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

Final Audit Report

Subject:

AUDIT ON GLOBAL CLAIMS-TO-ENROLLMENT MATCH FOR BLUECROSS AND BLUESHIELD PLANS

Report No. 1A-99-00-10-061

Date: September 8, 2011

--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

Global Claims-to-Enrollment Match
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-10-061 DATE: September 8, 2011

Michael R. Esser
Assistant Inspector General
for Audits

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

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EXECUTIVE SUMMARY

Federal Employees Health Benefits Program
Service Benefit Plan Contract CS 1039
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Global Claims-to-Enrollment Match
BlueCross and BlueShield Plans

REPORT NO. 1A-99-00-10-061 DATE: September 8, 2011

This final audit report on the Federal Employees Health Benefits Program (FEHBP) operations for all BlueCross and BlueShield (BCBS) plans questions $4,956,611 in health benefit charges. The BlueCross BlueShield Association (Association) and/or BCBS plans agreed with $3,189,414 and disagreed with $1,767,197 of the questioned charges.

Our limited scope audit was conducted in accordance with Government Auditing Standards. The audit covered health benefit payments from July 1, 2008 through September 30, 2010 as reported in the Annual Accounting Statements. Specifically, we reviewed claims paid from July 1, 2008 through September 30, 2010 that were potentially incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the BCBS Service Benefit Plan. We determined that the BCBS plans paid 23,244 claim lines that were incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage, resulting in overcharges of $4,956,611 to the FEHBP. These claims were paid for ineligible patients.

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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 all BlueCross and BlueShield (BCBS) plans.

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 BCBS 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 BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. There are approximately 63 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 BCBS plans, and OPM.

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

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

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

Findings from our previous global claims-to-enrollment match audit of all BCBS plans (Report No. 1A-99-00-08-065, dated June 23, 2009) for contract years 2005 through June 30, 2008 are in the process of being resolved.

Our preliminary results of the potential health benefit overcharges were presented in detail in a draft report, dated November 5, 2010. 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. Also, additional documentation provided by the Association and BCBS plans on various dates through June 27, 2011 was considered in preparing our final report.

II. OBJECTIVE, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of this audit was to determine whether the BCBS plans complied with contract provisions relative to patient enrollment eligibility.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

The audit covered health benefit payments from July 1, 2008 through September 30, 2010 as reported in the Annual Accounting Statements. Specifically, we reviewed claims paid from July 1, 2008 through September 30, 2010 that were potentially incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the BCBS Service Benefit Plan. Based on our claim error reports, we identified 112,328 claim lines, totaling $14,280,162 in payments, for 14,891 patients that were potentially incurred during gaps in patient coverage or after termination of patient coverage. From this universe of 14,891 patients, we selected and reviewed all patients with cumulative claim line payments of $2,500 or more. Our sample included 42,919 claim lines, totaling $10,865,500 in payments, for 884 patients. In addition, we identified 16,445 claim lines, totaling $2,121,428 in payments, for 1,076 patients that were potentially incurred when no patient enrollment records existed. From this universe of 1,076 patients, we selected and reviewed all patients with cumulative claim line payments of $2,500 or more. This sample included 9,382 claim lines, totaling $1,739,164 in payments, for 150 patients.

We did not consider each BCBS plan's internal control structure in planning and conducting our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Therefore, we do not express an opinion on each BCBS plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the BCBS plans had complied with the contract and the laws and regulations governing the FEHBP as they relate to patient enrollment eligibility. The results of our tests indicate that, with respect to the items tested, the BCBS plans did not fully comply with the provisions of the contract relative to patient enrollment eligibility. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Finding and Recommendations" section of this report. With respect to the items not tested, nothing came to our attention that caused us to believe that the BCBS plans 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 BCBS plans. 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 objective.

The audit was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida from March 2011 through July 2011.

METHODOLOGY

To test each BCBS plan's compliance with the FEHBP health benefit provisions related to patient enrollment eligibility, we selected all potential ineligible patients with cumulative claim line payments of $2,500 or more that were identified in computer searches. Specifically, we selected for review 42,919 claim lines, totaling $10,865,500 in payments, for 884 patients (from a universe of 112,328 claim lines, totaling $14,280,162 in payments, for 14,891 patients) that were potentially incurred during gaps in patient coverage or after termination of patient coverage with the BCBS Service Benefit Plan. Additionally, we selected for review 9,382 claim lines, totaling $1,739,164 in payments, for 150 patients (from a universe of 16,445 claim lines, totaling $2,121,428 in payments, for 1,076 patients) that were potentially incurred when no patient enrollment records existed. (See Schedule A for a summary of our sample selections by BCBS plan)

The claim samples were submitted to each applicable BCBS plan for their review and response. For each plan, we then conducted a limited review of their agreed responses and an expanded review of the disagreed responses to determine the appropriate questioned amount. We did not project the sample results to the universe of claims that were paid for potentially ineligible patients.

The determination of the questioned amount is based on the FEHBP contract, the Service Benefit Plan brochure, and the Association's FEP administrative manual.

III. AUDIT FINDING AND RECOMMENDATIONS

Claims Paid for Ineligible Patients **$4,956,611**

The BCBS plans paid 23,244 claim lines that were incurred when no patient enrollment records existed, during gaps in patient coverage, or after termination of patient coverage with the BCBS Service Benefit Plan, resulting in overcharges of $4,956,611 to the FEHBP. These claims were paid for ineligible patients.

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 following summarizes the results:

Enrollee Coverage Conflicts with Dates of Service

For the period July 1, 2008 through September 30, 2010, we performed a computer search to identify claims paid that were potentially incurred during gaps in patient coverage or after termination of patient coverage with the BCBS Service Benefit Plan. We identified 112,328 claim lines, totaling $14,280,162 in payments, for 14,891 patients that met this search criteria. Our search criteria took into consideration the 31-day grace period of temporary continuing coverage following termination of eligibility.

From this universe of 14,891 patients, we selected all patients with cumulative claim line payments of $2,500 or more to review. Our sample included 42,919 claim lines, totaling $10,865,500 in payments, for 884 patients (See Schedule A for a summary of our sample by BCBS plan). Based on our review, we determined that 20,443 claim lines, totaling $4,476,890 in payments, were paid for ineligible patients.[2]

Our audit disclosed the following for these questioned claim line payments:

- For 17,448 of the claim lines questioned, the members' enrollment data records that identified the patients' eligibility status in the FEP national claims system (FEP Direct System) were incorrect when the claims were paid. However, after receiving the patients' updated enrollment data, the BCBS plans did not review and/or adjust these claims that were incurred after the patients' termination dates of coverage. For these 17,448 claim lines, the enrollment data errors were identified on the members' rosters or the members' termination notices, which were received from the federal payroll offices, after the claims were already

[2] In addition, there were 5,745 claim lines, totaling $1,138,207 in payments, with eligibility errors that were identified by the BCBS plans before the start of our audit (i.e., November 5, 2010) and adjusted or voided by the Association's original response due date (i.e., January 7, 2011) to the draft report. Since these eligibility errors were identified by the BCBS plans before the start of our audit and adjusted or voided by the Association's original response due date to the draft report, we did not question these claim line payments in the final report.

paid. As a result, the FEHBP was overcharged $3,836,264 in claim payments for patients that were not eligible for benefits.

- For 2,111 of the claim lines questioned, the BCBS plans incorrectly paid these claim lines due to manual processing errors. As a result, the FEHBP was overcharged $469,879 in claim payments for patients that were not eligible for benefits.

- For 884 of the claim lines questioned, the members' enrollment data specifically noted the patients' eligibility status as terminated in the FEP Direct System when the claims were incurred; however, the FEP Direct System inadvertently allowed these claims to be paid. Specifically, the claim payment errors resulted from the FEP Direct System allowing these claims to bypass enrollment system edits or the BCBS plans' processors incorrectly applying override codes. As a result, the FEHBP was overcharged $170,747 in claim payments for patients that were not eligible for benefits.

Of the $4,476,890 in questioned charges, $1,256,591 (28 percent) was identified by the BCBS plans before the start of our audit (i.e., November 5, 2011). However, since the BCBS plans had not completed the recovery process and/or adjusted or voided these claims by the Association's original response due date (i.e., January 7, 2011) to the draft report, we are continuing to question these overcharges. The remaining questioned charges of $3,220,299 (72 percent) were identified as a result of our audit.

Patients with No Enrollment Records

For the period July 1, 2008 through September 30, 2010, we performed a computer search to identify claims paid that were potentially incurred when no patient enrollment records existed. We identified 16,445 claim lines, totaling $2,121,428 in payments, for 1,076 patients that met this search criteria. Our search criteria took into consideration the 31-day grace period of temporary continuing coverage following termination of eligibility.

From this universe of 1,076 patients, we selected all patients with cumulative claim line payments of $2,500 or more to review. Our sample included 9,382 claim lines, totaling $1,739,164 in payments, for 150 patients (See Schedule A for a summary of our sample by BCBS plan). Based on our review, we determined that 2,801 claim lines, totaling $479,721 in payments, were paid for ineligible patients.

Our audit disclosed the following for these questioned claim line payments:

- For 1,397 of the claim lines questioned, the members' enrollment data specifically noted the patients' eligibility status as terminated in the FEP Direct System when the claims were incurred; however, the FEP Direct System inadvertently allowed these claims to be paid. Specifically, the claim payment errors resulted from the FEP Direct System allowing these claims to bypass enrollment system edits or the BCBS plans' processors incorrectly applying override codes. As a result, the FEHBP was overcharged $212,563 in claim payments for patients that were not eligible for benefits.

- For 1,294 of the claim lines questioned, the members' enrollment data records that identified the patients' eligibility status in the FEP Direct System were incorrect when the claims were paid. However, after receiving the patients' updated enrollment data, the BCBS plans did not review and/or adjust these claims that were incurred after the patients' termination dates of coverage. For these 1,294 claim lines, the enrollment data errors were identified on the members' rosters or the members' termination notices, which were received from the federal payroll offices, after the claims were already paid. As a result, the FEHBP was overcharged $200,296 in claim payments for patients that were not eligible for benefits.

- For 110 of the claim lines questioned, the BCBS plans incorrectly paid these claim lines due to manual processing errors. As a result, the FEHBP was overcharged $66,862 in claim payments for patients that were not eligible for benefits.

Of the $479,721 in questioned charges, $68,670 (14 percent) was identified by the BCBS plans before the start of our audit (i.e., November 5, 2010). However, since the BCBS plans had not completed the recovery process and/or adjusted or voided these claims by the Association's original response due date (i.e., January 7, 2011) to the draft report, we are continuing to question these overcharges. The remaining questioned charges of $411,051 (86 percent) were identified as a result of our audit.

In addition to the questioned charges, we identified the following procedural issues requiring corrective action by the Association and/or FEP Operations Center:

- For 11,719 claim lines in our samples (totaling $3,190,174 in payments), the Association and/or BCBS plans identified that the members had coverage under different "R" identification (ID) numbers or patient codes (e.g., due to marital status change) . However, we noted that the FEP Direct System processed these claim payments under terminated "R" ID numbers or invalid patient codes. Consequently, these claim lines were initially identified as being paid for potentially ineligible patients but were actually paid for eligible patients.

  During our review, we identified that a BCBS plan or the FEP Operations Center can combine a member's paid claims under an old (ineligible) "R" ID number or patient code with the claims history of a new (eligible) "R" ID number or patient code. However, when a plan or the FEP Operations Center performs this change to the member's claims history, the FEP Direct System allows payment of claims under the ineligible "R" ID number or patient code. Since we did not receive the adjusted claim records for the "R" ID number and/or patient code changes performed by the plans and FEP Operations Center, the preliminary results of our claim error reports were adversely affected. As a result, 11,719 claim lines in our samples were initially identified as being paid for these potentially ineligible patients; however, these claim lines were actually paid for eligible patients.

- For 2,665 claim lines in our samples (totaling $321,087 in payments), the members' enrollment data records that identified the patients' eligibility status in the FEP Direct System were incorrect when the claims were paid. However, we noted that the BCBS plans and/or FEP Operations Center corrected the applicable patients' effective or termination dates of coverage in the FEP Direct System on or after October 1, 2010. As a

result of these enrollment date corrections, the patients' claims were actually incurred during effective dates of coverage.

Association's Response:

Enrollee Coverage Conflicts with Dates of Service

The Association agrees with $2,781,552 of the questioned charges. The Association states, "These overpayments were the result of retroactive enrollment changes. Where possible, recovery efforts have been initiated for the identified errors. The Plans will continue to pursue these overpayments as required by CS 1039, Section 2.3 (g) . . . Thus far, the Plans have recovered and returned to the Program a total of $437,858. . . .

These claim errors occurred as a result of the following:

- Member termination notices were not received from the federal payroll offices until after the claims were already paid.

- The Patient's eligibility information was incorrect on the FEP Enrollment System when the claims were processed. The correct patient eligibility information was added prior to the information request issue date; however, the Plan had not reviewed and adjusted these claims.

- Enrollment input errors occurred, resulting in an incorrect member roster (e.g., enrollment of a non-covered grandchild; incomplete enrollment data, or other dependent).

Due to the nature of the enrollment process, we will continue to receive retroactive enrollment updates after the claim has been processed. However, our Retroactive Enrollment Report that is generated daily to Plans is designed to identify and timely initiate recoveries on applicable erroneous payments. We are monitoring this process to continue to promote timely recoveries.

We disagree that the remaining . . . was paid in error based upon the following reasons:

- Recoveries were initiated and/or refunds received prior to the audit start date or before our response to the Draft Report was submitted.

- The Members had coverage under another identification number (due to marital status change, etc) and the claims transactions were not combined.

- The Members had coverage continued under a different option (Standard or Basic) due to change during Open Season."

Patients with No Enrollment Records

The Association disagrees with the questioned charges. The Association states, "Additional documentation to support our position will be provided . . . We have identified six primary

reasons why we contested that these claims were not paid incorrectly. These reasons are as follows:

- The Patient Code questioned was on the enrollment file.
- Refund requests were initiated prior to the start of the audit.
- The questioned contract identification number is still valid within the timeframe for the claims questioned.
- No paid claims were on file for the questioned Patient Codes only rejected transactions.
- The services were rendered during the grace period.
- The questioned members were covered under another identification number.

To prevent these errors from occurring in the future:

- We will continue to issue listings of retro enrollment termination reports to the Plans on a quarterly basis for their review (our System Wide Claims Review Process).
- We will continue to evaluate the current retroactive enrollment notification process to ensure that notices are issued to Plans timely.
- We have made modification to prevent the FEP Claims System from automatically adding new born babies to the member's enrollment file without evidence of the coverage status of the newborn.
- We are working with the Operations Center to evaluate the entire enrollment process to ensure that controls are in place for adding and terminating members. We expect this to be completed by the end of the first quarter 2012."

OIG Comments:

After reviewing the Association's response and additional documentation provided by the BCBS plans, we revised the questioned charges from our draft report to $4,956,611 ($4,476,890 + $479,721). If claims paid for ineligible patients were identified by the BCBS plans before the start of our audit (i.e., November 5, 2010) and adjusted or voided by the Association's original response due date to the draft report (i.e., January 7, 2011), we did not question these claim payment errors in the final report.

Based on the Association's response and the BCBS plans' additional documentation, we determined that the Association and/or plans agree with $3,189,414 ($2,795,425 for "Enrollee Coverage Conflicts with Dates of Service" plus $393,989 for "Patients with No Enrollment Records") and disagree with $1,767,197 ($1,681,465 for "Enrollee Coverage Conflicts with Dates of Service" plus $85,732 for "Patients with No Enrollment Records") of the revised

questioned charges.[3] Although the Association only agrees with $2,781,552 in its written response, the Association/BCBS plans' additional documentation supports concurrence with $3,189,414.

Based on the Association's response and/or the BCBS plans' documentation, the contested amount of $1,767,197 represents the following items:

Enrollee Coverage Conflicts with Dates of Service

- $1,256,591 of the contested amount represents 20,393 claim lines paid for ineligible patients that were identified by the BCBS plans before the audit started. However, the plans had not recovered these overpayments and adjusted or voided the claims by the Association's original response due date to the draft report. Since these overpayments had not been recovered and returned to the FEHBP by the Association's response due date, we are continuing to question this amount in the final report.

- $205,724 of the contested amount represents 930 claim lines that the BCBS plans agree were paid for ineligible patients. However, due to overpayment recovery time limitations with providers, the plans state that these claim payments are uncollectible. The plans did not provide sufficient documentation to support the overpayment recovery time limitations with providers or the attempted recovery efforts for these claim payments. Therefore, we are continuing to question this amount in the final report.

- $140,631 of the contested amount represents 776 claim lines that the BCBS plans agree were paid for ineligible patients. However, since all recovery efforts have been exhausted, the plans state that these claim payments are uncollectible. The plans did not provide sufficient documentation to support that all recovery efforts have been exhausted. Therefore, we are continuing to question this amount in the final report.

- $51,734 of the contested amount represents 2,993 claim lines that BCBS plans agree were paid for ineligible patients. However, since these claim payments were each $100 or less, the plans will not initiate recovery efforts for these payments. Although the plans consider claim payments of $100 or less as immaterial, these claims were for ineligible patients with cumulative claim line payments of $2,500 or more, which is material. Therefore, we are continuing to question this amount in the final report.

- $26,785 of the contested amount represents 119 claims lines that the WellPoint BCBS of Ohio plan states were paid correctly. However, this plan did not provide sufficient documentation to support that these claim lines were paid for eligible patients.

[3] After providing the written response to the draft report and the BCBS plans' spreadsheet responses and supporting documentation for the samples in February 2011, the Association provided additional documentation on June 27, 2011, agreeing with $393,989 and disagreeing with $85,732 of the questioned charges for the claims paid where the patients had no enrollment records.

Patients with No Enrollment Records

- $68,670 of the contested amount represents 141 claim lines paid for ineligible patients that were identified by the BCBS plans before the audit started. However, the plans had not recovered these overpayments and adjusted or voided the claims by the Association's original response due date to the draft report. Since these overpayments had not been recovered and returned to the FEHBP by the Association's response due date, we are continuing to question this amount in the final report.

- $17,062 of the contested amount represents 209 claim lines that the BCBS plans state were not charged to the FEHBP. However, the plans did not provide sufficient documentation to support that these claims were not charged to the FEHBP. Therefore, we are continuing to question this amount in the final report.

Recommendation 1

We recommend that the contracting officer disallow $4,956,611 in claim payments for ineligible patients, and verify that the BCBS plans return all amounts recovered to the FEHBP.

Recommendation 2

We recommend that the contracting officer instruct the Association to verify if the FEP Operations Center has implemented effective enrollment procedures. These procedures should ensure that members' enrollment data records, such as effective and/or termination dates of coverage, are entered correctly and timely into the FEP Direct System and allow for timely recovery of erroneous claim payments for ineligible patients.

Recommendation 3

We recommend that the contracting officer require the Association to have the FEP Operations Center identify the root cause(s) why the FEP Direct System allows claims to bypass enrollment system edits.

Recommendation 4

We recommend that the contracting officer require the Association to ensure that the BCBS plans and/or FEP Operations Center are using the enrollment verification systems, as required in the FEP Administrative Manual (Volume II, Chapter 21, Sections H through J).

Recommendation 5

We recommend that the contracting officer instruct the Association to have the FEP Operations Center either discontinue combining a member's claims paid under one "R" ID number or patient code with the claims history of a different "R" ID number or patient code, or provide the necessary claim adjustment records to the OIG to account for these changes.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

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February 16, 2011

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Reference: OPM DRAFT AUDIT REPORT
Global Enrollment Audit
Audit Report #1A-99-00-10-061
(Report dated and received 11/05/10)

Dear [redacted]

This is in response to the above referenced U.S. Office of Personnel Management (OPM) Draft Report concerning the Global Enrollment Audit for claims paid during the period of July 1, 2008 through September 30, 2010, which questioned $12,604,664 in potential payment errors. Our comments concerning the findings in the report are as follows:

Blue Cross Blue Shield Association (BCBSA) Response:

AI1. Enrollees Coverage Conflicts with Dates of Service $10,865,500

Our review of the OIG Draft Audit Report for claims paid for members that may have had gaps in coverage identified $2,781,552 in overpayments. These overpayments were the result of retroactive enrollment changes. Where possible, recovery efforts have been initiated for the identified errors. The Plans will continue to pursue these overpayments as required by CS 1039, Section 2.3 (g)(I). "Any benefit payments the Plans are unable to recover are allowable charges to the Program. In addition, as good faith erroneous payments, lost investment income is not applicable to these confirmed overpayments". Thus far, the Plans have recovered and returned to the Program a total of $437,858. An additional amount of $33,318 is still under review by the Plan and we will forward the results when available.

These claim errors occurred as a result of the following:

- Member termination notices were not received from the federal payroll offices until after the claims were already paid.

- The Patient's eligibility information was incorrect on the FEP Enrollment System when claims were processed. The correct patient eligibility information was added prior to the information request issue date, however, the Plan had not reviewed and adjusted these claims.

- Enrollment input errors occurred, resulting in an incorrect member roster (e.g., enrollment of a non-covered grandchild; incomplete enrollment data, or other dependent).

Due to the nature of the enrollment process, we will continue to receive retroactive enrollment updates after the claim has been processed. However, our Retroactive Enrollment Report that is generated daily to Plans is designed to identify and timely initiate recoveries on applicable erroneous payments. We are monitoring this process to continue to promote timely recoveries.

We disagree that the remaining $8,050,629 was paid in error based upon the following reasons:

- Recoveries were initiated and/or refunds received prior to the audit start date or before our response to the Draft Report was submitted.

- The Members had coverage under another identification number (due to marital status change, etc) and the claims transactions were not combined.

- The Members had coverage continued under a different option (Standard or Basic) due to change during Open Season.

Attachment A, which is a schedule used to identify the amount questioned, contested, and recovered by each Plan is attached.

AI2. Patients with No Enrollment Record **$1,739,163**

We contest that the entire questioned amount of $1,739,163 was not paid incorrectly. Additional documentation to support our position will be provided to you via the FTP site. We have identified six primary reasons why we contested that these claims were not paid incorrectly. These reasons are as follows:

- The Patient Code questioned was on the enrollment file.

- Refund requests were initiated prior to the start of the audit.

- The questioned contract identification number is still valid within the timeframe for the claims questioned.
- No paid claims were on file for the questioned Patient Codes only rejected transactions.
- The services were rendered during the grace period.
- The questioned members were covered under another identification number.

To prevent these errors from occurring in the future:

- We will continue to issue listings of retro enrollment termination reports to Plans on a quarterly basis for their review (our System Wide Claims Review Process).
- We will continue to evaluate the current retroactive enrollment notification process to ensure that notices are issued to Plans timely.
- We have made modifications to prevent the FEP Claims System from automatically adding new born babies to the member's enrollment file without evidence of the coverage status of the newborn.
- We are working with the Operations Center to evaluate the entire enrollment process to ensure that controls are in place for adding and terminating members. We expect this to be completed by the end of the first quarter 2012.

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

[redacted]

Executive Director
Program Integrity

[redacted]

Attachments

cc: [redacted]