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

Since 2011, the Plan has participated in a medical drug rebate program with the manufacturers of the [Redacted] and [Redacted] drugs. [Redacted] drug rebates are determined based on medical claims for these drugs, which are administered in physicians' offices. The medical drug rebates are received multiple times a year (usually on a quarterly basis) by the Plan and credited to the participating groups, including the FEP. From January 1, 2011 through September 30, 2013, the Plan received 10 FEP medical drug rebate amounts totaling $145,756. We selected and reviewed all of the FEP medical drug rebate amounts for the purpose of determining if the Plan timely returned these rebates to the FEHBP.

Based on our review, we determined that the Plan had not returned a medical drug rebate amount of $16,547 to the FEHBP. As a result of our finding, the Plan returned $17,181 to the FEHBP, consisting of $16,547 for the questioned medical drug rebate amount and $634 for applicable LII. We reviewed and accepted the Plan's LII calculation.

Additionally, the Plan made duplicate LOCA adjustments when returning four medical drug rebate amounts to the FEHBP. As a result, these four medical drug rebate amounts, totaling $46,428, were returned twice to the FEHBP. In theory, the impact of these duplicate LOCA adjustments should have resulted in a shortage of FEHBP funds in the Plan's FEP investment account. However, based on our analysis of the funds maintained in the FEP investment account as of September 30, 2013, we noted that there were excess FEHBP funds of approximately $5.7 million in the account (See the "Excess Funds in the Federal Employee Program Investment Account" audit finding (D1) on pages 11 through 15 for more details regarding these excess FEHBP funds). Due to this significant surplus of FEHBP funds in the Plan's FEP investment account, we did not question the monetary impact to the FEHBP for these duplicate LOCA adjustments.

Association's Response:

In an email (dated September 22, 2014), the Association agreed with this audit finding.

OIG Comments:

When responding to our initial audit inquiry, the Plan stated that procedures were added to track rebate receipts and applicable credits to the FEHBP on a quarterly basis. Also, the Plan stated that additional procedures are being implemented to ensure that LOCA drawdowns are calculated correctly and to prevent duplicate LOCA adjustments.

Recommendation 1

We recommend that the contracting officer require the Plan to return $16,547 to the FEHBP for the questioned drug rebate amount. Since we verified that the Plan returned $16,547 to the FEHBP for the questioned drug rebate amount, no further action is required for this amount.

Recommendation 2

We recommend that the contracting officer require the Plan to return $634 to the FEHBP for LII on the questioned drug rebate amount. Since we verified that the Plan returned $634 to the FEHBP for LII, no further action is required for this LII amount.

B. ADMINISTRATIVE EXPENSES

1. Out-of-System Adjustments $27,380

The Plan did not correctly calculate a year-end adjustment for the Supplemental Executive Retirement Plan (SERP) expenses that were charged to the FEHBP in 2011. As a result of this finding, the Plan returned $27,380 to the FEHBP, consisting of $26,181 for a SERP expense overcharge and $1,199 for applicable LII.

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

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

For the period 2008 through 2012, there were 108 out-of-system adjustments (OSA) totaling $38,303,260 in net FEP credits. From this universe, we selected and reviewed a judgmental sample of 16 OSAs, totaling $27,653,301 in net FEP credits, to determine whether the Plan properly charged or credited these adjustments to the FEHBP. Our sample included the OSAs with the highest credit and/or charge amounts for each year as well as unusual OSAs identified from our nomenclature review.

Based on our review of these OSAs, we determined that the Plan did not correctly calculate the SERP expense adjustment for 2011. The Plan's procedure is to charge the FEHBP an accrued SERP expense amount through the cost accounting system and then make a year-end OSA to true-up the charge to the actual SERP expense amount. When making the SERP expense adjustment for 2011, the Plan used an incorrect amount for the actual SERP expense, resulting in an overcharge of $26,181 to the FEHBP. As a result of our finding, the Plan returned $27,380 to the FEHBP, consisting of $26,181 for the SERP expense overcharge and $1,199 for applicable LII. We reviewed and accepted the Plan's LII calculation.

Association's Response:

The Association agrees with this finding. The Association states that the Plan returned the overcharge of $26,181 to the FEHBP on July 15, 2014 through a prior period adjustment. The Plan also transferred LII of $1,199 to the FEHBP on July 15, 2014

through an SPI. The Association also states, "The Plan's internal job aides have been updated to reference the appropriate sources for adjustment calculations."

Recommendation 3

We recommend that the contracting officer disallow $26,181 for the SERP expense overcharge in 2011. Since we verified that the Plan returned $26,181 to the FEHBP for the questioned SERP expense overcharge, no further action is required for this amount.

Recommendation 4

We recommend that the contracting officer require the Plan to return $1,199 to the FEHBP for LII on the questioned SERP expense overcharge. Since we verified that the Plan returned $1,199 to the FEHBP for LII on the SERP expense overcharge, no further action is required for this LII amount.

2. BlueCross BlueShield Association Dues $3,642

For 2010, the Plan did not allocate Association dues to the FEHBP in accordance with the agreement between the Association and OPM regarding dues chargeability. As a result of this finding, the Plan returned $3,642 to the FEHBP, consisting of $3,399 for Association dues overcharged to the FEHBP and $243 for applicable LII.

FEP Memorandum #12-24PI (Memorandum), titled BCBSA Regular Member Plan Dues and Other Assessments: 2007-2012, dated February 15, 2012, provides guidance to the BCBS plans with respect to charging the FEHBP for Association dues. The Memorandum also includes specific guidance related to the chargeability of the 2010 special dues assessment to the FEHBP. Specifically, the Memorandum states that this assessment is chargeable to the FEHBP after applying the allowability factor to the invoiced amount.

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

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

To determine the reasonableness of the amounts charged to the FEHBP, we reviewed each year within the audit scope and recalculated FEP's share of the Association dues in accordance with the methods in the Memorandum. We found that the Plan overcharged the FEHBP $3,399 for Association dues in 2010. This error occurred because the Plan did not apply the allowability factor to the Association's special dues assessment when determining the chargeable dues base for 2010. As a result of our finding, the Plan returned $3,642 to the FEHBP, consisting of $3,399 for Association dues overcharged to the FEHBP and $243 for applicable LII. We reviewed and accepted the Plan's LII calculation.

Association's Response:

The Association agrees with this finding. The Association states that the Plan returned the overcharge of $3,399 to the FEHBP on July 15, 2014 through a prior period adjustment. The Plan also transferred LII of $243 to the FEHBP on July 15, 2014 through an SPI.

Recommendation 5

We recommend that the contracting officer disallow $3,399 for Association dues that were overcharged to the FEHBP in 2010. Since we verified that the Plan returned $3,399 to the FEHBP for the questioned Association dues, no further action is required for this amount.

Recommendation 6

We recommend that the contracting officer require the Plan to return $243 to the FEHBP for LII on the questioned Association dues. Since we verified that the Plan returned $243 to the FEHBP for LII on the questioned Association dues, no further action is required for this LII amount.

C. STATUTORY RESERVE PAYMENTS

The audit disclosed no findings pertaining to statutory reserve payments. The Plan calculated and charged statutory reserve payments to the FEHBP in accordance with Contract CS 1039 and applicable laws and regulations.

D. CASH MANAGEMENT

1. Excess Funds in the Federal Employee Program Investment Account $5,776,229

Our audit determined that the Plan held excess FEHBP funds, totaling $5,776,229, in the dedicated FEP investment account as of December 31, 2013.

48 CFR 1632.170 (b)(2) states, "Withdrawals from the LOC account will be made on a checks-presented basis. Under a checks-presented basis, drawdown on the LOC is delayed until the checks issued for FEHB Program disbursements are presented to the carrier's bank for payment."

48 CFR 1632.771 (c) states, "FEHBP funds shall be maintained separately from other cash and investments of the carrier or underwriter."

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

The Plan's FEP investment account generally includes FEP working capital funds, approved LOCA drawdowns, health benefit refunds and recoveries from providers and subscribers, interest income earned, and other cash identified as due to the FEP. Based on Contract CS 1039, all funds deposited into the FEP investment account, such as health benefit refunds, interest income and excess working capital, should be returned to the FEHBP by adjusting the LOCA within 60 days after receipt by the BCBS plan.

In our standard information request, dated October 1, 2013, we requested the Plan to provide a detailed itemization of the funds in the dedicated FEP investment account as of September 30, 2013. Based on our review of the Plan's FEP investment account itemization, we determined that the Plan held a total of $5,729,621 in excess FEHBP funds as of September 30, 2013. We requested the Plan to research these excess FEHBP funds and provide us detailed explanations regarding the composition of these funds.

BCBS of Tennessee held nearly $5.8 million in excess FEHBP funds in the Plan's dedicated FEP investment account.

In response to our follow-up request, the Plan performed an additional itemization of the funds held in the dedicated FEP investment account as of December 31, 2013. Based on our review of this FEP investment account itemization and documentation provided by the Plan, we determined that the Plan held excess FEHBP funds of $5,776,229 as of December 31, 2013.

We noted the following issues regarding the excess FEHBP funds in the Plan's dedicated FEP investment account as of December 31, 2013:

- The Plan incorrectly withdrew $1,772,199 from the LOCA. Specifically, the Plan inadvertently made additional LOCA drawdowns for a Health Dialog reimbursement of $780,142 and electronic funds transfer (EFT) rejection errors of $992,057, resulting in the Plan being reimbursed twice for these health benefit charges. The following are the Plan's explanations for these LOCA drawdown errors.

  Additional Health Dialog Reimbursement: "On July 25, 2013, BCBST drew down approximately $780,000 (total for both the Basic and Standard accounts) in anticipation of a reimbursement check issuance to the BCBST corporate account for the monthly Health Dialog payment. On July 29, 2013, this reimbursement check cleared and was included in the listing of cleared checks on the bank statement. On the following day, BCBST made a drawdown based on the cleared check total but was unaware that this total included this Health Dialog reimbursement (which had been previously drawn down). As a result, BCBST inadvertently made an additional drawdown on this Health Dialog payment."

  EFT Rejection Errors: "The majority of FEP claims payments are made via electronic funds transfers (EFT) to providers. In certain instances, an EFT transaction may not fully clear to the provider and thus is considered to be a rejected EFT payment. BCBST receives a rejected EFT report from the issuing bank. BCBST's Accounts Payable department will issue a manual check to replace the rejected EFT in order to ensure the provider receives the payment. BCBST identified instances where the appropriate accounting did not occur in the drawdown calculation for checks issued to replace rejected EFT transactions. In these situations, funds on rejected EFT's were returned to the FEP Investment Account and a manual check was submitted to the provider. When these checks cleared, BCBST did not reduce the next drawdown by these amounts, and as a result, an additional drawdown was made on these items."

These specific LOCA drawdown errors totaled $1,772,199 of the excess FEHBP funds in the FEP investment account as of December 31, 2013.

- In 2010, the Plan received a refund of $223,664 from Magellan for FEP capitation overpayments applicable to contract years 2008 and prior. The Plan returned part of this refund, but did not return $113,772 of the refund amount to the FEHBP.

- According to the Plan, the remaining excess funds of $3,890,258 relate to periods prior to 2004, which is past the Plan's record retention period. Therefore, the Plan could not specifically identify the transactions relating to these excess funds.

As a result of the LOCA drawdown errors of $1,772,199, a refund amount of $113,772 not returned to the FEHBP, and the unexplained excess funds of $3,890,258 in the FEP investment account, we are questioning $5,776,229 in excess FEHBP funds held in the FEP investment account as of December 31, 2013. As a result of our finding, the Plan returned $1,885,971 of the questioned excess funds to the FEHBP on June 18, 2014. The Plan also returned the remaining questioned excess funds of $3,890,258 to the FEHBP on September 30, 2014.

Association's Response:

The Association agrees with this finding. The Association states, "The Plan was able to specifically identify $1,885,971 of excess funds held in the FEP investment account as of December 31, 2013, related to transactions occurring between 2004 and 2013. The Plan has provided OPM with supporting documentation and explanation[s] for these excess funds which included a Care Management provider reimbursement of $780,142; EFT rejection errors of $992,057; and Behavioral Health provider refunds of $113,772. The total of $1,885,971 was returned to FEHBP in June 2014. The remaining amount of excess funds of $3,890,258 relates to periods prior to 2004 which is beyond the Plan's record retention period. As a result, the Plan is unable to specifically identify the transactions that might have caused these variances, and will return the total amount of the excess funds to FEHBP."

The Association also states, "The following corrective actions have been implemented to prevent drawdown errors to the investment account:

- The working capital balance is now reconciled to the balance in the investment account on a monthly basis.

- A revision was made to the drawdown procedure to implement funds movement between the Plan Corporate account and FEP accounts via transfers. This change will eliminate the need for prefunding non-claims checks, thus eliminating the need for a future reduction and mitigating the risk of the aforementioned finding . . .

- As a result of the items identified above under 'EFT Rejection Errors', the drawdown procedure has been updated to include a line item to adjust the drawdown as needed based upon bank reporting of EFT returns.

- The monthly drawdown review has been expanded to give a more detailed and complete variance analysis of timing differences at the end of each period. The review now includes: a variance analysis of calculation to EFT deposit amount, an overnight sweep deposit versus withdrawal analysis and a rolling summary of identified variances to ensure resolution. The purpose of the expansion of the monthly review is to identify drawdown errors and correct them in a more expedient manner."

OIG Comments:

We did not assess LII on this audit finding since the questioned excess FEHBP funds were maintained in the Plan's dedicated FEP investment account.

Recommendation 7

We recommend that the contracting officer require the Plan to return $5,776,229 to the FEHBP for the questioned excess funds in the FEP investment account. Since we verified that the Plan returned $5,776,229 to the FEHBP for these questioned excess funds, no further action is required for this amount.

Recommendation 8

We recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the Plan has implemented additional corrective actions to prevent LOCA drawdown errors from occurring. (These corrective actions are included in the Association's response to the draft report.) Also, the contracting officer should require the Association to provide evidence or supporting documentation ensuring that the Plan has implemented corrective actions so that only necessary funds are maintained in the FEP investment account.

E. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit — Procedural

The Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases set forth in FEHBP Carrier Letter (CL) 2011-13. Specifically, the Plan did not report, or did not timely report, all fraud and abuse cases to the OIG. The Plan's non-compliance may be due in part to incomplete and/or untimely reporting of fraud and abuse cases to the Association's FEP Director's Office (FEPDO), as well as inadequate controls at the FEPDO to monitor and communicate the Plan's cases to the OIG. Without awareness of these existing potential fraud and abuse issues, the OIG cannot investigate the broader impact of these potential issues on the FEHBP as a whole.

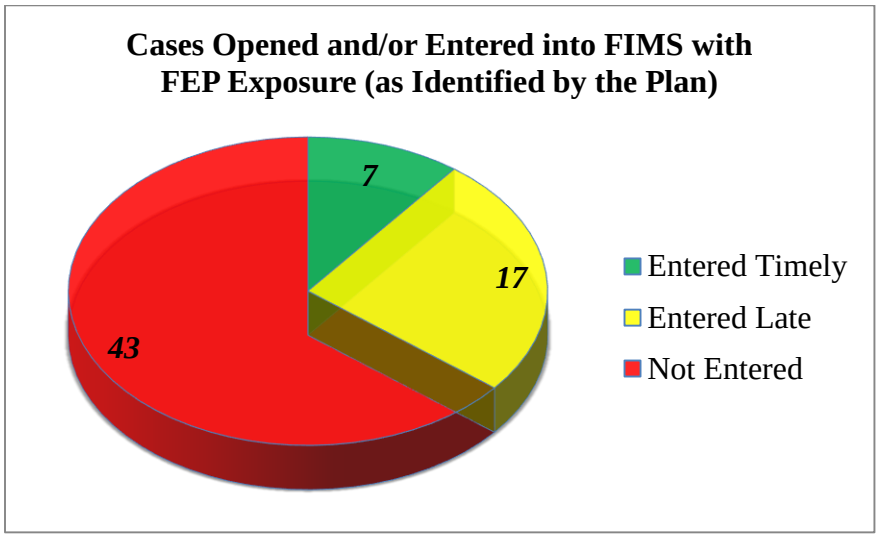
CL 2011-13 (Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General), dated June 17, 2011, states that all Carriers "are required to submit a written notification to the OPM OIG . . . within 30 working days of becoming aware of a fraud, waste or abuse issue 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 requirement.

During the period January 1, 2013 through December 31, 2013, the Plan opened 67 fraud and abuse cases that were identified as having FEP exposure. We reviewed these 67 cases with FEP exposure to determine if the cases were reported to the OIG as required by CL 2011-13. Based on our review, we determined that notifications for only 3 of the 67 fraud and abuse cases with FEP exposure were sent to the OIG. Because all of these cases have FEP exposure, and there is no dollar threshold for reporting suspected fraud against the FEHBP, these cases should have been reported to the OIG as required by CL 2011-13. Moreover, the three notifications that the OIG received were sent 33 to 99 days after the Plan had identified the FEP exposure, which does not meet the 30-day timeliness requirement defined in CL 2011-13.

The Plan's non-compliance with the communication and reporting requirements in CL 2011-13 may be due, in part, to the Plan untimely communicating or not reporting potential FEP fraud and abuse cases to the FEPDO's Special Investigations Unit (SIU). The FEPDO's SIU sends notifications of fraud and abuse cases to the OIG on behalf of the Plan. However, the Plan must first report the fraud and abuse cases with FEP exposure to the FEPDO's SIU, which is accomplished when the Plan enters the cases into the FEPDO's Fraud Information Management

The Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases.

System (FIMS).[3] The Plan and the FEPDO's internal policies and procedures require the Plan to enter a case into FIMS as soon as an investigation is opened and/or within 30 days of any relevant FEP fraud activity. However, of the 67 cases with FEP exposure during the period January 1, 2013 through December 31, 2013, we determined that only 7 cases were entered into FIMS timely, 17 cases were entered into FIMS untimely, and 43 cases were not entered into FIMS at all.



Without timely FIMS case entries by the Plan, the FEPDO's SIU cannot meet the FEHBP's contractual communication and reporting requirements.

In addition to the above, the Plan also opened 108 non-FEP fraud and abuse cases. We reviewed all of these cases to determine if there was FEP exposure. Based on our review, we determined that 49 of these cases had FEP exposure. After further review, we found that the Plan previously had identified FEP exposure for four of these cases but did not report them because the cases did not meet their investigative monetary thresholds. However, since there is no dollar threshold for reporting suspected fraud, waste and abuse issues against the FEHBP, these cases should have been reported to the OIG as required by CL 2011-13. Additionally, none of the 49 cases were added to FIMS or reported to the OIG as required by CL 2011-13.

Ultimately, both the Plan's untimely reporting of potential FEP cases to the FEPDO's SIU and the FEPDO SIU's inadequate controls to monitor the Plan's FIMS entries and notify the applicable entities of these cases have resulted in a failure to meet the communication and reporting requirements that are set forth in CL 2011-13. The lack of notifications and/or untimely case notifications did not allow the OIG to investigate

[3] FIMS is a multi-user, web-based case-tracking database that the FEPDO's SIU developed in-house.

whether other FEHBP Carriers are exposed to the identified provider committing fraud against the FEHBP. This also does not allow the OIG's Administrative Sanctions Group to be notified timely. Consequently, this non-compliance by the Plan and FEPDO may result in additional improper payments being made by other FEHBP Carriers.

Association's Response:

The Association disagrees with the statement that the Plan is not in compliance with the communication and reporting requirements set forth in CL 2011-13. The Association also disagrees that controls for the Plan's FIMS entries are inadequate.

The Association states, "The FEP Director's Office (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. Further, the Plan's FEP Fraud and Abuse Program is designed to protect patient safety and the health care assets of Federal beneficiaries."

The Association also states that the Plan had been following the guidance provided by the Association in the FEP Fraud, Waste, and Abuse Program Standards Manual (Manual). The Plan is committed to complying with CL 2011-13 and will further modify procedures as appropriate based on the Association's review of the Manual or after the issuance of updated guidelines by OPM.

OIG Comments:

Our review concluded that timeliness issues were in fact present regarding the communication and reporting of fraud and abuse cases to the FEPDO's SIU (via FIMS) and to the OIG (via official notification). Whether or not the guidance provided by the Association in the Manual is adequate, the Plan and Association are both responsible for working together to meet the contractual requirements set forth in Contract CS 1039 and CL 2011-13.

Note: In addition to the recommendations below, we also included the following recommendation in our draft audit report: "We recommend that the contracting officer direct the Association and/or Plan to provide OPM and the OIG an explanation and supporting documentation for each of the 21 cases (7 cases entered into FIMS timely plus 17 cases entered into FIMS untimely minus 3 cases reported to the OIG) that were entered into FIMS but not reported to the OIG. We also recommend that the contracting officer review the explanation and supporting documentation for each of these cases, and determine if these cases meet the communication and reporting requirements."

The Association addressed this recommendation and provided supporting documentation in response to our draft report. However, we will evaluate the Association's response to this recommendation during our current audit of the "Fraud and Abuse Case Reporting Process at the BlueCross BlueShield Association" (Report No. 1A-99-00-14-069) and report on the results accordingly.

Recommendation 9

We recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the Plan has implemented the necessary procedural changes to meet the communication and reporting requirements of fraud and abuse cases that are contained in CL 2011-13. We also recommend that the contracting officer instruct the Association to provide the Plan with more oversight to ensure the timely and complete entry of all FEP fraud and abuse cases into FIMS, and concurrently, timely and complete communication of those cases to the OIG.

Association's Response:

"BCBSA agrees with this recommendation and has reviewed the current BCBSA Fraud Waste and Abuse manual to ensure that the manual addresses all of the Program requirements. BCBSA is in the process of communicating the results of its review with the Plan and will work with the Plan to modify their procedures, as appropriate. BCBSA expects to complete this process by October 31, 2014.

BCBSA currently provides oversight to the Plan to ensure that entries into FIMS are timely and complete, and expects to continue to do so in the future."

The Association also states, "The Plan has now updated its procedure on entering cases in the Federal Employee Program (FEP) Fraud Information Management System (FIMS) to meet the communication and reporting requirements of fraud and abuse cases that are contained in CL 2011-13 . . . ."

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[Redacted] Lead Auditor

[Redacted] Auditor

[Redacted] Auditor

[Redacted] Auditor

[Redacted] Chief **[Redacted]**

[Redacted] Senior Team Leader

V. SCHEDULES

SCHEDULE A

BLUECROSS BLUESHIELD OF TENNESSEE
CHATTANOOGA, TENNESSEE

CONTRACT CHARGES

CONTRACT CHARGES*	2008	2009	2010	2011	2012	TOTAL
A. HEALTH BENEFIT CHARGES						
PLAN CODES 390	$322,428,553	$338,270,721	$347,655,153	$372,828,523	$394,993,588	$1,776,176,538
MISCELLANEOUS PAYMENTS AND CREDITS	4,528,077	5,646,494	7,921,181	7,038,032	9,728,466	34,862,250
PLAN CODES 890	0	0	0	0	67,888	67,888
MISCELLANEOUS PAYMENTS AND CREDITS	0	0	0	0	0	0
TOTAL HEALTH BENEFIT CHARGES	$326,956,630	$343,917,215	$355,576,334	$379,866,555	$404,789,942	$1,811,106,676
B. ADMINISTRATIVE EXPENSES						
PLAN CODE 390	$16,488,496	$16,892,384	$16,525,108	$16,609,216	$16,448,828	$82,964,032
PRIOR PERIOD ADJUSTMENTS	(138,970)	49,271	(117,899)	(24,566)	3,989	(228,175)
BUDGET SETTLEMENT REDUCTIONS	(385,304)	(1,090,162)	(423,093)	0	0	(1,898,559)
TOTAL ADMINISTRATIVE EXPENSES	$15,964,222	$15,851,493	$15,984,116	$16,584,650	$16,452,817	$80,837,298
C. STATUTORY RESERVE PAYMENTS						
PLAN CODE 390	$7,966,512	$8,831,866	$0	$9,068,255	$9,677,001	$35,543,634
TOTAL CONTRACT CHARGES	$350,887,364	$368,600,574	$371,560,450	$405,519,460	$430,919,760	$1,927,487,608

* This audit covered miscellaneous health benefit payments and credits and cash management activities from 2009 through September 30, 2013, as well as administrative expenses and statutory reserve payments from 2008 through 2012.

SCHEDULE B

BLUECROSS BLUESHIELD OF TENNESSEE
CHATTANOOGA, TENNESSEE

QUESTIONED CHARGES

AUDIT FINDINGS	2008	2009	2010	2011	2012	2013	2014	TOTAL
A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS								
1. Medical Drug Rebates*	$0	$0	$0	$16,583	$311	$259	$28	$17,181
TOTAL MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS	$0	$0	$0	$16,583	$311	$259	$28	$17,181
B. ADMINISTRATIVE EXPENSES								
1. Out-of-System Adjustments*	$0	$0	$0	$26,181	$492	$409	$298	$27,380
2. BlueCross BlueShield Association Dues*	0	0	3,399	87	64	53	39	3,642
TOTAL ADMINISTRATIVE EXPENSES	$0	$0	$3,399	$26,268	$556	$462	$337	$31,022
C. STATUTORY RESERVE PAYMENTS	$0	$0	$0	$0	$0	$0	$0	$0
D. CASH MANAGEMENT								
1. Excess Funds in the FEP Investment Account	$0	$0	$0	$0	$0	$5,776,229	$0	$5,776,229
TOTAL CASH MANAGEMENT	$0	$0	$0	$0	$0	$5,776,229	$0	$5,776,229
E. FRAUD AND ABUSE PROGRAM								
1. Special Investigations Unit (Procedural)	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL FRAUD AND ABUSE PROGRAM	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL QUESTIONED CHARGES	$0	$0	$3,399	$42,851	$867	$5,776,950	$365	$5,824,432

*** We included lost investment income (LII) within audit findings A1 ($634), B1 ($1,199), and B2 ($243). Therefore, no additional LII is applicable for these audit findings.**

APPENDIX

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
202.942.1000
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September 22, 2014

[redacted]
Experience-Rated Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, DC 20415-11000

Reference: **OPM DRAFT AUDIT REPORT**
Blue Cross Blue Shield of Tennessee (BCBST)
Audit Report No. 1A-10-15-14-030
(Dated July 15, 2014 and Received July 15, 2014)

Dear [redacted]

This is Blue Cross Blue Shield of Tennessee'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. Medical Drug Rebates $17,181

Recommendation 1

Since we verified that the Plan returned $16,547 to the FEHBP for the questioned drug rebate amount, no further action is required for this amount.

Recommendation 2

Since we verified that the Plan returned $634 to the FEHBP for LII on the

questioned drug rebate amount, no further action is required for this LII amount.

B. ADMINISTRATIVE EXPENSES

1. Out-of-System Adjustments $26,181

Recommendation 3

We recommend that the contracting officer disallow $26,181 for SERP expenses, and verify that these funds were returned to the FEHBP.

Plan's Response:

The Plan returned $26,181 to FEPHBP on July 15, 2014 by means of a prior period adjustment (PPA) #6350 submitted on July 1, 2014. The lost investment income was assessed and transferred to FEHBP on July 15, 2014 in the amount of $1198.94 using SPI#100859-390. The Plan's internal job aids have been updated to reference appropriate sources for adjustment calculations.

2. BlueCross BlueShield Association Dues $3,399

Recommendation 4

We recommend that the contracting officer disallow $3,399 for Association dues that were overcharged to the FEHBP in 2010.

Plan's Response:

The Plan returned $3,399 to FEHBP on July 15, 2014 by means of a prior period adjustment #6349 submitted on July 1, 2014. The lost investment income was assessed and transferred to FEHBP on July 15, 2014 in the amount of $242.75 using SPI#100858-390.

C. CASH MANAGEMENT

1. Excess Funds in the FEP Investment Account $5,776,229

Recommendation 5

We recommend that the contracting officer instruct the Plan to immediately return the questioned excess funds of $5,776,229 to the FEHBP (unless the Plan can provide evidence or supporting documentation that these funds are not FEHBP

funds), as well as all additional excess and/or overdraw amounts (e.g., LOCA drawdown errors) identified while resolving this audit finding.

Plan's Response

The Plan was able to specifically identify $1,885,971 of excess funds held in the FEP investment account as of December 31, 2013, related to transactions occurring between 2004 and 2013. The Plan has provided OPM with supporting documentation and explanation for these excess funds which included a Care Management provider reimbursement of $780,142; EFT rejection errors of $992,057; and Behavioral Health provider refunds of $113,772. The total of $1,885,971 was returned to FEHBP in June 2014. The remaining amount of excess funds of $3,890,258 relates to periods prior to 2004 which is beyond the Plan's record retention period. As a result, the Plan is unable to specifically identify the transactions that might have caused these variances, and will return the total amount of the excess funds to FEHBP.

Recommendation 6

We recommend that the contracting officer ensure that the Plan implements corrective actions to prevent these types of LOCA drawdown errors from occurring. The Plan should also implement corrective actions to ensure that only the necessary funds are maintained in the FEP investment account.

Plan's Response

The following corrective actions have been implemented to prevent drawdown errors to the investment account:

- The working capital balance is now reconciled to the balance in the investment account on a monthly basis.
- A revision was made to the drawdown procedure to implement funds movement between the Plan Corporate account and FEP accounts via transfers. This change will eliminate the need for prefunding non-claims checks, thus eliminating the need for a future reduction and mitigating the risk of the aforementioned finding specified in "Care Management provider reimbursement."
- As a result of the items identified above under "EFT Rejection Errors", the drawdown procedure has been updated to include a line item to adjust the drawdown as needed based upon bank reporting of EFT returns.
- The monthly drawdown review has been expanded to give a more detailed and complete variance analysis of timing differences at the end of each period. The review now includes: a variance analysis of calculation to EFT deposit amount, an overnight sweep deposit versus withdrawal

analysis and a rolling summary of identified variances to ensure resolution. The purpose of the expansion of the monthly review is to identify drawdown errors and correct them in a more expedient manner.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit — Procedural

Plan's Comments

As noted in the Plan's Response included in the body of the issue, the Plan had been following the guidance provided by the Blue Cross and Blue Shield Association (BCBSA) in the FEP FWA Manual. The Plan is committed to complying with CL 2011-13 and will further modify its procedures as appropriate based on BCBSA's review of the FWA manual as referenced in Recommendation 7 or upon the issuance of updated guidelines by OPM.

BCBSA Comments

BCBSA continues to disagree with the statement that the Plan is not in compliance with the communication and reporting requirements set forth in Contract CS 1039 and the Federal Employee Health Benefit Program (FEHBP) Carrier Letter (CL) 2011-13. BCBSA also disagrees that controls regarding Plans FIMS entries are inadequate.

The FEP Director's Office (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. Further, the Plan's FEP Fraud and Abuse Program is designed to protect patient safety and the health care assets of Federal beneficiaries.

Recommendation 7

We recommend that the contracting officer require the Association to provide evidence or supporting documentation ensuring that the Plan has implemented the necessary procedural changes to meet the communication and reporting requirements of fraud and abuse cases that are contained in CL 2011-13. We also recommend that the contracting officer instruct the Association to provide the Plan with more oversight to ensure the timely and complete entry of all FEP fraud and abuse cases into FIMS, and concurrently, timely and complete communication of those cases to the OIG.

Plan's Response

The Plan has now updated its procedure on entering cases in the Federal Employee Program (FEP) Fraud Information Management System (FIMS) to meet the communication and reporting requirements of fraud and abuse cases that are contained in CL 2011-13 See Attachment 1.

BCBSA Response

BCBSA agrees with this recommendation and has reviewed the current BCBSA Fraud Waste and Abuse manual to ensure that the manual addresses all of the Program requirements. BCBSA is in the process of communicating the results of its review with the Plan and will work with the Plan to modify their procedures, as appropriate. BCBSA expects to complete this process by October 31, 2014.

BCBSA currently provides oversight to the Plan to ensure that entries into FIMS are timely and complete, and expects to continue to do so in the future.

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

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

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

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

Sincerely,

[redacted]

[redacted], CISA, CRMA
Managing Director, Program Assurance

lr/rj

cc: [redacted], Contracting Officer, OPM
[redacted], FEP
[redacted], BCBST

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U.S. Office of Personnel Management
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-- CAUTION --

Report No. 1A-10-15-14-030