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

Final Audit Report

Subject:

AUDIT OF
HIGHMARK INC.
CAMP HILL, PENNSYLVANIA

Report No. 1A-10-13-14-003

Date: August 22, 2014

AUDIT REPORT

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

Highmark Inc.
Plan Codes 363/865
Camp Hill, Pennsylvania

REPORT NO. 1A-10-13-14-003 DATE: August 22, 2014

Michael R. Esser
Assistant Inspector General
for Audits

--CAUTION--

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
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Highmark Inc.
Plan Codes 363/865
Camp Hill, Pennsylvania

REPORT NO. 1A-10-13-14-003 DATE: August 22, 2014

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at Highmark Inc. (Plan), located in Camp Hill, Pennsylvania, questions $8,672 in administrative expenses and lost investment income (LII). The report also includes a procedural finding for the Plan's Fraud and Abuse (F&A) Program. The BlueCross BlueShield Association (Association) agreed ***(A)*** with the questioned amounts and generally disagreed 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 2008 through May 31, 2013 and administrative expenses 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 2008 through May 31, 2013 and the Plan's F&A Program from 2008 through August 31, 2013.

The audit results are summarized as follows:

MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

The audit disclosed no findings pertaining to miscellaneous health benefit payments and credits. Overall, we concluded that the Plan returned health benefit refunds and recoveries, including medical drug rebates, to the FEHBP in a timely manner, and properly charged miscellaneous payments to the FEHBP.

ADMINISTRATIVE EXPENSES

- **Unallocable Cost Centers *(A)*** **$6,025**

The Plan charged unallocable cost center expenses of $5,871 to the FEHBP in 2012. As a result of this finding, the Plan returned $6,025 to the FEHBP, consisting of $5,871 for these questioned cost center expenses and $154 for applicable LII.

- **Unallowable and/or Unallocable Expense Account *(A)*** **$2,647**

The Plan charged the FEHBP $2,584 for an unallowable and/or unallocable expense account in 2012. As a result of this finding, the Plan returned $2,647 to the FEHBP, consisting of $2,584 for the questioned expense account amount and $63 for applicable LII.

CASH MANAGEMENT

The audit disclosed no findings pertaining to the Plan's cash management activities and practices. Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations.

FRAUD AND ABUSE PROGRAM

- **Special Investigations Unit** **Procedural**

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. Specifically, the Plan did not report one fraud and abuse case and did not timely report three cases to the Office of Personnel Management's Office of the Inspector General (OIG). The Plan's non-compliance may be due in part to untimely reporting of fraud and abuse cases to the Association's Federal Employee Program 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. The Association generally disagreed with this procedural finding.

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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 Highmark Inc. (Plan). The Plan is located in Camp Hill, Pennsylvania.

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. This Plan is one of approximately 64 local BlueCross and BlueShield plans participating in the FEHBP.

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

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

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

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

All findings from our previous audit of the Plan (Report No. 1A-10-13-09-001, dated June 15, 2009) for contract years 2003 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 March 5, 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.

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 363 and 865 for contract years 2008 through 2012. During this period, the Plan paid approximately $1.8 billion in health benefit charges and $127 million in administrative expenses (See Figure 1 and Schedule A).

Specifically, we reviewed miscellaneous health benefit payments and credits (e.g., refunds, subrogation recoveries, medical drug rebates, and fraud recoveries) and cash management activities for 2008 through May 31, 2013, as well as the Plan's F&A Program for 2008 through August 31, 2013. We also reviewed administrative expenses for 2008 through 2012.

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.

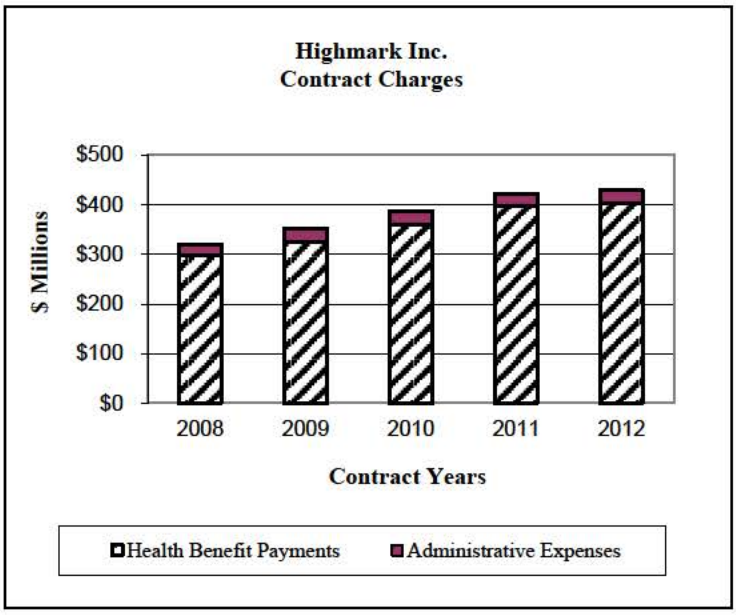

Figure 1 - Contract Charges

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 Camp Hill, Pennsylvania from October 21, 2013 through November 15, 2013. 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. We also judgmentally selected and reviewed 50 high dollar provider offsets, totaling $5,534,317 (from a universe of 245,673 offsets, totaling $46,200,031); 111 high dollar health benefit refunds, totaling $3,980,031 (from a universe of 22,917 refunds, totaling $9,404,871); 52 high dollar subrogation recoveries, totaling $1,187,774 (from a universe of 1,777 recoveries, totaling $3,676,753); all FEP medical drug rebate amounts, totaling [redacted] 10 high dollar provider audit recoveries, totaling $314,415 (from a universe of 91 recoveries, totaling $642,052); 6 fraud and abuse recoveries, totaling $55,315 (from a universe of 17 recoveries, totaling $61,739); 24 high dollar hospital settlements, totaling $2,793,331 in FEP payments (from a universe of 333 settlements, totaling $5,684,009 in net FEP payments); and 22 special plan invoices (SPI), totaling $6,601,413 in net FEP payments (from a universe of 375 SPI's, totaling $12,256,622 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.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2008 through 2012. Specifically, we reviewed administrative expenses relating to cost centers and pools, detailed and summary expense accounts, out-of-system adjustments, prior period adjustments, pension, post-retirement, employee health benefits, non-recurring projects, return on investment, subcontracts, Association dues, 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 the Plan's communication and reporting of fraud and abuse cases to test compliance with Contract CS 1039 and the applicable FEHBP Carrier Letters.

[2] The sample of provider offsets included all offsets of $39,000 or more. For the sample of health benefit refunds, we selected all refunds of $15,000 or more. For the sample of subrogation recoveries, we selected all recoveries of $10,000 or more. For the sample of provider audit recoveries, we selected all recoveries of $20,000 or more. For the sample of fraud and abuse recoveries, we selected all recoveries of $2,000 or more. For the sample of hospital settlements, we selected all payment amounts of $68,000 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 from each year in the audit scope.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

The audit disclosed no findings pertaining to miscellaneous health benefit payments and credits. Overall, we concluded that the Plan returned health benefit refunds and recoveries, including medical drug rebates, to the FEHBP in a timely manner, and properly charged miscellaneous payments to the FEHBP.

B. ADMINISTRATIVE EXPENSES

1. Unallocable Cost Centers $6,025

The Plan charged unallocable cost center expenses of $5,871 to the FEHBP in 2012. As a result of this finding, the Plan returned $6,025 to the FEHBP, consisting of $5,871 for these questioned cost center expenses and $154 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."

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."

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, the Plan allocated administrative expenses of $191,778,264 (before adjustments) to the FEHBP from 108 cost pools. From this universe, we selected a judgmental sample of 22 cost pools to review, which totaled $159,715,760 in expenses allocated to the FEHBP. We selected the cost pools based on high dollar amounts and our trend analysis. Additionally, because the Plan rolls up the individual cost centers into cost pools, we also selected a judgmental sample of 32 cost centers to review, from a universe of 248 cost centers. We selected these cost centers based on a nomenclature review. We reviewed the expenses from these cost pools and cost centers for allowability, allocability, and reasonableness.

Based on our review, we determined that the Plan allocated $5,871 to the FEP from two cost centers that did not benefit the FEHBP. The Plan included these cost centers (CC) in cost pools (CP) that allocated costs to the FEP in 2012. The following is a summary of the unallocable CC expenses charged to the FEHBP:

CP	CC Number	CC Name	Amount Charged
P0122	01847	Vice President, Health Services-Marketing	$5,632
P0256	04454	Corporate Taxes	239
			$5,871

According to the Plan, these errors were caused by the Plan incorrectly assigning CC 01847 to CP P0122 and incorrectly coding a direct charge in CC 04454 to CP P0256. As a result of this finding, the Plan returned $6,025 to the FEHBP, consisting of $5,871 for these questioned cost center expenses and $154 for applicable LII. We reviewed and accepted the Plan's LII calculation.

Association's Response:

The Association agrees with this finding. The Association states, "One cost pool allocated $239 to FEP based on an incorrect coding of a direct charge and the other cost pool allocated $5,632 to FEP based on an unallowable cost center that was assigned to an incorrect cost pool for 2012. The Plan moved the cost center to a cost pool that does not allocate to FEP. The Plan will submit Prior Period Adjustment forms, along with applicable Special Plan Invoices for lost investment income to FEP by June 30, 2014 and funds will be returned to OPM by July 31, 2014."

OIG Comments:

The Association provided documentation supporting that the Plan returned $6,025 to the FEHBP, consisting of $5,871 for the questioned cost center expenses and $154 for LII.

Recommendation 1

Since we verified that the Plan returned $5,871 to the FEHBP for the questioned cost center expenses, no further action is required for this amount.

Recommendation 2

Since we verified that the Plan returned $154 to the FEHBP for LII on the questioned cost center expenses, no further action is required for this LII amount.

2. Unallowable and/or Unallocable Expense Account $2,647

The Plan charged the FEHBP $2,584 for an unallowable and/or unallocable expense account in 2012. As a result of this finding, the Plan returned $2,647 to the FEHBP, consisting of $2,584 for the questioned expense account amount and $63 for LII.

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

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

For the period 2008 through 2012, the Plan allocated administrative expenses of $191,767,157 (before adjustments) to the FEHBP from 33 summary expense accounts. From this universe, we selected a judgmental sample of 12 summary expense accounts to review, which totaled $185,671,394 in expenses allocated to the FEHBP. We selected the summary expense accounts based on high dollar amounts and our trend analysis. Additionally, because the Plan rolls up the detailed expense accounts into these summary expense accounts, we also selected a judgmental sample of 23 detailed expense accounts to review, from a universe of 213 accounts. We selected these detailed expense accounts based on a nomenclature review. We reviewed the expenses from these accounts for allowability, allocability, and reasonableness.

Based on our review, we determined that the Plan charged the FEHBP for detailed expense account "706701" (Advertising) in 2012. Although Plan did not charge the entire amount in this expense account to the FEHBP, the FEP received an indirect allocation of $2,584 from this account, which should have been charged directly to the "Comprehensive Preferred Provider Organization" line-of-business. As a result of this finding, the Plan returned $2,647 to the FEHBP, consisting of $2,584 for the questioned expense account amount and $63 for applicable LII. We reviewed and accepted the Plan's LII calculation.

Association's Response:

The Association agrees with this finding. The Association states, "The Plan . . . filed a Prior Period Adjustment for $2,584 and an SPI for $63 in lost investment income. The funds were wired to OPM on June 4, 2014."

OIG Comments:

The Association provided documentation supporting that the Plan returned $2,647 to the FEHBP, consisting of $2,584 for the questioned expense account amount and $63 for LII.

Recommendation 3

Since we verified that the Plan returned $2,584 to the FEHBP for the questioned expense account amount, no further action is required for this amount.

Recommendation 4

Since we verified that the Plan returned $63 to the FEHBP for LII on the questioned expense account amount, no further action is required for this LII amount.

C. CASH MANAGEMENT

The audit disclosed no findings pertaining to the Plan's cash management activities and practices. Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations.

D. 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 that are set forth in FEHBP Carrier Letter (CL) 2011-13. Specifically, the Plan did not report one fraud and abuse case and did not timely report three cases to the OIG. The Plan's non-compliance may be due in part to 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 FEP fraud and abuse 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 August 31, 2013, the Plan entered 136 FEP cases into the FEPDO's Fraud Information Management System (FIMS). [3] We judgmentally selected 49 cases with high dollar FEP exposure. Of these, only six cases were related to fraud and abuse. [4] We reviewed these six cases to determine if they were reported to the OIG as required by CL 2011-13.

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

[4] The Plan's Financial Investigations and Provider Review Department does not distinguish between provider audit cases and fraud and abuse cases in their tracking system. Therefore, we could not determine which cases were related to fraud and abuse until after we had selected our sample.

Based on our review, we determined the following:

- Five of the six fraud and abuse cases were reported to the OIG; however, notifications for three of these five cases were reported untimely to the OIG. Specifically, the OIG received these notifications from 104 to 252 days after the Plan had identified FEP exposure, which does not meet the 30-day timeliness requirement in CL 2011-13.

- One of the six cases was not reported to the OIG. Since this case had FEP exposure, and there is no dollar threshold amount for reporting suspected fraud against the FEHBP, the case should have been reported to the OIG as required by 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's untimely communication of FEP fraud and abuse cases to the FEPDO's Special Investigation's 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 FIMS. 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 six fraud and abuse cases reviewed, we determined that three of these cases were entered into FIMS untimely by the Plan. Specifically, these cases were entered into FIMS from 102 to 825 days after the Plan had identified the FEP exposure. Without timely FIMS case entries by the Plan, the FEPDO's SIU cannot meet the FEHBP's contractual communication and reporting requirements.

In addition, the inclusion of provider audits into FIMS may also hinder compliance with the communication and reporting requirements. As previously noted, only 6 of the 49 cases we sampled for review were related to fraud and abuse issues; the remaining cases were provider audits, which were unrelated to fraud and abuse issues. Although both provider audits and fraud investigations are performed by the same department, that does not mean that every provider audit should be entered into FIMS. Because FIMS is a database for tracking and reporting fraud and abuse activities performed by the BCBS plans, FIMS should not include provider audits unless or until those audits lead to the identification of reportable fraud and abuse issues that potentially expose FEP dollars. If the Plan is entering provider audits that are no more than "routine" hospital or provider audits, then not only does this confuse what is a reportable issue to the OIG, but also potentially delays the reporting of actual fraud and abuse cases. Moreover, this may also result in overstating the Plan's fraud and abuse cases, recoveries, and/or savings that the FEPDO annually reports to OPM.

Ultimately, both the Plan's untimely reporting of FEP cases to the FEPDO's SIU and the FEPDO SIU's inadequate controls to monitor the Plan's FIMS entries and notify the appropriate 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 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 states, "The Plan continues to disagree with the statement that it 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 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."

OIG Comments:

Based on the results of our review, we continue to conclude that the Plan's reporting of fraud of abuse cases is not in compliance with the communication and reporting requirements set forth in CL 2011-13.

Recommendation 5

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 set forth 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:

The Association states, "The Plan developed the following Corrective Action Plan to address the recommendations:

1. The Plan through its Financial Investigations and Provider Review (FIPR) area will develop and implement a quality review process to monitor compliance with guidance contained in the FEP Standards for Fraud Identification Prevention and Reporting Manual by June 30, 2014.

2. The Plan through its FIPR area will notify the FIPR employees of audit findings and use this as training for future enhancements to the program."

The Association also states, "The BCBSA SIU staff provided on-site FIMS training to all Highmark FIPR staff on April 30, 2014."

Recommendation 6

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," "abuse," and "reasonable suspicion."

Association's Response:

The Association agrees with this recommendation and will work with the contracting officer to develop guidance for definitions of fraud, waste, abuse, and reasonable suspicion.

Recommendation 7

We recommend that the contracting officer direct the Association to provide OPM and the OIG full access to FIMS.

Association's Response:

The Association states, "BCBSA continues to disagree with the recommendation to provide the OPM OIG full access to FIMS. FIMS is an internal management reporting system used by BCBSA and Local Plans to report Fraud, Waste and Abuse cases. The FIMS system resides on a secured proprietary platform accessible to Blue Plan employees only. It would be physically impossible for the OPM/OIG to have access to FIMS. Also, before cases can be fully 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 would result in potential inefficiencies for FEP. However, in order to provide the OPM OIG investigators with more effective access to underlying case data, BCBSA developed and the contracting officer has agreed to the following process:

BCBSA will provide a monthly report on cases that have been referred to OPM OIG each month. The report would include cases sent during the preceding month. (The report provided in July would capture cases reported June 1 to June 30). A spread sheet would also be provided showing cases that were reported into FIMS but not sent to OPM OIG. The spread sheet would indicate why the case(s) was not referred to OPM/OIG."

OIG Comments:

We continue to recommend that the contracting officer direct the Association to provide the 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 identify non-compliance by a BCBS plan and/or the FEPDO such as untimely reporting. In addition, full access 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 fraud and abuse cases showed that the Plan's entries into FIMS had significant timeliness issues. Of the six fraud and abuse cases that we reviewed for the period January 1, 2013 through August 31, 2013, we determined that three cases were entered into FIMS timely and three cases untimely. If the OIG had full access to FIMS, all six 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 sooner.

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

HIGHMARK INC.
CAMP HILL, PENNSYLVANIA

CONTRACT CHARGES

CONTRACT CHARGES*	2008	2009	2010	2011	2012	TOTAL
A. HEALTH BENEFIT CHARGES						
PLAN CODES 363	$59,535,705	$67,789,294	$64,145,109	$74,626,487	$81,238,626	$347,335,221
MISCELLANEOUS PAYMENTS AND CREDITS	809,807	1,322,504	931,284	885,467	1,157,722	5,106,784
PLAN CODES 865	237,196,104	255,657,132	291,589,605	318,904,990	321,315,579	1,424,663,410
MISCELLANEOUS PAYMENTS AND CREDITS	809,676	1,196,987	2,159,468	2,881,523	(625,447)	6,422,207
TOTAL HEALTH BENEFIT CHARGES	$298,351,292	$325,965,917	$358,825,466	$397,298,467	$403,086,480	$1,783,527,622
B. ADMINISTRATIVE EXPENSES						
PLAN CODE 865	$23,346,076	$25,959,361	$28,568,689	$24,653,092	$25,654,832	$128,182,050
PRIOR PERIOD ADJUSTMENTS	(829,678)	1,506	0	(25,085)	(27,131)	($880,388)
BUDGET SETTLEMENT REDUCTIONS	(300,000)	0	(391,985)	0	0	($691,985)
TOTAL ADMINISTRATIVE EXPENSES	$22,216,398	$25,960,867	$28,176,704	$24,628,007	$25,627,701	$126,609,677
TOTAL CONTRACT CHARGES	$320,567,690	$351,926,784	$387,002,170	$421,926,474	$428,714,181	$1,910,137,299

* This audit covered miscellaneous health benefit payments and credits and cash management activities from January 1, 2008 through May 31, 2013, as well as administrative expenses from 2008 through 2012.

SCHEDULE B

HIGHMARK INC.
CAMP HILL, PENNSYLVANIA

QUESTIONED CHARGES

AUDIT FINDINGS*	2008	2009	2010	2011	2012	2013	2014	TOTAL
A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS	$0	$0	$0	$0	$0	$0	$0	$0
B. ADMINISTRATIVE EXPENSES								
1. Unallocable Costs Centers	$0	$0	$0	$0	$5,871	$92	$62	$6,025
2. Unallowable and/or Unallocable Expense Account	0	0	0	0	2,584	40	23	2,647
TOTAL ADMINISTRATIVE EXPENSES	$0	$0	$0	$0	$8,455	$132	$85	$8,672
C. CASH MANAGEMENT	$0	$0	$0	$0	$0	$0	$0	$0
D. FRAUD AND ABUSE PROGRAM								
1. Special Investigations Unit (Procedural)	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL FRAUD AND ABUSE PROGRAM	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL QUESTIONED CHARGES	$0	$0	$0	$0	$8,455	$132	$85	$8,672

*** We included lost investment income (LII) within audit findings B1 ($154) and B2 ($63). 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
Fax 202.942.1125

June 27, 2014

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

Reference: OPM Revised DRAFT AUDIT REPORT
Highmark Blue Cross Blue Shield of Pennsylvania (The Plan)
Revised Response to Audit Report Number 1A-10-13-14-003
(Dated and received on March 5, 2014 and amended on 6/18/2014)

Dear [redacted]

This is Highmark Blue Cross Blue Shield of Pennsylvania's revised 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 Blue Shield Association (BCBSA or Association) and the Plan are committed to enhancing our 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-No Findings

B. Administrative Expenses

1. Unallocable Costs $5,871

The Plan allocated $5,871 to FEP from two cost centers that did not benefit the FEHBP. The Plan included these cost centers in Cost Pools P0256 and P0122 that allocated costs to FEP in 2012..

Recommendation 1:

OPM recommends that the contracting officer disallows $5,871 for unallowable and/or unallocable charges in 2012, and verify that these funds were returned to the FEHBP.

Plan's Response:

The Plan agrees with the OPM finding that the Plan incorrectly allocated $5,871 to FEP from two Cost Pools. One cost pool allocated $239 to FEP based on an incorrect coding of a direct charge and the other cost pool allocated $5,632 to FEP based on an unallowable cost center that was assigned to an incorrect cost pool for 2012. The Plan moved the cost center to a cost pool that does not allocate to FEP. The Plan will submit Prior Period Adjustment forms, along with applicable Special Plan Invoices for lost investment income to FEP by June 30, 2014 and funds will be returned to OPM by July 31, 2014.

2. <u>Unallowable and/or Unallocable Expense Account</u> $2,584

Based on OPM's review, it was determined that the Plan charged the FEHBP for detailed expense account "706701 Advertising" in 2012.

Recommendation 2:

OPM recommends that the contracting officer disallows $2,584 for unallowable and/or unallocable charges in 2012, and verify that these funds were returned to the FEHBP.

Plan Response:

The Plan agreed with this finding and filed a Prior Period Adjustment for $2,584 and an SPI for $63 in lost investment income. The funds were wired to OPM on June 4, 2014.

C. Cash Management - No findings

D. Fraud and Abuse Program

1. Special Investigations Unit — Procedural

The Plan continues to disagree with the statement that it 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 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 3

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 set forth 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 Response:

The Plan developed the following Corrective Action Plan to address the recommendations:

1. The Plan through its Financial Investigations and Provider Review (FIPR) area will develop and implement a quality review process to monitor compliance with guidance contained in the FEP Standards for Fraud Identification Prevention and Reporting Manual by June 30, 2014.

2. The Plan through its FIPR area will notify the FIPR employees of audit findings and use this as training for future enhancements to the program.

BCBSA Response:

The BCBSA SIU staff provided on-site FIMS training to all Highmark FIPR staff on April 30, 2014.

Recommendation 4

To ensure that all FEHBP Carriers are reporting statistics to OPM based on the same definitions, OPM recommends that the contracting officers prepare and distribute to all Carriers the definitions for the terms "fraud", "waste", "abuse", and "reasonable suspicion."

BCBSA Response:

BCBSA agrees with this recommendation and will work with the contracting officer to develop guidance of definitions of Fraud, Waste and Abuse and reasonable suspicion. The FEPDO will continue to update BCBSA FEP Fraud Waste and Abuse manual as needed based on guidance received from the contracting officer.

Recommendation 5

OPM recommended that the contracting officer direct the Association to provide OPM and the OIG full access to FIMS.

BCBSA Response:

BCBSA continues to disagree with the recommendation to provide the OPM OIG full access to FIMS. FIMS is an internal management reporting system used by BCBSA and Local Plans to report Fraud, Waste and Abuse cases. The FIMS system resides on a secured proprietary platform accessible to Blue Plan employees only. It would be physically impossible for the OPM/OIG to have access to FIMS. Also, before cases can be fully 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 would result in potential inefficiencies for FEP. However, in order to provide the OPM OIG investigators with more effective access to underlying case data, BCBSA developed and the contracting officer has agreed to the following process:

BCBSA will provide a monthly report on cases that have been referred to OPM OIG each month. The report would include cases sent during the preceding month. (The report provided in July would capture cases reported June 1 to June 30). A spread sheet would also be provided showing cases that were reported into FIMS but not sent to OPM OIG. The spread sheet would indicate why the case(s) was not referred to OPM/OIG.

We appreciate the opportunity to provide our response to this revised 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, CSM
Managing Director, Program Assurance

[redacted]

Attachments

cc: [redacted], FEP
[redacted], Contracting Officer,
OPM [redacted], Highmark Inc.
[redacted], FEP