

US OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS

Final Audit Report

Subject:

AUDIT OF BLUECROSS BLUESHIELD OF ARKANSAS LITTLE ROCK, ARKANSAS

Report No. 1A-10-44-08-046

Date: February 25, 2009

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Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

AUDIT REPORT

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

BlueCross BlueShield of Arkansas
Plan Codes 020/520
Little Rock, Arkansas

REPORT NO. 1A-10-44-08-046

DATE: February 25, 2009

A handwritten signature in black ink, appearing to read "Michael R. Esser".

Michael R. Esser
Assistant Inspector General
for Audits



Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
BlueCross BlueShield Association
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Plan Codes 020/520
Little Rock, Arkansas

REPORT NO. 1A-10-44-08-046 DATE: February 25, 2009

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at BlueCross BlueShield of Arkansas (Plan) in Little Rock, Arkansas questions \$255,472 in health benefit charges. The BlueCross BlueShield Association (Association) agreed (**A**) with \$224,548 and disagreed (**D**) with \$30,924 of the questioned charges.

Our audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from 2005 through 2007, as well as miscellaneous payments and credits and administrative expenses from 2003 through 2007 as reported in the Annual Accounting Statements. In addition, we reviewed the Plan's cash management practices related to FEHBP funds for contract years 2003 through 2007.

Questioned items are summarized as follows:

HEALTH BENEFIT CHARGES

Claim Payments

- Omnibus Budget Reconciliation Act of 1990 Review \$131,555

The Plan incorrectly paid 26 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 pricing guidelines. Specifically, the Plan overpaid 21 claims by \$147,576 and underpaid 5 claims by \$16,021, resulting in net overcharges of \$131,555 to the FEHBP. The Association agreed with \$100,631 (A) and disagreed with \$30,924 (D) of the questioned charges.

- Claim Payment Errors (A) \$99,004

The Plan incorrectly paid 99 claims, resulting in overcharges of \$99,004 to the FEHBP.

Miscellaneous Payments and Credits

- Subrogation Recoveries (A) \$24,913

In one instance, the Plan did not return a subrogation recovery of \$9,862 to the FEHBP. Also, the Plan inadvertently increased a letter of credit (LOC) drawdown, instead of decreasing the drawdown, to return subrogation recoveries to the FEHBP, resulting in a drawdown error of \$9,983. As a result, the FEHBP is due \$24,913; consisting of \$9,862 for the subrogation recovery not returned to the FEHBP, \$9,983 for the LOC drawdown error, and \$5,068 for LII on these exceptions.

ADMINISTRATIVE EXPENSES

The audit disclosed no findings pertaining to administrative expenses. Overall, we concluded that the administrative expenses charged to the FEHBP were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable laws and regulations.

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 findings pertaining to cash management noted in the "Miscellaneous Payments and Credits" section.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

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

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 Center for Retirement and Insurance Services 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 63 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.

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.

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

All findings from our previous audit of the Plan (Report No. 1A-10-44-02-097, dated July 29, 2003) for contract years 1999 through 2001 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 October 10, 2008. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as the 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:

Health Benefit Charges

- To determine whether the Plan complied with contract provisions relative to benefit payments.
- 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.

SCOPE

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, 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 020 and 520 for contract years 2003 through 2007. During this period, the Plan paid approximately \$563 million in health benefit charges and \$36 million in administrative expenses (See Figure 1 and Schedule A).

Specifically, we reviewed approximately \$8 million in claim payments made from 2005 through 2007 for proper adjudication. In addition, we reviewed miscellaneous payments and credits, such as refunds and subrogation recoveries, administrative expenses, and cash management for 2003 through 2007.

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 operation. 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.

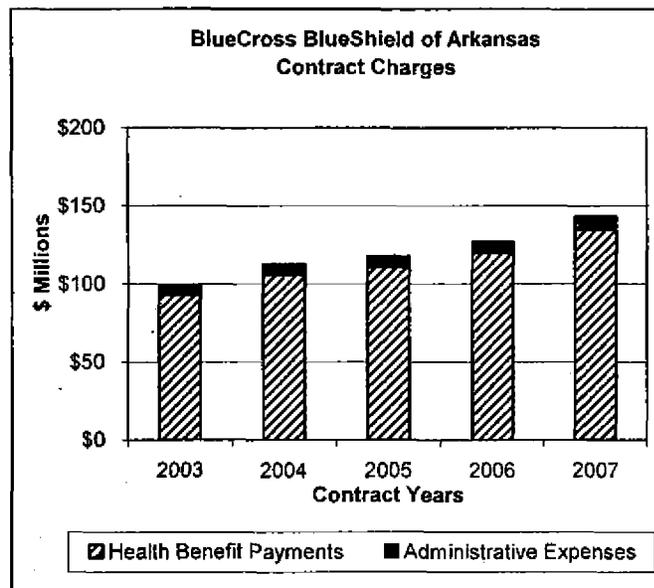


Figure 1 – Contract Charges

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, the FEP Operations Center, the Plan, and the Centers for Medicare and Medicaid Services. 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 Little Rock, Arkansas from August 4 through August 15, 2008 and September 15 through September 26, 2008. Audit fieldwork was also performed at our offices in Washington, D.C. and Jacksonville, Florida.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's claims processing, cost accounting, and financial systems by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 535 claims.² We used the FEHBP contract, the Service Benefit Plan brochure, the Plan's provider agreements, and the Association's FEP administrative manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous payments and credits. We also judgmentally selected and reviewed 59 health benefit refunds, totaling \$2,270,131 (from a universe of 8,875 refunds, totaling \$3,827,527); 50 subrogation recoveries, totaling \$1,920,719 (from a universe of 2,831 subrogation recoveries, totaling \$15,815,747); and 15 Special Plan Invoices, totaling \$1,634,447 in net payments (from a universe of 97 Special Plan Invoices, totaling \$4,815,982 in net payments) to determine if refunds and recoveries were promptly returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP. The results of these samples were not projected to the universe of miscellaneous payments and credits.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2003 through 2007. Specifically, we reviewed administrative expenses relating to cost centers, natural accounts, pension, post-retirement, employee health benefits, executive compensation, lobbying, non-recurring projects, and Health Insurance Portability and Accountability Act of 1996 compliance. We used the FEHBP contract, the FAR, and the FEHBPBAR to determine the allowability, allocability, and reasonableness of charges.

We also reviewed the Plan's cash management to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations.

² See the audit findings for "Omnibus Budget Reconciliation Act of 1990 Review" (A1.a) and "Claim Payment Errors" (A1.b) on pages 6 through 12 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT CHARGES

1. Claim Payments

a. Omnibus Budget Reconciliation Act of 1990 Review **\$131,555**

The Plan incorrectly paid 26 claims that were priced or potentially should have been priced under the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) pricing guidelines. Specifically, the Plan overpaid 21 claims by \$147,576 and underpaid 5 claims by \$16,021, resulting in net overcharges of \$131,555 to the FEHBP.

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." Part II, section 2.3(g) states, "If the Carrier or OPM determines that a Member's claim has been paid in error for any reason, the Carrier shall make a diligent effort to recover an overpayment"

OBRA 90 limits the benefit payments for certain inpatient hospital services provided to annuitants age 65 or older who are not covered under Medicare Part A. The FEHBP fee-for-service plans are required to limit the claim payment to the amount equivalent to the Medicare Part A payment.

Using a program developed by the Centers for Medicare and Medicaid Services (CMS) to price OBRA 90 claims, we recalculated the claim payment amounts for the claims in our samples that were subject to and/or processed as OBRA 90.

The following summarizes the claim payment errors.

OBRA 90 Claim Pricing Errors

For the period of 2005 through 2007, we identified 731 claims, totaling \$5,719,515 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 145 claims, totaling \$2,738,964 in payments, to determine if these claims were correctly priced by the FEP Operations Center and paid by the Plan. Our sample included all OBRA 90 claims with amounts paid of \$10,000 or more.

Based on our review, we determined that 16 claims were paid incorrectly, resulting in net overcharges of \$126,040 to the FEHBP. Specifically, the Plan overpaid 14 claims by \$139,316 and underpaid 2 claims by \$13,276.

The claim payment errors resulted from the following:

- The Plan inadvertently did not price eight claims under OBRA 90, resulting in overcharges of \$93,362 to the FEHBP.
- The FEP Operations Center priced seven claims using incorrect Medicare Diagnostic Related Group (DRG) codes. Consequently, the Plan overpaid five claims by \$39,318 and underpaid two claims by \$13,276, resulting in net overcharges of \$26,042 to the FEHBP.
- The Plan paid one claim using the incorrect local pricing amount, resulting in an overcharge of \$6,636 to the FEHBP.

Claims Not Priced Under OBRA 90 (Possible OBRA 90 Claims)

For the period of 2005 through 2007, we identified 126 claims, totaling \$187,791 in payments, that were potentially subject to OBRA 90 pricing guidelines but appeared to be priced under the Plan's standard pricing procedures. From this universe, we selected and reviewed a judgmental sample of 79 claims, totaling \$185,208 in payments, to determine if the Plan paid these claims properly. Our sample included all possible OBRA 90 claims with amounts paid of \$100 or more.

Based on this review, we determined that 10 claims were paid incorrectly, resulting in net overcharges of \$5,515 to the FEHBP. Specifically, the Plan overpaid seven claims by \$8,260 and underpaid three claims by \$2,745.

The claim payment errors resulted from the following:

- The Plan paid one claim using the incorrect billed charges, resulting in an overcharge of \$2,022 to the FEHBP.
- The Plan paid three claims using incorrect local pricing amounts, resulting in overcharges of \$1,907 to the FEHBP.
- The Plan inadvertently did not price six claims under OBRA 90, resulting in net overcharges of \$1,586 to the FEHBP. Specifically, the Plan overpaid three claims by \$4,331 and underpaid three claims by \$2,745.

Association's Response:

In response to the amount questioned in the draft report, the Association agrees with \$100,631 (\$95,116 + \$5,515) and disagrees with \$37,209 (\$30,924 + \$6,285) of the net overcharges. The Association states that the Plan has performed adjustments to correct the underpayments and initiated recovery efforts for the uncontested overpayments. The Association also states that these payments were good faith erroneous benefit

payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, lost investment income (LII) does not apply to the claim payment errors identified in this finding.

For the "OBRA 90 Claim Pricing Errors" finding, the Association states, "The Plan contests \$30,924 but does not contest \$95,116 in questioned costs. The questioned amount is contested because when the claims were re-processed with the FEP OBRA '90 Mainframe Pricer the new price was different than the price that was obtained by OPM OIG's use of the PC Pricer." Regarding the "Possible OBRA 90 Claims" finding, the Association states that the Plan does not contest \$5,515 in questioned costs.

In addition, the Association states, "To reduce these types of payment errors in the future, the FEP Director's Office has implemented the following corrective action plan:

- Identify all claims that were not OBRA '90 priced and provide to Plans for correction as part of the new FEP System-wide Claims review process.
- Modify FEP claims system to defer claims whenever a Plan indicates that a provider is not an approved provider. This will ensure that the Plan has submitted the proper information.
- Modify the FEP claims system to override Plan's indication of whether or not the Provider is a Medicare approved provider and validate the status through the FEP OBRA '90 software."

OIG Comments:

After reviewing the Association's response, we revised the amount questioned from the draft report to net overcharges of \$131,555. Based on the response, the Association agrees with \$100,631 and disagrees with \$30,924 of these net overcharges.

For the contested amount, the FEP Operations Center's OBRA 90 pricing amounts differed from the CMS Pricer amounts. Based on our experience with auditing BlueCross and BlueShield plans, we have found that these pricing differences occur because the mainframe pricing software used by the FEP Operations Center is not always up-to-date. Therefore, we will continue to use the latest version of the CMS Pricer program, which includes up-to-date pricing, to determine if claims paid under OBRA 90 were correctly priced by the FEP Operations Center and paid by the Plan.

Recommendation 1

We recommend that the contracting officer disallow \$147,576 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer allow the Plan to charge the FEHBP \$16,021 if additional payments are made to the providers to correct the underpayment errors.

Recommendation 3

Although the Association has developed a corrective action plan to reduce OBRA 90 findings, we recommend that the contracting officer instruct the Association to ensure that the Plan is following the corrective action plan.

b. Claim Payment Errors \$99,004

The Plan incorrectly paid 99 claims, resulting in overcharges of \$99,004 to the FEHBP.

As previously cited from Contract CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments.

The following summarizes the claim payment errors.

Amounts Paid Greater than Covered Charges

For the period of 2005 through 2007, we identified 188 claims where the amounts paid were greater than the covered charges by a total of \$71,860. From this universe, we selected and reviewed a judgmental sample of 46 claims with a total variance of \$68,698, and determined if the Plan paid these claims properly. Our sample included all claims where the amounts paid exceeded covered charges by \$100 or more. Based on our review, we identified 20 claim payment errors, resulting in overcharges of \$61,568 to the FEHBP.

The claim payment errors resulted from the following:

- The Plan inadvertently paid for unallowable incidental procedures on four claims, resulting in overcharges of \$34,226 to the FEHBP.
- The Plan paid five claims using incorrect allowances, resulting in overcharges of \$12,256 to the FEHBP.
- The Plan paid five claims without applying the provider discount, resulting in overcharges of \$7,491 to the FEHBP.

- The Plan made four duplicate claim payments, resulting in overcharges of \$6,472 to the FEHBP.
- The Plan inadvertently paid two claims incorrectly, resulting in overcharges of \$1,123 to the FEHBP. These overcharges were due to the Plan not pricing the claims in accordance with the provider contract, which required these claims to be paid at the lower of billed charges or contract allowance. In each instance, the Plan paid the claim at the higher amount (billed charges).

Assistant Surgeon Review

For the period 2005 through 2007, we identified 262 assistant surgeon claim groups, totaling \$70,085 in potential overpayments, that may not have been paid in accordance with the Plan's assistant surgeon pricing procedures. From this universe, we selected and reviewed a judgmental sample of 165 assistant surgeon claim groups, totaling \$65,698 in potential overpayments, to determine if the Plan paid these claims properly. Our sample included all assistant surgeon claim groups with potential overpayments of \$100 or more. The majority of these claim groupings contained one primary surgeon and one assistant surgeon claim. Based on our review, we determined that 74 claims were paid incorrectly, resulting in overcharges of \$29,798 to the FEHBP.

The claim payment errors resulted from the following:

- The Plan inadvertently priced 55 claims incorrectly, resulting in overcharges of \$20,833 to the FEHBP. These overcharges were due to a Plan system limitation that did not recognize the assistant surgeon modifier.
- The Plan incorrectly paid nine assistant surgeon claims that were subject to Omnibus Budget Reconciliation Act of 1993 (OBRA 93) pricing guidelines, resulting in overcharges of \$4,330 to the FEHBP. These errors were due to Palmetto (OBRA 93 pricing vendor) not recognizing the assistant surgeon pricing modifier and erroneously calculating the assistant surgeon allowance. The assistant surgeon allowance should have been priced at 16 percent of the primary surgeon's Medicare allowed amount.
- The Plan paid seven claims using incorrect allowances, resulting in overcharges of \$4,069 to the FEHBP.
- The Plan incorrectly paid one claim due to a processor inadvertently pricing incidental procedures, resulting in an overcharge of \$317 to the FEHBP.
- The Plan paid one claim without applying the assistant surgeon pricing percentage, resulting in an overcharge of \$218 to the FEHBP.

- Due to a billing error, the Plan priced one claim using an incorrect modifier, resulting in an overcharge of \$31 to the FEHBP.

System Review Overpayments

For health benefit claims incurred and reimbursed during the period January 1, 2007 through December 31, 2007, we identified 1,181,109 claim lines, totaling \$102,897,619 in payments, using a standard criteria based on our experience. From this universe, we judgmentally selected and reviewed a sample of 100 claims (representing 1,116 claim lines), totaling \$5,043,738 in payments, to determine if the Plan adjudicated these claims properly.³ Based on this review, we identified five claim payment errors, resulting in overcharges of \$7,638 to the FEHBP. In each instance, the Plan paid the claim using the incorrect allowance.

Association's Response:

The Association agrees with this finding. The Association states that the Plan has initiated recoveries for these claim overpayments. The Association also states that these payments were good faith erroneous benefit payments and fall within the context of CS 1039, Part II, section 2.3(g). Any payments the Plan is unable to recover are allowable charges to the FEHBP. As good faith erroneous payments, LII does not apply to these claim payment errors.

For the "Amounts Paid Greater than Covered Claims" finding, the Association states, "The incorrectly paid claims . . . were the result of Examiner error. . . . To reduce overpayments in the future, the Plan will provide additional training to claims examiner staff on a quarterly basis. The Plan also completes the FEPDO System-wide Claims Review (which includes a listing of Amounts Paid Greater than Charges Claims). These items combined should reduce payment errors of this nature in the future."

Regarding the "Assistant Surgeon Review" finding, the Association states, "The Plan reviewed the errors and determined that the errors were caused by a Local Plan system limitation that did not recognize the Assistant Surgeon Modifier. In addition, Examiner error contributed to this finding." The Association also states that the Plan implemented correction action to prevent these types of claim payment errors.

Regarding the "System Review Overpayments" finding, the Association states, "The Plan has reviewed the incorrectly paid claims and determined that the errors were the result of Examiner error. . . . To reduce overpayments in the future, the Plan will work with claims examiner staff to focus on specific issues noted from external audits and

³ We selected our sample from an OIG-generated "Place of Service Report" (SAS application) that stratified the claims by place of service (POS), such as provider's office, and payment category, such as \$50 to \$99.99. We judgmentally determined the number of sample items to select from each POS stratum based on the stratum's total claim dollars paid.

overpayment identification methods to minimize the likelihood of recurrence. The Plan employs several methods to identify overpayments.”

Recommendation 4

We recommend that the contracting officer disallow \$99,004 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 5

We recommend that the contracting officer instruct the Association to ensure that the Plan implemented and/or is implementing corrective actions to prevent these types of claim payment errors in the future.

2. Miscellaneous Payments and Credits

a. Subrogation Recoveries

\$24,913

The Plan did not return one subrogation recovery of \$9,862 to the FEHBP. Also, the Plan inadvertently increased a letter of credit (LOC) drawdown, instead of decreasing the drawdown, to return subrogation recoveries to the FEHBP, resulting in a drawdown error of \$9,983. As a result, the FEHBP is due \$24,913; consisting of \$9,862 for the subrogation recovery not returned to the FEHBP, \$9,983 for the LOC drawdown error, and \$5,068 for LII on these exceptions.

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.”

FEP Financial Policies and Procedures Bulletin Number 54, Refunds to FEP Letter of Credit Account, states: “A Plan receiving routine refunds is responsible for crediting the funds to the FEP Letter of Credit Account (LOCA) and investing the funds until the credit occurs. The Plan invests the refunds for the benefit of the FEHBP in the Plan’s dedicated FEP Investment Account. Plans may be liable for lost investment income if the funds are not invested or returned within 30 days of receipt. . . .”

Also, based on an agreement between OPM and the Association, dated March 26, 1999, BlueCross and BlueShield plans have 30 days to return refunds and recoveries to the FEHBP if received after March 31, 1999 before LII will be assessed.

48 CFR 1652.215-71(e) states that investment income lost on these funds must be credited to the FEHBP. In addition, section (f) of this regulation states, “All lost investment income payable shall bear simple interest at the quarterly rate determined by the Secretary of the Treasury”

For the period 2003 through 2007, we identified 2,831 subrogation recoveries totaling \$15,815,747. From this universe, we selected and reviewed a judgmental sample of 50 subrogation recoveries, totaling \$1,920,719, for the purpose of determining if the Plan promptly returned these recoveries to the FEHBP. Our sample included all subrogation recoveries of \$10,000 or more.

Based on our review, we noted the following exceptions:

- In one instance, the Plan did not return a subrogation recovery from 2003, totaling \$9,862, to the FEHBP.
- The Plan inadvertently increased the LOC drawdown on April 15, 2003, instead of decreasing the drawdown, to return subrogation recoveries to the FEHBP. As a result, the Plan overdrew \$9,983 from the LOC account.

In total, the Plan owes the FEHBP \$24,913; consisting of \$9,862 for the subrogation recovery not returned to the FEHBP, \$9,983 for the LOC drawdown error, and \$5,068 for LII on these exceptions. As part of this finding, we calculated LII through September 29, 2008 on these exceptions.

Association's Response:

The Association agrees with this finding. The Association states that the Plan submitted a Special Plan Invoice (SPI) to the FEP Director's Office for this audit finding and wire transferred \$24,944 to FEP on October 10, 2008. The SPI included additional LII of \$31.

Recommendation 6

We recommend that the contracting officer verify that the Plan credited the FEHBP \$19,845 (\$9,862 + \$9,983) for the subrogation recovery not returned and the LOC drawdown error.

Recommendation 7

We recommend that the contracting officer verify that the Plan credited the FEHBP \$5,068 (plus interest accruing after September 29, 2008) for LII on the subrogation recovery not returned to the FEHBP and the LOC drawdown error.

B. ADMINISTRATIVE EXPENSES

The audit disclosed no findings pertaining to administrative expenses. Overall, we concluded that the administrative expenses charged to the FEHBP were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable laws and regulations.

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 findings pertaining to cash management noted in the “Miscellaneous Payments and Credits” section.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experienced-Rated Audits Group

[REDACTED] Auditor-In-Charge

[REDACTED] Auditor

[REDACTED] Auditor

[REDACTED] Auditor

[REDACTED] Chief [REDACTED]

[REDACTED] Senior Team Leader

V. SCHEDULES
 BLUECROSS BLUESHIELD OF ARKANSAS
 LITTLE ROCK, ARKANSAS

CONTRACT CHARGES AND AMOUNTS QUESTIONED

CONTRACT CHARGES	2003	2004	2005	2006	2007	TOTAL	
A. HEALTH BENEFIT CHARGES							
PLAN CODE 020	\$50,727,046	\$57,254,559	\$58,262,200	\$62,607,507	\$70,560,848		\$299,412,160
MISCELLANEOUS PAYMENTS	375,702	360,551	348,154	1,413,432	2,032,668		4,530,507
PLAN CODE 520	41,662,319	48,132,780	51,980,000	55,362,816	62,327,308		259,465,223
MISCELLANEOUS PAYMENTS	0	0	0	0	0		0
TOTAL HEALTH BENEFIT CHARGES	\$92,765,067	\$105,747,890	\$110,590,354	\$119,383,755	\$134,920,824		\$563,407,890
B. ADMINISTRATIVE EXPENSES							
PLAN CODES 020/520	\$6,516,766	\$6,795,594	\$7,216,551	\$7,632,044	\$8,347,395		\$36,508,350
PRIOR PERIOD ADJUSTMENTS	0	0	(13,959)	0	0		(13,959)
TOTAL ADMINISTRATIVE EXPENSES	\$6,516,766	\$6,795,594	\$7,202,592	\$7,632,044	\$8,347,395		\$36,494,391
TOTAL CONTRACT CHARGES	\$99,281,833	\$112,543,484	\$117,792,946	\$127,015,799	\$143,268,219		\$599,902,281
AMOUNTS QUESTIONED (PER SCHEDULE B)							
A. HEALTH BENEFIT CHARGES	\$20,331	\$842	\$133,101	\$25,870	\$74,610	\$718	\$255,472
B. ADMINISTRATIVE EXPENSES	0	0	0	0	0	0	0
C. CASH MANAGEMENT	0	0	0	0	0	0	0
TOTAL QUESTIONED CHARGES	\$20,331	\$842	\$133,101	\$25,870	\$74,610	\$718	\$255,472

BLUECROSS BLUESHIELD OF ARKANSAS
LITTLE ROCK, ARKANSAS

QUESTIONED CHARGES

AUDIT FINDINGS	2003	2004	2005	2006	2007	2008	TOTAL
A. HEALTH BENEFIT CHARGES							
1. Claim Payments							
a. Omnibus Budget Reconciliation Act of 1990 Review	\$0	\$0	\$108,419	\$12,284	\$10,852	\$0	\$131,555
b. Claim Payment Errors	0	0	23,818	12,513	62,673	0	99,004
Total Claim Payments	\$0	\$0	\$132,237	\$24,797	\$73,525	\$0	\$230,559
2. Miscellaneous Payments and Credits							
a. Subrogation Recoveries	\$20,331	\$842	\$864	\$1,073	\$1,085	\$718	\$24,913
Total Miscellaneous Payments and Credits	\$20,331	\$842	\$864	\$1,073	\$1,085	\$718	\$24,913
TOTAL HEALTH BENEFIT CHARGES	\$20,331	\$842	\$133,101	\$25,870	\$74,610	\$718	\$255,472
B. ADMINISTRATIVE EXPENSES	\$0	\$0	\$0	\$0	\$0	\$0	\$0
C. CASH MANAGEMENT	\$0	\$0	\$0	\$0	\$0	\$0	\$0
TOTAL QUESTIONED CHARGES	\$20,331	\$842	\$133,101	\$25,870	\$74,610	\$718	\$255,472



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

December 9, 2008

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**Reference: OPM Draft Audit Report
Arkansas BlueCross BlueShield
Audit Report Number 1A-10-44-08-046
(Dated 10/10/2008 and received 10/10/2008)**

Dear [REDACTED]:

This is in response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report concerning Arkansas BlueCross BlueShield. Our comments concerning the findings in the report are as follows:

A. HEALTH BENEFIT CHARGES

1. Claim Payment Errors

a. Omnibus Budget Reconciliation Act of 1990 \$137,840

The Plan overpaid 23 claims for \$165,321 and underpaid 7 claims for \$27,481 for a net overpayment amount of \$137,840.

• Claims Not Priced Under OBRA '90 \$11,800

The Plan contests \$6,285 but does not contest that a net of \$5,515 in claim payments may have been paid in error. The questioned amount is contested based on the fact that four claims questioned in the sample are not subject to OBRA '90 pricing, since another insurance carrier was primary for three claims and one claim contained a mental health diagnosis.

Adjustments have been performed to correct the underpayments and recovery efforts have been initiated on the agreed overpayments.

• **OBRA 90 Claim Pricing Errors** **\$126,040**

The Plan contests \$30,924 but does not contest \$95,116 in questioned costs. The questioned amount is contested because when the claims were re-processed with the FEP OBRA '90 Mainframe Pricer the new price was different than the price that was obtained by OPM OIG's use of the PC Pricer.

Adjustments have been performed to correct the underpayments and recovery efforts have been initiated on the agreed overpayments.

To reduce these types of payment errors in the future, the FEP Director's Office implemented the following corrective action plan:

- Identify all claims that were not OBRA '90 priced and provide to Plans for correction as part of the new FEP System-wide Claims review process.
- Modify FEP claims system to defer claims whenever a Plan indicates that a provider is not an approved provider. This will ensure that the Plan has submitted the proper information.
- Modify the FEP claims system to override Plan's indication of whether or not the Provider is a Medicare approved provider and validate the status through the FEP OBRA '90 software.

The Plan also has several methods in place to identify overpayments. These methods include, but are not limited to the FEP System-wide Claim Review, COB and Duplicate claims reports provided by the FEP Director's Office, and routine audits performed by the Plan's internal claims staff. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith erroneous benefits payments, lost investment income does not apply to the payments identified in this finding.

b. Claim Payment Errors **\$99,004**

We do not contest the questioned claim overpayment amount totaling \$99,004 to the FEHBP.

• **Amount Paid Greater than Charges** **\$61,568**

The incorrectly paid claims for Amount Greater than Charges were the result of Examiner error. The Plan has initiated recovery on all overpayments and \$58,052 has been returned to the Program as of November 30, 2008. To reduce overpayments in the future, the Plan will provide additional training to claims examiner staff on a quarterly basis. The Plan also completes the FEPDO System-wide Claims Review (which includes a listing of Amount Paid Greater than Charges Claims). These items combined should reduce payment errors of this nature in the future.

• **Assistant Surgeon** **\$29,798**

We do not contest this finding. The Plan reviewed the errors and determined that the errors were caused by a Local Plan system limitation that did not recognize the Assistant Surgeon Modifier. In addition, Examiner error contributed to this finding. The Plan has initiated recovery on all overpayments.

The Plan implemented the following corrective action:

Corrective Action

The Plan's Local Claims System was modified through system configuration and edit changes to support proper processing of claims submitted with the AS modifier.

The Plan will complete the System-wide Claim Review Report provided by the FEPDO when it is received which includes assistant surgeon claims.

System Review Overpayments **\$7,638**

The Plan does not contest this finding. The Plan has reviewed the incorrectly paid claims and determined that the errors were the result of Examiner error. The Plan has initiated recovery on all overpayments.

To reduce overpayments in the future, the Plan will work with claims examiner staff to focus on specific issues noted from external audits and overpayment identification methods to minimize the likelihood of recurrence. The Plan employs several methods to identify overpayments. These methods include, but are not limited to the, FEP System-wide Claim Review, COB and Duplicate claims reports provided by the FEP Director's Office, and routine audits performed by the Plan's internal claims staff.

While these measures are not absolute, they provide reasonable assurances that such items will be identified. Accordingly, to the extent that errors did occur, the payments are good faith erroneous benefits payments and fall within the context of CS 1039, Section 2.3(g). Any benefit payments the Plan is unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income does not apply to the payments identified in this finding.

2. Miscellaneous Payments and Credits

a. Subrogation Recoveries

\$24,913

The Plan does not contest the questioned amount of \$24,913 related to Subrogation Recoveries. The Plan submitted a Special Plan Invoice to the FEP Director's Office and wired \$24,944 to FEP on October 10, 2008, which included additional lost investment income of \$31.

We appreciate the opportunity to provide our response to each of the findings and request that our comments be included in their entirety as part of the Final Audit Report.

Sincerely,

[REDACTED]

Executive Director
Program Integrity

[REDACTED]

cc:

[REDACTED]