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

Final Audit Report

Audit of Triple-S Salud's Federal Employees Health Benefits Program Pharmacy Operations as Administered by MC-21 Corporation for Contract Years 2012 through 2015

Report Number 1H-05-00-17-017
December 10, 2018

charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to its members were in accordance with the U.S. Office of Personnel Management Contract Number CS 1090 and applicable Federal regulations.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of Triple-S Salud's (Plan) Pharmacy Operations as Administered by MC-21 Corporation (pharmacy benefits manager or PBM). Our audit consisted of a review of administrative fees, claims processing, drug manufacturer rebates, fraud and abuse program, and performance guarantees as they relate to the FEHBP for contract years 2012 through 2015. Our site visit was conducted from August 14 through August 24, 2017, at the Plan's office in San Juan, Puerto Rico and the PBM's office in Caguas, Puerto Rico. Additional audit work was completed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania.

Michael R. Esser
Assistant Inspector General for Audits

ABBREVIATIONS

5 CFR 890	**Title 5, Code of Federal Regulations, Chapter 1, Part 890**
Act	**Federal Employees Health Benefits Act**
Agreement	**The Pharmacy Benefit Management Agreement between Triple-S Salud and MC-21 Corporation**
Contract	**OPM Contract Number CS 1090**
CY	**Contract Year**
FEHBP	**Federal Employees Health Benefits Program**
HIO	**Healthcare and Insurance Office**
OIG	**Office of the Inspector General**
OPM	**U.S. Office of Personnel Management**
PBM	**MC-21 Corporation (Pharmacy Benefits Manager)**
Plan	**Triple-S Salud**

TABLE OF CONTENTS

I. BACKGROUND

This report details the results of our audit of Triple-S Salud's (Plan) pharmacy operations as administered by MC-21 Corporation (Pharmacy Benefits Manager or PBM) for contract years (CY) 2012 through 2015. The audit was conducted pursuant to the provisions of Contract CS 1090 (Contract) between the U.S. Office of Personnel Management (OPM) and the Plan; the Pharmacy Benefit Management Agreement between the Plan and the PBM (Agreement); Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890). The audit was performed by OPM's Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended.

The Federal Employees Health Benefits Program (FEHBP) was established by the Federal Employees Health Benefits Act (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 (HIO) has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the HIO contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the Act are implemented by OPM through regulations codified in 5 CFR 890.

Pharmacy Benefit Managers are primarily responsible for processing and paying prescription drug claims. The services provided typically include retail pharmacy, mail order, and specialty drug benefits. For drugs acquired through retail, the PBM contracts directly with the approximately 50,000 retail pharmacies located throughout the United States. For maintenance prescriptions that typically do not need to be filled immediately, the PBM offers the option of mail order pharmacies. The PBM also provides specialty pharmacy services for members with rare and/or chronic medical conditions. Pharmacy Benefit Managers are used to develop, allocate, and control costs related to the pharmacy claims program.

The Plan contracted with the PBM, located in Caguas, Puerto Rico, to provide pharmacy benefits and services to plan members for CYs 2012 through 2015. Section 1.11 of the Contract includes a provision which allows for audits of the program's operations. Additionally, section 1.28(a) of the Contract outlines transparency standards that require the PBM to provide pass-through pricing based on its cost. Our responsibility is to review the performance of the PBM to determine if the Plan charged costs to the FEHBP and provided services to its members in accordance with the Contract, the Agreement, and the Federal regulations.

This is the first audit of the Plan's pharmacy operations as administered by the PBM. The results of our audit were discussed with Plan and PBM officials at an exit conference on July 10, 2018. In addition, a draft report, dated August 28, 2018, was provided to the Plan and PBM for review and comment. The Plan's response to the draft report was considered in preparing the final report and is included as an Appendix.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The main objective of the audit was to determine whether the costs charged to the FEHBP and services provided to its members were in accordance with the terms of the Contract, the Agreement, and applicable Federal regulations.

Our specific audit objectives were to determine if:

Administrative Fees Review

- The Plan paid the PBM administrative fees in accordance with their Agreement and if the fees were properly documented.

Claims Processing Review

- Any claims were paid for ineligible dependents age 26 and older, excluded drugs, non-FEHBP members, members from another group, debarred pharmacies, and drugs with a zero quantity filled.

- Drugs with a high quantity dispensed or high dollar claims were paid correctly.

- The pricing elements for retail, mail order, and specialty drug claims were transparent and paid correctly in accordance with the Agreement.

Drug Manufacturer Rebates Review

- The FEHBP was credited the appropriate amount of drug manufacturer rebates in a timely manner.

Fraud and Abuse Program Review

- The Plan and the PBM complied with the requirements of fraud, waste, and abuse in Carrier Letter 2014-29 and if potential fraud cases were being reported to OPM.

Performance Guarantees Review

- The Plan and the PBM's performance standards were properly calculated, if the guarantees were met, and if any associated penalties were paid timely.

SCOPE AND METHODOLOGY

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

This performance audit included a review of the administrative fees, claims processing, drug manufacturer rebates, fraud and abuse program, and performance guarantees related to the FEHBP for CYs 2012 through 2015. As part of our survey work, we conducted a site visit at the Plan's office in San Juan, Puerto Rico and the PBM's office in Caguas, Puerto Rico from August 14 through August 24, 2017. The audit fieldwork was completed at our office in Cranberry Township, Pennsylvania from January 17 through July 10, 2018.

The Plan is responsible for providing FEHBP members with medical and prescription drug benefits. To meet this responsibility, the Plan collected premium payments of approximately $590.7 million in CYs 2012 through 2015, of which approximately two-thirds was paid by the government on behalf of Federal employees. In its annual accounting statements, the Plan reported total pharmacy claims paid of approximately $223.8 million for CYs 2012 through 2015 (See below).

Contract Year	Earned Premiums	Number of Pharmacy Claims	Amount of Claims Paid
2012	$141,985,915	900,968	$50,415,447
2013	$141,469,467	901,932	$54,721,790
2014	$146,640,663	906,189	$56,995,429
2015	$160,615,392	954,975	$61,641,799
Total	**$590,742,437**	**3,664,064**	**$223,774,465**

In planning and conducting the audit, we obtained an understanding of the Plan's and PBM'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. Additionally, 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 and PBM's system of internal controls taken as a whole.

We also conducted tests of accounting records and other auditing procedures as we considered necessary to determine compliance with the Contract, the Agreement and Federal regulations. Exceptions noted in the areas reviewed are set forth in the "Audit Findings 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 Plan and PBM had not complied, in all material respects, with those provisions.

In conducting the audit, we relied to varying degrees on computer-generated data provided by the Plan and PBM. Due to the 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, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

To determine whether costs charged to the FEHBP and services provided to its members for contract years 2012 through 2015 were in accordance with the terms of the Contract, Agreement, and applicable Federal regulations, we performed the following audit steps:

Administrative Fees Review

- For each CY, we reviewed the monthly administrative fee invoices and line items, to determine if the PBM's fees were properly calculated and supported in accordance with the terms of the Agreement between the Plan and the PBM.

Claims Processing Review

Unless stated otherwise, the claim samples below were selected from the complete claims universe of 5,166,039 claims, totaling $223,775,064, for CYs 2012 through 2015 (the paid claims data differs from the amounts reported in the table above due to timing, claim adjustments, and reversals).

- We identified and reviewed all 430 dependents, 26 years of age or older, to determine if the members were eligible for coverage due to a disability and because they were incapable of self-support.

- We identified and reviewed the Plan's non-covered drugs list to determine if any claims were paid for excluded drugs.

- We reviewed all claims to determine if any were paid for non-FEHBP members or members enrolled in another FEHBP plan code.

- Using National Provider Identifiers, we reviewed all claims to determine if any payments were made to pharmacies debarred by the OIG's Administrative Sanctions Office.

- We reviewed all claims to ensure that none were paid with a zero quantity dispensed.

- We judgmentally selected and reviewed all claims over 1,000 metric quantity and $10,000 (82 claims totaling approximately $3 million) to determine if the claims were allowable and properly paid.

- We judgmentally selected and reviewed all claims over $40,000 (33 claims totaling approximately $1.6 million) to determine if the claims were allowable and properly paid.

- We identified a universe of 1,770,013 retail pharmacy claims totaling approximately $109 million for the top 4 retail pharmacies. From this universe, we randomly selected 40 claims for each CY (160 claims totaling $6,882) to determine if the pricing elements were transparent and if the claims were paid correctly.

- We identified a universe of 14,549 specialty pharmacy claims, totaling approximately $39 million, for the top four retail pharmacies. From this universe, we randomly selected 20 claims from each CY (80 claims totaling $260,832) to determine if the pricing elements were transparent and if the claims were paid correctly.

- We identified a universe of 1059 mail order pharmacy claims totaling approximately $245,000. From this universe, we randomly selected 50 claims, totaling $8,879, to determine if the pricing elements were transparent and if the claims were paid correctly.

Drug Manufacturer Rebates Review

- We identified a universe of approximately $11.5 million in drug manufacturer rebates for the 2013 through 2015 contract years. We excluded 2012 since many of the 2012 rebate collections were from the 2011 contract year. From this universe, we randomly selected 30 rebate collections (10 collections per each year) totaling $72,008. We then reviewed the collections to determine if the rebates were properly supported, accurately calculated, and remitted to the Plan.

Fraud and Abuse Program Review

- We reviewed all potential fraud and abuse cases reported by the PBM to the Plan to determine if those cases were reported to OPM.

- We reviewed the Plan's policies and procedures for fraud and abuse to ensure that they comply with OPM's standards.

Performance Guarantees Review

- For each CY, we reviewed all performance guarantees to determine if the guarantees were met, reported accurately, and that any associated penalties were paid to the Plan timely.

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

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Administrative Fees Review

The results of our review showed that the Plan paid the correct administrative fees to the PBM in accordance with their contract.

B. Claims Processing Review

1. Overage Dependents $679,616

The Plan paid $679,616 in pharmacy claims for 197 dependents age 26 or older who should no longer be eligible for FEHBP coverage.

In accordance with FEHBP regulations and the OPM instructions, your family member immediately loses eligibility for coverage when your child reaches age 26, unless he/she is incapable of self-support due to a disability.

We found 197 dependents age 26 or older whose eligibility to participate in the FEHBP was unsupported.

Title 5, Code of Federal Regulations, Section 890.302 allows dependent children under the age of 26 and dependents age 26 or older who are incapable of self-support due to a disability to be covered by the enrollment of a Federal employee or annuitant in the FEHBP. The regulation also requires certification from a physician and a decision by the Federal employment office showing that the dependent is incapable of self-support due to a disability in order for the Plan to continue providing coverage to that member beyond their 26th birthday.

Section 3.8 of the Contract, Contractor Records Retention, requires the Plan to maintain individual enrollee and patient records for a period of six years after the end of the contract term for which the claim records relate.

We reviewed all pharmacy claims for 2012 through 2015 to determine if any were paid for dependents age 26 and older. Our review identified 430 dependents who had claims incurred and paid 31 days after their 26th birthday (a 31-day grace period is allowed). We requested supporting documentation from the Plan to show why these dependents were eligible for continued coverage in the FEHBP. The Plan provided sufficient support for 233 of the 430 dependents, showing that the members were eligible for coverage in the FEHBP due to being disabled and incapable of self-support. However, the Plan was unable to provide sufficient

eligibility documents for the remaining 197 dependents, who received $679,616 in pharmacy claim payments from 2012 through 2015. When we asked why there was not sufficient evidence of eligibility for the questioned dependents, the Plan responded that the reason for not having evidence now could be due to changes in their systems or the age of the enrollment, since some are more than 20 years old.

Because the Plan cannot provide sufficient evidence showing why it continued coverage for the 197 dependents over age 26, we were unable to verify their eligibility or properly assess the Plan's controls for terminating dependent coverage at age 26. Additionally, we were unable to determine if any of these dependents were fraudulently enrolled in the FEHBP since there was not sufficient enrollment documentation showing why the Plan was covering them. Since the FEHBP records retention clause requires the Plan to maintain documentation supporting costs for a period of six years, we are questioning $679,616 in pharmacy claim payments for ineligible dependents until the Plan can provide sufficient evidence showing why it continued coverage for these individuals.

Recommendation 1

We recommend that the Plan provide evidence to show that the 197 overage dependents were eligible to remain enrolled in the FEHBP due to a disability and being incapable of self-support, or return $679,616 to the program for improper claim payments.

Plan Response:

The Plan only found 31 dependents as ineligible and agreed to return $3,120.96 to the FEHBP. Another 21 dependents were retroactively cancelled at the requests of their agencies, for which the Plan stated it should not be responsible. Finally, the eligibility for another 106 dependents is unknown at this time, and the Plan is working to obtain the appropriate documentation to support their eligibility status. The Plan thoroughly reviewed its claims system and determined that all other members being questioned in this report are eligible for FEHBP coverage and provided what it believes to be appropriate documentation to the OIG (see full response in the appendix).

OIG Comment:

We reviewed all documentation provided by the Plan during the audit and in response to the draft report. We agree that the Plan has worked diligently to obtain supporting documentation for the overage dependents, which it did not maintain. After our review of all documentation submitted by the Plan, we disagree with both the number of ineligible

dependents and dollar amount of improper claim payments. The OIG has not received evidence that supports the eligibility of 197 overage dependents who incurred $679,616 in improper claim payments, which is what we questioned in the finding above.

Recommendation 2

We recommend that the Plan review its system controls for terminating dependents upon turning age 26 to ensure that ineligible members are not enrolled in the FEHBP.

Plan Response:

The Plan agreed to follow our recommendation by reviewing its system controls and implementing automated controls to terminate dependent enrollments once they reach age 26.

OIG Comment:

Even though a dependent is terminated at age 26, please ensure that your system allows for temporary coverage up to 31 days for any authorized grace period.

Recommendation 3

We recommend that the Plan implement policies and procedures to ensure that member eligibility documentation is maintained for a period of six years after claims are paid in accordance with its records retention clause. This means it should maintain evidence to support the eligibility for disabled dependents for up to six years after they are no longer enrolled in the FEHBP.

Plan Response:

The Plan agreed to revise its records retention policy to address our recommendation. It will submit the revised policy within the next 30 days for OPM's review and approval.

C. Drug Manufacturer Rebates Review

The results of our review showed that the PBM correctly invoiced, collected and credited the drug manufacturer rebates for the Plan in accordance with its manufacturer agreements and the contract between the Plan and the PBM.

D. Fraud and Abuse Program Review

The results of our review showed that the Plan and the PBM had sufficient policies and procedures in place to help prevent fraud, waste, and abuse.

E. Performance Guarantees Review

The results of our review showed that the PBM complied with the performance guarantees and penalties outlined in its Agreement with the Plan.

APPENDIX

September 26, 2018

VIA ELECTRONIC MAIL- [redacted]@opm.gov

[redacted]
Group Chief
Special Audits Group
U.S. Office of Personnel Management
1900 E Street, NW Room 3424
Washington, DC 20415

Dear [redacted]:

Triple-S Salud, Inc. (Triple-S), acknowledges receipt of the draft report No. 1H-05-00-17-017 (the Report) detailing the results of the Office of Personnel Management (OPM) audit of Triple-S's Federal Employees Health Benefits Program Pharmacy Operations as Administered by MC-21 Corporation (PBM). The audit included a review of the administrative fees, claims processing, drug manufacturer rebates, fraud and abuse program, and performance guarantees for contract years 2012 through 2015. In response to the Report, as follows, we include a general description and comments to each one of the Report's recommendations that properly addresses your office's initial impressions, along with corresponding documentation.

Executive Summary:

The objective of the audit was to determine whether costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to its members were in accordance with the U.S. Office of Personnel Management Contract Number CS 1090 and applicable Federal regulations. The audit consisted of a review of the administrative fees, claims processing, drug manufacturer rebates, fraud and abuse program, and performance guarantees as they relate to the FEHBP for contract years 2012 through 2015. The site visit was conducted from August 15 through August 24, 2016, at the Plan's office in San Juan, Puerto Rico and the PBM's office in Caguas, Puerto Rico.

As a result of the audit, your office determined that the Plan needs to strengthen its procedures and controls related to dependent eligibility. Specifically, the audit identified the following deficiency that requires corrective action from Triple-S:

- The Plan paid $1,120,164 in pharmacy claims for 312 dependents age 26 or older who should no longer be eligible for FEHBP coverage.

Additionally, the Report reflects three recommendations that derived from the above defined finding.

After taking into consideration the results reflected in the Report, Triple-S partially disagrees with the same. As such, we have included supporting documentation to that extent. Nonetheless, Triple-

S is fully aware of its contractual obligations with the FEHBP, and will work diligently to address all of the Report's recommendations.

Recommendations:

Recommendation 1
The OPM recommends that Triple-S provides evidence to show that the 312 dependents were eligible to remain enrolled in the FEHBP due to a disability and incapable of self-support, or return $1,120,164 to the program for improper claim payments.

Response:

The Plan has thoroughly reviewed its claims data to identity the 312 dependents that were found to be ineligible as a result of the audit. The Plan has been able to determine that as of September 26, 2018, 173 dependents were eligible, for which the amount of $752,393.11 was paid in accordance with OPM requirements. As such, the Plan has identified proper documentation that supports the dependent continued enrollment after the eligibility age of 26 for 31 dependents. Specifically, the Plan has identified various dependents that are Medicare recipients, as incapable dependents. To that extent, the Plan is including copy of the dependent's Medicare card, clinical data or detailed account of drug expenditures to support this contention. Additionally, as part of Triple-S' analysis, it was determined that the Plan, as a Carrier is dependent upon information provided by the corresponding agencies to determine eligibility of insureds and dependents. To that extent if the agency does not submit data in a timely manner, Plan records will be affected.

The Plan has identified 106 members in which we will continue outreach efforts in order to gather appropriate documentation to support eligibility status. All information received after this date will be submitted to OIG accordingly.

The Plan determined that claims for 119 of the identified dependents, were paid within the 31-day period after the dependent reached the age eligibility limit. To that extent, claims were paid correctly under this exception that amounts to $64,078.26 dollars.

Additionally, the Plan determined that 21 dependents, were retroactively cancelled as requested by their agency, for which Triple-S will not be responsible for the finding.

Finally, Triple-S, found that 31 dependents, were ineligible. As such, the amount of $3,120.96 were incorrectly paid and the Plan will proceed accordingly with OIG's recommendation.

Please refer to Attachment 1, 2 and the Updated Overage Dependent List

Recommendation 2
The OPM recommends that Triple-S reviews its system controls for terminating dependents upon turning age 26 to ensure that ineligible members are not enrolled in the FEHBP.

Response:

In consideration of OPM's recommendation, the Plan has reviewed its system controls and has implemented automated controls to terminate dependent enrollments once the dependent has attained a specific age. This functionality will prospectively terminate enrollment based on date of birth of the dependent once they reach 26 years of age. We confirm that this set ups are currently configured for the FEHBP group. Dependent rules can be specified for handicapped dependents.

Recommendation 3
The OPM recommends that Triple-S implements policies and procedures to ensure that member eligibility documentation is maintained for a period of six years after claims are paid in accordance with its records retention clause. This means it should maintain evidence to support the eligibility for disabled dependents for up to six years after they are no longer enrolled in the FEHBP.

Response:

Triple- S includes its current record retention policy. The purpose of the policy is to ensure a company-wide compliance structure to secure a supportable record retention system to assure uniformity in all operational units. Nonetheless, Triple-S is revising the policy to address the OPM's recommendation. Triple-S will submit its revised policy within the next 30 days for final review and approval.

Please refer to Attachment 3

If additional information is needed, please feel free to contact me at [redacted] or write me an e-mail at [redacted]

Sincerely,

[redacted]
Triple-S Salud

Cc: [redacted], President

Report Fraud, Waste, and Mismanagement

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse

By Phone:

Toll Free Number:	(877) 499-7295
Washington Metro Area:	(202) 606-2423

By Mail:

Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100