



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

Final Audit Report

**Supplemental Audit of Blue Cross and Blue Shield of
Florida, Inc.'s Durable Medical Equipment, Home
Health, and Home Infusion Benefits as Administered
by CareCentrix**

**Report Number 1A-10-41-17-011
April 3, 2020**

EXECUTIVE SUMMARY

Supplemental Audit of Blue Cross and Blue Shield of Florida, Inc.'s Durable Medical Equipment, Home Health, and Home Infusion Benefits as Administered by CareCentrix

Report No. 1A-10-41-17-011

April 3, 2020

Why Did We Conduct The Audit?

The objectives of our supplemental audit were to determine whether Blue Cross and Blue Shield of Florida, Inc. (Plan) charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to FEHBP members in accordance with the terms of its contract with the U.S. Office of Personnel Management (OPM). Specifically, our objective was to determine whether the Plan's arrangement with CareCentrix Inc. (CareCentrix) complied with contract provisions relative to health benefit payments.

What Did We Audit?

The Office of the Inspector General (OIG) has completed a limited scope supplemental audit of the Plan's arrangement with CareCentrix to administer its durable medical equipment, home health, and home infusion benefits. The supplemental audit covered claim payments from January 1, 2012, through October 31, 2015, and was conducted at the Plan's location in Jacksonville, Florida.



Michael R. Esser
Assistant Inspector General
for Audits

What Did We Find?

Our supplemental audit found that because CareCentrix performs both the duties of a carrier (setting up a provider network and coordinating with actual health care service providers) and of a provider (submitting the claim for payment and accepting member payments), the Plan should only charge costs related to provider services as a claim cost. All other carrier duties that CareCentrix performs should be charged as an administrative expense and should be subject to the Plan's administrative expense limitations.

However, as OPM and the Plan considered CareCentrix's contractual arrangement to be that of a provider and allowed CareCentrix to charge its entire administrative fee as a health care cost, the Plan potentially overstated its health benefit expenses and understated its administrative expenses, respectively, on the Blue Cross and Blue Shield annual accounting statements.

ABBREVIATIONS

Association	Blue Cross and Blue Shield Association
BCBS	Blue Cross and Blue Shield
CareCentrix	CareCentrix, Inc.
Contract	Contract CS 1039 between OPM and the Association
CFR	Code of Federal Regulations
DME	Durable Medical Equipment
FEHB Act	Federal Employees Health Benefits Act
FEHBP	Federal Employees Health Benefits Program
FEP	Federal Employee Program
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plan	BCBS of Florida, Inc.
SBP	Service Benefit Plan

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I. BACKGROUND

This final report details the findings, conclusions, and recommendations resulting from our supplemental audit of the Federal Employees Health Benefits Program (FEHBP) operations at Blue Cross and Blue Shield of Florida, Inc. (Plan) located in Jacksonville, Florida. This supplemental audit focused on claims paid to CareCentrix, Inc. (CareCentrix), which was contracted by the Plan to administer its durable medical equipment (DME), home health, and home infusion benefits. The supplemental audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits Act (FEHB Act), 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 Blue Cross and Blue Shield Association (Association), on behalf of participating Blue Cross and Blue Shield (BCBS) plans, entered into contract CS 1039 (Contract), a Government-wide Service Benefit Plan (SBP) contract, with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers. There are 36 BCBS companies participating in the FEHBP. The 36 companies are comprised of 64 local BCBS plans.

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

The Association has also established an FEP Operations Center. CareFirst BCBS, located in Owings Mills, Maryland, performs the activities of the FEP Operations Center. 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.

¹ Throughout this report, when we refer to "FEP," we are referring to the SBP 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.

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

The most recent audit report issued that covered claim payments for the Plan was Report Number 1A-10-41-12-019, dated October 17, 2012. All recommendations from this audit have been closed.

The results of this current supplemental audit were discussed with Plan and Association officials throughout the audit and at an exit conference dated February 22, 2019. 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 supplemental audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms the Contract. Specifically, our objective was to determine whether the Plan's contractual arrangement with CareCentrix complied with the Contract's provisions relative to health benefit payments.

SCOPE AND METHODOLOGY

We conducted our limited scope supplemental 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 supplemental audit objectives.

This performance audit is supplemental to audit report number 1A-10-41-16-029, Audit of the Claims Processing and Payment Operations at Blue Cross and Blue Shield of Florida, Inc., dated March 30, 2020, and focuses on DME, home health, and home infusion payments made to CareCentrix for the period January 1, 2012, through October 31, 2015.

As part of our audit fieldwork, we conducted a site visit at the Plan's offices in Jacksonville, Florida from April 6, 2016, through April 26, 2016. Remaining audit fieldwork was completed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from May 2016 through November 2019.

We reviewed the Association's Government-wide SBP Annual Accounting Statements as they pertain to Plan codes 090 and 590 (Plan Codes related to the Plan) for Contract years 2012 through October 31, 2015². We determined that the Plan paid approximately \$5.65 billion in health benefit charges during this time period, a portion of which was paid to CareCentrix for its administration of the Plan's DME, home health, and home infusion benefits.

In planning and conducting our supplemental audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of 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 supplemental audit

² Although the audit scope covered January 1, 2012, through October 31, 2015, the Association's Government-wide SBP 2015 Annual Accounting Statement reports through year-end December 31, 2015.

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.

We also conducted tests to determine whether the Plan had complied with the Contract and the laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan did not fully comply with the provisions of the Contract related to claim payments. The "Audit Finding and Recommendations" section of this audit report explains in detail the exceptions noted.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP Director's Office, the FEP Operations Center, and the Plan. Through the performance of audits and an in-house claims reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of claims for each type of review. The BCBS claims data is provided to us on a monthly basis by the FEP Operations Center, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the Plan's local claims system. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

To determine whether the Plan's contractual arrangement with CareCentrix complied with the Contract's provisions relative to health benefit payments, we reviewed the DME claims selected in audit report number 1A-10-41-16-029 and determined if the amount paid to CareCentrix included an administrative fee as well as the amounts paid to the actual provider of the services.

The sample selected and reviewed in performing the supplemental audit was not statistically based. Consequently, the results were not projected to the universe since it is unlikely that the results are representative of the universe taken as a whole.

III. AUDIT FINDING AND RECOMMENDATIONS

During our audit of the FEHBP's operations at the Plan, we identified issues specifically related to its arrangement with CareCentrix. Because of their significant impact to the FEHBP, we prepared this supplemental final report to disclose them. All other results of our audit of the FEHBP's operations at the Plan were discussed in a separate report (Report #1A-10-41-16-029).

A. Program Improvement Area

1. CareCentrix Incorrectly Designated as a Provider

We determined that while CareCentrix does indeed perform services that a provider typically performs, it also performed services that are more in line with those performed by a health carrier, making it a "quasi" provider.

However, because OPM, the Association, and the Plan incorrectly designated the CareCentrix contract as a provider contract, CareCentrix was allowed to include its administrative costs to administer DME, home health, and home infusion benefits as part of its health care costs. In doing so, the Plan bypassed the administrative expense caps set up as part of the SBP requirements and potentially increased the member cost share on claims.

On September 1, 2011, the Plan entered into a seven-year contract with CareCentrix to administer its DME, home health, and home infusion benefits. The goal of this relationship was to improve patient outcomes and quality of care, and better manage medical costs by processing the above types of medical claims on behalf of the Plan. This contract also provided the Plan with access to CareCentrix's preferred provider networks. For these services, CareCentrix added an administrative fee to each claim that it submitted to the Plan for payment.

Based on this contractual relationship, the Plan, Association, and OPM's contracting office considered the CareCentrix contract to be a provider contract. Their position is based on an exception provided within the definition of a subcontractor under 48 CFR 1602.170-15. This clause states that "Subcontractor means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor or another subcontractor, except for providers of **direct** [emphasis added] medical services or supplies pursuant to the Carrier's health benefits plan."

This basis was confirmed in an email from OPM's Contracting Officer sent on June 21, 2016, which stated, "According to the definition . . . CareCentrix would be considered a provider contract instead of a subcontract. There is an exception to the subcontractor rule if you are a provider of medical services or supplies."

The Association goes to great lengths to explain that the term “health care provider” is not defined in the regulations governing the FEHBP. However, the term is defined elsewhere in other Federal regulations:

- 42 United States Code 280g-15 (j) (3) [as it applies to the Affordable Care Act] defines a provider as any individual or entity “licensed, registered, or certified under Federal or State laws or regulations to perform health care services;” and
- 29 CFR section 825.125 (a) (1) [as it applies to the Family and Medical Leave Act] defines a provider as “A doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices”

More recent and updated regulations, although unrelated to the FEHBP, define a “health care provider” as an individual or entity licensed or authorized to perform health care services or practice medicine.

However, in additional discussions with OPM’s contracting office, it described CareCentrix as a quasi-provider. As stated above, the results of our review agree with this description. CareCentrix performs some duties exclusively performed by a provider of health care services, but also provides services that are exclusively performed by a health plan. For instance, it submits claims to the Plan for payment (plus its administrative fee) and collects member cost shares (co-pay and/or coinsurance) as an actual provider of health care services would do. It also has set up a network of providers, set up contacts with providers, resolves claim issues, and ensures that the actual providers of the medical services are paid as a health plan would do.

What CareCentrix does not do is ALL of the things that a provider does. Therefore, treating it solely as a provider, and not considering its other nature, is only to the financial detriment of the FEHBP and its subscribers, and to the financial benefit of the Plan. Reporting the full amount paid to CareCentrix as a health benefit expense serves only to overstate that expense on the Plan’s BCBS annual accounting statement and understate its administrative expenses. Perhaps part of the CareCentrix administrative fee is an applicable claim cost, but not all of it. This also potentially allowed the Plan to inadvertently exceed its administrative expense cap during the years of the audit.

Recommendation 1

We recommend that the contracting officer review its determination of CareCentrix as a “provider” so that the FEHBP and its members may be protected from potential inflated health care costs caused by similar contractual relationships going forward.

Recommendation 2

We recommend that the contracting officer direct the Association to instruct its local plans, where these types of contracts exist, to have their vendors (quasi-providers) bill those costs associated with plan/carrier type activities separately as an administrative cost, for health plan-related activities, and as a health claim cost, for provider-related activities, going forward.

Association Response

The Association disagrees with this recommendation stating that CareCentrix is properly designated as a provider. Therefore, it believes our assertions that costs were inflated and administrative expense cap exceeded are incorrect.

APPENDIX



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Deleted by the OIG – Not Relevant to the Final Report

Received: September 12, 2019

**Reference: Supplemental Audit of Blue Cross and Blue Shield of Florida, Inc.
Audit Report Number 1A-10-41-17-011
(Dated and Received July 26, 2019)**

Deleted by the OIG – Not Relevant to the Final Report

This is our response to the above referenced U.S. Office of Personnel Management (“OPM”) Draft Audit Report covering the Federal Employees’ Health Benefits Program (“FEHBP”) for Blue Cross and Blue Shield of Florida, Inc. dba Florida Blue (“Plan”). Our comments concerning the findings in this report are as follows:

A. Improperly Charged Administrative Expenses

1. Contract Overcharges

Recommendation 1:

“We recommend the contracting officer require the Plan to discontinue its practice of charging CareCentrix’s administrative fees to individual claims. The Plan should establish a separate cost center for administrative fees paid to CareCentrix and require these fees to be included in their proposed administrative budget amounts for each fiscal year.”

Plan Response:

The Plan and the Blue Cross and Blue Shield Association (“BCBSA”) respectfully disagree with the OIG’s conclusion that the Plan’s contracted provider of durable medical equipment (“DME”), home health, and home infusion benefits, CareCentrix, Inc. (“CareCentrix”), is not a provider of direct medical services or supplies under the Federal Employee Program (“FEP”) Service Benefit Plan (“SBP”). The Plan and BCBSA further disagree with the OIG’s assertion that CareCentrix is, instead, a “subcontractor” or subcontracted Third Party Administrator (“TPA”) under Contract No. CS1039 (the “Contract”). Therefore, the Plan and BCBSA also disagree that contracting with CareCentrix as a provider resulted in any overstatement or misreporting of either health benefit or administrative costs under the Contract.

It has been over 30 years since the Federal Employees Health Benefits Acquisition Regulations (“FEHBAR”) definition pertaining to subcontractors has been modified and there is no regulatory definition of “providers of direct medical services” as relied upon by OIG. Since that time the health

care delivery system in the United States has undergone tremendous changes, including how care is delivered and by whom. Providers of medical services and supplies to members render care and provide services that are materially different than the prime contract administrative functions performed by the Plan and should be treated accordingly.

Therefore, the Plan and BCBSA appreciate the concerns raised by the OIG and agree to work with the OPM Contracting Officer regarding any prospective contract or policy changes regarding more contemporary definitions of subcontractors and providers and the classification of these allowable contract costs under the Contract and FEHBAR.

Applicable Terminology Supports Plan

The Plan and BCBSA agree with the Contracting Officer's assessment in the June 21, 2016 e-mail, as cited by the OIG, that the "*CareCentrix [contract] would be considered a provider contract instead of a subcontract.*" Since the FEHBAR does not include a definition of "provider" then the Contracting Officer's assessment should have been given significant deference by OIG in the conduct of the audit and the Draft Audit Report. Such deference is appropriate since the Contracting Officer's assessment is also consistent with the definition of Large Provider Agreements under the FEHBAR. The OIG has not cited any contrary, controlling authority rebutting the position stated by the Contracting Officer or the position put forward by the Plan during the audit. The OIG asserts, instead, that CareCentrix is a Third Party Administrator ("TPA") and not a "true health care provider." There are not definitions, however, of "provider," "true health care provider," or "TPA" in the FEHBAR.

Applicable FEHBAR and Contract terms support the Plan and the Contracting Officer's characterization of CareCentrix as a provider and related health benefit costs. The FEHBAR defines a "subcontractor" as "*any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.*" 48 CFR § 1602.170-15. By asserting that CareCentrix is a TPA, the OIG concluded that the related CareCentrix costs should have been charged as subcontractor administrative expenses by the Plan. The FEHBAR term subcontractor, however, does not apply to CareCentrix. CareCentrix does not actually "furnish supplies or services to or for a prime contractor" under the first part of the definition. CareCentrix provides services to its downstream providers (discussed more fully below) and to FEP members. CareCentrix is reimbursed by the Plan on a fee for service ("FFS") basis for the services provided to FEP members. This is spelled out for members under the service benefit plan which is incorporated as part of the Contract. The FEP SBP provides that:

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers. We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. SBP, Section 1 (2012-2015).

The Plan contract with CareCentrix governs the conditions and obligations related to the reimbursement for covered services for eligible Plan members. Even to the extent that CareCentrix provides for functions that are also obligations of FFS Experience Rated Carriers does not fundamentally change the relationship, *i.e.*, that CareCentrix provides services to members. Most notably, the Plan only pays CareCentrix when a claim is submitted on behalf of a member for health benefits. Also, the network management function and other functions performed by CareCentrix

are very important, but a smaller component of the agreement compared to the medical and equipment costs for rendering care. These other functions, e.g., quality, credentialing, etc., are also in other types of provider arrangements.

The Plan and BCBSA's position is also supported by litigation addressing subcontractor status in the context of the applicability of the federal nondiscrimination clauses. The U.S. Department of Labor, Administrative Review Board, established that providers to Blue Cross Blue Shield plans under the SBP, specifically CS1039, were not subcontractors because the prime contract is a contract for insurance and not for health care, such that the provider services are not necessary for performance of the contract. See *OFCCP v. Bridgeport Hospital*, ARB Case No. 00-034, 2003 OFCCP Lexis 3, WL 244810 (January 31, 2003) (in *UPMC Braddock et al., v. Harris*, No. 1:09-cv-01210 (D.D.C. Mar. 30, 2013) a different result was reached with respect to providers under FEHBP HMO plans, but the Court and OPM recognized and noted the distinctions between insurance contracts and HMO plan contracts). The Board's decision in the *Bridgeport Hospital* case broadly supports that CareCentrix is not a subcontractor under the FEHB program.

The FEHBAR expressly excludes "*providers of direct medical services or supplies pursuant to the Carrier's health benefits plan*" from the definition of subcontractor. 48 CFR § 1602.170-15. CareCentrix specifically provides the type of services that would qualify as "direct medical services or supplies" when taking into consideration other references in the FEHBAR, the Contract, and CareCentrix activities provided on behalf of its downstream providers and members under the SBP. Since neither "provider" nor "providers of direct medical services or supplies" are defined in the FEHBAR, the description of activities under the Large Provider Agreement definition are helpful in determining whether CareCentrix should be excluded from the subcontractor definition. The pertinent part of the definition describing the types of services covered by the Large Provider Agreement requirements is as follows:

A vendor of services or supplies such as mail order pharmacy services, pharmacy benefit management services, mental health and/or substance abuse management services, preferred provider organization services, utilization review services, and/or large case or disease management services. This representative list includes organizations that own or contract with direct providers of healthcare or supplies, or organizations that process claims or manage patient care. A hospital is not considered to be a vendor for purposes of this chapter. 48 CFR § 1602.170-16.

Although CareCentrix does not meet the Large Provider Agreement definition because it does not meet the magnitude requirements of the FEHBAR, CareCentrix is the type of provider OPM contemplated to be within the scope of the Large Provider Agreement rule changes. The description specifically includes "*preferred provider organization services*" and "*organizations that own or contract with direct providers of healthcare or supplies*" which would include CareCentrix. These entities are clearly carved out of the subcontractor definition and related subcontract requirements by way of inclusion in the Large Provider listed activities.

OPM included a list of providers under § 1602.170-16 of the FEHBAR that is broader than the narrow definition of "direct provider" put forward by OIG. In adopting and modifying the Federal Acquisition Regulation ("FAR") definition of subcontractor in 1987, OPM specifically excluded providers stating that it was "not OPM's intention to review the records of and approve those entities. The elimination of providers from the definition of 'subcontractor' enables OPM to apply the provisions of the subcontractor clause (1652.244-70) to contracts based on price analysis as

well as to those based on cost analysis.” 52 Fed. Reg. 16032, 16035 (May 1, 1987). OPM also noted that providers were not included in the definition of “subcontractor” and were not subject to the FEHBAR subcontracting provisions when discussing implementation of the Notice of Significant Events. Id. at 16036.

OPM confirmed that providers were not subcontractors, including preferred provider organizations and organizations that own and/or contract with direct providers of medical services and supplies, in comments to the subsequent final rule concerning Large Provider Agreements. OPM stated that:

Historically, we have not considered providers of healthcare services or supplies to be subcontractors, as the term is defined in the Federal Acquisition Regulation (FAR), because hundreds of thousands of such agreements between carriers and providers are in place, and until recently, the dollar value of each agreement was relatively small. However, the healthcare delivery system has changed and new large healthcare delivery entities now play a significant role in the industry. FEHB carriers now contract with these entities for services that represent a significant portion of individual carriers’ total costs charged to the FEHB Program, and in the aggregate represent a sizeable portion of overall Program costs. Because of the impact of these costs on the FEHB Program, we are expanding our oversight in this area. 70 Fed. Reg. 31374, 31375 (June 1, 2005).

In making the rule change, OPM specifically included provider organizations and organizations that own and/or contract with direct providers of medical services and supplies as entities falling under the Large Provider notice and information requirements. Id. at 31375, 31379.

Simply put, OPM did not consider providers as subcontractors so they were excluded by definition in 1987. When OPM sought to regulate other aspects of provider relationships for oversight purposes, OPM clarified what it thought was a provider by including a list of the types of providers and provider activities that would be covered by the new provider requirements for providers meeting certain magnitude thresholds. Those activities include the services provided by CareCentrix which are now questioned by OIG. The exclusion of providers as subcontractors remained intact and the remainder of the definition clearly does not apply to CareCentrix. These two rulemaking actions by OPM show that the OIG’s interpretation is inconsistent with the current regulatory scheme. The OIG’s conclusions disregard existing definitions in favor of non-existent ones and do not take into consideration the activities of CareCentrix under its contract with the Plan.

The way in which Plans are required to account for contract costs is also supportive of the Plan and BCBSA’s position with respect to CareCentrix. Pursuant to Contract § 3.2 and FEHBAR § 1652.216-71 (*Accounting and Allowable Cost*), a Plan must classify contract costs, absent specific contract terms to the contrary, as follows:

- (i) *Benefits. Benefit costs consist of payments made and liabilities incurred for **covered health care services on behalf of FEHBP subscribers** less any refunds, rebates, allowances or other credits received.*
- (ii) *Administrative expenses. Administrative expenses consist of all actual, allowable, allocable and reasonable expenses incurred in the **adjudication of subscriber benefit claims or incurred in the Carrier’s overall operation of the business**. Unless otherwise stated in the contract, administrative*

*expenses include, in part: all taxes (excluding premium taxes, as provided in section 1631.205-41), insurance and reinsurance premiums, medical and dental consultants used in the adjudication process, concurrent or managed care review **when not billed by a health care provider** and other forms of utilization review, the cost of maintaining eligibility files, legal expenses incurred in the litigation of benefit payments and bank charges for letters of credit. Administrative expenses exclude the cost of Carrier personnel, equipment, and facilities directly used in the delivery of health care services, which are benefit costs, and the expense of managing the FEHBP investment program which is a reduction of investment income earned. 48 C.F.R. § 1652.216-71 (emphasis added).*

The Plan's recording of the CareCentrix costs were correct since they fall within the benefit section as being incurred for covered health care services. The recording of those costs as benefit costs were also correct because they were not for the adjudication of claims nor related to the Plan's overall operation of its business. It is also notable that "concurrent or managed care review" costs are not considered administrative costs when billed by a health care provider.

The method of accounting for CareCentrix fees proposed by the OIG is not sufficiently consistent with the relevant contractual or regulatory authorities. Further, the summary of excess administrative costs as calculated by the OIG is not sufficiently based on actual data such that the Plan believes that it would be improper to certify to such expenses under the Contract and § 3.2 since they do not represent actual costs. The OIG's extrapolation does not take into consideration CareCentrix's cost structure or actual administrative costs.

CareCentrix Activities

The OIG based its conclusion in the report that CareCentrix is a TPA and not a provider since it "processes claims on behalf of the Plan" and "administers a provider network" which the Plan utilizes to provide care (benefits) to FEP members. The OIG's conclusion that CareCentrix processes claims on behalf of the Plan is inaccurate. CareCentrix does not process claims on behalf of the Plan. The adjudication of claims, *i.e.*, whether a claim is paid or denied, is done by the Plan.

CareCentrix's claims submission activities are, however, consistent with provider activities and not Plan functions. For example, CareCentrix performs several functions related to claims submission, including applying pre-submission clean claim edits, ensuring claim completeness, and assisting in the resolution of claims issues with the Plan. CareCentrix also collects member cost shares (a provider function) and ensures that downstream network providers are paid in full. These activities are consistent with provider administrative functions and not Plan administrative functions. By performing these services, downstream providers do not incur these costs and CareCentrix can manage related costs and negotiate lower rates for certain services. These are all functions that occur at hospitals, clinics, outpatient facilities, and professional practices; it is arbitrary for the OIG to treat the CareCentrix agreement differently without specific, applicable authority.

CareCentrix also provides services consistent with the provision of benefits under the SBP as a provider of direct medical services. CareCentrix arranges for covered home care services, including home skilled nursing and therapies, durable medical equipment, orthotics and prosthetics, and home infusion. CareCentrix facilitates inpatient hospital discharges by securing the appropriate downstream provider to deliver the requested services, coordinating dates of care, and coordinating

with hospitals regarding services. Similar patient staffing functions are done by CareCentrix for members in need of home care unrelated to a hospital discharge. These activities include coordinating care for FEP members by securing the appropriate downstream provider to deliver the requested services, coordinating dates of care, and coordinating with the referral source. These are all activities consistent with providing member benefits. The fact that these activities are provided, in the case of CareCentrix, by a provider that also provides network management is not a valid reason to treat CareCentrix benefit costs differently than those of other providers.

The OIG failed to consider that by providing support for the downstream providers in the network that the costs for providing benefits under the SBP are avoided at the rendering provider level, but are still incurred in providing benefits at the CareCentrix level. As noted above, this relieves the rendering provider from having to provide or procure additional support for these functions and allows CareCentrix to negotiate for better rates and control certain costs. CareCentrix does not actually charge a separate fee for these services since they are part of the contracted rates for the provision and coordination of care as they would be in other FFS arrangements.

As noted in the audit report, CareCentrix does provide and administer a network of downstream providers, which are available to FEP members. The network management services include contracting, monitoring of network providers, resolving network inquiries, and credentialing and re-credentialing in accordance with National Committee for Quality Assurance (“NCQA”) and URAC standards. CareCentrix monitors network quality, patient safety, and reliability and similarly monitors care coordination activities. The fact that some of these activities can also be performed by a Plan does not change the Plan’s position since these are activities performed by other types of providers and the network function is specifically included under the Large Provider listing of provider types, namely, “organizations that own or contract with direct providers of healthcare or supplies.” 48 CFR § 1602.170-16. Clearly, the benefits provided by CareCentrix go beyond TPA services and have been appropriately categorized and claimed by the Plan.

Based on the forgoing, the Plan and the BCBSA respectfully disagree with the interpretations and terms as applied by the OIG with respect to CareCentrix claims and the OIG’s Recommendation 1.

Deleted by the OIG – Not Relevant to the Final Report

For the aforementioned reasons, the Plan and the BCBSA respectfully disagree with the findings and recommendations in the Draft Audit Report. Thank you for this opportunity to respond to the recommendations included in this draft. If you have any questions, please contact me at [REDACTED] or [REDACTED] at [REDACTED].

Sincerely,

[REDACTED]

Managing Director, FEP Program Assurance
Cc: [REDACTED], OPM Contracting Officer



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