



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

Final Audit Report

Subject:

AUDIT OF BLUECROSS BLUESHIELD OF MICHIGAN DETROIT, MICHIGAN

Report No. 1A-10-32-12-062

Date: July 19, 2013

--CAUTION--

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AUDIT REPORT

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

BlueCross BlueShield of Michigan
Plan Codes 210/710
Detroit, Michigan

REPORT NO. 1A-10-32-12-062

DATE: July 19, 2013



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Assistant Inspector General
for Audits

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EXECUTIVE SUMMARY

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

BlueCross BlueShield of Michigan
Plan Codes 210/710
Detroit, Michigan

REPORT NO. 1A-10-32-12-062 DATE: July 19, 2013

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of Michigan (Plan), located in Detroit, Michigan, questions \$250,961 in health benefit charges, administrative expenses, and lost investment income (LII). The report also includes a procedural finding regarding the Plan's Fraud and Abuse (F&A) Program. The BlueCross BlueShield Association (Association) agreed (**A**) with the questioned charges and LII of \$250,961, but generally disagreed (**D**) with the procedural finding regarding the Plan's F&A Program.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered miscellaneous health benefit payments and credits and administrative expenses from 2007 through 2011 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management practices related to FEHBP funds and the Plan's F&A Program from 2007 through 2011.

The audit results are summarized as follows:

MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

- **Blanket Settlements (A)** **\$4,845**

The Plan had not totally returned 27 Federal Employee Program (FEP) fraud recoveries that were included in 3 blanket settlements of unidentified refunds and recoveries. As a result of this finding, the Plan returned \$4,845 to the FEHBP for these fraud recoveries.

- **██████████ Rebates (A)** **\$3,975**

In one instance, the Plan had not returned a portion of a ██████████ rebate amount to the FEHBP. As a result of this finding, the Plan returned \$3,975 to the FEHBP, consisting of \$3,664 for the questioned ██████████ rebate amount and \$311 for LII on this amount.

ADMINISTRATIVE EXPENSES

- **Unallowable and/or Unallocable Expenses (A)** **\$241,663**

The Plan charged unallowable and/or unallocable cost center and natural account expenses of \$231,771 to the FEHBP. As a result of this finding, the Plan returned \$241,663 to the FEHBP, consisting of \$231,771 for these questioned cost center and natural account expenses and \$9,892 for applicable LII.

- **Prior Period Adjustments (A)** **\$478**

The Plan returned \$96,546 to the FEHBP for non-chargeable FEP administrative expenses and applicable LII. Although the Plan appropriately returned these funds to the FEHBP by submitting prior period adjustments (PPA), the Plan only calculated LII on these non-chargeable expenses through April 29, 2011. However, during our review of PPA's, we found that the Plan did not transfer the principle amounts of these non-chargeable expenses into the FEP investment account until December 5, 2011. As a result of this finding, the Plan returned additional LII of \$478 calculated on these non-chargeable administrative expenses.

CASH MANAGEMENT

Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the audit findings pertaining to cash management noted in the "Miscellaneous Health Benefit Payments and Credits" section.

FRAUD AND ABUSE PROGRAM

- **Special Investigations Unit (D)**

Procedural

The Plan's Special Investigations Unit is not in compliance with contract CS 1039, the FEHBP Carrier Letters issued by the Office of Personnel Management (OPM), and guidance provided by the Association's FEP Director's Office, which are related to F&A Programs and notifying OPM's Office of the Inspector General of fraud and abuse cases in the FEHBP. As a result of the Plan's non-compliance, fraud and abuse may go undetected and unreported within the FEHBP, and the overall effectiveness of the Plan's F&A Program cannot be accurately measured.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

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

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

BACKGROUND

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

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

The Association has established a Federal Employee Program (FEP¹) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, member BlueCross and BlueShield plans, and OPM.

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

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

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

All findings from our previous audit of the Plan (Report No. 1A-10-32-05-034, dated March 24, 2006) for contract years 2001 through 2004 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 December 18, 2012. 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 if the Plan operates an effective Fraud and Abuse (F&A) Program for the prevention, detection, and/or recovery of fraudulent claims as required by the FEHBP contract.

SCOPE

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

We reviewed the BlueCross and BlueShield FEHBP Annual Accounting Statements as they pertain to Plan codes 210 and 710 for contract years 2007 through 2011. During this period, the Plan paid approximately \$1.2 billion in health benefit charges and \$93 million in administrative expenses (See Figure 1 and Schedule A).

Specifically, we reviewed miscellaneous health benefit payments and credits (e.g., refunds, subrogation recoveries, drug rebates and fraud recoveries), administrative expenses, cash management activities, and the Plan's F&A Program for 2007 through 2011.

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

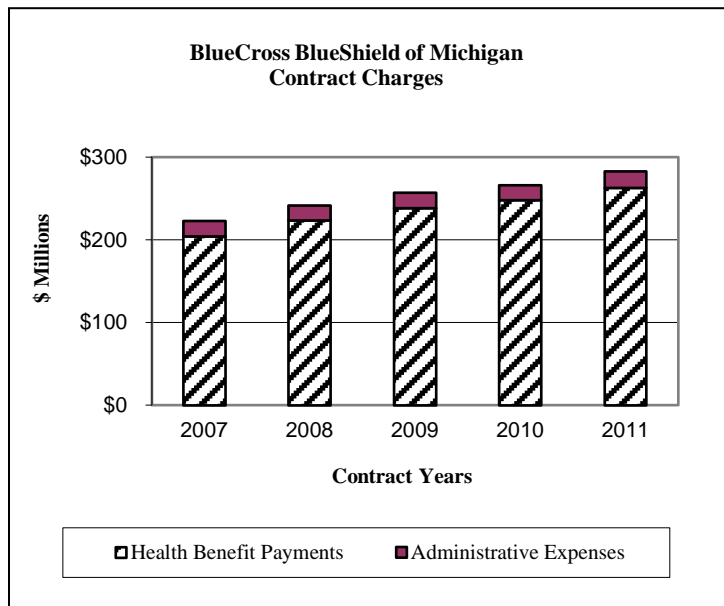


Figure 1 - Contract Charges

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations (FAR) and Federal Employees Health Benefits Acquisition Regulations (FEHBAR), as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and federal procurement regulations. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Findings and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

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

The audit was performed at the Plan's office in Detroit, Michigan from August 7, 2012 through August 31, 2012. Audit fieldwork was also performed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania.

METHODOLOGY

We obtained an understanding of the internal controls over the 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 130 high dollar health benefit refunds, totaling \$3,534,066 (from a universe of 39,428 refunds, totaling \$14,139,092); 24 high dollar provider audit recoveries, totaling \$1,342,738 (from a universe of 2,136 recoveries, totaling \$6,924,076); 30 high dollar special plan invoices (SPI), totaling \$299,384 in net FEP credits (from a universe of 256 SPI's, totaling \$2,302,421 in net FEP payments); 10 high dollar [REDACTED] rebates, totaling \$74,282 (from a universe of 21 rebates, totaling \$133,502); all 4 of the corporate blanket settlements, totaling \$45,037,456 in corporate unidentified refunds and recoveries; 10 high dollar provider advance adjustments, totaling \$5,653,360 in net FEP payments (from a universe of 20 adjustments, totaling \$9,231,041 in net FEP payments); and 20 high dollar hospital settlements, totaling \$625,292 in net FEP payments (from a universe of 112 settlements, totaling \$2,919,035 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 2007 through 2011. Specifically, we reviewed administrative expenses relating to cost centers, natural accounts, out-of-system adjustments, prior period adjustments, pension, post-retirement, employee health benefits, executive compensation, non-recurring projects, gains and losses, return on investment, and the Health Insurance Portability and Accountability Act of 1996. We used the FEHBP contract, the FAR, and the FEHBPBAR to determine the allowability, allocability, and reasonableness of charges.

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

² The sample of health benefit refunds included all cash receipts of \$10,000 or more and all provider offsets of \$14,000 or more. For provider audit recoveries, the sample consisted of the two highest dollar recoveries from each category schedule provided by the Plan. For the SPI sample, we selected three SPI's with the highest dollar miscellaneous payments and three SPI's with the highest dollar miscellaneous credits from each year. For [REDACTED] rebates, we selected the two highest dollar rebate amounts from each year. For provider advances, we selected the highest payment amount and the highest credit amount from each year. For hospital settlements, we selected the two highest payment amounts and the two highest credit amounts from each year.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Blanket Settlements

\$4,845

We determined that the Plan had not totally returned 27 FEP fraud recoveries that were included in 3 blanket settlements of unidentified refunds and recoveries. As a result of this finding, the Plan returned \$4,845 to the FEHBP for these fraud recoveries.

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

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

The Plan returns corporate unidentified refunds and recoveries, including fraud recoveries, through blanket settlements that are allocated to all lines of business, including FEP. We reviewed all four of the blanket settlements during the audit scope, totaling \$45,037,456, for the purpose of determining whether these settlements were properly allocated and returned to the FEHBP.

Based on our review, we identified 27 FEP fraud recoveries, totaling \$4,900, that were inadvertently included in 3 of these blanket settlements. These fraud recoveries were from two FEP member specified cases. However, since these FEP fraud recoveries were included in the blanket settlement process, the Plan only allocated and returned \$55 of these recoveries to the FEHBP, instead of the total amount of \$4,900. As a result of this finding, the Plan returned an additional \$4,845 (\$4,900 minus \$55) to the FEHBP for these FEP fraud recoveries. We did not assess LII on this questioned amount since we determined that the LII amount is immaterial.

Association’s Response:

The Association agrees with this finding.

OIG Comments:

The Plan provided documentation to support that the questioned fraud recoveries were deposited into the FEP investment account and returned to the letter of credit account (LOCA) on various dates from September 7, 2012 through November 30, 2012.

Recommendation 1

Since we verified that the Plan returned \$4,845 to the FEHBP for the questioned fraud recoveries, no further action is required for this amount.

2. [REDACTED] Rebates \$3,975

We determined that in one instance, the Plan had not returned a portion of a [REDACTED] [REDACTED] rebate amount to the FEHBP. As a result of this finding, the Plan returned \$3,975 to the FEHBP, consisting of \$3,664 for the questioned [REDACTED] rebate amount and \$311 for LII on this amount.

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

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

The Plan participates in a drug rebate program with the manufacturer of the [REDACTED] [REDACTED] rebates are determined based on medical claims for [REDACTED] drugs that are administered in physicians’ offices. The Plan contracts with a vendor that collects these [REDACTED] rebates from the manufacturer and then wire transfers these funds to the Plan, which in turn credits the rebates to the participating groups, including FEP. For the period 2007 through 2011, there were 21 [REDACTED] rebate amounts, totaling \$133,502, for FEP. From this universe, we selected and reviewed a judgmental sample of 10 drug rebate amounts, totaling \$74,282, for the purpose of determining whether the Plan timely returned these funds to the FEHBP. Our sample included the two highest drug rebate amounts from each year.

Based on our review, we noted that the Plan received a drug rebate amount in 2009, of which \$6,653 was due to the FEHBP. The Plan timely returned \$2,989 of this drug rebate amount to the FEHBP, but had not returned the remaining amount of \$3,664. Specifically, this drug rebate amount was not deposited into the FEP investment account nor returned to the LOCA. As a result of this finding, the Plan returned \$3,975 to the FEHBP, consisting of \$3,664 for the questioned drug rebate amount and \$311 for LII on this amount. We reviewed and accepted the Plan’s LII calculation.

Association’s Response:

The Association agrees with this finding.

OIG Comments:

The Plan provided documentation to support that the questioned drug rebate amount and LII were deposited into the FEP investment account on August 30, 2012 and returned to the LOCA on September 12, 2012.

Recommendation 2

Since we verified that the Plan returned \$3,664 to the FEHBP for the questioned drug rebate amount, no further action is required for this amount.

Recommendation 3

Since we verified that the Plan returned \$311 to the FEHBP for LII on the questioned drug rebate amount, no further action is required for this LII amount.

B. ADMINISTRATIVE EXPENSES

1. Unallowable and/or Unallocable Expenses **\$241,663**

The Plan charged unallowable and/or unallocable cost center and natural account expenses of \$231,771 to the FEHBP. As a result of this finding, the Plan returned \$241,663 to the FEHBP, consisting of \$231,771 for these questioned cost center and natural account expenses and \$9,892 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.”

For the period 2007 through 2011, the Plan allocated administrative expenses of \$98,258,526 to the FEHBP from 339 cost centers and 82 natural accounts. From this universe, we selected a judgmental sample of 55 cost centers to review, which totaled \$55,760,427 in expenses allocated to the FEHBP. We also selected a judgmental sample of 25 natural accounts to review, which totaled \$54,918,429 in expenses allocated to the FEHBP. We selected the cost centers and natural accounts based on high dollar amounts, high dollar allocation methods, and our nomenclature review and trend analysis. We reviewed the expenses from these cost centers and natural accounts for allowability, allocability, and reasonableness.

Based on our review, we determined that the Plan charged the following cost center (CC) and natural account (NA) expenses to the FEHBP that were expressly unallowable and/or did not benefit the FEHBP or only minimally benefited the FEHBP:

<u>Number</u>	<u>Name</u>	<u>Reason for Questioning</u>	<u>Amount Charged</u>
CC 06210	Office of the General Counsel	Unallowable	\$166,568
CC 22540	Membership Billing Systems	Unallocable	30,641
NA 70407	UAW Dependent Scholarship	Unallowable	18,937
NA 70408	NBU Dependent Scholarship	Unallowable	<u>15,625</u>
			<u>\$231,771</u>

In regard to the questioned expenses charged to the FEHBP, 48 CFR 31-205-47(f)(3) (Costs Related to Legal and Other Proceedings) and 48 CFR 31-205.44(j) (Training and Education Costs) provide specific criteria to the extent that such costs are expressly unallowable. Based on our review of the Plan’s documentation, the above CC and NA expenses charged to the FEHBP did not comply with the federal regulations. As a result of this finding, the Plan returned \$241,663 to the FEHBP, consisting of \$231,771 for the questioned CC and NA expenses and \$9,892 for applicable LII. We reviewed and accepted the Plan’s LII calculation.

Association’s Response:

The Association agrees with this finding. The Association states, “BCBSM agreed with this finding and submitted the appropriate Prior Period Adjustments to cover the period 2007-2011. On January 25, 2013, the Federal Employee Program (FEP) received a wire transfer from BCBSM in the amount of \$241,663 which covered the principal amount of \$231,771 and \$9,892 in lost investment income.”

The Association also states, “In order to prevent future non-chargeable costs to the FEP, and as a corrective action, BCBSM added the two natural accounts to its unallowable cost process. In addition, BCBSM will continue to monitor, review and update as necessary its cost center allocations process to ensure accuracy and continued program compliance.”

OIG Comments:

The Association provided documentation supporting that the Plan wire transferred \$231,771 for the questioned CC and NA expenses and \$9,892 for LII into the Association’s FEP joint operating account on January 25, 2013. The Association subsequently wire transferred these funds to OPM on February 4, 2013.

Recommendation 4

Since we verified that the Plan returned \$231,771 to the FEHBP for the questioned CC and NA expenses, no further action is required for this amount.

Recommendation 5

Since we verified that the Plan returned \$9,892 to the FEHBP for LII on the questioned CC and NA expenses, no further action is required for this LII amount.

2. Prior Period Adjustments

\$478

The Plan returned \$96,546 to the FEHBP for non-chargeable FEP administrative expenses and applicable LII. Although the Plan appropriately returned these funds to the FEHBP by submitting prior period adjustments (PPA), the Plan only calculated LII on these non-chargeable expenses through April 29, 2011. However, during our review of PPA's, we found that the Plan did not transfer the principle amounts of these non-chargeable expenses into the FEP investment account until December 5, 2011. As a result of this finding, the Plan returned additional LII of \$478 calculated on these non-chargeable administrative expenses.

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 2007 through 2011, there were eight PPA's totaling \$245,240 in net charges to the FEHBP. From this universe, we selected and reviewed a judgmental sample of six PPA's, totaling \$250,474 in net charges, to determine whether the Plan properly charged these adjustments to the FEHBP. Our sample included all PPA's with charges or credits of \$10,000 or more.

Based on our review, we found that the Plan did not return the correct amount of LII for non-chargeable administrative expenses that were returned to the FEHBP through PPA's. Specifically, we verified that the Plan submitted a PPA that contained three adjustments, including two of our sample items, to return \$87,878 to the FEHBP for non-chargeable administrative expenses and \$8,668 in LII. These exceptions were identified by the Association in a 2010 Control Performance Review of the Plan. Although the Plan credited the FEHBP for LII calculated through April 29, 2011 on these non-chargeable expenses, the principal amounts of these non-chargeable expenses were not transferred into the FEP investment account until December 5, 2011. As a result of this finding, the Plan returned additional LII of \$478 calculated on these non-chargeable administrative expenses.³

³ We initially calculated that the Plan owed additional LII of \$1,343 to the FEHBP, but we subsequently reduced this LII amount by \$865 since the Plan used an incorrect interest rate (i.e., a higher rate) when calculating the original LII amount returned to the FEHBP.

Association’s Response:

The Association agrees with this finding. The Association states, “BCBSM agreed with this finding and submitted the proper Special Plan Invoice to cover the 2011 issue. On January 25, 2013, FEP received a wire transfer from BCBSM that included the \$478 of lost investment income.”

The Association also states, “In order to prevent future Lost Investment Income miscalculation, BCBSM has updated its procedures and will calculate interest using the date funds are transferred to the FEP investment account.”

OIG Comments:

The Association provided documentation supporting that the Plan wire transferred the questioned LII amount of \$478 into the Association’s FEP joint operating account on January 25, 2013. The Association subsequently wire transferred this LII amount to OPM on February 4, 2013.

Recommendation 6

Since we verified that the Plan returned \$478 to the FEHBP for the questioned LII on the non-chargeable administrative expenses, no further action is required for this LII amount.

C. CASH MANAGEMENT

Overall, we concluded that the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations, except for the audit findings pertaining to cash management noted in the “Miscellaneous Health Benefit Payments and Credits” section.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit

Procedural

Our review of the Plan’s Special Investigations Unit (SIU), known as Corporate and Financial Investigations (CFI), revealed that the CFI has many positive characteristics. Specifically, the Plan’s CFI is an active member of the health care fraud community, not only in Michigan but also nationally. This Plan is committed to investigating fraud, waste, and abuse and has a comprehensive Fraud and Abuse (F&A) Program.

Another impressive characteristic is that the Plan’s CFI takes all allegations of fraud seriously. Because of budget constraints and competing priorities, we rarely see an SIU utilize resources for every complaint or lead. During the scope of the audit, CFI opened more than 11,000 cases. The Plan’s CFI has demonstrated a willingness to work with and share provider and patient information with local, state, and Federal law enforcement agencies to investigate health care fraud, waste, and abuse. During the scope of the audit, CFI referred over 600 cases to various law enforcement agencies. CFI readily shares

information with the prosecutor in the hopes of obtaining a successful conviction and recovery.

However, we are unclear why the Plan is reluctant to acknowledge the law enforcement authority of OPM's OIG. Many opportunities to work jointly have been lost because the Plan refuses to report cases to the OIG, and the FEP Director's Office does not enforce the FEHBP contract.

Even though the Plan's CFI has many positive aspects, it is not in compliance overall with contract CS 1039, and other guidance issued by OPM and the Association's FEP Director's Office (FEPDO), in relation to F&A Programs and notifying OPM's OIG of fraud and abuse cases in the FEHBP. Specifically, we determined that the Plan did not report or timely report all potential FEP fraud and abuse cases to the FEPDO and/or OPM's OIG. Also, the Plan's reported recoveries and savings were inaccurate and/or incomplete. Furthermore, from the information provided, we determined that the FEHBP received a negative return on investment (ROI) from this Plan's F&A Program activities. Ultimately, the Plan's non-compliance is a result of the Plan's policies and procedures that do not specifically address the FEHBP, as well as the FEPDO's lack of oversight, direction, and guidance provided to the Plan. As a result of the Plan's non-compliance, fraud and abuse may go undetected and unreported within the FEHBP, and the overall effectiveness of the F&A Program cannot be accurately measured.

Incomplete and Untimely Reporting – FEHBP Fraud Cases

Our review of the Plan's CFI revealed that the Plan did not report all potential FEP fraud cases to the FEPDO and that many of the cases that were reported to the FEPDO were reported untimely. In addition, neither the Plan nor the FEPDO provided one case notification or referral to OPM's OIG as required by OPM guidance. This lack of referrals and/or untimely reporting of investigations does not allow OPM's OIG to investigate whether other FEHBP carriers are exposed to the identified provider committing fraud against the FEHBP. It also does not allow the OIG's Administrative Sanctions Group to be notified timely. This may result in additional improper payments being made by other FEHBP carriers to these unscrupulous providers.

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

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

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

The primary vehicle for the local BCBS plan’s anti-fraud unit to report potential FEP fraud and abuse cases and other anti-fraud activities to the FEPDO is the Fraud Information Management System (FIMS). FIMS is a multi-user web-based case tracking database, developed by the FEPDO to facilitate and monitor FEP-related investigations. Local BCBS plans began using FIMS in January 2007, and since the inception of FIMS, the FEHBP has paid \$1,520,303 to build and implement the system.

The Plan did not enter all of its FEP potential fraud and abuse cases into FIMS as required. In order to test the Plan’s compliance with the reporting requirements in OPM’s Carrier Letters and applicable FEPDO guidance, we requested the Plan’s provider and pharmacy related fraud cases, as well as FEP subscriber cases, for the period January 1, 2007 through December 31, 2011. The Plan’s CFI stated that they had a total of 7,919 cases in its own case tracking system for that time period. Of these cases, 7,485 had a Tax Identification Number (TIN). However, from the information provided, we only found 4,821 cases with a **unique** TIN. We entered the 4,821 cases into the FEHBP Data Warehouse and identified matches for 4,418 of the cases. All but 4 of the 4,418 cases had FEHBP exposure of \$1 or more and therefore should have been entered into FIMS. In addition, we determined that 2,645 of these fraud and abuse cases contained FEHBP exposure greater than \$20,000. All of those cases should have been reported to OPM and the OIG (based on CL Number 2007-12). As previously stated, not one case was referred to the OIG.

The FIMS Plan SIU User Guide (FIMS Guide) states that the FEPDO SIU expects the local BCBS plans’ SIUs to include FEP claims in all investigations/reviews and to report investigations/reviews that involve FEP **timely regardless of the outcome and/or dollar threshold** (Emphasis added). The guide further advises to not wait until the investigation is complete and/or until fraud is proven before entering it into the tracking system. Lastly, FIMS Guide, Section 3.3.1, states, “Anything reported in a Plan’s data entry system should be reported concurrently in FIMS in order to comply with OPM’s contract with BCBSA.”

In contrast to the contract, OPM Carrier Letters and FEPDO guidance the Plan’s policy was to enter cases into FIMS when the CFI investigation substantiated fraud resulting in a federal, state and/or local prosecutor/law enforcement authority issuing a (arrest/search) warrant or (criminal) indictment. The CFI unit stated that they were not aware that this policy was not compliant with OPM’s contract and carrier letter guidance or the FEPDO’s policies. However, as indicated by our review below, the CFI was not complying with its own policies. Of the 132 cases that the Plan did enter into FIMS, the cases were entered, on average, approximately 413 days **after the case was initiated**; and more than 240 days **after the indictment, warrant, conviction, or sentencing**

occurred. Entering cases in a tracking system eight months after the indictment and sentencing serves no real purpose to the Plan or the FEHBP, and is not in compliance with the OPM contract, CL 2007-12, and CL 2011-13 for reporting fraud and abuse cases timely to the OIG.

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

The Plan's incomplete and untimely reporting is also a result of the FEPDO's lack of oversight and proper guidance. FEPDO SIU staff met with the Plan's CFI only three times during the audit period, and the last FIMS training was performed in 2008. Therefore, analysts and investigators hired after 2008 have not received the FIMS training. In addition, although the Plan's CFI Vice President and the FEPDO's FEP SIU Director of Anti-Fraud both attended 16 to 20 quarterly meetings of the National Anti-Fraud Advisory Board (NAAB) during the audit period, neither the Plan nor the FEPDO provided any information to suggest that issues related to compliance and/or non-compliance with reporting cases into FIMS, FEP oversight issues, or any other related FEHBP requirements or training took place or were even discussed. The FEHBP pays all of FEPDO's travel expenses for these meetings, which have taken place in locations such as Honolulu, Chicago, and New Orleans, because it expects them to benefit the Program. Our review showed no evidence that these meetings or training events had any effect on the FEHBP regarding the Plan's compliance with OPM and FEPDO guidance; the amount of recoveries or savings; or patient safety/health care outcomes.

Furthermore, a memorandum summarizing an FEPDO SIU staff review of the CFI in September 2009 stated that the staff "reviewed that FIMS entries all reported aggressive investigative activities. Plan reports in FIMS cases even when FEP members are not exposed or impacted. Overpayment and recovery efforts are conducted through a separate Audit department. **No significant FIMS concerns were identified** (Emphasis Added). FIMS files reflect updates whenever arrests, indictments and sentences occur." The last sentence of the memo states, "FIMS file to be reviewed bi-annually."

Although the FEPDO stated they had found "no significant FIMS concerns," a simple review of the 62 FIMS entries in 2007, 2008 and 2009 prior to the FEPDO's review showed that only 6 of the 62 cases were reported in FIMS on the same date of the Plan's noted "active" or case initiation date. None of the 62 cases were ever reported to OPM's OIG. This is in clear contrast to the FEPDO's own policies and procedures and is not compliant with OPM contract 1039 and OPM CL 2007-12. Therefore, we cannot

determine what criteria the FEPDO used to determine its compliance with OPM's contract and other guidance.

It is also clear that the FEPDO understood that the Plan's overpayment and recovery efforts were not being reported by the CFI because the memo stated that, "Overpayment and recovery efforts are conducted through a separate Audit department." However, without this information, the FEPDO cannot report accurate fraud and abuse activities to OPM in its annual Fraud and Abuse Report as required by CL 2003-25. Lastly, we saw no evidence that the FIMS file had been reviewed bi-annually since the 2009 review.

As an example of the ramifications of the Plan and the FEPDO's non-compliance, we reviewed a case initiated in July 2007 by the Plan's CFI. The case was related to an FEP member who put an ineligible dependent spouse on his health plan. The FEHBP had paid a total of \$59,840 in benefits for the ineligible dependent, which met the OPM CL 2007-12 dollar threshold for reporting potential fraud and abuse cases to the OIG. The Plan notified the FEPDO SIU of their case findings in October of 2007. After two months had passed, the FEPDO Anti-Fraud Director wrote to the Plan on December 17, 2007 and stated, "We have decided not to pursue either a prosecution or restitution" on this case. The letter went on to say that the FEPDO Director had spoken to the FEP member and to OPM and their feeling was that no fraud had been intended.

This case was never reported to the OIG as required per the OPM CL 2007-12. Furthermore, there is no documentation that the FEPDO spoke to a prosecutor, OPM, or any government authority for possible prosecution, or initiated any type of investigation. Therefore, it is unclear how the FEPDO determined there was no intent to defraud and under what authority the FEPDO determined the member should not have to repay improperly paid FEHBP funds. The FEPDO's failure to properly report the case to the OIG may have resulted in improper payments, totaling \$59,840, related to this case.

As another example, we found a case that was initiated on May 29, 2007 that was provided to the Plan's CFI by the FEPDO SIU. This case involved the allegation that the FEP member was doctor shopping for and abusing prescription narcotics. The total estimated loss at the time the FEPDO requested the Plan's CFI to investigate the case was \$37,689. Although the case met the dollar threshold, the allegation of drug abuse is also considered a patient safety and harm issue by definition in CL 2003-23 and CL 2007-12, triggering another requirement to report the case to the OIG. Yet, the FEPDO never reported this case to the OIG.

The FEP member was later convicted in September of 2008. Even after the Plan reported the conviction to the FEPDO SIU, the FEPDO again failed to report the issue to the OIG as required. As a result, the conviction was never reported to the member's employer for a review of the member's national security clearance level and other potential employment related administrative actions.

Ultimately, the Plan's untimely reporting to the FEPDO, the FEPDO's lack of oversight of the Plan, and the lack of reporting to the OIG, has caused an unknown amount of financial damage to the FEHBP. With at least 132 cases entered into FIMS of providers and FEP members being convicted of health care fraud crimes, which were never reported to the OIG, there could be providers who received benefit payments from other FEHBP carriers because OPM was unable to suspend a provider's payments pending conviction. In addition, at least two FEP members who were convicted of illegally obtaining or utilizing their FEHBP benefits may still be employed by the Federal Government with a spotless security clearance.

Incomplete and Inaccurate Reporting – FEHBP Recoveries and Savings

Our review of the Plan's reporting of FEHBP fraud recoveries, savings, and dollar loss was incomplete and mainly based on estimates and allocation of corporate-wide figures.

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

In response to our request for total FEP actual fraud recoveries, the Plan stated that they return FEP fraud recoveries as part of their annual Customer Savings Refund Blanket Settlement (CSRBS) process in which net refunds received are allocated to all lines of business based on the percentage of claim payments made by each group. Therefore, the Plan only identifies the amount of refunds allocated to FEP and not refunds that were specific to FEP.

The Plan only provided actual savings related to two FEHBP-specific cases that were reported in FIMS, and there was no documentation supporting that any actual savings information from these cases was reported to the FEPDO timely within FIMS.

The Plan could not provide a true FEP dollar loss for the majority of cases investigated because it does not specifically obtain or separate out FEHBP losses, unless the case is FEP specific. The Plan further clarified that when a fraud case involves a specific FEP member, and FEP funds can be clearly identified, then it is the intent of CFI that the Plan's corporate recoveries department return these funds to the FEHBP. The Plan said any specifically identified FEP funds related to these cases should not be included within the CSRBS process.

Additionally, the CSRBS refunds are only performed one time per year by the Plan, occurring a full year after the calendar year of the received refunds. This again causes the Plan to be unable to report in FIMS timely, accurate recoveries and/or actual savings through any related denied claims for the FEHBP.

The plan also acknowledged that it could only estimate cost avoidance (referred to by the CFI as Implied Savings) for FEP-specific cases, and was unable to provide a reliable cost avoidance calculation for any specific group including the FEP. The Plan calculates "Implied Savings" (cost avoidance) and defines it as "Cost avoidance represents an

annualized amount of money BCBSM would have paid if action against a provider was not undertaken. It is the equivalent of one year's worth of estimated fraudulent billings by a provider." The Plan's estimated implied savings for the FEHBP from 2007 through 2011 was \$86,043.

As a result, because of the Plan's methodology on calculating FEP recoveries, actual savings and cost avoidance, it is unclear how the required annual fraud and abuse reporting by the FEPDO to OPM can be accurate and authenticated if the Plan is not providing timely and specific FEHBP recoveries separately through the Special Plan Invoice process and/or entering the financial recovery, actual savings, and cost avoidance information into FIMS for each reported case.

Costs and Benefits of the Plan's Fraud and Abuse Program Activities

Based on our review, the FEHBP does not appear to derive a benefit from the Plan's fraud and abuse activities. Based on the information provided by the Plan, the ROI for this program was between a negative \$8 and a negative \$31 per dollar spent.

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

From January 1, 2007 through December 31, 2011, the Plan charged the FEHBP a minimum of \$450,967 to perform activities related to its FEP F&A Program. Although we found additional costs beyond the Plan's CFI unit, the Plan was unable to provide accurate total costs related to its total F&A Program.

CFI only performs actual fraud investigations but has responsibility for the Plan's complete corporate-wide fraud, waste, and abuse program. CFI has a sub-unit called CFI-Federal Programs. The FEHBP was charged a combined \$450,967 for these two units/programs. All of these charges were related to the Plans' F&A Program.

Other Plan departments, including Provider Utilization Review, Provider Prepayment Utilization Review, Corporate Recoveries, and Corporate Compliance also have responsibility for a portion of the Plan's fraud and abuse activities. These departments allocated costs of \$1,198,988 to the FEHBP. However, despite guidance within the FEP Standards Manual to budget in all departments for fraud and abuse activities, the Plan was unable to provide documentation or determine what portion of the \$1,198,988 in allocated costs were associated with the Plan's fraud and abuse program activities. Therefore, we determined the range of costs to be between \$450,967 and \$1,649,955.

Next, we identified total recoveries and actual savings for the FEHBP of \$53,577 from 2007 through 2011.⁴ This consists of actual FEHBP fraud recoveries of \$35,760 as well as \$17,817 in actual savings for the FEHBP related to provider pre-payment reviews, which could be tracked to a CFI fraud and abuse activity or case.

⁴ The calculation does not include 2011 fraud and abuse recoveries. The Plan has yet to calculate FEP's allocable portion of these recoveries to be returned to the FEHBP through the 2011 blanket settlement process.

Based on the Plan's reported information related to costs, recoveries and actual savings, the return on investment was between a negative \$8 and a negative \$31 per dollar spent. In other words, for every \$8 to \$31 the FEHBP provided to the Plan's fraud and abuse program activities, the FEHBP received \$1.00 in return.

According to annual reports issued by the CFI unit, the Plan's anti-fraud activities have resulted in corporate savings, recoveries, and cost avoidance in excess of \$61 million, or an average of \$12.2 million per year during the audit scope. It is unclear which line of business benefits from the efforts that resulted in these total savings. Combining recoveries, actual savings and cost avoidance during the audit scope, the Plan's anti-fraud activities accounted for total FEP savings, recoveries, and cost avoidance of \$139,630 or only 0.23 percent of the Plan's overall reported fraud and abuse savings, recoveries, and cost avoidance. In contrast, the FEP line-of-business represents approximately 1.5 to 2 percent of the Plan's overall business.

Association's Response:

The Association disagrees that the Plan's SIU (CFI) is not in compliance with CS 1039 and other OPM and BCBSA guidance. The Association states that the BCBSA FEP has a system of controls and processes that monitor, identify, investigate and recover fraudulent and abusive FEP payments. According to the Association, "The BCBSA FEP Fraud Control Program is designed to protect patient safety and the health care assets of Federal beneficiaries. *The primary goal of the Program is the proactive prevention and detection of fraud on a national basis* – that is, to prevent fraudulent claims from being paid at the outset. This goal is accomplished by joint efforts between BCBSA and the Local Plans using various methods, including utilizing anti-fraud software; by reviewing tips, leads and referrals from different sources; and by coordinating efforts and sharing information on current schemes and industry trends with Local Blue Plans, law enforcement, prosecutory agencies, industry associations, medical and/or licensing boards and other health insurance carriers."

BCBSA's processes for ensuring that local plans are in compliance with their anti-fraud responsibilities include Plan visits; FEP and FIMS training; posting manuals and other useful guides on the FEP SIU website and communication with the FEP executives at the local plans. This Plan is an industry leader at health care fraud prevention and investigation. It uses many investigative techniques including undercover activity, surveillance, data and computer analysis, patient interviews, medical record reviews and cooperating witnesses to ensure success at the prosecution phase of the investigation. The Plan has developed relationships with several law enforcement agencies, including the Federal Bureau of Investigation, the Department of Health and Human Services' OIG, and the Federal Drug Enforcement Agency, as well as several local and state law enforcement agencies and departments.

The Association provided the Plan's CFI statistics for the time period covered by the audit scope. Some of the statistics included were that the CFI opened 11,271 cases; referred 632 cases to law enforcement; and referred over \$33 million for recovery and

had an overall corporate cost avoidance of over \$27 million. According to the Association, FEP has always had a prominent place in the Plan's investigations. The Plan was an original member of the National Anti-Fraud Advisory Board (NAAB) and developed an FEP Best Practices Guide Book that was provided to all local plans.

Regarding the untimely reporting of cases, the Association disagrees that the Plan's untimely reporting of cases to FEPDO and FEPDO's lack of oversight of the Plan caused an unknown amount of financial damage to the FEHBP. The Association also disagrees with OIG's interpretation of its internal policies and procedures for inputting cases into FIMS. The Association states, "The intent of BCBSA's policy at that time was not that Local Plans enter every complaint or issue they record which may later be found to have FEP exposure as defined by OPM OIG, but for Local Plans to enter a case into FIMS once the Plan has completed its initial assessment of the issue and confirmed the initial complaint of fraudulent activity. BCBSA defines exposure as a dollar amount paid in which a confirmed fraud, waste or abuse issue exists."

Managing the timing for reporting cases in FIMS is also key to the success of the Plan's investigations because it protects the case as well as the safety of investigators. Due to these concerns, FEPDO has historically allowed the Plan to report cases at the time a warrant was issued because the issue had been clearly established as fraudulent and the safety of investigators and witnesses were no longer a concern.

The Association states, "BCBSM's ability to report cases is affected by external forces including for example, sealed indictments, delayed reporting by law enforcement of arrests/convictions, and elongated timelines from time of plea to formal sentencing."

The Association also contends that during the audit scope the Plan did not receive any inquiries from OIG as to why they were not receiving any cases from the Plan (through FEPDO). The Plan recommends that the OIG establish a presence in the Detroit area because it has been identified as a high risk Medicare fraud area. The Association also states that ". . . in checking with Federal Agencies responsible for the prosecution of health care fraud in Detroit, not one agency indicated that they knew OPM OIG existed."

Regarding the NAAB meetings noted in the report, the Association states, "These meetings are not necessarily meant to address only specific FEP training and/or compliance issues for the Local Plans, but are held to discuss issues of national significance and scope which may affect many or all of Plans, including Plans' FEP business."

The Association states that the FEP receives a benefit from all of the Plan's investigation activities whether the fraud involved FEHBP dollars or not. Criminally charged providers are placed on a Prepayment Utilization Review program (PPUR), which requires all claims for medical services to be submitted in hard copy with medical records. There is a substantial reduction in claims submissions after a provider is notified of being placed on PPUR.

Regarding the allocation of fraud recoveries, the Plan allocates the monetary recoveries based on group membership. One hundred percent of the recovery is returned to FEP for FEP specific investigations.

The Plan's CFI disagrees with the OIG's ROI calculation. The Plan states that the calculation is inaccurate and doesn't take into account all of the factors associated with a fraud program. Recovery shouldn't be the determining factor in the effectiveness of an SIU. The Plan states, "The true measure of an effective SIU should include: investigative effectiveness; staff expertise; analysis of systems/ policies that may have allowed fraud to occur; initiation of corrective action on any deficiency identified; removal of participation; licensure action; pursuit of recovery either criminally or civilly; cost avoidance achieved by identifying and preventing fraudulent claim submissions before they occur; and the deterrent effect achieved by prosecution, publicity and recovery."

Even though both the Association and the Plan disagree with the conclusions reached in the report, they do agree that some of the recommendations in the report will be adopted to enhance their current program.

OIG Comments:

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

We agree that the CFI had impressive statistics during the audit scope. However, we are still concerned about the lack of FEP cases and recoveries included in those statistics. Only 132 of the 11,271 cases opened involved FEHBP funds. Of the 632 cases referred to law enforcement, none of the cases involved FEHBP funds or were referred to the OIG. The FEHBP received a total of \$35,760, or a tenth of one percent, of the \$33 million recovered by the Plan. Even though the FEP is not a large percentage of the Plan's business (approximately 1.5 to 2 percent), we expect more FEP cases opened and referred and more recoveries of FEHBP funds.

The Association disagrees with the OIG's position that all complaints should be entered into FIMS and that the Plan's reporting of cases was untimely. The Association states that local plans should enter cases into FIMS after an **initial** assessment is completed and fraudulent activity is confirmed. However, these are not the instructions given to this Plan. The Association allowed this Plan to wait until a warrant was issued before entering the cases into FIMS. The criteria for reporting potential fraud and abuse cases to the OIG are located in Carrier Letters 2007-12 and 2011-13. These Carrier Letters require **all Plans** to report potential fraud and abuse cases when there is a reasonable suspicion that fraud has occurred against the FEHBP. Nowhere in these Carriers Letters does it state that the fraudulent activity must be confirmed. Moreover, the fact that the

FEPDO allowed the Plan to not only deviate from the Carrier Letters but also from the Association's internal guidance shows that the FEPDO knowingly violated the terms of the contract with OPM.

Any external forces that caused delays in the Plan reporting its cases in FIMS timely is irrelevant because the Plan didn't report its cases/investigations in FIMS at the initiation of its cases. But again it was FEPDO that allowed the Plan to report its cases untimely. The Association does not state in its response why it did not refer any of the cases that were reported in FIMS to the OIG. However, the Association does infer that the OIG should have contacted them and inquired why it had not received cases from this Plan. It is the Association's responsibility, not the OIG's, to provide case referrals as required in the Carrier Letters discussed above. The OIG has no access to FIMS and relies solely on the FEPDO to provide case notifications and referrals. The OIG had no knowledge of the 132 cases reported by the Plan until the initiation of the audit. The FEPDO is the conduit between the OPM's OIG and the local plans. It is the responsibility of the Association (and FEPDO) to perform adequate oversight of the local plan's fraud and abuse activities. The Association and the Plan state that the cases were reported after the case had been established and a warrant issued to protect the safety of witnesses and the Plan's investigators. As a law enforcement organization, we understand the need to keep investigators and other law enforcement safe from harmful situations. However, we view the non-reporting of these cases to the law enforcement arm of the FEHBP (i.e., OPM's OIG), including undercover operations and other investigative activities the Plan is engaged in, as dangerous. It is the failure to communicate between all parties that may cause harm to those individuals on the front line. There is no evidence that reporting a case to the OIG in a timely manner has ever caused harm to any case, Plan investigator, or law enforcement official.

The OIG agrees that it would be beneficial to establish a presence in Michigan but we do not have the resources to have a presence in all FEHBP markets. As such, we rely heavily on the Plan's SIU to address the FEHBP in their investigations and to inform the OIG via FIMS reporting that the FEHBP may be exposed in their cases. During the audit scope, the Plan reported zero FEHBP dollars recovered and saved in FIMS.

Regarding the NAAB meetings, the Association states that these meetings are an essential component of its oversight role in that they allow the Association and the local plans to collaborate and address issues of national significance. The Association also states that the meetings are not meant to only address FEP training or compliance issues but are held to discuss issues of national significance that may affect all Plans. The OIG understands that the meetings are not held solely to discuss the FEP; however, since the FEHBP is paying the travel expenses for FEPDO it expects the Program to receive some benefit. We saw no evidence that the meetings or training events had any effect on the FEHBP regarding the Plan's compliance with the contract, OPM guidance, or FEPDO guidance. In fact, it was the FEPDO's staff that stated that they had no significant concerns about this Plan in 2009 even though the Plan was not reporting its cases timely in FIMS, nor was the Plan providing the required statistics, such as recoveries and savings, in FIMS.

The Plan states that the ROI calculation used by the OIG is an inaccurate representation because it does not take into effect all factors in a fraud, waste, and abuse program. We agree that the ROI calculation does not take into consideration all areas of a fraud and abuse program and that the ROI standard is not a complete assessment of a unit's anti-fraud activities. However, we do believe that the calculation can provide an overall reasonableness assessment of an anti-fraud program. We were hindered in calculating this Plan's ROI because it did not provide essential elements, such as savings and costs from PPUR and other areas, needed to determine a truly reflective ROI.

Most Federal agencies that investigate fraud, waste, and abuse provide an ROI for their activities. It's simply one tool used to measure a fraud and abuse program's activities and effectiveness. The Plan itself reported an ROI in its Annual Corporate Fraud and Abuse reports to management. Moreover, FEPDO is the one carrier that began providing OPM with the ROI calculation. We simply continued to use it in reviewing each local plan. We are open to discussing the relevant criteria needed to calculate an ROI for each plan, as well as discussing other criteria or measurements to determine the effectiveness of an SIU.

The Plan does not specifically identify FEHBP losses in any of its provider related cases. It simply applies a percentage (based on membership) to any recovery received. These recoveries, amounting to \$35,760, were reported outside of FIMS and returned over a year after the Plan obtained the recoveries. The FEPDO knew that fraud recoveries and savings were accounted for outside of FIMS, but failed to require the Plan to comply with its own internal policies and procedures. We also found specific FEHBP member recoveries lumped into and shared with all of the Plan's lines of business. We acknowledge that the Plan did correct the recovery amount once the OIG brought it to their attention; however, with no change in its procedures, it is likely that the Plan will continue to share FEHBP recoveries with other lines of business.

Recommendation 7

We recommend that the contracting officer have the Association verify that the Plan implements a policy to review and investigate all FEHBP potential exposure upon the initiation of any and all fraud, waste, and abuse allegations and/or issues within the CFI. The Plan should timely report all fraud, waste, and abuse allegations and/or issues in FIMS, based on the guidelines established by the Association's FEP SIU and required by applicable FEHBP Carrier Letters.

Association's Response:

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

case information in their local databases and FIMS for every case or allegation they investigate.”

However, the Association agrees that the guidelines for reporting fraud, waste, and abuse activity into FIMS may not have been clear enough to ensure full compliance with the applicable Carrier Letters. The Association has developed a corrective action plan which includes a revised FEP Fraud, Waste and Abuse Program Standards Manual that includes enhanced definitions and clearer FEP requirements; FIMS training for staff; procedures to ensure cases are entered appropriately in FIMS while protecting identity and confidentiality; and evaluating and updating its fraud, waste, and abuse procedures at the conclusion of the corrective action plan.

The Plan reiterates its concerns regarding early notification of cases to OIG. The Plan states that the law enforcement agencies it works with have advised it that they will no longer work with the Plan if the Plan shares confidential case information with anyone else. The Plan would like to work with the OIG and FEPDO to determine when case information must be reported in FIMS.

OIG Comments:

As stated earlier, Carrier Letters 2007-12 and 2011-13 require all plans to report fraud and abuse cases where there is a reasonable suspicion that a fraud has occurred against the FEHBP. Nowhere in these letters does it state that the Plan must confirm the initial complaint of fraudulent activity. We also expect the FEPDO to follow OPM guidance and no longer allow local BCBS plans to report cases at the time a warrant is issued.

The OIG does agree to work with the Association, the FEPDO, and OPM’s contracting officers to develop agreed-upon definitions and clearer guidance regarding the reporting of fraud and abuse cases to the OIG.

The Plan is concerned with the Carrier Letter’s case reporting requirements because it believes that reporting the cases earlier in their development will negatively impact the case, their partnerships with law enforcement agencies, and the FEHBP. While we applaud the Plan’s partnerships with other law enforcement agencies, it actually has a contractual obligation to work with the FEHBP’s law enforcement arm, the OIG at OPM. We are unclear why the Plan shares confidential information with other law enforcement agencies but does not feel comfortable sharing the same information with the OIG.

The OIG is also unclear why this particular Plan is unable to share information timely. There is no evidence that complying with the OIG guidance regarding case sharing and reporting has ever caused any harm or safety issue to any other law enforcement entity, officer or local health plan anti-fraud personnel. The OIG would be happy to speak to any law enforcement agency that has concerns about the sharing of confidential information.

Recommendation 8

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

Association's Response:

The Association agrees with this recommendation.

Recommendation 9

We recommend that the contracting officer instruct the Plan to update its F&A policy and procedure manual to accurately reflect the requirements of the FEHBP, industry standards, and case sharing and reporting guidelines, as well as the annual reporting requirements of Carrier Letters 2003-23 (Fraud and Abuse Industry Standards), 2003-25 (Revised FEHB Quality Assurance and Fraud and Abuse Reports), and 2011-13 (Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General). In addition, we recommend that the contracting officer require the Plan to adhere to its policy regarding the return of all FEP-specific fraud recoveries solely to the FEHBP and not including those recoveries as part of its blanket settlement process.

Association's Response:

The Association agrees with this recommendation. Also, the Plan's CFI will develop policies specific to the FEP.

Recommendation 10

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

Association's Response:

The Association does not agree that it should provide full access to FIMS. The Association states, "unlimited access by the OIG to the system at this time would result in potential inefficiencies for FEP. However, in order to provide the OIG investigators with efficient, effective and faster access to cases, BCBSA will submit alternative processes for sharing relevant case information with the OIG on an established and timely basis."

The Association agrees to invite the OPM's OIG to participate in select portions of the NAAB meetings, such as case sharing and items specific to FEP.

OIG Comments:

We continue to recommend that the contracting office 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 the OIG and the agency to monitor BCBSA fraud and abuse activity and FEPDO oversight, and will allow the OIG to make inquiries when we notice Plan non-compliance such as untimely reporting. In addition, it will provide necessary information for analysis purposes prior to future OIG audits. This alone will save time and money for the local plans and FEPDO.

The analysis of this Plan's FIMS entries showed that none of the 132 cases entered by the Plan were reported to the OIG. It also showed that the Plan's entries into FIMS had significant timeliness issues. If the OIG had full access to FIMS, those 132 cases would have been reviewed and investigated. Also, the OIG would have notified the Plan and FEPDO of the untimely reporting issue in real time and resolved the issue much earlier.

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

Recommendation 11

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

Association's Response:

The Association disagrees with this recommendation. It states that the contract only requires that the Association calculate and report an aggregate ROI to OPM. The FEP will calculate ROI for all local plans using the following standard:

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

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

OIG Comments:

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

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

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

██████████, Auditor-In-Charge

██████████, Auditor

██████████, Auditor

██████████, Auditor

██████████, Chief ██████████

██████████, Senior Team Leader

Office of Investigations

██████████, Special Agent-In-Charge

██████████, Special Agent-In-Charge

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

V. SCHEDULES

BLUECROSS BLUESHIELD OF MICHIGAN
DETROIT, MICHIGAN

CONTRACT CHARGES

CONTRACT CHARGES*	2007	2008	2009	2010	2011	TOTAL
A. HEALTH BENEFIT CHARGES						
PLAN CODES 210 MISCELLANEOUS PAYMENTS AND CREDITS	[REDACTED]	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]	\$ [REDACTED]
PLAN CODES 710 MISCELLANEOUS PAYMENTS AND CREDITS	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
TOTAL HEALTH BENEFIT CHARGES	\$204,351,024	\$223,299,858	\$238,549,289	\$247,656,679	\$262,959,174	\$1,176,816,024
B. ADMINISTRATIVE EXPENSES						
PLAN CODE 210 PRIOR PERIOD ADJUSTMENTS	[REDACTED]	[REDACTED] 0	[REDACTED]	[REDACTED] 0	[REDACTED]	[REDACTED]
TOTAL ADMINISTRATIVE EXPENSES	\$18,204,950	\$18,507,107	\$18,794,729	\$18,133,675	\$19,731,794	\$93,372,255
TOTAL CONTRACT CHARGES	\$222,555,974	\$241,806,965	\$257,344,018	\$265,790,354	\$282,690,968	\$1,270,188,279

* This audit covered miscellaneous health benefit payments and credits, administrative expenses, and cash management activities from 2007 through 2011.

BLUECROSS BLUESHIELD OF MICHIGAN
 DETROIT, MICHIGAN
 QUESTIONED CHARGES

AUDIT FINDINGS*	2007	2008	2009	2010	2011	2012	2013	TOTAL
A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS								
1. Blanket Settlements	\$0	\$737	\$2,308	\$1,100	\$700	\$0	\$0	\$4,845
2. ██████████ Drug Rebates	0	0	3,717	117	94	47	0	3,975
TOTAL MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS	\$0	\$737	\$6,025	\$1,217	\$794	\$47	\$0	\$8,820
B. ADMINISTRATIVE EXPENSES								
1. Unallowable and/or Unallocable Expenses	\$12,993	\$16,975	\$14,208	\$29,515	\$163,398	\$4,356	\$218	\$241,663
2. Prior Period Adjustments	0	0	0	0	478	0	0	478
TOTAL ADMINISTRATIVE EXPENSES	\$12,993	\$16,975	\$14,208	\$29,515	\$163,876	\$4,356	\$218	\$242,141
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	\$12,993	\$17,712	\$20,233	\$30,732	\$164,670	\$4,403	\$218	\$250,961

* We included lost investment income (LII) within audit findings A2 (\$311), B1 (\$9,892), and B2 (\$478). Therefore, no additional LII is applicable for these audit findings.

March 08, 2013



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

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**Reference: OPM DRAFT AUDIT REPORT
BlueCross BlueShield of Michigan
Audit Report Number 1A-10-32-12-062
(Dated December 18, 2012 and Received December 18, 2012)**

Dear ██████████:

BlueCross BlueShield Association (BCBSA) and Blue Cross Blue Shield of Michigan (BCBSM) acknowledge receipt of the U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP), dated December 18, 2012, (hereafter, "Report"). The following is a combined response to the above referenced Report.

BCBSA and BCBSM are committed to enhancing FEHBP administration to address concerns identified by OPM. That said, BCBSA and BCBSM disagree with some of the statements and facts set out in the Report. BCBSA and BCBSM request the report be modified for the Fraud, Waste and Abuse section based upon the comments provided to the draft report below.

Specific comments concerning the findings and statements in the Report are as follows:

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

1. Blanket Settlements \$4,845

OPM questioned \$4,845 in fraud recoveries that were included in blanket settlements. BCBSM agreed with this finding and submitted the appropriate Special Plan Invoices to cover the period 2008-2011. In the Report, OPM confirmed the return of these funds to the FEHBP and stated that no further action is required for this questioned amount. Therefore, BCBSA and BCBSM consider this issue closed.

2. **Drug Rebates** **\$3,975**

OPM questioned \$3,975 in drug rebates. BCBSM agreed with this finding and submitted the appropriate Special Plan Invoices to cover the period 2009-2012. In the Report, OPM confirmed the return of these funds to the FEHBP and stated that no further action is required for this questioned amount. Therefore, BCBSA and BCBSM consider this issue closed.

B. ADMINISTRATIVE EXPENSES

1. **Unallowable and/or Unallocable Expenses** **\$231,771**

OPM questioned \$231,771 unallowable and/or unallocable expenses related to certain cost centers and natural accounts. BCBSM agreed with this finding and submitted the appropriate Prior Period Adjustments to cover the period 2007-2011. On January 25, 2013, the Federal Employee Program (FEP) received a wire transfer from BCBSM in the amount of \$241,663 which covered the principal amount of \$231,771 and \$9,892 in lost investment income. The financial documentation was forwarded to the OPM OIG for their review.

In order to prevent future non-chargeable costs to the FEP, and as a corrective action, BCBSM added the two natural accounts to its unallowable cost process. In addition, BCBSM will continue to monitor, review and update as necessary its cost center allocations process to ensure accuracy and continued program compliance.

2. **Prior Period Adjustments** **\$478**

OPM stated that BCBSM did not return the correct amount of Lost Investment Income (LII) for non-chargeable administrative expenses returned to the FEP via Prior Period Adjustments (PPAs). BCBSM agreed with this finding and submitted the proper Special Plan Invoice to cover the 2011 issue. On January 25, 2013, FEP received a wire transfer from BCBSM that included the \$478 of lost investment income. The financial documentation was forwarded to the OPM OIG for their review.

In order to prevent future Lost Investment Income miscalculation, BCBSM has updated its procedures and will calculate interest using the date funds are transferred to the FEP investment account.

C. CASH MANAGEMENT

There are no findings and as such BCBSA and BCBSM have no additional feedback.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit

Procedural

OPM stated in its Report that BCBSM's SIU is not in compliance with CS 1039, the Federal Acquisition Rules and other OPM and BCBSA guidance. Additionally the Report set forth OPM's position that BCBSM's non compliance was the result of BCBSA's lack of oversight, direction and guidance as well as BCBSM's lack of policies specific to FEP. For the reasons set forth below, BCBSA and BCBSM disagree with these statements.

The BCBSA FEP has created a system of controls and processes that monitor, identify, investigate and recover fraudulent and abusive payments of FEP funds. The goal of this system and these processes is to safeguard FEHBP from fraud, waste and abuse. Further, BCBSA asserts that it has adequate processes in place to initiate fraud investigations and monitor and manage Plan performance.

The BCBSA FEP Fraud Control Program is designed to protect patient safety and the health care assets of Federal beneficiaries. *The primary goal of the Program is the proactive prevention and detection of fraud on a national basis* – that is, to prevent fraudulent claims from being paid at the outset. This goal is accomplished by joint efforts between BCBSA and the Local Plans using various methods, including utilizing anti-fraud software; by reviewing tips, leads and referrals from different sources; and by coordinating efforts and sharing information on current schemes and industry trends with Local Blue Plans, law enforcement, prosecutory agencies, industry associations, medical and/or licensing boards and other health insurance carriers.

The BCBSA FEP Fraud Control Program is comprised of a number of elements including BCBSA's FEP SIU staff and consultant staff, the anti-fraud staffs of the Local Blue Plans and the anti-fraud staffs of BCBSA's pharmacy benefit managers (PBMs). In order to successfully educate, manage, and analyze the activities of the units and individuals in these various organizations, BCBSA's FEP SIU has created a central organizational structure to oversee and coordinate the activities of the involved parties, as well as developed reporting software- the Fraud Information Management System (FIMS)- to manage cases. BCBSA's processes for ensuring that Local Plans are in compliance with their anti-fraud responsibilities to FEP

include: Plan visits; education and training on FEP and FIMS; posting information on the FEP SIU website on BlueWeb, including manuals and user guides; and communication with FEP executives at the Local Plans in conjunction with the specific FEPDO Director of Account Management assigned to that Plan.

BCBSM's SIU, the Corporate Financial Investigations (CFI) unit works together with the BCBSA FEP Fraud Control Program. BCBSM's CFI has been in existence for over 30 years and uses a unique and effective investigative/prosecutorial model of fraud prevention. CFI was the first health plan department of its kind dedicated to detecting, investigating and seeking the prosecution of health care fraud. BCBSM has always taken great pride in CFI's professionalism and investigative efforts. CFI is recognized as a national leader in combating health care fraud and was a founding member of the National Health Care Fraud Association as well as instrumental in the development of the BCBSA National Anti-Fraud Advisory Board.

In addition to its investigative work, CFI has also been innovative in its approach to anti-fraud efforts by developing four specific pieces of state legislation that address health care fraud. The Michigan Health Care False Claims Act was the first of its kind in the United States and established the ground work for today's prosecution of health care fraud at the state level. CFI also provided congressional testimony in the development of the Federal Health Care False Claims Act enacted in 1996. Additionally, CFI has participated in the initial health care fraud training of FBI agents at the training headquarters in Quantico, Virginia.

BCBSM's CFI has a thirty-nine member staff dedicated to health care fraud prevention and investigation. Twenty-four of those staff members are highly trained former law enforcement professionals with extensive white collar criminal investigation and prosecution experience. CFI's investigative techniques include undercover activity, surveillance, data and computer analysis, patient interviews, medical record reviews and the development and use of cooperating witnesses, to name a few. The CFI model uses these fraud investigation techniques effectively and appropriately so that BCBSM and the coordinating law enforcement agencies can prevail during the prosecution phase. BCBSM has established model relationships with several law enforcement agencies, including:

- Federal Bureau of Investigation
- Office of Inspector General – Department of Health and Human Services
- U.S. Postal Inspection Service

- Federal Drug Enforcement Agency
- United States Secret Service
- U.S. Immigration and Customs Enforcement
- Homeland Security
- Internal Revenue Service
- Food and Drug Administration
- Michigan State Police
- Michigan Attorney General
- Michigan Department of Community Health
- 83 Michigan County Prosecutor Offices
- Numerous Michigan Sheriff Departments and local police agencies

During the time period covered by the OPM OIG audit, 2007 – 2011, CFI:

- received 135,991 hotline calls,
- opened 11,271 cases,
- closed 11,530 cases,
- referred 632 cases to law enforcement,
- obtained 607 warrants and indictments, 588 arrests, 491 convictions and
- referred over \$33 million for recovery and had an overall corporate cost avoidance of over \$27 million.

FEP has always had a prominent place in BCBSM's CFI investigations. Due in part to being recognized as an industry leader, BCBSM's CFI was an original member of the FEP National Anti-Fraud Advisory Board that provided investigative training to Local Blues Plan investigators and developed a FEP Best Practices Guide Book that was disseminated to all Blue Plans. **Note:** The FEP National Anti-Fraud Advisory Board was subsequently absorbed into the agenda of the National NAAB, and the 2002 FEP Best Practices Guide Book was subsequently replaced by the original FEP Fraud and Abuse Standards Manual. CFI has also been a member of the FEP Prescription Drug Fraud Investigative Network for the FEPDO, conducting investigations nationally.

The FEHBP receives benefit from CFI's robust and effective fraud, waste and abuse program. CFI has demonstrated experience in identifying, investigating and collaborating with law enforcement agencies to prosecute fraud and obtain recovery

judgments. CFI applies the same aggressive and thorough effort to all inquiries and cases, including those that are FEP specific or which may have an FEHBP impact.

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

During the Exit Conference discussion of BCBSM's Fraud Program, the OIG staff referenced positive aspects of BCBSM's fraud, waste and abuse program, including compliments regarding CFI's aggressive investigative techniques and protection of FEP assets as well as mentioning that CFI's operations could serve as a model for other SIUs. BCBSA and BCBSM would like those positive findings included in the final report.

In summary, the BCBSA FEP Fraud Control Program and BCBSM's SIU have a robust, unique, and effective program to combat fraud, waste and abuse that is consistent with the requirements of CS 1039 and the associated regulations and guidance.

2. Incomplete and Untimely Reporting- FEHBP Fraud Cases and Incomplete and Inaccurate Reporting – FEHBP Recoveries and Savings

At the outset, BCBSA believes the statement “Ultimately, the Plan’s untimely reporting to the FEPDO, the FEPDO’s lack of oversight of the Plan, and the lack of reporting to OPM’s OIG, has caused an unknown amount of financial damage to the

FEHBP” has not been supported by the facts and is speculative. Therefore, we request that this statement be removed from the Report. Furthermore, BCBSA believes that OPM’s reference to the cost of implementing FIMS (\$1,520,303) is irrelevant to the OPM OIG audit finding of “Incomplete and Untimely Reporting of FEHBP Fraud Cases” and, therefore, should also be removed from the Report.

BCBSA disagrees with the OPM OIG’s interpretation of the internal policies and procedures setting forth the criteria for Local Plans’ case input into FIMS. Based on the finding, the OIG interprets the FEP policy as requiring Plans to enter all cases into FIMS in which FEP may have exposure, regardless of whether that exposure is related to an initial accusation or established fraudulent activity. The OIG is calculating exposure simply as a dollar of Program funds paid to a provider in question. However, this definition of exposure is overly broad and would result in the inputting of a substantial number of cases where it is ultimately determined that there were no payment of FEP funds related to the initial accusation or suspected fraudulent activity. Reporting false positives would result in an inefficient process where resources would be distracted from pursuing actual antifraud activities to address situations that were later found not to be fraud, waste and abuse activities. Additionally, reporting of all suspected fraud, waste and abuse activities would present a significant burden and impediment to the overall administration of the fraud, waste and abuse program for FEP, including difficulty generating valuable data reports with accurate representations and gaining a complete understanding of actual fraud, waste and abuse activity.

The intent of BCBSA’s policy at that time was not that Local Plans enter every complaint or issue they record which may later be found to have FEP exposure as defined by OPM OIG, but for Local Plans to enter a case into FIMS once the Plan has completed its initial assessment of the issue and confirmed the initial complaint of fraudulent activity. BCBSA defines exposure as a dollar amount paid in which a confirmed fraud, waste or abuse issue exists. Page 22 of the FEP Fraud Prevention and Reporting Manual in effect at the relevant time states, “Local Plans are required to notify the FEP SIU of potential fraud cases.” However, it refers the reader to Section 3.3 of the FEP FIMS manual for further clarification. Section 3.3 (Page 11) of the FIMS manual states that FIMS is a system for reporting **FEP fraud cases**. (Emphasis added). It also states that FIMS serves as the primary vehicle to report FEP fraud related cases. Cases, in which a Plan confirms that there is not a potential fraud issue or that the issue is unrelated to FEP, are not required to be entered into FIMS.

Additionally, for BCBSM’s CFI, managing the timing for reporting cases to FIMS is key to the success of CFI’s investigative model as it protects BCBSM’s case as well as in some investigations, the safety and lives of investigators. As a result, the FEPDO allowed BCBSM to report cases at the time a warrant was issued and as

such, when the activity being investigated had clearly been established as fraudulent and the safety of investigators and cooperating witnesses was no longer an issue. For these reasons, BCBSA and BCBSM disagree with the OIG's statement that 4,418 cases should have been reported into the FIMS system. Most of the 4,418 cases reviewed by OPM OIG during the audit were determined to be either unfounded or the result of billing errors, and as such, would not have qualified for entry into FIMS. During this audit period, BCBSM did enter 132 cases into the FIMS system because BCBSM determined these cases fit the FEP FIMS Manual criteria for reporting.

The Report also states that cases which were entered into FIMS were not always entered timely. BCBSM's ability to report cases is affected by external forces including for example, sealed indictments, delayed reporting by law enforcement of arrests/convictions, and elongated timelines from time of plea to formal sentencing.

Additionally, CFI has entered information in the FIMS system consistently since the conception of the system. The OIG investigators indicated that they received no FIMS information for the five years included in this audit period. It is unclear why after five years of alleged non-reporting that BCBSM did not receive any inquiries from OPM OIG. CFI also notes that while CFI did not consult with OPM OIG directly, it does appear that OPM OIG was aware of at least one CFI investigation concerning a Michigan provider. CFI's investigation disclosed that the doctor under investigation was providing steroids to body builders and submitted diagnosis codes indicating dwarf gonadism. The CFI investigation determined that these diagnosis codes were false and were being submitted for claims payment purposes only. CFI also discovered that federal employees were patients of this provider and had claims submitted with a dwarf gonadism diagnosis. CFI had developed an investigative plan that included potential undercover activity. CFI was directed, however, to cease investigation. This doctor remains practicing today, submitting claims for services and prescribing high volumes of Schedule II narcotics. Because it was instructed to stop the CFI investigation, BCBSM continues to suffer losses for both individual and group business.

During the audit, BCBSM CFI learned that the closest OPM OIG agent is located in Pittsburgh, Pennsylvania. It should also be noted that CFI has never received an inquiry or correspondence directly from OPM OIG. Furthermore, in checking with Federal Agencies responsible for the prosecution of health care fraud in Detroit, not one agency indicated that they knew OPM OIG existed. During the audit, CFI

explained its understanding that BCBSM had the sole responsibility for detecting, investigating and seeking prosecution for FEP cases at BCBSM. BCBSM CFI also believed that it was BCBSM's responsibility to initiate recoveries and seek licensure action for convicted providers. From that perspective, CFI's primary concern has always been the protection of FEP and other BCBSM customers' assets through the prosecution, recovery and licensure process.

During the audit, OPM OIG indicated that had OPM OIG had case reports from CFI, they would have reviewed other carrier payments to determine if those payments were applicable to the CFI prosecution. BCBSM CFI inquired as to who the other SIU individuals were and none were provided. CFI advised that it has never received any information from any other carrier nor from the OPM OIG. CFI also informed the OPM OIG that the U.S. Department of Health and Human Services and Department of Justice has designated certain cities as high Medicare fraud areas and established joint federal task forces to attack the health care fraud problem in these cities. Detroit, Michigan has been designated as one of those high risk for fraud cities and BCBSM CFI suggested that the OPM OIG establish a presence in the designated cities or at least attend the task force meetings to establish relationships with other federal agencies responsible for the investigation of health care fraud.

The Report also includes statements concerning the BCBSA National Anti-Fraud Advisory Board (NAAB) meetings between the FEPDO SIU and Local Plan representatives. BCBSM participates in the NAAB, a national anti-fraud advisory board consisting of about 15 Local Plans that meet regularly to address system-wide issues. By agreement, the locations of the meetings of the NAAB rotate among the home offices of the participating Plans. These meetings are an essential component of BCBSA's comprehensive national anti-fraud oversight role in that they allow BCBSA and the Local Plans to collaborate and address issues of national significance and foster enhanced coordination of all anti-fraud efforts. These meetings are not necessarily meant to address only specific FEP training and/or compliance issues for the Local Plans, but are held to discuss issues of national significance and scope which may affect many or all of Plans, including Plans' FEP business.

The investigations undertaken as a result of NAAB board interaction are not limited to just FEP and include a global perspective. In this fashion, providers identified as committing fraud against any health care payment source or jeopardizing the safety of any patient can be prosecuted, recovery initiated, appropriate licensure action

requested, potential debarment initiated, and removal from all lines of business implemented.

Although BCBSA and BCBSM disagree with the conclusion regarding the sufficiency of their overall fraud and abuse activities, BCBSA and BCBSM seek to continuously improve their program and accordingly, agree that some of the recommendations included in the Report will be adopted to enhance their current program as further set out below in the Recommendations section.

3. Cost and Benefits of the Plan's Fraud and Abuse Activities

BCBSM disagrees with the statement that the FEHBP does not appear to derive benefit from BCBSM's fraud and abuse activities.

Importantly, the OPM OIG failed to recognize the overall impact of BCBSM CFI investigative activities. FEP receives a benefit from all of BCBSM's investigative activities whether FEP specific or not and whether the fraud involved FEHBP program dollars or not.

Criminally charged providers are placed in a Prepayment Utilization Review program (PPUR), which requires that all claims for medical supplies and services must be submitted via hard copy with medical records. These claims are then reviewed by a medical consultant to make an appropriate payment determination. Notably, there is a substantial reduction in claims submissions after a provider is notified of being placed on PPUR. Additionally, convicted providers are deparicipated by BCBSM and no longer able to receive reimbursement directly¹ from the Enterprise. Studies have shown that deparicipated provider income drops approximately 80% and typically does not increase thereafter. BCBSM sends a notice of convicted providers to the State of Michigan for licensure action and also sends a report of adverse actions to the Health Information Practitioner Data Bank (HIPDB). The reputation that BCBSM has received in pursuing prosecutions has further served to reduce fraudulent claims by providers. All of these actions, as recognized by the OIG

¹ In accordance with current Michigan law, BCBSM must reimburse subscribers for services rendered by licensed providers that have been deparicipated unless or until the provider appears on a government sanction, debarment or exclusion listing, including the OPM listing. If a provider appears on the OPM sanction list, BCBSM does not issue payment to either the provider or the subscriber unless otherwise required by Section 2.7(a) of the FEP Contract.

investigator, have an “immeasurable deterrence” in combating health care fraud and loss to FEP.

With respect to fraud recoveries, BCBSM’s practice is to allocate the monetary recoveries from all cases by group membership percentage. As such, in an effort to make FEP whole, BCBSM has endeavored to return recoveries based upon the percentage of FEP business, except for FEP specific investigations where 100% of the recovery is returned to FEP. The allocation that BCBSM makes for fraud recoveries has occurred outside of the FIMS system and is based on overall FEP membership percentage for all fraud investigations where BCBSM receives recoveries whether a specific FEP loss could be identified or not.

It is BCBSM CFI’s opinion that the Return on Investment (ROI) presented by the OPM OIG auditors in the Report is an inaccurate representation as it does not take into account all factors associated with a fraud, waste and abuse program. It should be noted that BCBSM CFI does not develop a ROI due to the appearance of a quota, nor does it have a requirement for the number of cases referred to law enforcement, warrants and indictments, arrests or convictions. The reason for this is because in criminal cases, defense attorneys routinely argue to juries that the only reason their clients are on trial is so that BCBSM can reach its ‘quota’ to justify the existence (and funding) of the BCBSM CFI unit.

While recovery should be an expected outcome from investigations, the measurement of ROI should not be the determining factor in the effectiveness of a Special Investigation Unit. The advent of the Special Investigation Unit is in part a recognition that the traditional audit and recovery process does not work when dealing with perpetrators of fraud. To ignore the primary responsibility of the Special Investigative Unit in evaluating the effectiveness of the SIU is short-sighted. The true measure of an effective SIU should include: investigative effectiveness; staff expertise; analysis of systems/ policies that may have allowed fraud to occur; initiation of corrective action on any deficiency identified; removal of participation; licensure action; pursuit of recovery either criminally or civilly; cost avoidance achieved by identifying and preventing fraudulent claim submissions before they occur; and the deterrent effect achieved by prosecution, publicity and recovery. This is not an all inclusive list. Most law enforcement elements of investigations are not based on the measurement of ROI. The OPM OIG audit does not appear to have evaluated these other factors in assessing the effectiveness of the BCBSM anti-fraud program.

It is confusing that the OPM OIG stated in its Report “based upon our review, the FEHBP does not appear to derive a benefit from the Plan’s fraud and abuse activities”, yet the OIG investigators stated on numerous occasions including at the Exit Conference that if they had their way, they would model all SIU plans after the BCBSM Corporate and Financial Investigations Department.

Recommendations

Recommendation 6 - OPM recommends that the contracting officer have the Association verify that the Plan implements a policy to review and investigate all FEP potential exposure upon the initiation of any and all fraud, waste, and abuse allegations and/or issues within the CFI. The Plan should timely report all fraud, waste, and abuse allegations and/or issues in FIMS, whether substantiated or not, based on the guidelines established by the Association’s FEP SIU and required by OPM’s Carrier Letter 2011-13 (Mandatory Information Sharing via Written Case Notifications to OPM’s Office of the Inspector General).

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

Additionally, Local Plans maintain a local case or project database in which they record all the related case activity. It would be duplicative and an inefficient use of FEP funds for Plans to maintain case information in their local databases and FIMS for every case or allegation they investigate. It is the intent of BCBSA that Local Plans only enter case information into FIMS once they have confirmed that there is a reasonable basis to believe that fraud exists and there is confirmation of FEP exposure based on the original accusation, complaint, or fraudulent activity.

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

- BCBSA conducted a thorough examination of available industry definitions of Fraud, Waste and Abuse. The resulting enhanced definitions were included in the Revised FEP Fraud, Waste and Abuse Program Standards Manual that was issued to Plan SIU departments on December 28, 2012. The revised manual was also issued to Persons With Primary FEP Responsibility and Primary Internal Audit Responsibility on February 15, 2013. The revised manuals make FEP requirements clearer and should result in greater adherence to requirements for case input. BCBSA will also continue to evaluate the FEP Fraud, Waste and Abuse Program Standards Manual to determine whether any additional guidance is required on how Local Plans should report fraud, waste and abuse cases in FIMS.
- BCBSA has updated its policy to require Plan staff to attend training that is specific to FIMS reporting or other contractually mandated requirements. Roll-out scheduled completion date is June 30, 2013.
- BCBSA will work with BCBSM to develop appropriate procedures to ensure cases are entered into FIMS in a manner acceptable to OPM and BCBSA, while at the same time protecting the identify and confidentiality of CFI's sources, methods and personnel by June 30, 2013.
- BCBSM will evaluate and update its fraud, waste and abuse procedures at the conclusion of BCBSA corrective actions noted above by December 31, 2013.

Notwithstanding the above, BCBSM reiterates that it has a very developed and intensive investigative process that could be impeded by some of the reporting requirements. Specifically, for cases involving undercover activity, early notification could jeopardize the safety of undercover operatives, as well as impact the investigation. Also BCBSM routinely works cooperatively with other law enforcement agencies that share information with BCBSM in a confidential manner. CFI has been advised by these law enforcement agencies that if the confidential information shared with BCBSM is disclosed to anyone else, the law enforcement agencies will not be able to work with BCBSM in the same manner. To that end, it is BCBSM's desire to meet OPM's underlying need and seek to balance the interests of all stakeholders to assure the intent of the requirements are achieved. Both of these outcomes of reporting cases in FIMS too early are huge setbacks to CFI's program and are contrary to the best interests of FEP as well as our other customers. BCBSM has had some preliminary discussions with OPM OIG about this situation and also with FEPDO, and would like to continue such discussions to reach a mutual understanding about when case information will be reported in FIMS.

BC also notes that OPM appears to have a more expansive definition of Fraud, Waste and Abuse, treating all categories the same whereas the current focus and Plan procedures have been centered mainly around fraud reporting.

Recommendation 7 - OPM OIG recommends that the contracting officer have the Association verify that BCBSM implements a process to track all instances of CFI initiated recoveries, claim denials and cost avoidance, and link the recoveries, actual savings, and cost avoidance to the initiated cases and/or investigations in order to accurately report FEP related recoveries and actual and/or projected savings to the Association and OPM annually, as required in Carrier Letter 2003-25 (Revised FEHB Quality Assurance and Fraud and Abuse Reports).

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

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

Recommendation 8 - OPM OIG recommends that the contracting officer instruct the Plan to update its Fraud & Abuse policy and procedure manual to accurately reflect the requirements of the FEHBP, industry standards, case sharing and reporting guidelines, as well as the annual reporting requirements of Carrier Letters 2003-23 (Fraud and Abuse Industry Standards), 2003-25 (Revised FEHB Quality Assurance and Fraud and Abuse Reports), and 2011-13 (Mandatory Information Sharing via Written Case Notifications to OPM's Office of the Inspector General). In addition, OPM OIG recommends that the contracting officer require the Plan to adhere to its policy regarding the return of all FEP-specific fraud recoveries solely to the FEHBP and not including those recoveries as part of its blanket settlement process.

Response - BCBSM agrees with the recommendation to update its fraud, waste and abuse policy and procedure manual to accurately reflect the requirements of the FEHBP. It is BCBSM's standard procedure to assure FEP rules, regulations and policies are embedded in BCBSM CFI's daily activities even though no specific BCBSM FEP policy was documented.

Although BCBSM's CFI has not maintained policies that are specific to any particular group, BCBSM will use this opportunity to develop a policy specific to FEP. This activity will be coordinated with the BCBSA action plan in Recommendation 6.

Recommendation 9 - OPM recommends that the contracting officer direct the Association to provide OPM and OPM's OIG full access to FIMS and the BCBSA National Anti-Fraud Advisory Board meetings.

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

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

Recommendation 10 - OPM OIG recommends that the contracting officer require the Plan to provide the methodology and a measure of performance (based on industry standards) ensuring that the Fraud & Abuse Program is a benefit to the FEHBP, in accordance with Contract CS 1039, Section 1.9(a).

Response - BCBSA disagrees with the recommendation to require the BCBSM Plan to provide a methodology and measure for determining the benefits of the Plan's fraud program. CS 1039 states that the Carrier will calculate and report an aggregate ROI to OPM. For this reference, the Carrier is the Blue Cross Blue Shield Association. To ensure that an appropriate, industry standard based ROI is reported, FEP will calculate ROI for the 2012 contract year for all Local Plans based upon the following industry standard:

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

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

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

Sincerely,

[REDACTED]

[REDACTED]

Director, Program Assurance

[REDACTED]

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