



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

Final Audit Report

Subject:

AUDIT OF BLUE CROSS AND BLUE SHIELD'S MAIL ORDER PHARMACY OPERATIONS AS ADMINISTERED BY CVS CAREMARK IN 2006 AND 2007

Report No. 1H-01-00-11-011

Date: February 2, 2012

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Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

AUDIT REPORT

**AUDIT OF BLUE CROSS AND BLUE SHIELD'S MAIL
ORDER PHARMACY OPERATIONS AS ADMINISTERED
BY CVS CAREMARK IN 2006 AND 2007**

**CONTRACT CS 1039
PLAN CODE 10**

Report No. 1H-01-00-11-011

Date: 02/02/12

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

**Michael R. Esser
Assistant Inspector General
for Audits**



Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

EXECUTIVE SUMMARY

**AUDIT OF BLUE CROSS AND BLUE SHIELD'S MAIL
ORDER PHARMACY OPERATIONS AS ADMINISTERED
BY CVS CAREMARK IN 2006 AND 2007**

**CONTRACT CS 1039
PLAN CODE 10**

Report No. 1H-01-00-11-011

Date: 02/02/12

The enclosed audit report details the results of our audit of Blue Cross and Blue Shield's (Plan) mail order pharmacy operations as administered by CVS Caremark, the Plan's pharmacy benefit manager (PBM), in 2006 and 2007. The primary objective of our audit was to determine if the Plan complied with the regulations and requirements contained within Contract CS 1039, between the Plan and the Office of Personnel Management, and the requirements within its contract with the PBM. The audit was performed at the PBM's location in Scottsdale, Arizona, from February 14 through March 4, 2011.

The audit covered mail order pharmacy claims and the Plan's adherence to its contractual requirements for contract years 2006 and 2007. This report questions \$325,378 in prescription drug overpayments. The results of our audit have been summarized below.

PHARMACY CLAIMS

With the exception of the issues specified below, the results of our audit showed that the Plan complied with the contractual requirements contained within Contract CS 1039 and the requirements within its contract with the PBM, as they relate to the payment of pharmacy claims and program performance.

- **Recoverable Claim Payments** **\$304,616**

After receiving notice of 197 members who terminated coverage, the Plan failed to go back and recover 367 improper claim payments totaling \$304,616.

- **Ineligible Member Claims** **\$20,762**

The PBM filled 78 prescriptions and charged the FEHBP \$20,762 for 33 members who were reported by the Plan as ineligible at the time the claim was adjudicated.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The results of our review showed that the PBM, administrator of the mail order pharmacy benefits for the Plan, had policies and procedures in place to address the Health Insurance Portability and Accountability Act's Standards for Electronic Transactions, Privacy Rules, and Security Rules.

FRAUD AND ABUSE PROGRAM

The results of our review showed that the PBM's policies and procedures for fraud and abuse complied with section 1.9(c) of Contract CS 1039, and met all eight industry standards for fraud and abuse programs outlined in FEHBP Carrier Letter 2003-23.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This report details the results of our audit of Blue Cross and Blue Shield's (Plan) Federal Employees Health Benefits Program (FEHBP) mail order pharmacy operations as administered by CVS Caremark, the Plan's pharmacy benefit manager (PBM), in 2006 and 2007. The audit was conducted pursuant to the provisions of Contract CS 1039; 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 the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended. The audit fieldwork took place at the PBM's office in Scottsdale, Arizona from February 14 through March 4, 2011. Additional audit work was completed in our Washington, D.C. and Cranberry Township, Pennsylvania offices.

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 (HIO) has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations codified in 5 CFR 890. Health insurance coverage is made available through contracts with various health insurance carriers that provide service benefits, indemnity benefits, or comprehensive medical services.

The Blue Cross and Blue Shield Association (Association), on behalf of participating Blue Cross and Blue Shield 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 Blue Cross and Blue Shield plans throughout the United States to process the health benefit claims of its federal subscribers.

The Association has established a Federal Employee Program (FEP) 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, Blue Cross and Blue Shield 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.

Pharmacy Benefit Managers (PBMs) are primarily responsible for processing and paying prescription drug claims. The services typically include both retail and mail order drug benefits. For drugs acquired through the “local” drugstore, the PBMs contract 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, PBMs offer the option of mail order pharmacies. The PBM is used by the Plan to develop, allocate, and control costs related to the pharmacy claims program.

OPM’s HIO has overall responsibility for administering the FEHBP, including the publication of program regulations and agency guidelines. 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. Compliance with the laws and regulations applicable to the FEHBP is the responsibility of the Plan’s management, which includes establishing and maintaining a system of internal controls.

The Plan’s pharmacy operations and responsibilities under contract CS 1039 are carried out by the PBM, which is located in Scottsdale, Arizona. Contract CS 1039 section 1.11 includes a provision which allows for audits of the program’s operations. Our responsibility is to review the performance of this PBM to determine if the Plan charged costs to the FEHBP and provided services to its members in accordance with this contract.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary objectives of this audit were to:

- Obtain reasonable assurance that the Plan complied with the provisions of the FEHB Act and regulations that are included, by reference, in the FEHBP contract.
- Determine whether costs charged to the FEHBP and services provided to its members were in accordance with the terms of the FEHBP contract and federal regulations.

SCOPE

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, appropriate evidence to provide a reasonable basis for our audit 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 covered pharmacy claims and the Plan's adherence to its contractual requirements for contract years 2006 and 2007. The audit scope included a review of the PBM's compliance with the Health Insurance Portability and Accountability Act (HIPAA), its Fraud and Abuse Program, and Internal Controls related to its claim processing system. In 2006 and 2007, the Plan paid \$4,452,949,964 in prescription drug charges to the PBM (see Schedule A).

In planning and conducting the 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.

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

We also conducted tests to determine whether the Plan had complied with the Contract, Service Agreements, 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. 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 the PBM had not complied, in all material respects, with those provisions.

METHODOLOGY

To test whether the Plan accurately charged the FEHBP for 2006 and 2007 prescription drug benefits and complied with its contractual requirements, we performed the following audit steps:

Member Eligibility Review

- We reviewed all 954 claims over \$100 out of a universe of 8,195 claims that were identified as having eligibility issues to determine if the member was enrolled at the time of service.
- We selected the 100 oldest FEHBP members, out of 3,996,311 members for 2006 and 3,949,928 members for 2007, who incurred prescription drug claims and compared their information to death records to ensure that pharmacy claims were not being paid for deceased members.
- We selected 150 dependents age 22 and over (the first 50 from each age group; 22-30, 31-50 and 51-79) out of a universe of 3,820 dependents to determine if each member was eligible for FEHBP coverage at the time of receiving pharmacy benefits.
- We reviewed the pharmacy claims data to determine if any payments were made to non-FEHBP members, or to members enrolled in another group or plan code.

Covered Drug Review

- We reviewed the pharmacy claims data to determine if any claims were processed for drugs that were excluded from FEHBP benefits, as listed in the Plan's Benefit Brochure.
- We reviewed the pharmacy claims data to determine if any claims were processed for drugs that have not been approved by the Federal Drug Administration.
- We queried claims over \$50,000 from the pharmacy claims data and reviewed all 192 claims over \$50,000 to ensure that they were properly supported by the original script.

Adjudication Review

- We reviewed the pharmacy claims data to determine if any payments were made for a duplicate claim.
- Out of a universe of 52,484 claims totaling \$390,780,778, that represented members age 100 and older and claims over \$5,000, we reviewed 5,008 claims totaling \$2,726,359 to determine if any prescriptions were being refilled too soon.
- We queried claims over \$5,000 that had a day supply greater than 90 days from the pharmacy claims data and reviewed all 50 claims to determine if mail order prescriptions were being filled with the appropriate day supply.

Prescription Review

- We reviewed the pharmacy claims data to determine if any claims were paid for prescriptions showing a zero quantity dispensed.
- We reviewed 25,384 prescriptions out of a universe of 22,758,178 prescriptions with standard drug packaging sizes to determine if the proper amounts were dispensed.
- We reviewed all claims to determine if payments were made for nutritional supplements, which is an excluded benefit for most members.
- We selected 50 claims that were designated as “Dispense as Written” out of a universe of 605 claims and verified the requirement on the original scripts to ensure that generic substitution was not an option.
- We reviewed claims paid for controlled substances to determine if the prescriptions were refilled according to the Controlled Substance Act.

Pricing Review

- We reviewed a third party audit report, performed by Mercer, to determine if the pharmacy claims were priced according to the overall effective discount listed in the contract between the Plan and the PBM.
- We reviewed an independent financial analysis, performed by Mercer, of all bids for mail order pharmacy services to determine if the PBM offered the best rate and if the overall effective discount was more beneficial than receiving rebates.
- We reviewed the 2006 and 2007 Annual Accounting Statements and Year End Adjustments to determine what recoveries, settlement, and price adjustments were made by the PBM and if the amounts were credited back to the FEHBP.

Performance Review

- We obtained the FEP’s Annual Control and Performance Review of Caremark’s Mail Service Program for 2006 and 2007 and reviewed the Performance Penalty Reports to determine if the PBM met the performance standards set by the Plan and OPM.
- We surveyed the Plan’s initiatives to determine if any value-based benefits have been implemented and if the initiatives decreased costs or increased benefits to FEHBP members.
- We reviewed several drug utilization reports to determine if the Plan is using the information provided by the PBM to help reduce program costs.

Compliance Review

- We reviewed prior audits on internal controls related to the Quantum Leap mail order claims processing system to determine the existence and effectiveness of internal control policies on segregation of duties, claims processing, payments, claim system edits, high dollar reviews, etc.
- We reviewed the information provided by the PBM in response to our Claims Processing Questionnaire to help assess its internal controls.

- We conducted a walkthrough of one of the PBM's mail order facilities to observe the claims processing system, how prescriptions are filled, and to determine if the procedures match the Plan's response to our questionnaire.
- We obtained all of the PBM's policies and procedures that address the HIPAA Standards for Electronic Transactions, Privacy Rules, and Security Rules to determine if the carrier has documented its compliance with this Federal regulation.
- We reviewed the PBM's policies and procedures for fraud and abuse to determine if the Plan complied with section 1.9(c) of Contract CS 1039 and met all eight industry standards for fraud and abuse programs outlined in FEHBP Carrier Letter 2003-23.

The samples selected during our review 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 as a whole. We used Contract CS 1039 to determine if claim processing and administrative fees charged to the FEHBP were in compliance with the terms of the Contract.

The results of our audit were discussed with Plan officials throughout the audit and at the exit conference. In addition, a draft report, dated September 23, 2011, was provided to the Plan for review and comment. The Plan's response and the PBM's comments on the draft report were considered in preparing the final report and are included as Appendices to this report.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. PHARMACY CLAIMS

With the exception of the issues specified below, the results of our audit showed that the Plan complied with the contractual requirements contained within Contract CS 1039 and the requirements within its contract with the PBM, as they relate to the payment of pharmacy claims and program performance.

1. Recoverable Claim Payments **\$304,616**

We reviewed all 2006 and 2007 mail order pharmacy claims equal to or greater than \$100 to determine if the member was eligible at the time the claim was processed. During our review, we identified 367 claims totaling \$304,616 that were paid after 197 members terminated coverage. Because these claims were processed prior to the Plan being notified of the member's termination, the Plan is responsible for initiating recovery on these claims after receiving retro-effective eligibility updates.

Contract No. CS 1039, Section 2.3(g) *Erroneous Payments*, states that "If the carrier or OPM determines that a Member's claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider."

Because the Plan did not initiate recovery on these claims after receiving retro-effective eligibility updates, the FEHBP was overcharged \$304,616.

The Plan's Comments:

The Plan responded that the PBM will initiate recovery efforts on the identified claims and noted that the Refund Recovery process is not a FEP Financial responsibility but is a function of the PBM.

The PBM's Comments:

The PBM disagreed with this finding and maintains its position that the claims in question were allowed to process because the PBM's system showed that the member was covered on the date the prescription was filled. The PBM received a retro-effective eligibility update terminating the member's coverage subsequent to filling the prescription.

When retroactive eligibility updates are received CVS Caremark applies the modifications to the member eligibility in the CVS Caremark system. From the date Caremark receives a termination update, claims no longer process for that member. Any claims that were paid between the actual termination date and the date Caremark received

notification of termination should be identified in the FEP Operations Center Refund Recovery Process.

The FEP sends the PBM two Refund Recovery tapes, one for Mail and one for Retail. Each tape contains any Mail or Retail specific claims that need to be voided due to a retroactive eligibility transaction. Because none of the identified claims were included with the recovery tapes sent by the FEP, the PBM did not initiate a refund recovery for these claims. It should be noted that the Refund Recovery process is the complete responsibility of the FEP Financial group and applies to both Mail and Retail Claims.

OIG Comments:

The Plan agrees that the claims need to be recovered and states that it will have the PBM initiate recovery efforts on the claims in question. Because OPM maintained the contract with the Plan, we want to clarify that it was ultimately the Plan's responsibility to initiate recovery on these claims. If recovery services are contracted out to the PBM, then the Plan is responsible for adding any requirements from Contract CS 1039 to its contract with the PBM. This includes the requirement to make a prompt and diligent effort to recover erroneous payments. In addition, due to the delay in initiating refund recovery and the expectation that the claim payments will be difficult to recover, the FEHBP should not be held responsible for these erroneous payments.

Recommendation 1

We recommend that the contracting office require the Plan to credit back to the FEHBP \$304,616 for 367 claims paid for ineligible members, in which refund recovery was not initiated.

Recommendation 2

We recommend that the contracting office require the Plan to do a thorough review of its records and initiate and document the recovery of erroneous payments related to ineligible members in 2006 and 2007.

Recommendation 3

We recommend that the Plan have clear policies and procedures in place to show when the recovery process for erroneous payments is initiated and how refund recoveries are handled after the PBM's service agreement expires.

2. Ineligible Member Claims \$20,762

We reviewed all 2006 and 2007 mail order pharmacy claims over \$100 to determine if members were eligible for coverage at the time the claim was processed. During our review, we identified 78 claims totaling \$20,762 that were paid for 33 ineligible

members. The Plan's enrollment system listed each of the members as ineligible for coverage at the time the PBM processed the claims.

Schedule D, Section 1.1a of the 2005 - 2007 Mail Service Prescription Drug Benefit Contract between the Plan and the PBM, states that the PBM shall determine if the individual submitting the prescription is a member who is eligible for coverage on the date the prescription is received. Section 1.2 states that if a member fails to meet any eligibility criteria, the PBM shall deny or reject the prescription and classify each such prescription as a claim line denied or a claim line rejected.

Additionally, Schedule D, Section 8.1 of the 2005 - 2007 Mail Service Prescription Drug Benefit Contract between the Plan and the PBM, states that the FEP Operations Center may send the PBM a notice of Erroneous Prescriptions Dispensed indicating that the Plan has determined that the benefits previously provided to a member have changed due to either an eligibility processing error by the FEP Operations Center or an enrollment termination. Contract CS 1039 requires the Plan to make a diligent effort to recover any corresponding overpayment to the member. The PBM agrees to promptly implement effective overpayment recovery procedures that are mutually acceptable to the parties and in compliance with the provisions of Contract CS 1039.

Because the eligibility of 33 members was not properly updated and verified prior to filling these prescriptions, the FEHBP was overcharged \$20,762.

The Plan's Comments:

The Plan did not respond to this finding. Instead, the Plan forwarded the PBM's official response listed below.

The PBM's Comments:

The PBM disagrees with this finding. It has reviewed the claims in question and maintains its position that the claims were processed because the PBM's system showed that the member was covered on the date the prescription was filled. The PBM subsequently received a retro-effective eligibility update terminating the member's coverage.

OIG's Comment:

We acknowledge the PBM's response and hold the Plan responsible for initiating refund recovery on these claims. Although the PBM maintains that its system indicated eligible members at the time the claims were processed, supporting documentation obtained from both the FEP's eligibility database and enrollment files sent to the OIG indicated that the members were ineligible at the time the claims were processed. The PBM and the Plan have not provided a response as to why their member eligibility records didn't match. Regardless of any delay between the two systems, recovery on these claims should have been initiated once retro-effective eligibility updates were processed.

Recommendation 4

We recommend that the contracting office require the Plan to credit back to the FEHBP \$20,762 in ineligible claim payments.

Recommendation 5

We recommend that the contracting office require the Plan to adopt a better system of controls for sending eligibility updates to the PBM and ensure that the PBM verifies each member's eligibility at the time a prescription is received.

B. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The results of our review showed that the PBM has policies and procedures in place to address the HIPAA Standards for Electronic Transactions, Privacy Rules, and Security Rules.

C. FRAUD AND ABUSE PROGRAM

The results of our review showed that the PBM's policies and procedures for fraud and abuse complied with section 1.9(c) of Contract CS 1039 and met all eight industry standards for fraud and abuse programs outlined in FEHBP Carrier Letter 2003-23.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Special Audits Group

██████████, Auditor-In-Charge

██████████, Staff Auditor

██████████, Group Chief ██████████

██████████, Senior Team Leader

**AUDIT OF BLUE CROSS AND BLUE SHIELD'S
MAIL ORDER PHARMACY OPERATIONS
AS ADMINISTERED BY CVS CAREMARK
CONTRACT YEARS 2006 - 2007**

**CONTRACT CHARGES
REPORT NUMBER 1H-01-00-11-011**

PRESCRIPTION DRUG BENEFITS

A. PHARMACY CLAIMS

2006 MAIL ORDER PRESCRIPTION DRUG CLAIM PAYMENTS	\$2,033,185,377
2007 MAIL ORDER PRESCRIPTION DRUG CLAIM PAYMENTS	\$2,419,764,587

TOTAL CONTRACT CHARGES	<u>\$4,452,949,964</u>
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**AUDIT OF BLUE CROSS AND BLUE SHIELD'S
MAIL ORDER PHARMACY OPERATIONS
AS ADMINISTERED BY CVS CAREMARK
CONTRACT YEARS 2006 - 2007**

**QUESTIONED COSTS
REPORT NUMBER 1H-01-00-11-011**

AUDIT FINDINGS

2006 - 2007

A. PHARMACY CLAIMS

1. Recoverable Claim Payments	\$304,616
2. Ineligible Member Claims	\$20,762

TOTAL QUESTIONED COSTS

\$325,378

Appendix A

November 11, 2011

[redacted], Chief
Special Audits Group
Office of Personnel Management
1900 E Street, N.W., Room 6400
Washington, D.C. 20415



BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans
Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
202.942.1000
Fax 202.942.1125

**Reference: OPM DRAFT EDP AUDIT REPORT
CVS/Caremark- Blue Cross Blue Shield
Mail Service Pharmacy Vendor
Audit Report Number 1H-01-00-11-011**

Dear [redacted],:

This report is in response to the above-referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) Audit of CVS Caremark's Mail Service Pharmacy Benefit Administration for 2006 through 2007. Our comments regarding the findings in this report are as follows:

A. Pharmacy Claims

1. Recoverable Claim Payments \$304,616

Recommendation 1 & 2

OIG recommended that CVS Caremark provide documentation the recovery efforts were initiated to recover payments payment to ineligible members.

CVS Caremark Response to Recommendation 1 & 2: CVS Caremark reviewed the claims in question and maintains its position that the claims in question were allowed to process because the CVS Caremark system showed that the member was covered on the date of fill. CVS Caremark received a retro-effective eligibility update terming the members coverage subsequent to filling the prescription.

Refund recovery was not initiated for these claims. When eligibility updates are received with retroactive changes, CVS Caremark applies these modifications (terminations, enrollment changes, member status changes, etc.) to the member's eligibility in the CVS Caremark system upon receipt of the change. From the date Caremark receives the termination update, claims will no longer process for that member. Any

claims that were paid prior to the actual date of termination and the date Caremark received notification should be identified in the FEP Operations Center Refund Recovery Process.

At the beginning of each month, the FEP Operations Center performs a sweep of enrollment or benefit changes on a monthly basis. This sweep identifies any member ID's in which termination dates were processed for the contract. Any claims paid past the termination date are flagged and identified to systematically void the identified claims. Based on these results, FEP sends Caremark two Refund Recovery tapes, one for Mail & one for Retail. Each tape contains any Mail or Retail specific claims that need to be voided due to a retroactive eligibility transaction.

On approximately the first Sunday of the month, the Refund Recovery files are fed into the CVS Caremark (automated Refund Recovery system), which uses the files to create the necessary void transactions, subsequently generating a single Refund Recovery letter to the subscriber that lists out all (Mail & Retail) claims that were voided and asks for a refund of the total dollars involved. Once the initial Refund Recovery letter is sent, the claims are put into suspense to see if a response from the member is received. Beginning in April 2007, after 30 days, if funds had not been received a second (30 day) letter is generated. This is repeated at the 60 and 90 day intervals per member as appropriate. If after 110 days CVS Caremark has not received a refund from the member, and an open balance on the member history will be created at FEP. If CVS Caremark receives a check before that 110 day timeframe, the FEP Claims unit will complete an R-transaction (i.e. a systematic financial transaction that tells the FEPOC that Caremark has received the member's refund), with a request to apply the refund amount to the open balance. These funds are deposited into the FEP Wells Fargo Bank Account.

It should be noted that the Refund Recovery process is 100% FEP Financial responsibility and applies to both Mail & Retail Claims. All returned funds are handled via the Retail plan code (089). In the case of a partial payment, R-transactions and claims activity will only be released to cover the amount submitted by the member.

[redacted],
Draft Response
CVS/Caremark Mail Service Audit
Page 3

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Not Relevant to the Final Report**

[redacted],
Draft Response
CVS/Caremark Mail Service Audit
Page 4

**Deleted by the OIG
Not Relevant to the Final Report**

3. Ineligible Members

\$20,762

Recommendation 5 & 6

OIG recommended that CVS Caremark credit back the \$20,762 payments made for drugs dispensed to members no longer eligible for cover under the Federal Employee Program. In addition, the auditors recommended that FEP adopt a better system of controls for sending eligible updates to the PBM and ensure the PBM verifies each member's eligibility at the time the prescription request is received..

CVS/Response to Recommendation 5 & 6

CVS Caremark reviewed the claims in question and maintains its position that the claims in questions were allowed to process because the CVS Caremark system showed that the member was covered on the date of fill. CVS Caremark received a retro-effective eligibility update terming the members coverage.

**Deleted by the OIG
Not Relevant to the Final Report**

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

Sincerely,

[redacted],
Executive Director, Program Integrity

rcm/jb

cc: [redacted],, OPM
[redacted],, CVS/Caremark
[redacted],, FEP
[redacted],, FEP

Appendix B

December 13, 2011

[redacted], Senior Team Leader
Office of the Inspector General
U. S. Office of Personnel Management
800 Cranberry Woods Drive, Suite 130
Cranberry Township, PA 16066
Email: luke.johnson@opm.gov



BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans
Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
202.942.1000
Fax 202.942.1125

**Reference: OPM DRAFT EDP AUDIT REPORT
CVS/Caremark- Blue Cross Blue Shield
Mail Service Pharmacy Vendor
Audit Report Number 1H-01-00-11-011**

Dear [redacted],:

This letter is in follow-up to the Draft Response to the above audit report. The following responses are addendum to Recommendations 1 & 2 and a response to Finding # 4.

Recommendation 1 & 2

OIG recommended that CVS Caremark provide documentation the recovery efforts were initiated to recover payments payment to ineligible members.

Response to Recommendation 1&2

Caremark will initiate recovery efforts on the identified claims. In addition, it should be noted that the Refund Recovery process is not FEP Financial responsibility but is a function of the vendor.

**Deleted by the OIG
Not Relevant to the Final Report**

**Deleted by the OIG
Not Relevant to the Final Report**

If you have any questions, please feel free to contact me at 202.942.1159.

Sincerely,

[redacted],
Director, Program Assurance

cc: [redacted],, OPM
[redacted],, FEP
[redacted],, FEP