



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

Final Audit Report

**Audit of the Compass Rose Health Plan's
Pharmacy Operations as Administered by
Express Scripts, Inc. for
Contract Years 2012 through 2015**

**Report Number 1H-06-00-17-026
August 16, 2018**

EXECUTIVE SUMMARY

Audit of the Compass Rose Health Plan's Pharmacy Operations As Administered by Express Scripts, Inc.

Report No. 1H 06-00-17-026

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Why Did We Conduct the Audit?

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 terms of U.S. Office of Personnel Management (OPM) Contract Number CS 1065 with the Compass Rose Health Plan (Plan), the Plan's agreement with Express Scripts, Inc. (PBM), and the applicable Federal regulations.

What Did We Audit?

The Office of the Inspector General (OIG) has completed a performance audit of the Plan's pharmacy benefits operations as administered by the PBM. Our audit included reviews of administrative fees, claim payments, fraud and abuse, performance guarantees, and pharmacy rebates related to the FEHBP for contract years 2012 – 2015. We conducted a fieldwork site visit from September 18 through 22, 2017, at the PBM's office in St. Louis, Missouri. Additional audit fieldwork was completed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania.



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for Audits*

What Did We Find?

We determined that the Plan and the PBM need to strengthen procedures and controls related to the following audit areas:

Administrative Fees Review

- The PBM incorrectly billed the Plan for specialty pharmacy claim administrative fees.

Pharmacy Claim Payments Review

- The PBM initially overcharged the Plan \$85,854 for brand name mail order pharmacy claims paid between July 31, 2014, and December 31, 2014.
- The Plan paid 161 pharmacy claims totaling \$14,226 for dependents that were ineligible for coverage when the prescription was filled.
- The Plan did not provide the PBM with the appropriate provider listing to prevent payments to debarred providers.

Fraud and Abuse Program Review

- The Plan did not report suspected fraud cases received from the PBM to the OPM OIG.

Performance Guarantees Review

- The Plan failed to notify the PBM of a performance guarantee penalty due in the amount of \$6,250 for contract year 2013.

In addition, we identified two opportunities for program improvements related to mail order dispensing fees/reduced copay and maintaining documentation to support copay overrides.

ABBREVIATIONS

2012 Agreement	The Integrated Prescription Drug Program Agreement between Compass Rose Health Plan and Express Scripts, Inc. for 2012-2014
2014 Amendment 1	Amendment (dated January 1, 2014) to the Integrated Prescription Drug Program Agreement between Compass Rose Health Plan and Express Scripts, Inc. for 2012-2014
2014 Amendment 2	Amendment (dated July 1, 2014) to the Integrated Prescription Drug Program Agreement between Compass Rose Health Plan and Express Scripts, Inc. for 2012-2014
2015 Agreement	The Integrated Prescription Drug Program Agreement between Compass Rose Health Plan and Express Scripts, Inc. for 2015-2017
5 CFR 950	Title 5, Code of Federal Regulations, Chapter 1, Part 890
Act	Federal Employees Health Benefits Act
AWP	Average Wholesale Price
Contract	Contract Number CS 1065
CY	Contract Years
FEHBP	Federal Employees Health Benefits Program
FWA	Fraud, Waste, and Abuse
FWA Report	Fraud, Waste and Abuse Recovery and Savings Data Reports
HIO	Healthcare and Insurance Office
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
PBM	Express Scripts, Inc.
Plan	Compass Rose Health Plan

TABLE OF CONTENTS

	<u>Page</u>
EXECUTIVE SUMMARY	i
ABBREVIATIONS	ii
I. BACKGROUND	1
II. OBJECTIVES, SCOPE, AND METHODOLOGY	3
III. AUDIT FINDINGS AND RECOMMENDATIONS	9
A. ADMINISTRATIVE FEES REVIEW	9
1. Specialty Pharmacy Administrative Fees	9
B. PHARMACY CLAIM PAYMENTS REVIEW	10
1. Pharmacy Claim Payment Errors	10
2. Over-Age Dependents	11
3. Debarment Listing	13
C. FRAUD AND ABUSE PROGRAM REVIEW	14
1. Failure to Report Suspected Fraud, Waste and Abuse Cases	14
D. PERFORMANCE GUARANTEES REVIEW	15
1. Performance Standard Penalty Payment	15
E. PHARMACY REBATES REVIEW	17
F. PROGRAM IMPROVEMENT AREAS	17
1. Excess Mail Order Dispensing Fees/Reduced Copay	17
2. Copay Override Documentation	19
APPENDIX (The Plan’s Response to the Draft Report, dated June 1, 2018)	
REPORT FRAUD, WASTE, AND MISMANAGEMENT	

I. BACKGROUND

This report details the results of our audit of the Compass Rose Health Plan's (Plan) pharmacy operations as administered by Express Scripts, Inc. (PBM) for contract years (CY) 2012 through 2015. The audit was conducted pursuant to the provisions of Contract Number CS 1065 (Contract) between the U.S. Office of Personnel Management (OPM) and the Plan; the Integrated Prescription Drug Program Agreements between the Plan and the PBM; Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890). The report covers a period in which the agreement between the Plan and the PBM underwent significant changes. The original agreement, covering 2012 through 2014 (2012 Agreement), was amended twice; the first covering January 1, 2014, through June 30, 2014 (2014 Amendment 1), and the second covering July 1, 2014, through December 31, 2014 (2014 Amendment 2). The Plan and the PBM entered into a new agreement beginning in 2015 (2015 Agreement). 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 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 entered into an Agreement with the PBM, located in St. Louis, Missouri, to provide pharmacy benefits and services to its members for CYs 2012 through 2015. Section 1.11 of the Contract with OPM includes a provision which allows for audits of the program's operations. Additionally, section 1.26(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 Agreements, and Federal regulations.

This report represents the OIG's 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 during a January 4, 2018, exit conference. On May 2, 2018, we issued a draft report to the Plan and PBM for review and comment. We considered the Plan's draft report response when preparing the final report. The Plan's response is included as an Appendix to this report.

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 Agreements, 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.
- The Plan's letter of credit account pharmacy benefit withdrawals were in accordance with the terms of the FEHBP contract.

Pharmacy Claim Payments Review

- Claims were paid for ineligible dependents age 26 and older.
- Claims were paid for non-covered drugs.
- Claims were paid for non-FEHBP members or members enrolled in an alternate plan code.
- Claims were paid to debarred pharmacies.
- The pricing elements for the retail, mail order, and specialty drug claims were transparent and paid correctly and in accordance with the Agreement.

Fraud and Abuse Program Review

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

Performance Guarantees Review

- The PBM’s performance reports and any associated penalties were properly calculated and submitted timely.

Pharmacy Rebates Review

- The pharmacy rebates related to the Plan were properly supported, accurately calculated, and remitted to the Plan in a timely manner.

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 reviews of administrative fees, the fraud and abuse program, performance guarantees, pharmacy claim payments, and pharmacy rebates related to the FEHBP for CYs 2012 through 2015. The audit fieldwork was conducted from September 18, 2017, through February 23, 2018, and was completed at our Washington, D.C. and Cranberry Township, Pennsylvania offices.

The Plan is responsible for providing FEHBP members with medical and prescription drug benefits. To meet this responsibility, the Plan collected total premium payments¹ of approximately [REDACTED] in CYs 2012 through 2015, of which approximately two-thirds was paid by the government on behalf of Federal employees. Total pharmacy claims paid were approximately [REDACTED] in CYs 2012 through 2015 (See below).

Contract Year	Total Drug Claims	Drug Claims Paid
2012	[REDACTED]	[REDACTED]
2013	[REDACTED]	[REDACTED]
2014	[REDACTED]	[REDACTED]
2015	[REDACTED]	[REDACTED]
Total	[REDACTED]	[REDACTED]

¹ Total premium payments include monies for hospitalization, physician, and prescription drugs in the FEHBP.

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. 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 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 Agreements 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 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. 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 CYs 2012 through 2015 were in accordance with the terms of the Contract and applicable Federal regulations, we performed the following audit steps:

Administrative Fees Review

- We judgmentally selected and reviewed the largest administrative fee invoice for those fees covering 2012 and 2013 (outlined in the 2012 Agreement), 2014 (outlined in 2014 Amendment 1), and 2015 (outlined in the 2015 Agreement) to determine if the fees were properly calculated and supported in accordance with the terms of the Agreements between the Plan and the PBM. Specifically, we selected three invoices, totaling \$929,526, from a universe of [REDACTED] invoices, totaling [REDACTED].

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.

Pharmacy Claim Payments Review

Unless stated otherwise, the claim samples below were selected from the complete claims universe of [REDACTED] claims, totaling [REDACTED], for CYs 2012 through 2015.²

- We identified a universe of [REDACTED] members with claims for dependent children aged 26 or older, totaling [REDACTED]. From the universe we judgmentally selected 36 members, with claims totaling \$127,329, for review and determined if the dependent children were eligible for coverage at the date of service of the claims. The samples were selected utilizing the following methodology:
 - Claims for all members with claims totaling \$1,500 or more. Specifically, we selected 21 members with claims totaling \$119,120; and
 - Claims for all remaining members with dependent children aged either 26 or 27, with claims totaling \$250 or greater. Specifically, we selected 15 additional members with claims totaling \$8,209.
- During our review of the over-aged dependent universe, we identified a number of members with dependent children listed with ages 60 or greater. As a result, we judgmentally selected all members (11 members with claims totaling \$3,432) for review to determine if the eligibility status listed (dependent child) was correct.
- To determine if any claims were paid for non-covered drugs, we performed a query to identify all 33 National Drug Codes (NDC) that the Plan provided and indicated were not covered during the scope of the audit. For mail order and retail claims, we judgmentally

² These totals are obtained from the claims data files provided by the PBM and do not reconcile to the totals reported by the Plan in the Annual Accounting Statements due to timing and the inclusion of reversals/credits in the PBM data files.

selected all claims with NDCs matching the PBMs exclusion list with claims totaling \$5,000 or more. Specifically, the samples were selected as follows:

- For mail order claims, we selected 3 NDCs with claims totaling \$48,811, from a universe of 11 NDCs with claims totaling [REDACTED].
- For retail claims, we selected 9 NDCs with claims totaling \$127,643, from a universe of 33 NDCs with claims totaling [REDACTED].
- We reviewed all claims to determine if any were paid for non-FEHBP members or members enrolled in another FEHBP plan code.
- We reviewed all claims to determine if any payments were made to pharmacies debarred by the OIG's Administrative Sanctions Office.
- From the retail pharmacy claims universe of [REDACTED] claims, totaling [REDACTED], we identified the top 25 retail pharmacies (by total amount paid) and judgmentally selected 200 claims, totaling \$22,376, from the top five pharmacies to determine if the claims were paid in accordance with the Plan's benefit brochure and that the claim's pricing elements were transparent in accordance with the Contract's transparency standards. Specifically, we selected the sample using the following methodology:
 - From those claims paid for brand name drugs, we randomly selected five claims per year from each pharmacy selected. As a result, we reviewed 100 brand name drug claims totaling \$20,153.
 - From those claims paid for generic drugs, we randomly selected five claims per year from each pharmacy selected. As a result, we reviewed 100 generic drug claims totaling \$2,223.
- From the specialty pharmacy claim universe of [REDACTED] claims, totaling [REDACTED], we judgmentally selected 80 claims, totaling \$156,571, to determine if the claims were paid in accordance with the Plan's benefit brochure and that claim pricing elements were transparent in accordance with the Contract's transparency standards. Specifically, we selected the sample using the following methodology:
 - From those specialty claims paid at retail pharmacies, we randomly selected 10 claims per year from the top five pharmacies identified in the retail pharmacy claim review. This resulted in 40 retail pharmacy specialty claims totaling \$18,440 being selected for review.

- From those specialty claims paid at mail order pharmacies, we randomly selected 10 claims per year. As a result, we selected 40 mail order pharmacy specialty claims, totaling \$138,131, for review.
- We identified a universe of [REDACTED] mail order pharmacy claims totaling [REDACTED]. From this universe, we randomly selected 15 brand name and 15 generic claims from each CY (120 claims, totaling \$39,842) to determine if the claims were paid in accordance with the Plan's benefit brochure and that claim pricing elements were transparent in accordance with the Contract's transparency standards.

Pharmacy Rebates Review

From CYs 2012 through 2014, we judgmentally selected the CY quarter with the largest amount of manufacturer rebates reported. Specifically, we selected three quarterly reports, with rebates totaling \$3,931,478, from a universe of 12 quarterly reports, with total rebates reported of [REDACTED]. From these three quarterly reports we selected all therapeutic descriptions with net rebates totaling \$100,000 or more, to determine if the rebates reported were calculated accurately and paid to the Plan. Specifically, we selected 12 therapeutic descriptions, totaling \$3,070,349, from a universe of [REDACTED] therapeutic descriptions, totaling [REDACTED].

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

1. Specialty Pharmacy Administrative Fees

Procedural

The PBM incorrectly under-billed the Plan for specialty pharmacy claim administrative fees in CYs 2012 through 2014.

The PBM incorrectly under-billed the Plan for administrative fees.

The Plan and PBM Agreements set forth specific administrative fees paid by the Plan (on a per claim basis) in CYs 2012 through 2015. From January 1, 2012, through June 30, 2014, the fee structure included three tier levels (set forth in the 2012 Agreement). Amendment 2 modified the fees to include only one tier level (which was continued in the 2015 Agreement). The Plan is billed administrative fees on a monthly basis.

We reviewed a sample of administrative fee invoices to determine if they were in accordance with the various Agreements and if they were supported by verifiable information. We found that the PBM incorrectly billed the Plan each month for specialty pharmacy administrative fees for the period 2012 through 2014. We also noted that following the amendment the PBM did not apply fee increases in the billing system beginning in 2013 (2012 fee levels were maintained in the billings) and that the fee changes in the July 1, 2014, amendment were not applied fully until 2015.

The PBM stated that the billing errors occurred because its system had limited logic that could not account for more than one administrative fee associated with specialty claims. Therefore, it had to manually quantify the number of claim lines for each invoice.

Additionally, the PBM stated that its billing department was not aware of the fee changes and therefore they were not implemented. The PBM stated that it became aware of the problem following the implementation of Amendment 2. Beginning with the CY 2015 invoices, the PBM stated (and we confirmed) that it had corrected all problems and that the billings to the Plan were accurate. All financial discrepancies in the billings have been resolved between the Plan and PBM.

Because the PBM's administrative fee billing system was unable to accommodate multiple levels of fees and its billing department was unaware of fee changes, the PBM incorrectly billed the Plan for specialty pharmacy claim administrative fees in CYs 2012 through 2014.

Recommendation 1

We recommend that the PBM implement controls that will ensure timely and accurate updates to the billing system when administrative fee changes occur.

Plan Response:

The Plan agrees with this recommendation and states that the PBM has implemented controls to help ensure timely and accurate updates to the billing system when administrative fee changes occur. Additionally, the Plan stated that it has implemented procedures for oversight of administrative fee changes.

B. PHARMACY CLAIM PAYMENTS REVIEW

1. Pharmacy Claim Payment Errors

Procedural

The PBM initially overcharged the Plan \$85,854 for mail order brand name pharmacy claims paid between July 31, 2014, and December 31, 2014.

Schedule A, Section 2.1 of the 2012 Agreement (effective through December 31, 2014) states that mail order pharmacy claims will be paid at a certain percentage off of Average Wholesale Price (AWP) for brand name drugs or Maximum Allowable Cost for generic drugs.

The PBM initially overcharged the Plan \$85,854 for mail order brand name drug claims in 2014.

2014 Amendment 2 (effective July 1, 2014) added Section 9 (Mail Order Pharmacy Component Discount Guarantee) to the above Agreement. This set an average discount guarantee off of AWP that was less than that set in the 2012 Agreement for mail order brand name drugs paid between July 1, 2014, and December 31, 2014. This amendment did not supersede the AWP discount for mail order drugs (Schedule A, Section 2.1 above).

During our review of mail order pharmacy claims, we identified eight brand name drug claims (paid between July 31, 2014, and December 31, 2014) that paid at the guarantee rate set in 2014 Amendment 2, instead of the discount rate set in the 2012 Agreement (paid at a lesser discount). This resulted in an overcharge to the FEHBP of \$85,854.

The PBM stated that the error was the result of changes it made to the adjudication rates for mail order brand name pharmacy claims so that the rates would match the July 1, 2014, guarantee amendment. The PBM implemented this rate change on July 31, 2014.

Discussions with the Plan determined that the Mail Order Acquisition Cost Guarantee, set forth in the 2012 Agreement, ultimately corrected this overpayment and returned the \$85,854 to the FEHBP following the close of CY 2014.

As a result, no monies are due to the FEHBP. However, the PBM's use of the incorrect AWP discount caused the Plan to initially overpay \$85,854 to the PBM.

Recommendation 2

We recommend that the PBM institute procedures to ensure that fixed discount rates in its adjudication system are set to the contracted rate(s) and not set to match guarantees.

Plan Response:

The Plan agrees with the recommendation and states that the PBM has affirmed that contracted rates are being utilized and internal controls have been applied to ensure guarantee and adjudication accuracy. Additionally, the PBM monitors internal processes and makes adjustments when necessary. The Plan also stated that it has implemented procedures to monitor compliance and accuracy.

2. Over-Age Dependents

\$14,226

The Plan paid 161 pharmacy claims, for 14 dependent children, that were ineligible for coverage when the prescription was filled. As a result, the FEHBP was overcharged \$14,226.

5 CFR 890.302(b)(1), states that "A child under the age of 26, or a child of any age who is incapable of self-support because of a mental or physical disability which existed before age 26, is considered to be a family member eligible to be covered" under the FEHBP.

The Plan paid pharmacy claims for ineligible over-age dependents.

Section 2.3(g) of the Contract states that "It is the Carrier's responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program."

Additionally, section 2.3(g)(12) of the Contract states, "In compliance with the provisions of the Contracts Dispute Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous payment where the Contracting Officer determines that (a) the

Carrier's failure to appropriately apply its operating procedure caused the erroneous payment”

We reviewed a sample of claims for dependent children age 26 or older to determine if they were eligible for coverage. From our sample, we found 14 dependents age 26 or older who were not eligible for coverage on the dates of service. Of those identified, 12 were not properly terminated upon turning age 26. The Plan was unable to provide supporting documentation for a disability determination for the two remaining dependents.

The Plan stated that its third party administrator's eligibility system does not systematically terminate dependents upon turning 26 years of age. The Plan did conduct internal audits to identify unallowable claims, which resulted in terminating some ineligible dependents. However, the Plan did not initiate any recovery efforts for those claims that were unallowable. In addition, the Plan failed to maintain proper documentation to support two dependents who were permanently disabled.

By not systematically terminating dependents at age 26, failing to initiate recovery efforts for those claims that were unallowable, and not maintaining proper documentation, the FEHBP was overcharged \$14,226.

Recommendation 3

We recommend that the Plan return \$14,226 to the FEHBP for erroneous claim payments on ineligible overage dependents.

Plan Response:

The Plan agrees with the recommendation and states that it has returned the amount in question to the FEHBP.

Recommendation 4

We recommend that the Plan identify and initiate recoveries on all claims paid for ineligible dependents.

Plan Response:

The Plan agrees with the recommendation and states that it has begun initiating recoveries on all claims.

Recommendation 5

We recommend that the Plan update its policies and procedures for identifying ineligible members to include systematically terminating dependents at age 26.

Plan Response:

The Plan agrees with the recommendation and states that it has implemented a policy and procedure for identifying ineligible members to include systematically terminating dependents at age 26.

3. Debarment Listing

Procedural

The Plan did not provide the PBM with the OPM OIG's debarment/suspension list to ensure that payments are not made for FEHBP pharmacy claims submitted by debarred providers.

The Plan did not provide the OPM OIG's debarment/suspension list to the PBM.

The OIG's Guidelines for Implementation of FEHBP Debarment and Suspension Orders instructs FEHBP carriers, when dealing with FEHBP members and enrollees, to use OPM's data for debarments.

Additionally, the above guidelines also instruct each FEHBP carrier to designate a member of its staff to serve as a point of contact with the OPM OIG on administrative sanction matters.

During our review of the PBM's debarment implementation procedures, we found that the PBM uses other Federal government exclusion lists in its system edits to ensure that claim payments are not made to debarred providers. However, it does not use OPM OIG's debarment/suspension list.

The Plan stated that it did not provide an OPM OIG debarment/suspension list to the PBM because access to OPM OIG's debarment/suspension list was set up for a previous third party administrator. The Plan stated this has been corrected and that going forward it can directly access and communicate the list to its vendors, including the PBM.

By not providing the PBM with the appropriate FEHBP debarment/suspension list, the Plan increased the risk of pharmacy claims being paid to debarred providers or pharmacies.

Recommendation 6

We recommend that the Plan develop policies and procedures to ensure that its PBM receives the OPM OIG’s debarment/suspension list and that updates are provided timely.

Plan Response:

The Plan agrees with this recommendation and states that it has developed and implemented a process to ensure its PBM receives the OPM OIG's debarment/suspension list and updates.

C. FRAUD AND ABUSE PROGRAM REVIEW

1. Failure to Report Suspected Fraud, Waste and Abuse Cases

Procedural

The Plan did not report to the OIG any of the suspected fraud, waste, and abuse (FWA) cases that the PBM identified for CYs 2012 through 2015.

According to Carrier Letter 2011-13, the Plan’s Special Investigative Unit is required to submit a written notification to the OIG within 30 working days of becoming aware of an issue where there is a reasonable suspicion that a fraud has occurred or is occurring against the FEHBP. Reportable issues include the identification of emerging fraud schemes; suspected internal fraud or abuse by Plan employees, contractors, or subcontractors; suspected fraud by providers who supply goods or services to members; suspected fraud by individual members; issues of patient harm; and Plan participation in class action lawsuits. There is no financial threshold for these initial case notifications.

The Plan failed to report to the OPM OIG any suspected fraud, waste or abuse cases identified by the PBM.

Also, updated Carrier Letter 2014-29 states, “FEHBP Carriers are required to submit a written notification to [the OIG] within 30 working days when there is a potential reportable FWA that has occurred against the FEHB Program. [The OIG] considers a potential reportable FWA as, after a preliminary review of the complaint, the carrier takes an affirmative step to investigate the complaint ... There is no financial threshold for these case notifications.”

To determine if all suspected fraud cases were reported to the OIG, we reviewed a list of cases reported to the Plan by the PBM for CYs 2012 through 2015 and the annual Fraud, Waste and Abuse Recovery and Savings Data Reports (FWA Report) submitted to OPM by

the Plan. We requested a list from the OIG's Office of Investigations of case referrals from the Plan for the same period.

Our review determined that during CYs 2012 through 2015, the PBM reported to the Plan eight suspected cases of FWA. The annual FWA Reports submitted to OPM by the Plan showed only three cases were opened and no cases were referred to the OIG during the same period.

The Plan stated that it did not receive any referrals that it believed needed to be reported to the OIG. However, Carrier Letter 2011-13 clearly states that Plans are required to submit a written notification to the OPM OIG within 30 working days of becoming aware of an issue where there is a reasonable suspicion that a fraud has occurred or is occurring against the FEHBP.

By not reporting any potential FWA cases to the OIG, the Plan adversely affected the OIG's ability to investigate these cases and increased the risk of possible overcharges to the FEHBP.

Recommendation 7

We recommend that the Plan adopt procedures to ensure that it complies with all official FWA guidance in place at the time of reporting and continue to follow that guidance until such time of an official update or until a replacement is issued.

Plan Response:

The Plan agrees with this recommendation and stated that it has implemented an enhanced process per the most recent requirements from OPM.

D. PERFORMANCE GUARANTEES REVIEW

1. Performance Standard Penalty Payment \$6,250

The Plan failed to notify the PBM of a performance guarantee penalty due for CY 2013. As a result, the PBM did not pay \$6,250 in penalty payments to the Plan.

Section 5.3 of the 2012 Agreement states that upon receipt of the Performance Standard Annual Report, the Plan will give the PBM written notice of its election to assess any applicable penalties due from the PBM in the form of a Performance Standard Penalties Letter. The potential penalties ranged from \$6,250 to \$50,000 per CY.

The Plan failed to request a penalty due from the PBM for a missed performance guarantee.

We reviewed all performance guarantees for CYs 2012 through 2015 to determine compliance with the guarantees by the PBM and if any penalties due were actually paid to the Plan. Our review found that the Plan did not notify the PBM of one guarantee that it failed to meet.

The Plan stated that it did not receive the penalty payment because it failed to request it. The Plan has since requested the missed payment. The Plan is working with the PBM to revise the notification process to ensure that future penalties are not missed.

As a result of not notifying the PBM of the missed 2013 performance guarantee, the PBM did not remit \$6,250 in penalty payments to the Plan.

Recommendation 8

We recommend that the Plan provide confirmation of the penalty payment to OPM once received.

Plan Response:

The Plan stated that the penalty payment was received from the PBM for the amount of \$6,250 via a check dated 10/24/2017.

OIG Comment:

The Plan should also provide documentation to support the return of the funds to the FEHBP through its Letter of Credit Account.

Recommendation 9

We recommend that the Plan modify its Agreement with the PBM so that any penalty payments due are automatically initiated within 30 days of the Performance Standard Annual Report.

Plan Response:

The Plan agrees with the recommendation and states that it is in the process of amending the current contract to automatically initiate payments for any penalties due within a mutually agreeable time period of receiving the Performance Standard Annual Report.

Recommendation 10

We recommend that the Plan implement policies and procedures to ensure tracking of all performance guarantees and associated penalties.

Plan Response:

The Plan agrees with the recommendation and states that it has implemented policies and procedures for tracking of all performance guarantees and associated penalties. Tracking of performance guarantees and associated penalties will be reviewed and internally audited as reports are received from the PBM. The PBM has confirmed reporting will be provided for all performance guarantees listed in the PBM contract. The PBM also agrees to assist in tracking of all performance guarantees and penalties. In addition, the Plan stated that it will randomly review performance guarantees and report findings to its Quality Improvement Committee.

E. PHARMACY REBATES REVIEW

Our review determined that the PBM properly supported, calculated, and remitted pharmacy rebates to the Plan in accordance with the Contract and drug manufacturers' agreements during the scope of the audit.

F. PROGRAM IMPROVEMENT AREAS

1. Excess Mail Order Dispensing Fees/Reduced Copay

During the scope of our audit, we found that the PBM processed 2,793 mail order claims with a 30-day supply that could have been processed at a retail pharmacy with a lower dispensing fee. Additionally, the PBM charged the members a single retail copay for each of these claims, instead of the mail order copay shown in the benefit brochure.

Allowing a 30-day mail order supply at the retail copay cost the FEHBP nearly \$50,000 in excess fees.

The 2012 Agreement specified average dispensing fees for both retail and mail order. In addition, the Plan's benefit brochure states that prescription drugs with up to a 31-day supply can be filled using retail pharmacies at a retail copay. Prescription drugs with up to a 90-day supply can be filled using mail order services at twice the retail copay.

During our pricing review of mail order pharmacy claims for CYs 2012 through 2015, we identified 2,793 claims that were inappropriately processed at a lower retail copay. The mail order copay should have been twice the amount of retail in accordance with the Plan's benefit brochure. Additionally, all of the claims were for a 30-day supply, which could have been filled at a retail pharmacy with a dispensing fee averaging \$12 less per fill. When we asked the PBM why these mail order claims were processed for a 30-day supply at the lower retail copay, the PBM provided an internal document indicating that mail order drugs less than 31 days were allowed to process using a copay identical to that offered at retail.

After we disclosed this issue to the Plan, it was unaware that the PBM was filling 30-day prescriptions using the mail order service with a retail copay. We also found that the Plan's benefit brochure was misleading, since it suggests that up to 31-day supplies should be filled at a retail pharmacy, and it clearly shows mail order to be twice the copay of retail.

Because the PBM allowed 30-day mail order drugs at a retail copay, the FEHBP was overcharged nearly \$50,000 during the scope of our audit in excess dispensing fees and reduced member copays.

Recommendation 11

We recommend that Plan direct the PBM to modify its claims system to ensure that all mail order pharmacy claims are processed using the copay structure stated in the benefit brochure.

Plan Response:

The Plan agrees with the recommendation and states that it is working with the PBM to ensure all prescriptions are processed using the copay structure stated in the benefit brochure.

Recommendation 12

We recommend that OPM direct the Plan to modify its contract with the PBM to ensure that members may only obtain prescriptions of less than 31 days at retail pharmacies unless specifically approved by the Plan.

Plan Response:

The Plan agrees with the recommendation and states that beginning with benefit year 2019 members will only be able to obtain prescriptions for greater than 84-day supplies at mail order. All supplies less than 84-day must be filled at retail pharmacies. The Plan stated that this will not apply to specialty medications.

2. Copay Override Documentation

The Plan and PBM did not maintain sufficient documentation to support all copay overrides entered for Plan members.

On average, the Plan failed to document reasons for copay overrides for 68 percent of applicable claims.

During our review of mail order pharmacy claims, we found a claim where the copay applied was inconsistent with the copay shown in the Plan's benefit brochure. We determined that the claim in question was paid in accordance with a copay override created by the PBM at the request of the Plan. Neither the Plan nor the PBM maintained documentation to support this copay override. Therefore, we

expanded our review to determine if the Plan and/or the PBM maintained proper documentation of copay overrides.

The Plan may grant copay overrides in many cases; however, in all override cases it should maintain documentation to support its decisions. The Plan stated that during the scope of our audit there were no written procedures in place regarding the review and granting of override requests.

We reviewed a sample of claims for members that received copay overrides during CYs 2012 through 2015, to determine if support for the reason was maintained by the Plan or PBM. We found that the Plan and PBM did not maintain documentation on copay overrides for 68 percent and 86 percent of the claim lines sampled, respectively. In addition, the Plan or its eligibility administrator (not the PBM), entered 76 percent of the claim line overrides into the Plan's prior authorization system.

The Plan and the PBM were able to provide documentation with specific explanations for the copay overrides increasingly over the years of our review (see table below). The Plan stated that due to security reasons, most of the discussions and approvals made by its eligibility administrator in 2012 and 2013 were made verbally and that documentation was not regularly maintained. Upon switching to a new administrator in 2014, procedures were changed with more documentation being maintained.

	Plan Override Reason Not Documented	PBM Override Reason Not Documented	Prior Authorization Entered by Plan
2012	96%	95%	88%
2013	93%	99%	87%
2014	42%	78%	65%
2015	13%	59%	54%
Weighted Avg.	68%	86%	76%

Other specific issues identified in our review were:

- Most of the copay overrides were set to terminate a year from the effective date, typically spanning across two calendar years (those for vacations or overseas trips are usually for much shorter terms).
- Copay overrides for two members were provided open-ended (with termination dates in the year 2099).
- Many of the overrides set the copay at a fixed dollar amount rather than systematically linking it to the current copay level in effect. Of the two open-ended overrides, one was set to a \$60 copay, which was correct in 2012, but changed to \$70 copay in later years. Fixing the copay amount through an override is concerning due to the potential that the Plan's copay structure can change from year to year.

Discussions with the Plan indicated that it had no formal process in place to review copay overrides. However, after we addressed our concerns with the Plan, it began to work with the PBM in implementing internal reviews to ensure that records reflect the actual copay override reasons.

Recommendation 13

We recommend that the Plan implement procedures to improve its management of copay overrides to ensure that the reasons for the override are documented and maintained.

Plan Response:

The Plan agrees with the recommendation and states that it has implemented policies and procedures to improve management of copay overrides to ensure the reasons for the override are documented and maintained sufficiently.

Recommendation 14

We recommend that the Plan require the PBM's prior authorization system to more accurately reflect the reason for copay overrides.

Plan Response:

The Plan agrees with the recommendation and states that processes have been implemented to ensure the prior authorization system is accurately reflecting the reason for copay overrides.

Recommendation 15

We recommend that the Plan ensure that no prior authorizations are permanently set at fixed copay amounts, so that benefit changes from year to year take effect.

Plan Response:

The Plan agrees with the recommendation and states that it has implemented a policy and procedure to ensure that no future prior authorizations are permanently set at fixed copay amounts.

Recommendation 16

We recommend that the Plan establish policies and procedures to routinely review all copay overrides to ensure that they are still valid and necessary.

Plan Response:

The Plan agrees with the recommendation and states that it has implemented policies and procedures to routinely review copay overrides to ensure they are still valid and necessary. In addition, it will routinely perform random reviews of copay overrides to ensure compliance with procedures and report findings to its Quality Improvement Committee.

APPENDIX



11490 COMMERCE PARK DRIVE
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RESTON, VA 20191

(571) 449-2366
(866) 368-7227

June 1, 2018

[REDACTED]
Chief, Special Audits Group
Office of Personnel Management
Office of Inspector General

Dear [REDACTED],

Below is our response to your preliminary PBM Audit report. We appreciate the opportunity to review your findings and recommendations and provide a response. We have put our response directly below each recommendation. Please let us know if you need any additional information for any of our responses. For recommendation 5, we have submitted re-payment of the \$14,226 as part of our LOCA draw scheduled for today. We can provide you with confirmation once we have it.

Questions or requests can be directed to me at [REDACTED],
[REDACTED] or [REDACTED], Pharmacy Benefits Manager at [REDACTED].

Thank you for your time, support and suggestions, all are much appreciated and are making us a better Plan.

Sincerely,

[REDACTED]
[REDACTED]
Director, Health Plan Administration

**Deleted by the OIG
Not relevant to the final report**

Report No. 1H-06-00-17-026

A. ADMINISTRATIVE FEES REVIEW

1. Specialty Pharmacy Administrative Fees

Procedural

**Deleted by the OIG
Not relevant to the final report**

Recommendation 2³

We recommend that the PBM implement controls that will ensure timely and accurate updates to the billing system when administrative fee changes occur.

Plan Response:

The Plan agrees with this recommendation. Compass Rose was assured by the PBM that controls have been implemented to help ensure timely and accurate updates to the billing system when administrative fee change occurs. Starting in 2015, the tiered pricing originally in the contract has been replaced with a single admin fee and an automated invoicing process. Additionally, the PBM performs a post implementation review of all administrative/ancillary fees entered to ensure completeness and accuracy of administrative fee setup. Compass Rose has also implemented procedures for oversight of administrative fee changes.

B. PHARMACY CLAIM PAYMENTS REVIEW

1. Pharmacy Claim Payment Errors

\$85,854

**Deleted by the OIG
Not relevant to the final report**

Recommendation 4

We recommend that the PBM institute procedures to ensure that fixed discount rates in its adjudication system are set to the rate(s) contracted and not set to match guarantees.

³ Recommendations 1 and 3 from the draft report have been dropped. However, all recommendations listed in the Appendix have maintained the original recommendation number referenced in that report.

Plan Response:

The Plan agrees with the recommendation. The PBM affirms that contracted rates are being utilized and internal controls have been applied to ensure guarantee and adjudication accuracy. The PBM continues to monitor internal processes and make adjustments when necessary. Compass Rose has implemented oversight activity to monitor compliance and accuracy.

**Deleted by the OIG
Not relevant to the final report**

2. Over-Age Dependents \$14,226

**Deleted by the OIG
Not relevant to the final report**

Recommendation 5

We recommend that the Plan return \$14,226 to the FEHBP for erroneous claim payments on ineligible overage dependents.

Plan Response:

The Plan agrees with the recommendation and has returned to the FEHBP \$14,226 as part of the June 1, 2018, LOCA drawdown.

Recommendation 6

We recommend that the Plan identify and initiate recoveries on all claims paid for ineligible dependents.

Plan Response:

The Plan agrees with the recommendation and using our overpayment process as a guideline has begun initiating recoveries on all claims.

Recommendation 7

We recommend that the Plan update its policies and procedures for identifying ineligible members to include systematically terminating dependents at age 26.

Plan Response:

The Plan agrees with the recommendation and has implemented a policy and procedure for identifying ineligible members to include systematically terminating dependents at age 26. Compass Rose identifies 26-year-old dependent children and coverage is terminated in a timely manner to prevent payment of claims for ineligible individuals. In addition, we are implementing an oversight process to verify timely terminations.

3. **Debarment Listing**

Procedural

Deleted by the OIG
Not relevant to the final report

Recommendation 8

We recommend that the Plan develop policies and procedures to ensure that its PBM receives the OPM OIG's debarment/suspension list and that updates are provided timely.

Plan Response:

The Plan agrees with this recommendation. Compass Rose has developed and implemented a process to ensure its PBM receives the OPM OIG's debarment/suspension list and updates. Compass Rose sends the list and updates to specific contacts at Express Scripts when received.

C. **FRAUD AND ABUSE REVIEW**

1. **Failure to Report Suspected Fraud, Waste and Abuse Cases**

Procedural

Deleted by the OIG
Not relevant to the final report

Recommendation 9

We recommend the Plan adopt procedures to ensure that it complies with all official FWA guidance in place at the time of reporting and continue to follow that guidance until such time of an official update or until a replacement is issued.

Plan Response:

The Plan agrees with this recommendation and has implemented an enhanced process per the most recent requirements from OPM. Compass Rose is following this process and sending suspected FWA cases as required to OIG.

D. PERFORMANCE GUARANTEES REVIEW

1. Performance Standard Penalty Payment

\$6,250

**Deleted by the OIG
Not relevant to the final report**

Recommendation 10

We recommend that the Plan provide confirmation of the penalty payment to OPM once received.

Plan Response:

The plan confirms the penalty payment was received from the PBM for the amount of \$6,250 dated 10/24/2017 on check number [REDACTED].

Recommendation 11

We recommend that the Plan modify its Agreement with the PBM so that any penalty payments due are automatically initiated within 30 days of the Performance Standard Annual Report.

Plan Response:

The Plan agrees with the recommendation. Compass Rose and the PBM in good faith are in the process of amending the current contract to automatically initiate payments for any penalties due within a mutually agreeable time period of receiving the Performance Standard Annual Report.

Recommendation 12

We recommend that the Plan implement policies and procedures to ensure tracking of all performance guarantees and associated penalties.

Plan Response:

The Plan agrees with the recommendation. Compass Rose has implemented policies and procedures for tracking of all performance guarantees and associated penalties. Tracking of performance guarantees and associated penalties will be reviewed and internally audited as reports are received from the PBM. The PBM has confirmed reporting will be provided for all performance guarantees listed in the PBM contract. The PBM also agrees to assist in tracking of all performance guarantees and penalties. In addition, Compass Rose will randomly review performance guarantees and report findings to the Quality Improvement Committee (QIC).

E. PROGRAM IMPROVEMENT AREAS

1. Excess Mail Order Dispensing Fees/Reduced Copay

**Deleted by the OIG
Not relevant to the final report**

Recommendation 13

We recommend that Plan direct the PBM to modify its claims system to ensure that all mail order pharmacy claims are processed using the copay structure stated in the benefit brochure.

Plan Response:

The Plan agrees with the recommendation. Compass Rose is working with the PBM to ensure all prescriptions are processed using the copay structure stated in the benefit brochure. For benefit year 2019, only greater than 84-day supplies will be processed at mail order. Compass Rose will monitor claims to confirm all prescriptions are processed using the copay structure stated in benefit brochure.

Recommendation 14

We recommend that OPM direct the Plan to modify its contract with the PBM to ensure that members may only obtain prescriptions of less than 31 days at retail pharmacies unless specifically approved by the Plan.

Plan Response:

The Plan agrees with the recommendation. Compass Rose in good faith will work with the PBM to ensure members may only obtain prescriptions for greater than 84-day supplies at mail order starting in benefit year 2019. All supplies less than 84-day must be filled at retail pharmacies. This does not apply to specialty medications. Current members utilizing mail order prescriptions for less than an 84-day supply will be notified before Open Season regarding the plan change for 2019 to prevent member disruption.

2. Copay Override Documentation

**Deleted by the OIG
Not relevant to the final report**

Recommendation 15

We recommend that the Plan implement procedures to improve its management of copay overrides to ensure that the reasons for the override are documented and maintained.

Plan Response:

The Plan agrees with the recommendation. Compass Rose has implemented a policy and procedure to improve management of copay overrides to ensure the reasons for the override are documented and maintained sufficiently. Compass Rose will monitor copay overrides to ensure the PBM is accurately reflecting the reason for copay overrides. In addition, Compass Rose will routinely randomly review select copay overrides to ensure compliance with procedures and report findings to the Quality Improvement Committee (QIC).

Recommendation 16

We recommend that the Plan require the PBM's prior authorization system to more accurately reflect the reason for copay overrides.

Plan Response:

The Plan agrees with the recommendation. Compass Rose and the PBM have implemented processes to ensure the prior authorization system is accurately reflecting the reason for copay overrides. Compass Rose will monitor copay

overrides to ensure the PBM is accurately reflecting the reason for copay overrides. In addition, Compass Rose will routinely randomly review select copay overrides to ensure compliance with procedures and report findings to the Quality Improvement Committee (QIC).

Recommendation 17

We recommend that the Plan ensure that no prior authorizations are permanently set at fixed copay amounts, so that benefit changes from year to year take effect.

Plan Response:

The Plan agrees with the recommendation. Current fixed copay amounts will be reset at plan year end to account for any benefit changes that take effect from year to year. Any current copay override approved past the plan year will be reviewed and updated. In addition, Compass Rose has implemented a policy and procedure to ensure that no future prior authorizations are permanently set at fixed copay amounts.

Recommendation 18

We recommend that the Plan establish policies and procedures to routinely review all copay overrides to ensure that they are still valid and necessary.

Plan Response:

The Plan agrees with the recommendation. Compass Rose has implemented a policy and procedure to routinely review copay overrides to ensure they are still valid and necessary. In addition, Compass Rose will routinely randomly review select copay overrides to ensure compliance with procedures and report findings to the Quality Improvement Committee (QIC).



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>

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Washington Metro Area: (202) 606-2423

By Mail: Office of the Inspector General
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