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

Final Audit Report

Subject:

AUDIT OF CAPITAL BLUECROSS HARRISBURG, PENNSYLVANIA

Report No. 1A-10-36-08-043

Date: February 5, 2009

--CAUTION--

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

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

Capital BlueCross
Plan Code 361
Harrisburg, Pennsylvania

REPORT NO. 1A-10-36-08-043 DATE: February 5, 2009

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Assistant Inspector General
for Audits

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
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EXECUTIVE SUMMARY

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This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations at Capital BlueCross (Plan) in Harrisburg, Pennsylvania questions $24,259 in health benefit charges. The BlueCross BlueShield Association (Association) agreed *(A)* with $12,160 and disagreed *(D)* with $12,099 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered claim payments from 2005 through 2007 as reported in the Annual Accounting Statements.

Questioned health benefit charges are summarized as follows:

- **Omnibus Budget Reconciliation Act of 1990 Review** **$19,700**

  The Plan incorrectly paid two claims, resulting in overcharges of $19,700 to the FEHBP. The Association agreed with $12,160 *(A)* and disagreed with $7,540 *(D)* of the questioned charges.

- **Claim Payment Errors *(D)*** **$4,559**

  The Plan incorrectly paid six claims, resulting in overcharges of $4,559 to the FEHBP.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

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

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

BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's 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 (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.

All findings from our previous audit of the Plan (Report No. 1A-10-36-02-031, dated November 25, 2002) for contract years 1998 through 2000 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 3, 2008. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objectives were 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 code 361 for contract years 2005 through 2007. During this period, the Plan paid approximately $244 million in health benefit charges (See Schedule A). Specifically, we reviewed approximately $9 million in claim payments made from 2005 through 2007 for proper adjudication.

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.

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, 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 Harrisburg, Pennsylvania from August 13 through August 15, 2008. Audit fieldwork was also performed at our office in Cranberry Township, Pennsylvania.

METHODOLOGY

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

To test the Plan's compliance with the FEHBP health benefit provisions, we selected and reviewed samples of 403 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.

[2] See the audit findings for "Omnibus Budget Reconciliation Act of 1990 Review" (A1) and "Claim Payment Errors" (A2) on pages 5 through 10 for specific details of our sample selection methodologies.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. HEALTH BENEFIT CHARGES

1. Omnibus Budget Reconciliation Act of 1990 Review — $19,700

The Plan incorrectly paid two claims, resulting in overcharges of $19,700 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 . . . ."

The 2007 BlueCross and BlueShield (BCBS) Service Benefit Plan brochure, section 10, states, "Our allowance . . . is the negotiated amount that Preferred providers . . . have agreed to accept as payment in full . . . ."

The Omnibus Budget Reconciliation Act of 1990 (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 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.

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

For the period 2005 through 2007, we identified 1,288 claims, totaling $463,018 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 24 claims, totaling $238,592 in payments, to determine if the Plan paid these claims properly. Our sample included all possible OBRA 90 claims with amounts paid of $5,000 or more.

Based on our review, we determined that one claim was not subject to OBRA 90 pricing but contained a Plan pricing error, resulting in an overcharge of $17,620 to the FEHBP. The error was due to an examiner oversight causing the claim to be priced at billed charges rather than the applicable per diem amount.

OBRA 90 Claims

For the period 2005 through 2007, we identified 1,303 claims, totaling $10,467,115 in payments, that were subject to OBRA 90 pricing guidelines. From this universe, we selected and reviewed a judgmental sample of 121 claims, totaling $3,128,911 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 $15,000 or more.

Based on our review, we determined that one claim was not subject to OBRA 90 pricing but contained a pricing variance, resulting in an overcharge of $2,080 to the FEHBP. This overcharge was due to the Plan pricing a claim, which was incurred in 2005, with a 2006 per diem rate of $1,541 rather than the 2005 per diem rate of $1,476. Refer to audit finding A2 of this report for additional details regarding this Plan pricing issue.

Association's Response:

The Association agrees with $12,160 and disagrees with $7,540. The Association 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 does not apply to the claim payment errors identified in this finding.

For the claim overpayment questioned under the "Claims Not Priced Under OBRA 90" review, the Association agrees with $12,160 and disagrees with $5,460. The Association states that the repricing of the claim showed an overpayment amount of $12,160 instead of the questioned amount of $17,620. For the claim overpayment questioned under the "OBRA 90 Claim" review, the Association disagrees with the entire questioned amount of $2,080.

In reference to the total contested amount, the Association states, "Claims were priced properly based on the setup and configuration of the Legacy system, which had been used by Capital Blue Cross (CBC) to pay facility claims for over 20 years. . . . Within the Legacy system, pricing is based on either a 'claims priced on or after' or 'admissions on or after' basis. Facilities using interim percentage rate arrangements will use a 'claims priced on or after' rate screen and providers using contract rates will reflect an 'admissions on or after' rate screen. For claims processed using 'admissions on or after' rates, the pricing is dependent on both the admission date and the pricing/paid date. With this screen there is a 60-day or '2-month' run out for the processing of claims incurred in the previous period, but not paid until the next period. If a prior period claim is processed after the run out period, the claim is processed at the current year rate. Providers are aware of and accept this pricing methodology."

The Association also states, "Further validation of the effectiveness of the Plan's system of internal controls over the process is evidenced by a low volume of errors (1 out of 355 or .3%) identified during this audit. Because the error was due to examiner oversight, follow up training and counseling will be provided.

In addition, the Plan has several methods in place to identify overpayments. These methods include, but are not limited to the System Wide Claims Reports; COB claims reports and Duplicate claims reports provided by the FEP Director's Office and routine claims quality assurance audits performed by the Plan's Internal Auditors. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary."

OIG Comments:

For the claim overpayment questioned under our "Claims Not Priced Under OBRA 90" review, we will continue to question $17,620. Our overpayment amount is different from the Plan's overpayment amount because the Plan repriced the claim, which was incurred in 2003, with a 2007 per diem rate of $1,050 rather than the applicable 2003 per diem rate of $630.

For the claim overpayment questioned under our "OBRA 90 Claims" review, we will continue to question $2,080. As we previously stated, this overpayment resulted from the Plan pricing a claim, which was incurred in 2005, with a 2006 per diem rate of $1,541 rather than the applicable 2005 per diem rate of $1,476.

We will continue to question the above claim overpayments using the effective contract rates as stated within the provider agreements. Furthermore, when providers negotiate new contract period rates that are greater than prior contract period rates, the FEHBP and its subscribers are adversely affected by the "two-month run out". Based on our experience with auditing other BCBS plans, we have found that this "two-month run out" is not common practice.

Also, as previously cited, the 2007 benefit plan brochure states that the Plan allowance is the negotiated amount that prefered providers have agreed to accept as payment. The Plan's provider agreements do not address a "two-month run out" for prior period contract rates. Therefore, when claims with dates of service for a prior contract period are priced with the new contract period's rates, the Plan's allowances do not reflect the negotiated amounts stated within the provider agreements.

Recommendation 1

We recommend that the contracting officer disallow $19,700 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

2. Claim Payment Errors — $4,559

The Plan incorrectly paid six claims, resulting in overcharges of $4,559 to the FEHBP.

As previously cited from 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. Also, the 2007 BCBS Service Benefit Plan brochure states that the Plan allowance is the negotiated amount that preferred providers have agreed to accept as payment in full.

The following summarizes the claim payment errors.

System Review

For health benefit claims reimbursed during the period January 1, 2007 through December 31, 2007, we identified 463,376 claim lines, totaling $82,547,157 in payments, using a standard criteria based on our audit experience. From this universe, we selected and reviewed a judgmental sample of 100 claims (representing 1,637 claim lines), totaling $4,384,891 in payments, to determine if the Plan adjudicated these claims properly.[3] Based on our review, we determined that one claim was paid incorrectly, resulting in an overcharge of $2,312 to the FEHBP. This overcharge was due to the Plan pricing a claim, which was incurred in 2006, with a 2007 per diem rate of $1,609 rather than the 2006 per diem rate of $1,541.

Both rates were correctly loaded into the Plan's Legacy claims processing system; however, the Plan programmed its claims system to exercise a "two-month run out" period for contract rates. Specifically, when new contract rates were entered into the Legacy system, the old contract rates would only be used to price claims for an additional two months after the contract rates were terminated. After the two months, a claim with dates of service for the prior contract period would be priced with the new contract period's rates. The Plan utilized this approach with all providers that were reimbursed based on admission dates rather than process date.

Because the Plan's Legacy claims processing system incorrectly applied a "two-month run out" for contract rates, we requested that the Plan identify all claims that were potentially associated with this "two-month run out" issue, and determine if the claims were priced and paid according to provider contract rates effective for each claim's admission date. Due to the voluminous claims data, the Plan submitted a listing of its top 10 FEP providers. From this listing, we selected the top two providers, Pinnacle and Reading Hospitals, for review.

[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.

We selected and reviewed an additional sample of 48 claims, totaling $534,384 in payments, to determine if the Plan paid these claims properly. Our sample included all claims with amounts paid of $1,000 or more. Based on our review, we determined that five of these claims were paid incorrectly, resulting in additional overcharges of $2,247 to the FEHBP. These overcharges were due to the Plan programming its claims system to exercise a "two-month run out" period for contract rates.

On June 1, 2008, the Plan changed its claims system to Facets, which does not apply the "two-month run out" period for contract rates. Therefore, this issue will not affect future FEHBP claims.

Amounts Paid Greater than Covered Charges

For the period 2005 through 2007, we identified 1,908 claims where the amounts paid were greater than the covered charges by a total of $725,825. From this universe, we selected and reviewed a judgmental sample of 110 claims with a total variance of $484,739, and determined if the Plan paid these claims properly. Our sample included all claims where the amounts paid exceeded covered charges by $2,000 or more. We identified immaterial claim payment errors, which are not being questioned.

Association's Response:

The Association disagrees with this finding.

In response to the questioned amount of $2,312 in the draft report, the Association states, "The claim was priced properly based on the setup and configuration of the Legacy system, which had been used by Capital Blue Cross (CBC) to pay facility claims for over 20 years. . . . Within the Legacy system, pricing is based on either a 'claims priced on or after' or 'admissions on or after' basis. Facilities using interim percentage rate arrangements will use a 'claims priced on or after' rate screen and providers using contract rates will reflect an 'admissions on or after' rate screen. For claims processed using 'admissions on or after' rates, the pricing is dependent on both the admission date and the pricing/paid date. With this screen there is a 60-day or '2-month' run out for the processing of claims incurred in the previous period, but not paid until the next period. If a prior period claim is processed after the run out period, the claim is processed at the current year rate. Providers are aware of and accept this pricing methodology."

In response to the expanded sample, the Association states, "The result of the expanded review continues to support the Plans method of claims payment . . . For claims processed using 'admissions on or after' rates, the pricing is dependent on both the admission date and the pricing/paid date. With this screen there is a 60-day or '2-month' run out for the processing of claims incurred in the previous period, but not paid until the next period. If a prior period claim is processed after the run out period, the claim is processed at the current year rate. Providers are aware of and accepted this pricing methodology."

OIG Comments:

We will continue to question the overcharge of $2,312 from the draft report, as well as the overcharges of $2,247 identified in the expanded sample. Also, we will continue to use the effective contract rates, as stated within the provider agreements, as the basis for determing these overcharges. Furthermore, when providers negotiate new contract period rates that are greater than the prior contract period rates, the FEHBP and its subscribers are adversely affected by the "two-month run out" period. Based on our experience with auditing other BCBS plans, we have found that this "two-month run out" period is not common practice.

Also, as previously cited, the 2007 benefit brochure states that the Plan allowance is the negotiated amount that preferred providers have agreed to accept as payment. The Plan's provider agreements do not mention a "two-month run out" for prior period contract rates. Therefore, when claims with dates of service for a prior contract period are priced with the new contract period's rates, the Plan's allowances do not reflect the negotiated amounts stated within the provider agreements.

Recommendation 2

We recommend that the contracting officer disallow $4,559 in claim overcharges, and verify that the Plan returns all amounts recovered to the FEHBP.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Experience-Rated Audits Group

[redacted], Auditor-In-Charge

[redacted] Auditor

[redacted] Chief [redacted]

[redacted], Senior Team Leader

V. SCHEDULE A

CAPITAL BLUECROSS
HARRISBURG, PENNSYLVANIA

HEALTH BENEFIT CHARGES AND AMOUNTS QUESTIONED

HEALTH BENEFIT CHARGES	2005	2006	2007	TOTAL
PLAN CODE 361	$69,116,336	$79,344,737	$94,285,626	$242,746,699
MISCELLANEOUS PAYMENTS	(265,081)	194,440	1,105,537	1,034,896
TOTAL HEALTH BENEFIT CHARGES	$68,851,255	$79,539,177	$95,391,163	$243,781,595

AMOUNTS QUESTIONED	2005	2006	2007	TOTAL
1. OMNIBUS BUDGET RECONCILIATION ACT OF 1990 REVIEW	$0	$2,080	$17,620	$19,700
2. CLAIM PAYMENT ERRORS	0	1,777	2,782	4,559
TOTAL AMOUNTS QUESTIONED	$0	$3,857	$20,402	$24,259

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

December 3, 2008 (Revised 12/15/08)

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Reference: **OPM DRAFT AUDIT REPORT**
Capital Blue Cross
Audit Report Number 1A-10-53-08-045
(Dated and received October 3, 2008)

Dear [redacted]:

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) operations for Capital Blue Cross. Our comments concerning the findings in the report are as follows:

B. HEALTH BENEFIT CHARGES

1. Omnibus Budget Reconciliation Act of 1990 $19,700

The Plan contests $7,540 of questioned costs but does not contest that $12,160 may have been paid in error. One claim (Claim Sample # 24), in the amount of $17,620 was questioned as a possible OBRA '90 claim payment error. The Plan agrees that the claim was paid in error but does not agree with the amount questioned. The re-pricing of the claim showed an overpayment amount of $12,160 instead of the OPM questioned amount of $17,620. Therefore, the Plan agrees that $12,160 of this claim was overpaid but contests the remaining balance of $5,460. The Plan stated that the claim overpayment was caused by a manual error. Additionally, the Plan contests the entire $2,080 for Claim Sample Number 25 from the OBRA '90 Claims Pricing Errors listing.

In reference to the total contested amount, the Plan stated that, "Claims were priced properly based on the setup and configuration of the Legacy system, which had been used by Capital Blue Cross (CBC) to pay facility claims for over 20 years." The Plan further stated that, "Within the Legacy system, pricing is based on either a 'claims priced on or after' or 'admissions on or

after' basis. Facilities using interim percentage rate arrangements will use a 'claims priced on or after' rate screen and providers using contract rates will reflect an 'admissions on or after' rate screen. For claims processed using 'admissions on or after' rates, the pricing is dependent on both the admission date and the pricing/paid date. With this screen there is a 60-day or '2-month' run out for the processing of claims incurred in the previous period, but not paid until the next period. If a prior period claim is processed after the run out period, the claim is processed at the current year rate. Providers are aware of and accept this pricing methodology."

Further validation of the effectiveness of the Plan's system of internal controls over the process is evidenced by a low volume of errors (1 out of 355 or .3%) identified during this audit. Because the error was due to examiner oversight, follow up training and counseling will be provided.

In addition, the Plan has several methods in place to identify overpayments. These methods include, but are not limited to the System Wide Claims Reports; COB claims reports and Duplicate claims reports provided by the FEP Director's Office and routine claims quality assurance audits performed by the Plan's Internal Auditors. While these measures are not absolute, they provide reasonable assurances that such items will be identified. Efforts will be made to periodically examine existing procedures and add additional controls where necessary. 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. System Review **$2,312**

The Plan contests the entire amount of Claim Sample # 94 in the amount of $2,312. The Plan stated that, "The claim was priced properly based on the setup and configuration of the Legacy system, which had been used by Capital Blue Cross (CBC) to pay facility claims for over 20 years." The Plan further stated that, "Within the Legacy system, pricing is based on either a 'claims priced on or after' or 'admissions on or after' basis. Facilities using interim percentage rate arrangements will use a 'claims priced on or after' rate screen and providers using contract rates will reflect an 'admissions on or after' rate screen. For claims processed using 'admissions on or after' rates, the pricing is dependent on both the admission date and the pricing/paid date. With this screen there is a 60-day or '2-month' run out for the processing of claims incurred in the previous period, but not paid until the next period. If a

prior period claim is processed after the run out period, the claim is processed at the current year rate. Providers are aware of and accept this pricing methodology."

Expanded System Review

The Plan was instructed to identify all claims paid from January 1, 2005 through May 31, 2008 that were potentially associated with the "two-month run out" issue and determine if the claims were priced and paid according to provider contract rates effective for each claim's admission date. The result of the expanded review continues to support the Plans method of claims payment (Attachment A). For claims processed using 'admissions on or after' rates, the pricing is dependent on both the admission date and the pricing/paid date. With this screen there is a 60-day or '2-month' run out for the processing of claims incurred in the previous period, but not paid until the next period. If a prior period claim is processed after the run out period, the claim is processed at the current year rate. Providers are aware of and accept this pricing methodology."

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.

[redacted]

Executive Director
Program Integrity

[redacted]

cc: [redacted]