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

Final Audit Report

Subject:

SUPPLEMENTAL REPORT ON THE AUDIT OF CAREFIRST BLUECROSS BLUESHIELD OWINGS MILLS, MARYLAND

Report No. 1A-10-85-14-011

Date: March 14, 2014

--CAUTION--

AUDIT REPORT

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

CareFirst BlueCross BlueShield
Washington, D.C. and Maryland Service Areas
Plan Codes 080/081/190/580/582/690
Owings Mills, Maryland

REPORT NO. 1A-10-85-14-011 DATE: 03/14/2014

Michael R. Esser
Assistant Inspector General
for Audits

--CAUTION--

EXECUTIVE SUMMARY

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This supplemental final report on the Federal Employees Health Benefits Program (FEHBP) operations at CareFirst BlueCross BlueShield (Plan), which specifically included the Washington, D.C. and Maryland Service Areas, questions $1,865,071 in health benefit charges. The BlueCross BlueShield Association (Association) and/or Plan agreed with $1,402,741 and disagreed with $462,330 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from June 2010 through February 2013 as reported in the Annual Accounting Statements.

The questioned health benefit charges are summarized as follows:

- **Bundle Pricing Error (System Error #2)** **$1,652,087**

  Based on our review of the bundle pricing processing error, we determined the Plan incorrectly paid 3,763 claims, resulting in net overcharges of $1,652,087 to the FEHBP. Specifically, the Plan overpaid 3,761 claims by $1,652,127 and underpaid 2 claims by $40.

- **Non-Covered Services (System Error #1 and #3)** **$212,984**

  Based on our review of the non-covered services processing errors, we identified the Plan incorrectly paid 273 claims, resulting in overcharges of $212,984 to the FEHBP.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This supplemental 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 CareFirst BlueCross BlueShield (Plan), pertaining to the Washington, D.C. and Maryland Service Areas. The Plan is located in Owings Mills, Maryland.

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 includes 2 of the 64 local BCBS plans participating in the FEHBP.

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

During our recent global audit of claims where the amounts paid exceeded covered charges (Report No.1A-99-00-13-003, dated November 22, 2013), we determined that CareFirst BCBS did not identify, review and/or adjust the claims that were potentially affected by three local system [redacted] processing errors and/or initiate recoveries for the actual overpayments. Due to the potential impact of these system errors, we requested the Plan to identify and/or review all FEP claims that were potentially processed and paid incorrectly.

We did not issue a draft audit report for this supplemental audit. However, we did communicate the results of this audit to the Plan in written audit inquiries and through a formal exit conference with the Plan and BCBS Association officials on February 21, 2014. The Plan's responses to our information requests and audit inquiries were considered in preparation of this final audit report.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

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

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 080, 081, 190, 580, 582, and 690 for contract years 2010 through 2012. During this period, the Plan paid approximately $5.2 billion in health benefit charges (See Schedule A).

The scope of this audit was limited to the review of claims paid for the [redacted] processing errors identified on the global amounts paid exceeded covered charges audit. For each claims system processing error, we identified the review period as the date [redacted] began processing claims incorrectly through the date the [redacted] system corrections were implemented. We reviewed the following claims for the scope of this audit:

- "System Error #1" - Outpatient claims paid from June 2010 through April 2012 that contained non-covered services.

- "System Error #2" - Outpatient claims paid from June 2010 through September 2012 that contained bundle pricing methods.

- "System Error #3" - Inpatient claims paid from June 2010 through February 2013 that contained non-covered services.

Using these search criteria, we identified 4,994 claims, totaling $8,345,822 in charges for "System Error #1"; 77,505 claims, totaling $185,936,084 in charges for "System Error #2"; and 841 claims, totaling $8,711,019 in charges for "System Error #3". In total, we identified 83,340 claims, totaling $202,992,925 in charges to the FEHBP, related to the [redacted] claims processing errors.

Due to the limited scope of this audit, we did not consider the Plan's internal control structure in planning and conducting our auditing procedures. For the areas selected for review, our audit approach consisted mainly of substantive tests of transactions and not tests of controls.

Therefore, 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 relative to claim payments. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Finding 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, and the Plan. 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. Through audits and a reconciliation process, we have verified the reliability of the claims data in 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, which was used to identify the universe of claims for each type of review. 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 our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from October 2013 through February 2014.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's claims processing system by inquiry of Plan officials.

To test the Plan's compliance with the FEHBP health benefit provisions related to the 3 [redacted] claims processing errors identified during our audit, we selected for review all 4,994 outpatient claims, totaling $8,345,822 in charges, related to "System Error #1" and all 841 inpatient claims, totaling $8,711,019 in charges, related to "System Error #3". Additionally, we selected for review all claims with amounts paid of $500 or more for "System Error #2". Our sample included 48,760 claims, totaling $175,631,104 in charges (out of 77,505 claims, totaling $185,936,084 in charges). In total, we selected for review 54,595 claims, totaling $192,687,945 in charges to the FEHBP.

The sample selections were submitted to the Plan for their review and response. We then conducted a limited review of the Plans' "paid incorrectly" responses and an expanded review of the Plan's "paid correctly" responses. Specifically, we verified the supporting documentation, the accuracy and completeness of the Plan's responses, determined if the claims were paid correctly, and/or calculated the appropriate questioned amounts for the claim payment errors.

We used the FEHBP contract, the 2010 through 2013 Service Benefit Plan brochures, 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.

these recoveries, by damaging the strength of the provider network and in the loss of substantial provider discounts. Accordingly, the Plan believes that allowing these charges ultimately benefits the FEHBP more than attempting to recover the overpayment and breaching the Plan's provider agreements.

On September 19, 2013, the Plan implemented a new procedure to identify potential claim payment errors after system corrections have been applied. The Plan states that this new procedure ensures that claim scans are conducted to identify potentially impacted claims, and that adjustments of claims are completed timely.

OIG Comments:

Based on our review of the Plan's response to our audit inquiries, the Plan agrees with $85,847 and disagrees with $127,137 of the questioned charges. For the $127,137 contested overpayments, the Plan agrees these claims were paid incorrectly. However, due to overpayment recovery time limitations with providers, the Plan states that these overpayments are uncollectible. Since these overpayments were identified as a result of our audit, we are continuing to question this amount in the final report. If the Plan had timely identified these overpayments when the errors were identified in March 2012 ("System Error #1") and October 2012 ("System Error #3"), the Plan's recovery efforts would have been within the applicable time limitations and the overpayments would have been recoverable.

Recommendation 5

We recommend that the contracting officer disallow $212,984 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 6

Although the Plan updated their post-installation standard operating procedures to identify, review, and/or adjust the claims that are impacted when system errors are identified and fixes are installed on the Plan's local claims processing system, we recommend that the contracting officer require the Plan to provide evidence or documentation supporting that the Plan's updated standard operating procedures are being implemented.

Recommendation 7

For the $127,137 in claim overpayments where the provider's contract deems the overpayments uncollectible due to time limitations, we recommend that the contracting officer require the Plan to repay these claim overpayments, as they did not make a prompt and diligent effort to recover these overpayments as specified in Contract CS 1039.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Information Systems Audits Group

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V. SCHEDULE A

CAREFIRST BLUECROSS BLUESHIELD
WASHINGTON, D.C. AND MARYLAND SERVICE AREAS

HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED

HEALTH BENEFIT CHARGES	2010	2011	2012	TOTAL
DC SERVICE AREA:				
PLAN CODES 80/81/580/582:	$928,393,362	$1,040,386,071	$1,154,308,259	$3,123,087,692
MISCELLANEOUS PAYMENTS	8,843,947	8,632,091	8,634,028	26,110,066
TOTAL	$937,237,309	$1,049,018,162	$1,162,942,287	$3,149,197,758
MARYLAND SERVICE AREA				
PLAN CODES 190/690:	616,648,774	666,917,203	707,633,614	1,991,199,591
MISCELLANEOUS PAYMENTS	6,245,258	6,729,869	6,950,914	19,926,041
TOTAL	$622,894,032	$673,647,072	$714,584,528	$2,011,125,632
TOTAL HEALTH BENEFIT CHARGES	$1,560,131,341	$1,722,665,234	$1,877,526,815	$5,160,323,390

AMOUNTS QUESTIONED	2010	2011	2012	TOTAL
1. IMPROPER BUNDLED PRICING (SYSTEM ERROR #2)	74,365	596,239	981,483	1,652,087
2. NON-COVERED SERVICES (SYSTEM ERROR #1 AND #3)	$60,962	$101,021	$51,001	$212,984
TOTAL QUESTIONED CHARGES	$135,327	$697,260	$1,032,484	$1,865,071

*** We did not review the miscellaneous payments and credits on this audit.**