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 RETAIL PHARMACY OPERATIONS AS ADMINISTERED BY CVS CAREMARK IN 2006 AND 2007

Report No. 1H-01-00-11-063

Date: August 8, 2012

--CAUTION--

This audit report has been distributed to Federal officials who are responsible for the administration of the audited program. This audit report may contain proprietary data which is protected by Federal law (18 U.S.C. 1905). Therefore, while this audit report is available under the Freedom of Information Act and made available to the public on the OIG webpage, caution needs to be exercised before releasing the report to the general public as it may contain proprietary information that was redacted from the publicly distributed copy.

AUDIT REPORT

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

CONTRACT CS 1039
PLAN CODE 10

Report No. 1H-01-00-11-063 **Date:** August 8, 2012

Michael R. Esser
Assistant Inspector General for Audits

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EXECUTIVE SUMMARY

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

CONTRACT CS 1039
PLAN CODE 10

Report No. 1H-01-00-11-063 **Date:** August 8, 2012

The enclosed audit report details the results of our audit of Blue Cross and Blue Shield's (Plan) retail 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 in our Washington, D.C. and Cranberry Township, Pennsylvania offices from September 30, 2011 to December 29, 2011.

The audit covered retail pharmacy claims and the Plan's adherence to its contractual requirements for contract years 2006 and 2007. This report questions $689,762 in prescription drug overpayments, which includes $7,437 for lost investment income calculated through June 30, 2012. The results of our audit have been summarized below.

MEMBER ELIGIBILITY REVIEW

- **Member Eligibility Problems Identified** **$682,325**

  We identified 7,212 claims, totaling **$644,395**, that should have been recovered after eligibility updates were received showing the members were ineligible at the time of service.

Additionally, we identified 652 claims, totaling **$37,930**, which were paid for members who, according to the Plan's enrollment data, were ineligible at the time of service.

NON-COVERED DRUG REVIEW

The results of our review showed that the Plan did not improperly pay for non-covered drugs.

DEBARRED PHARMACIES REVIEW

The results of our review showed that the Plan had the appropriate procedures in place to prevent payments to debarred pharmacies.

DUPLICATE CLAIMS REVIEW

The results of our review showed that the Plan had the appropriate procedures in place to prevent duplicate claim payments.

COPAYMENT REVIEW

Our review of the 2006 and 2007 claim copayments did not identify any errors, and it appears as if the PBM applied the correct copayment amounts to drugs filled under the Standard Option and Basic Option benefit plans.

ZERO QUANTITY REVIEW

The results of our review showed that the Plan had the appropriate procedures in place to prevent the payment of claims with zero quantities dispensed.

INTERNAL CONTROLS REVIEW

The results of our review showed that the Plan complied with the contractual requirements contained within Contract CS 1039 in relation to internal control policies and the annual reporting of health benefits paid.

PERFORMANCE REVIEW

The results of our review showed that the PBM was held accountable to the performance standards and penalties required, and that the PBM furnished the required drug utilization reports that are specified in the contract for contract years 2006 and 2007.

PRICING REVIEW

The results of our review showed that the Overall Effective Discount rates given to the Plan for contract years 2006 and 2007 were met and were more cost beneficial to the Plan than receiving rebates.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The results of our review showed that the PBM 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

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.

PROGRAM IMPROVEMENT AREAS

- **Non-Covered Drug Review** **Procedural**

  The PBM provided numerous non-covered drug listings, which were used to identify potential errors in our draft audit report. These listings were unclear and led to our report inadvertently questioning claims properly paid.

- **Duplicate Claims Review** **Procedural**

  The PBM did not include all data fields/indicators in the claims data provided to the OIG. As a result of this incomplete information, our draft audit report incorrectly identified claim adjustment records as duplicate claims.

LOST INVESTMENT INCOME ON FINDINGS

As a result of the questioned claims for ineligible members who were ineligible at the time of service ($37,930), the FEHBP is due lost investment income of **$7,437** through June 30, 2012 (interest will continue to accrue after that date until all questioned costs are returned to the FEHBP).

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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) retail 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 was performed in our Washington, D.C. and Cranberry Township, Pennsylvania offices from September 30, 2011 to December 29, 2011.

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, 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 FEHB Act are implemented by OPM through regulations codified in 5 CFR 890.

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. 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 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.

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.

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 $5,569,273,111 in prescription drug charges (claims and administrative costs) 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 identified potential error universes within the full claims universe of 123,602,076 claim lines, totaling $5,357,220,152, and performed the following audit steps:

Member Eligibility Review

- We identified 147 members, with claims paid totaling $199,209, who had a date of birth prior to January 1, 1903. We judgmentally selected the 30 oldest members identifiable by Social Security Number, with claims paid totaling $34,982, to determine if claims were paid for deceased members.
- We identified 23,538 members with claims paid (totaling $6,505,915) either before enrollment was effective, after enrollment was terminated, or during gaps in insurance coverage. We judgmentally selected the 50 members (totaling $527,867) with the greatest amount paid by the FEHBP to determine if the members were eligible at the time the claims were paid.
- We identified 2,066 members, with claims paid totaling $1,745,313, who at one time were Blue Cross and Blue Shield subscribers but no longer appeared to have coverage for the years reviewed. We judgmentally selected the 50 members (totaling $528,496) with the greatest amount paid by the FEHBP to determine if the members were eligible at the time the claims were paid.
- We identified 417,088 claim lines (totaling $27,442,058) for member dependents age 23 and over. We randomly selected 50 claim lines from the dependent universe and reviewed all claims paid to those dependents (4,798 claim lines, totaling $318,308) to determine if each dependent was eligible for FEHBP coverage at the date the claim was incurred.
- We reviewed the full claims universe to determine if any payments were made to non-FEHBP members, or to members enrolled in another group or plan code.

Non-Covered Drug Review

- Using the PBM's excluded drug list, we judgmentally selected a sample of 827 (out of 2,132) National Drug Codes (NDCs) and performed a search to determine if any claims were paid for those excluded NDCs.

Debarred Pharmacies Review

- Using the OIG Administrative Sanctions Department's Debarred Pharmacies List, we identified and reviewed 4 pharmacies with 2,820 claim lines, totaling $84,402, to determine if the claims were properly paid.

Duplicate Claims Review

- We identified 250,360 potential duplicate claim payments totaling $16,192,706. We judgmentally selected 105 potential duplicate claim payments to determine if the claims were paid in error.

Copayment Review

- We randomly selected 50 claims for drugs paid under the Standard Option for each of the years 2006 and 2007.
- We randomly selected 50 claims respectively for generic drugs, formulary brand-name drugs, and non-formulary brand-name drugs paid under the Basic Option for each of the years 2006 and 2007.
- The selected claims were reviewed to determine if the copayments were applied in accordance with the benefits outlined under the Basic Option and Standard Option within the 2006 and 2007 service benefit plan brochures.

Zero Quantity Review

- We identified 11,517 claim lines, totaling $890,214, as claims paid with zero quantities dispensed. We judgmentally selected all claim lines over $400 (112 claim lines, totaling $87,134) to determine if the claims were paid correctly.

Internal Controls Review

- We reviewed prior audits of the PBM's internal controls related to the Remote Electronic Claims Adjudication Process (RECAP) retail pharmacy claims processing system to determine the existence and effectiveness of internal control policies on 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 determine if its internal controls appear to be adequate.
- We compared the paid prescription retail claims amounts reported on Schedule 4 of the Plan's 2006 and 2007 Annual Accounting Statements to the 2006 and 2007 retail prescription claims data that was provided to OPM by the PBM to determine if there were material discrepancies.

Performance Review

- We obtained the FEP's Annual Control and Performance Review of Caremark's Retail Prescription Benefit 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.

Pricing Review

- We reviewed a third party audit report 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 a third party independent financial analysis of all bids for pharmacy services to determine if the PBM offered the best rate and if the overall effective discount was more beneficial than receiving rebates.

Health Insurance Portability and Accountability Act

- We obtained 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.

Fraud and Abuse

- 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.

Only those samples specifically identified as such were statistically based. Consequently, the results of the non-statistical samples 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 an exit conference. In addition, a draft report, dated January 3, 2012, was provided to the Plan for review and comment. The Plan's responses 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. MEMBER ELIGIBILITY REVIEW

1. Member Eligibility Problems Identified $682,325

We identified 7,212 claims, totaling $644,395, that should have been recovered after eligibility updates were received showing the members were ineligible at the time of service. Additionally, we identified 652 claims, totaling $37,930, which were paid for members who, according to the Plan's enrollment data, were ineligible at the time of service.

We compared the Plan's enrollment data to the claims paid by the PBM in 2006 and 2007 to determine if any claims were potentially paid during a period when a member was ineligible to receive benefits. Our comparison identified a potential error universe of 25,604 members with claims paid totaling $8,251,228. We sampled the top 100 members (by total amount paid) with 11,986 claims, totaling $1,056,363, to determine if the Plan's eligibility information showed the member as ineligible to receive benefits at the time the claim was paid (making the claim unallowable), or if the Plan's eligibility information was updated after the date the claim was paid to show the member was ineligible (making the claim recoverable).

Recoverable Claims Due to Eligibility Updates

Contract CS 1039, Section 2.3 (g) Erroneous Payments states, "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."

We reviewed the sampled members and found that 68 members (with 7,212 claims, totaling $644,395) were not eligible at the time of service. However, our review found that the Plan's eligibility system showed the members as eligible at the time of service. The Plan should have initiated recoveries as soon as the Plan's eligibility system was updated to show the member was ineligible at the time of service.

Because the Plan erroneously paid these claims and had not recovered the overpayments, the FEHBP was overcharged $644,395.

Recommendation 1

We recommend that the contracting office require the Plan to initiate and document recovery efforts on all 7,212 claims questioned, totaling $644,395, and return those funds recovered to the FEHBP.

The PBM's Comments:

The PBM agreed that the questioned claims had retroactive changes made to the enrollment records after adjudication and that refund recovery was initiated or is in process for the questioned claims.

Recommendation 2

We recommend that the contracting office ensure that the Plan reviews and improves its system of controls for identifying members with retroactive enrollment changes, promptly informs the PBM of all retroactive changes, identifies any claims erroneously paid in the interim, and promptly initiates and documents its recovery efforts.

The Plan's Comments:

The Plan responded that the "(FEP) has an existing system of controls currently in place to promote the timely identification of claims impacted by retroactive enrollment changes and where applicable the initiation of recovery within 30 days of payment error confirmation. For enrollment activities, the FEP Operations Center updates enrollment and eligibility information throughout each business day; at the end of each day, all enrollment and eligibility updates for that day are compiled and sent to Caremark."

It further states that "once the enrollment updates are processed the FEP claims system identifies any claims that may be impacted by changes to the enrollment/eligibility data. Those identified claims are sent to Caremark via the "Retroactive Enrollment File" on a monthly basis." The PBM "is required to review these claims listings and, where appropriate, send recovery letters to the members requesting refunds."

The PBM "also has a performance measure that once payment errors are identified, recovery letters should be sent 30 days from the confirmation of payment errors." The Plan stated that the PBM's performance on this measure shows that they were in compliance for 2011.

OIG Comments:

We do understand that the Plan has existing controls in place to recover claims inadvertently paid due to retroactive enrollment changes. However, our review of the 7,212 claims questioned showed that only 3,165 claims (totaling $315,795) have begun the recovery process. This leaves 4,047 claims (totaling $328,600) or 56 percent of the total claims questioned with no recovery action begun at the time of the writing of this report.

Further review of the 3,165 claims where recovery has been initiated found that the recoveries were initiated well past the date the Plan's enrollment system was updated with correct information showing the members with no coverage. In fact, the average

delay in initiating recoveries was 207 days after the enrollment data was updated, well beyond the 30 days that the Plan states in its response.

Additionally, no evidence was provided that showed any additional follow-up was made after the initial recovery letter was sent as is required by Contract CS 1039 (Section 2.3 (g) (2)).

Unallowable Claims for Ineligible Members

FEHBAR 1652.216-71 and Contract CS 1039, Section 3.2 (b) Definition of costs (1) state, "The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable."

Additionally, Contract CS 1039, Section 3.2 (b) (1) (i) states that the Carrier must "on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary."

We reviewed the sampled members and found 5 members (with 652 claims, totaling $37,930) who were not eligible at the time of service, and that the Plan's eligibility system was updated to show their ineligibility before the date of service.

Due to the ineligibility of those 5 members at the time of service, the FEHBP was overcharged $37,930.

Recommendation 3

We recommend that the contracting office require the Plan to credit back to the FEHBP $37,930 in ineligible claim payments.

The PBM's Comments:

The PBM disagrees with the finding. It contends that the claim payments were paid correctly at the date of fill and that retroactive enrollment changes are the reason for the overpayments identified. It states that refunds have been, or are in the process of being, initiated to recover and return the funds to the program.

The Plan's Comments:

The Plan restated the PBMs assertion that the questioned overpayments were the result of retroactive enrollment changes. It also stated that there are controls in place to provide the PBM with listings of claims impacted by the retroactive changes on a monthly basis and that the PBM is contractually required to begin recovery efforts within 30 days of receipt of the reports. Additionally, the Plan stated that the PBM has been instructed to initiate recoveries on all confirmed overpayments and adjust the claims for any recoveries to credit the Program.

OIG Comments:

We acknowledge the PBM's response and hold the Plan responsible for initiating the recovery process. We have determined that the five members' claims questioned were ineligible at the time of payment and that the Plan's eligibility database indicates that these members were ineligible prior to the services incurred. The Plan provided no further documentation from its eligibility database to show that these members were eligible. It is ultimately the Plan's responsibility to update the PBM in a timely manner.

Additionally, it is our opinion that the $37,930 in payments questioned do not meet the definition of "good faith payments." We base this opinion on the fact that a reasonable business person would not pay a claim for an individual with terminated coverage. As stated above, the Plan's own eligibility database shows that the members questioned were ineligible at the time the claims were incurred. It is then our assumption that the Plan was aware of the eligibility status of these individuals at that time. However, this information was apparently not communicated to the PBM by the Plan. As a result, we have determined that these payments are unreasonable and unallowable charges against the contract which must be returned immediately, regardless of the Plan's recovery efforts, and are subject to lost investment income (LII).

Finally, as a result of the high rate of errors identified during this review, we intend to conduct a more expanded review of Member Eligibility for contract years 2006 and 2007, excluding those members reviewed here, in a future audit.

B. NON-COVERED DRUG REVIEW

The results of our review showed that the Plan did not improperly pay for non-covered drugs. However, the drugs questioned in the draft report were misidentified as excluded drugs due to the auditors receiving indistinct excluded drug lists from the PBM.

C. DEBARRED PHARMACIES REVIEW

The results of our review showed that the Plan had the appropriate procedures in place to prevent payments to debarred pharmacies.

D. DUPLICATE CLAIMS REVIEW

The results of our review showed that the Plan had the appropriate procedures in place to prevent duplicate claim payments.

E. COPAYMENT REVIEW

Our review of the 2006 and 2007 claim copayments did not identify any errors, and it appears as if the PBM applied the correct copayment amounts to drugs filled under the Standard Option and Basic Option benefit plans.

F. ZERO QUANTITY REVIEW

The results of our review showed that the Plan had the appropriate procedures in place to prevent the payment of claims with zero quantities dispensed.

G. INTERNAL CONTROLS REVIEW

The results of our review showed that the Plan complied with the contractual requirements contained within Contract CS 1039 in relation to internal control policies and the annual reporting of health benefits paid.

H. PERFORMANCE REVIEW

The results of our review showed that the PBM was held accountable to the performance standards and penalties required and that the PBM furnished the required drug utilization reports that are specified in the contract for contract years 2006 and 2007.

I. PRICING REVIEW

The results of our review showed that the Overall Effective Discount rates given to the Plan for contract years 2006 and 2007 were met and were more cost beneficial to the Plan than receiving rebates.

J. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILTY 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.

K. FRAUD AND ABUSE

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

L. PROGRAM IMPROVEMENT AREAS

1. Non-Covered Drug Review — Procedural

The PBM provided numerous non-covered drug listings, which were used to identify potential errors in our draft audit report. These listings were unclear and led to our report inadvertently questioning claims properly paid.

During our review of the PBM's responses to our non-covered drug finding included in our draft report, we became aware that many of the listings were for drugs that were not covered unless other criteria (like pre-authorization) were met, which would then allow the drug to be covered. Additionally, many of the lists were for drugs that were not

covered under mail-order, but were allowable in a retail setting. Finally, further discussion with OPM determined that there were also cases where a drug was allowed for off-label usage if a provider approved its use to treat certain conditions after member appeal.

As a result of the lists provided to us not including all possible exceptions, not distinguishing between mail-order and retail, and not including drugs allowed for off-label usage by OPM, our non-covered drug review had numerous false hits.

Recommendation 4

We recommend that the contracting officer direct the Plan to ensure that the PBM's excluded drug list(s) are more explanatory as to which drugs are actually unallowable and which excluded drugs may be covered under special circumstances for both mail-order and retail drugs.

The PBM's and Plan's Comments:

The draft audit report did not include this recommendation. Therefore, the PBM and Plan did not address this in their responses.

2. Duplicate Claims Review **Procedural**

The PBM did not include all data fields/indicators in the claims data provided to the OIG. As a result of this incomplete information, our draft audit report incorrectly identified claim adjustment records as duplicate claims.

In response to our sampled duplicate claim payments questioned in the draft report, the PBM indicated to us, with supporting documentation, that the claims we had questioned were actually claim reversals, which we confirmed. Our duplicate claim payment samples were pulled from the 2006 and 2007 prescription claims data received from the PBM. We used the PBM's process to identify reversal/adjustment pairs, as summation records were created to total up the original and adjustment records. However, the prescription claims data provided to us by the PBM did not include and populate the Pre-Authorization "flag," which played a factor in populating our sample with numerous false hits.

Recommendation 5

We recommend that the contracting officer require the Plan to ensure that the PBM includes the Pre-Authorization flag in its future claims records provided to the OIG.

The PBM's and Plan's Comments:

The draft audit report did not include this recommendation. Therefore, the PBM and Plan did not address this in their responses.

M. LOST INVESTMENT INCOME ON AUDIT FINDINGS

The FEHBP is due $7,437 for LII related to the $37,930 questioned for members who were ineligible at the time of service.

FEHBAR 1652.215-71 and Contract CS 1039, Section 3.4 Investment Income (d), state "Investment income lost as a result of unallowable, unallocable, or unreasonable charges against the contract shall be paid from the first day of the contract term following the contract term in which the unallowable charge was made and shall end on the earlier of: (1) the date the amounts are returned to the Special Reserve (or the Office of Personnel Management); (2) the date specified by the Contracting Officer; or (3) the date of the Contracting Officer's Final Decision." In addition, Section 3.4 Investment Income (f) provides that LII shall bear simple interest at the quarterly rate determined by the Secretary of the Treasury under the authority of 26 U.S.C. 6621 (a) (2).

We computed LII that would have been earned using the rates specified by the Secretary of Treasury and determined that FEHBP is due $7,437 for LII, calculated from erroneous claim payments made in 2006 and 2007 on the questioned members.

Recommendation 6

We recommend that the contracting office require the Plan to credit the FEHBP $7,437 for LII on the audit finding calculated through June 30, 2012 (interest will continue to accrue after that date until all questioned costs are returned to the FEHBP).

The PBM's and Plan's Comments:

The draft audit report did not include LII on audit findings. Therefore, the Plan and PBM did not address this in their responses.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Special Audits Group

[redacted], Auditor-In-Charge

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[redacted], Senior Team Leader

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

REPORT NUMBER 1H-01-00-11-063

SCHEDULE A - CONTRACT CHARGES	
A. PHARMACY CLAIMS	
2006 Retail Prescription Drug Claim Payments	$2,634,940,769
2007 Retail Prescription Drug Claim Payments	2,934,332,342
TOTAL CONTRACT CHARGES	$5,569,273,111

SCHEDULE B - QUESTIONED COSTS	
A. MEMBER ELIGIBILITY REVIEW	
1. Member Eligibility Problems Identified	
- Recoverable Claims Due to Eligibilty Updates	$644,395
- Unallowable Claims for Ineligible Members	37,930
Total Member Eligibility Claims Questioned	$682,325
B. LOST INVESTMENT INCOME (See Schedule C)	$7,437
TOTAL QUESTIONED COSTS	$689,762

SCHEDULE C

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

REPORT NUMBER 1H-01-00-11-063

LOST INVESTMENT INCOME CALCULATION

LOST INVESTMENT INCOME	2006	2007	2008	2009	2010	2011	2012	TOTAL
A. QUESTIONED CHARGES (Subject to Lost Investment Income)								
Unallowable Claims for Ineligible Members	$ 18,391	$ 19,539	$ -	$ -	$ -	$ -	$ -	$ 37,930
TOTAL	$ 18,391	$ 19,539	$ -	$ -	$ -	$ -	$ -	$ 37,930
B. LOST INVESTMENT INCOME CALCULATION								
a. Prior Years Total Questioned (Principal)	$ -	$ 18,391	$ 19,539	$ -	$ -	$ -	$ -	
b. Cumulative Total	$ -	$ -	$ 18,391	$ 37,930	$ 37,930	$ 37,930	$ 37,930	
c. Total	$ -	$ 18,391	$ 37,930	$ 37,930	$ 37,930	$ 37,930	$ 37,930	
d. Treasury Rate: January 1 - June 30	5.125%	5.250%	4.750%	5.625%	3.250%	2.625%	2.000%	
e. Interest (d * c)	$ -	$ 483	$ 901	$ 1,067	$ 616	$ 498	$ 379	$ 3,944
f. Treasury Rate: July 1 - December 31	5.750%	5.750%	5.125%	4.875%	3.125%	2.500%		
g. Interest (f * c)	$ -	$ 529	$ 972	$ 925	$ 593	$ 474		$ 3,493
Total Interest By Year (e + g)	$ -	$ 1,012	$ 1,873	$ 1,992	$ 1,209	$ 972	$ 379	$ 7,437

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Federal Employee Program
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Washington, D.C. 20005
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February 10, 2012

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

Reference: OPM DRAFT AUDIT REPORT
CVS/CAREMARK Retail Pharmacy Operations
Audit Report Number 111-01-00-11-063
(Dated January 3, 2012 Received January 3, 2012)

Dear

This is our response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) for Retail Pharmacy Operations at CVS/Caremark. Our comments concerning the findings in this report are as follows:

A. MEMBER ELIGIBILITY REVIEW $819,043

1. Member Eligibility Problems Identified $681,597

The OIG Auditors identified 7,655 claims, totaling $681,597 that should have been recovered after eligibility updates were received showing the ineligible at the time of service.

Recommendation 1

The OIG Auditors recommended that the contracting office direct the Plan to begin recovery of those claims identified and credit back to the FEHBP those monies recovered. Additionally, the Plan should provide an explanation as to why these claims were paid in error.

Response to Recommendation 1

CVS/Caremark agreed that the claims in question had retroactive changes made to the enrollment records after the adjudication of the transactions. Refund recovery was initiated or is in process for these claims. Attachment 1 is a spreadsheet that identifies the status of each of the transactions.

Recommendation 2

The OIG Auditors recommended that the contracting office direct the Plan to adopt a better system of controls for initiating recovery of claims after member eligibility updates deem them unallowable.

Response to Recommendation 2

The Federal Employee Program (FEP) has an existing system of controls currently in place to promote the timely identification of claims impacted by retroactive enrollment changes and where applicable the initiation of recovery within 30 days of payment error confirmation. For enrollment activities, the FEP Operations Center updates enrollment and eligibility information throughout each business day; at the end of each day, all enrollment and eligibility updates for that day are compiled and sent to Caremark.

Additionally, once the enrollment updates are processed the FEP claims system identifies any claims that may be impacted by changes to the enrollment/eligibility data. Those identified claims are sent to Caremark via the “Retroactive Enrollment File” on a monthly basis. CVS/Caremark is required to review these claims listings and, where appropriate, send recovery letters to the members requesting refunds.

CVS/Caremark also has a performance measure that once payment errors are identified, recovery letters should be sent 30 days from the confirmation of payment errors. CVS Caremark performance on this measure for 2011 was shown that they are in compliance with this measure.

Recommendation 3

The OIG Auditors recommended that the contracting office direct the Plan to respond as to whether claim recoveries were initiated and if they were not why.

Response to Recommendation 3

CVS/Caremark has indicated that recovery was initiated or is in process as provided in Attachment 3.c.

2. Unallowable Claims for Ineligible Members **$137,446**

The OIG Auditors identified that due to the ineligibility of 13 members at the time of service, the FEHBP was overcharged $137,446.

Recommendation 4

The OIG Auditors recommended that the contracting office direct the Plan to begin recovery of those claim identified and credit back to the FEHBP those monies recovered. Additionally, the Plan should provide an explanation as to why these claims were paid in error.

Response to Recommendation 4

CVS/Caremark disagrees that claim payments totaling $26,622 were paid incorrectly. Documentation to support the reasons for the contested items is included in the attachments. However, CVS/Caremark does agree that claim payments totaling $104,473 were paid correctly at the dates of fill for the prescriptions but later Retroactive Contract Terminations were generated which resulted in the overpayments. Refunds have been initiated or are in process for these confirmed payment errors. As of January 31, 2012, $30,594 has been recovered and returned to the Program.

Recommendation 5

The OIG Auditors recommended that the contracting office direct the Plan to adopt a better system of controls for reviewing dependant eligibility when there are changes in Plan Codes and dependant updates.

Response to Recommendation 5

The enrollment process at the Contract level and special eligibility exceptions is owned and controlled by the Payroll Offices. The timeliness of any contract updates is determined by the Payroll Offices. The Operations Center validates the eligibility of dependents and can add dependents, if they meet the established relationship requirements.

The FEP Operations Center has both an audit and a quality process for monitoring the accuracy of enrollment data. This process also includes the validation of dependent coverage by sending letters and following up with the contract holder. The Audit Process is described in Attachment 2.A. The audit results are used to report the Operations Center enrollment accuracy performance. The goal for this measure is 99% which has been met by the Operations Center for the last eight quarters. Attachment 2.B is a description of the internal Quality Process within the Enrollment Department at

the Operations Center. This is an internal tool that is used to promote the proficiency of the overall enrollment process. In addition, the identified errors are used as training tools for those processors who handle the manual/deferred transactions.

Most of the identified enrollment exceptions were the result retroactive enrollment changes. The Payroll Offices submitted updates/changes to the contracts that had effective dates that ranged from two weeks to years in the past. In the meantime, claims were being paid because the coverage still showed active at the time of adjudication. Anytime updates are made to the FEP Enrollment System, the claims system is also checked to identify any claims that may be impacted by changes to the eligibility data. These identified claims are then sent via the "Retroactive Enrollment Files" to Caremark on a monthly basis. The Retroactive Enrollment Files contain listings of potential impacted claims that must be reviewed and where appropriate recovery letters are to be sent to the members requesting refunds. Refund recovery actions are to be taken within 30 days of confirmation that payment errors have occurred.

Recommendation 6

The OIG Auditors recommended that the contracting office direct the Plan to respond as to why their eligibility system showed ineligibility and why the PBM's (Pharmacy Benefit Manager) system showed ineligibility and the PBM's system showed eligibility for the claims in question.

Response to Recommendation 6

CVS/Caremark's disagrees with this finding. A review was conducted of all the questioned claims. The enrollment documentation on FEPExpress matched CVS/Caremark's local enrollment system.

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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

cc: [REDACTED], CVS/Caremark
[REDACTED]r, FEP
[REDACTED], FEP
[REDACTED], FEP

From: [redacted]
Sent: Tuesday, March 06, 2012 4:31 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Response to OPM Draft Audit Report 111-01-00-063

[redacted] below is our response:

Recommendation 4

The OIG Auditors recommended that the contracting office direct the Plan to begin recovery of those claim identified and credit back to the FEHBP those monies recovered. Additionally, the Plan should provide an explanation as to why these claims were paid in error.

FEP's Response to Recommendation 4

For the enrollment issues identified in this audit, most of the overpayments were from Retro Enrollment Changes at the Contract/Member Levels. The controls that are in place include the updating of the enrollment data which will generate the listings of the impact claims on a monthly basis to the PBMs. The PBMs are required by contract to initiate recoveries within 30 days of the receipt of the reports. Caremark has been instructed to initiate recoveries on all confirmed overpayments and adjust the claims for any recoveries to credit the Program.