



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

Final Audit Report

Subject:

**AUDIT OF
GROUP HEALTH INCORPORATED'S
PHARMACY OPERATIONS
CONTRACT YEAR 2009**

Report No. 1H-80-00-10-062

Date: September 8, 2011

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Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

AUDIT REPORT

**Audit of Group Health Incorporated's
Pharmacy Operations
Contract Year 2009
Contract CS 1056**

**Plan Code 80
New York, New York**

REPORT NO. 1H-80-00-10-062

DATE: September 8, 2011

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

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



Office of the
Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

EXECUTIVE SUMMARY

**Audit of Group Health Incorporated's
Pharmacy Operations
Contract Year 2009
Contract CS 1056**

**Plan Code 80
New York, New York**

REPORT NO. 1H-80-00-10-062

DATE: September 8, 2011

At the request of the Office of Personnel Management's (OPM) contracting office, the Office of the Inspector General has completed a performance audit of Group Health Incorporated's (GHI) Federal Employees Health Benefits Program (FEHBP) 2009 pharmacy operations. The primary objective of the audit was to determine if GHI complied with the regulations and requirements contained in Contract CS 1056, between GHI and OPM. We were also asked by the contracting office to verify whether a special drawdown of \$29 million, which was paid to GHI to cover its pharmacy claim payments from January through September of 2009, was an amount that was truly owed to GHI and was supported by sufficient documentation. The audit was conducted in New York, New York from September 7 through September 24, 2010.

The audit covered pharmacy claims, drug manufacturer rebates, and GHI's adherence to its contractual requirements for contract year 2009. Our review showed that the special drawdown of \$29 million requested by GHI to pay its January through September 2009 pharmacy claims was valid and was supported by adequate documentation. Our review also showed that GHI charged the FEHBP the appropriate fees and expenses related to its 2009 prescription drug benefits except for the six findings identified in this report.

This report questions \$115,913 in improper payments for prescription drug benefits, which includes \$7,893 for lost investment income calculated through July 31, 2011. The results of our audit have been summarized below.

PHARMACY CLAIMS

- **Dependent Eligibility** **\$53,726**

GHI processed 358 pharmacy claims, totaling \$53,726, for 30 members age 22 and over whose eligibility could not be verified. GHI should not continue covering dependents age 22 and over without proper documentation to show that these dependents remain eligible for FEHBP coverage.

- **Unallowable Charges for Nutritional Supplements** **\$29,814**

GHI processed 143 claims, totaling \$29,814, for nutritional supplements without verifying that these drugs were a covered benefit under the FEHBP. Nutritional supplements are only covered for the treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria.

- **Pharmacy Claim Pricing** **\$19,252**

GHI incorrectly priced 93 claims, which cost the FEHBP an additional \$19,252 in 2009. These claims were priced higher than the agreed-upon price listed in each pharmacy's contract.

- **Debarred Pharmacy Payments** **\$3,789**

GHI paid an FEHBP debarred provider, Better Health Pharmacy Inc., \$3,789 for 97 claims in 2009. This pharmacy was debarred by OPM in 2004. Once a provider is debarred, it is GHI's responsibility to ensure that the provider is flagged in its claims system to prevent future payments.

- **Claims Paid after Member Termination** **\$1,439**

GHI processed 14 claims for members after their termination date. These 5 members incurred \$1,439 in prescription drug payments during 2009. GHI should have denied the claims since the members were no longer enrolled in the FEHBP.

DRUG MANUFACTURER REBATES

The results of our review showed that drug manufacturer rebates received by GHI in 2009 were properly allocated and returned to the FEHBP based on group specific member utilization.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The results of our review showed that GHI has policies and procedures in place to address the Health Insurance Portability and Accountability Act Standards for Electronic Transactions, Privacy Rules, and Security Rules.

FRAUD AND ABUSE PROGRAM

The results of our review showed that GHI's policies and procedures for fraud and abuse complied with section 1.9(c) of Contract CS 1056 and met all eight industry standards for fraud and abuse programs outlined in FEHBP Carrier Letter 2003-23.

LOST INVESTMENT INCOME

- **Lost Investment Income on Improper Payments** **\$7,893**

The FEHBP is due \$7,893 for lost investment income on improper payments made for 2009 prescription drug benefits, calculated through July 31, 2011. In addition, the contracting officer should recover lost investment income on amounts due for the period beginning August 1, 2011 until all questioned costs have been returned to the FEHBP.

LACK OF AUDITEE COOPERATION DURING AUDIT

We experienced numerous difficulties in obtaining sufficient evidence from GHI to satisfy several of our audit objectives. Because we were unable to obtain information from GHI, we could not initially complete our work in several audit areas. Therefore, we strongly encourage the contracting office to work with GHI to ensure it understands its responsibilities relating to the Contract's records retention and right to inspection requirements. We also encourage the contracting office to explore whatever remedies are at its disposal to penalize GHI for its inability to meet its contractual requirements.

CONTENTS

PAGE

EXECUTIVE SUMMARY	i
I. INTRODUCTION AND BACKGROUND	1
II. OBJECTIVES, SCOPE, AND METHODOLOGY	2
III. AUDIT FINDINGS AND RECOMMENDATIONS	6
A. <u>PHARMACY CLAIMS</u>	6
1. Dependent Eligibility	6
2. Unallowable Charges for Nutritional Supplements	7
3. Pharmacy Claim Pricing	8
4. Debarred Pharmacy Payments	8
5. Claims Paid after Member Termination	9
B. <u>DRUG MANUFACTURER REBATES</u>	10
C. <u>HEALTH INSURANCE PORTABILITY AND ACCOUNTABILTY ACT</u>	10
D. <u>FRAUD AND ABUSE PROGRAM</u>	10
E. <u>LOST INVESTMENT INCOME</u>	10
1. Lost Investment Income on Improper Payments	10
IV. LACK OF AUDITEE COOPERATION DURING AUDIT	12
V. MAJOR CONTRIBUTORS TO THIS REPORT.....	13
SCHEDULE A – CONTRACT CHARGES	
SCHEDULE B – SUMMARY OF QUESTIONED COSTS	
SCHEDULE C – LOST INVESTMENT INCOME	
APPENDIX (GHI’s response to the draft report, issued May 31, 2011)	

I. INTRODUCTION AND BACKGROUND

INTRODUCTION

At the request of the Office of Personnel Management's (OPM) contracting office, we completed an audit of Group Health Incorporated's (GHI) Federal Employees Health Benefits Program (FEHBP) pharmacy operations for contract year 2009. The audit was conducted pursuant to the provisions of Contract CS 1056; 5 U.S.C. Chapter 89; and 5 Code of Federal Regulations (CFR) Chapter 1, Part 890. The audit was performed by the OPM's Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended. The audit field work took place at GHI's office in New York, New York from September 7 through September 24, 2010. Additional audit work was completed in our Washington, D.C. and Cranberry Township, Pennsylvania offices.

BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations codified in Title 5, Chapter 1, Part 890 of the CFR. Health insurance coverage is made available through contracts with various health insurance carriers that provide service benefits, indemnity benefits, or comprehensive medical services.

In 1960, GHI entered into a government-wide contract (CS 1056) with OPM to provide health insurance benefits as an Experience-Rated Health Maintenance Organization authorized by the FEHB Act. In 2005, GHI and the Health Insurance Plan of New York (HIP) merged to form the largest health insurer based in New York State with a combined membership of more than four million members in the New York City metropolitan area and combined revenues of over \$7 billion. In 2006, HIP and GHI affiliated as EmblemHealth companies. With the merger, GHI and HIP continued to maintain separate contracts with OPM and offered separate health insurance plans to FEHBP members.

This was our first audit of GHI's pharmacy operations. The audit was initiated at the request of OPM's Contracting Office to help verify a special drawdown of \$29 million from the Letter of Credit (LOC) account. The single drawdown was made during the fourth quarter of 2009 in order to reimburse GHI for pharmacy claim payments made from January 1, 2009 to September 30, 2009. The late drawdown was a result of inter-office communication errors after GHI ended its external Pharmacy Benefit Manager (PBM) contract with Express Scripts and began processing pharmacy claims internally through EmblemHealth's pharmacy claims system.

Because GHI administered its own pharmacy benefits in 2009, all pharmacy agreements were fully transparent under the contract with OPM, including its agreement for mail order benefits with Medco. Based on regulations, GHI is not allowed to profit on its pharmacy benefits, and all prices should be passed through to the FEHBP.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary objectives of this audit were to:

- Obtain reasonable assurance that GHI complied with the provisions of the Federal Employees Health Benefits Act and regulations that are included, by reference, in the FEHBP contract.
- Determine whether GHI charged costs to the FEHBP and provided services to FEHBP members in accordance with the FEHBP contract.
- Ensure that the special drawdown of \$29 million paid to GHI represented actual pharmacy claims cost and was supported by sufficient documentation.

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, drug manufacturer rebates, and GHI's adherence to its contractual requirements for contract year 2009. The audit scope included a review of GHI's current Fraud and Abuse Program, Health Insurance Portability and Accountability Act (HIPAA) Policies and Procedures, and Internal Controls related to its claim processing system. In 2009, GHI paid \$39,380,973 in prescription drug charges and received manufacturer rebates of [REDACTED] related to these pharmacy costs (see Schedule A).

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

In conducting our audit, we relied to varying degrees on computer-generated data provided by GHI. 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 GHI had complied with the Contract, Service Agreement, 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. The results of our audit indicate that, with respect to the items tested, GHI complied with all provisions of the Contract, Service Agreement, and the Federal procurement regulations, except for the six findings explained in detail in the “Audit Findings and Recommendations” section of this report.

METHODOLOGY

To test whether GHI accurately charged the FEHBP for 2009 prescription drug benefits and complied with its contractual requirements, we performed the following audit steps:

Administrative Expense and Profit Review

- We reviewed the pharmacy claims data to determine if GHI added any additional fees for administrative expenses or profit.

Pricing Review

- We selected 5 out of 110 pharmacies that received the highest dollar amount from GHI for retail pharmacy services and reviewed each of their claim payments to ensure that they were priced according to the pharmacy’s contract with GHI.
- We reviewed all claim payments made to Medco for FEHBP mail order pharmacy benefits to ensure that each claim was priced according to the pharmacy’s contract with GHI.

Member Eligibility Review

- We selected the 50 oldest FEHBP members out of 26,334 who incurred prescription drug claims and compared their information to death records to ensure that drugs were being filled for active members.
- We selected all dependents age 22 and over to determine if each member was eligible for FEHBP coverage at the time of receiving pharmacy benefits.
- We reviewed the pharmacy claims data to determine if any payments were made to non-FEHBP members or members enrolled in another group or plan code.

Debarred Pharmacy Review

- We compared the pharmacy claims data to the General Services Administration’s Excluded Parties List to determine if payments were made to pharmacies debarred by the Department of Health and Human Services or OPM.

Claim System Review

- We reviewed all 701 claims over \$3,000, totaling \$3,457,615 out of a universe of 611,619 claims totaling \$39,380,973, to determine if GHI processed any duplicate claims or if claims contained duplicate therapy for an FEHBP member.
- We reviewed the pharmacy claims data to determine if GHI made payments for drugs that were never filled or were reported as having zero quantities dispensed.

Excluded Drug Review

- We reviewed the pharmacy claims data to determine if any claims were processed for drugs that were excluded from FEHBP Benefits, as listed in GHI's Medical Plan Brochure.
- We reviewed the pharmacy claims data to determine if any claims were processed for drugs that have not been approved by the Federal Drug Administration.
- We reviewed all 143 pharmacy claims that had a quantity of over 5,000 units filled, totaling \$29,814 out of a universe of 611,619 claims totaling \$39,380,973, to determine if these drugs were covered under the FEHBP.

Manufacturer Rebate Review

- We reviewed all drug manufacturer rebates received by GHI and determined if the proper amount was allocated and returned to the FEHBP based on group specific member utilization.

Internal Control Review

- We reviewed GHI's internal control policies and procedures that apply to its claims processing system to determine what controls were in place and if there were any significant deficiencies that required attention.
- We reviewed GHI's claims system edits to determine if they were used by the carrier to effectively and efficiently process pharmacy claims.
- We observed the manual processing of a pharmacy claim to gain a better understanding of what data is populated, what data is entered, and how the adjudication process works.
- We tested the validity of the total 2009 pharmacy claim payments that were reported to OPM by observing a query direct from GHI's data warehouse, where user access and edits are limited.

HIPAA Review

- We obtained all of GHI'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 Program Review

- We reviewed GHI's policies and procedures for fraud and abuse to determine if the carrier complied with section 1.9(c) of Contract CS 1056 and met all eight industry standards for fraud and abuse programs outlined in FEHBP Carrier Letter 2003-23.

The samples selected during our review were not statistically based. Consequently, the results could not be projected to the universe since it is unlikely that the results are representative of the universe as a whole. We used Contract CS 1056 to determine if claim processing and administrative fees charged to the FEHBP were in compliance with the terms of the Contract.

The initial results of the audit were provided to GHI in written inquiries and were discussed with GHI officials throughout the audit and at the exit conference. In addition, a draft report, dated April 18, 2011, was provided to GHI for review and comment. GHI's comments on the draft report were considered in preparing the final report and are included as an Appendix to this report.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. PHARMACY CLAIMS

1. Dependent Eligibility

\$53,726

We reviewed the 2009 pharmacy claims data to determine if any claims were paid for dependents age 22 and over. We identified 358 claims totaling \$53,726 that were paid for services incurred by 30 overage dependents. We asked GHI to provide documentation showing how it determined that these dependents were still eligible for FEHBP coverage after turning age 22. GHI was unable to support that these claims were paid in accordance with the Contract.

Page 62 of GHI's 2009 FEHBP benefit brochure states that dependents are no longer eligible for coverage after they turn 22 years of age unless the individual is incapable of self-support, usually due to a mental or physical disability.

Because GHI could not support the eligibility of the 30 overage dependents mentioned above, we were unable to determine if these claims were allowable charges to the FEHBP.

GHI's Comment:

GHI disagrees with this finding. GHI's computerized membership records going back to 1988 reveal the enrollees to be classified as "permanently disabled". Their status has not, to the plan's knowledge, been changed and has not been questioned by OPM/OIG in previous (and now) closed audits. If OPM has records that indicate otherwise they should share them with GHI. In the event OPM's records do indicate otherwise (or are not conclusive), then the plan can search its offsite paper records to document the basis for the permanent disability status.

OIG's Comment:

We disagree with GHI's response since the eligibility of these 30 members has not been validated with supporting documentation. Because the FEHBP paid for claims incurred by these individuals, GHI should be able to show why these dependents were covered as active enrollees after turning age 22. As stated above, page 62 of GHI's 2009 FEHBP benefit brochure states that dependents are no longer eligible for coverage after they turn 22 years of age unless the individual is incapable of self-support, usually due to a mental or physical disability. Proof of eligibility typically includes an evaluation by a physician showing that the individual is incapable of self support. A member's eligibility should be verified every time a claim is processed. This means that eligibility should be maintained on file at all times to show that dependents over age 22 remain eligible for FEHBP coverage.

Recommendation 1

We recommend that the contracting office require GHI to credit back to the FEHBP \$53,726 for 358 improper claim payments.

Recommendation 2

We recommend that the contracting office require GHI to adopt new system controls that will verify and document a dependent’s eligibility for extended FEHBP coverage after turning age 22 or age 26 beginning January 1, 2011.

2. Unallowable Charges for Nutritional Supplements **\$29,814**

We reviewed the 2009 pharmacy claims data to identify prescriptions with quantities over 5,000 dispensed to determine if the identified drugs were for covered program benefits. We identified 143 claims totaling \$29,814 that were paid for nutritional supplements. We asked GHI to provide documentation showing how it determined that these nutritional supplements were allowable program benefits. GHI was unable to support that these claims were paid in accordance with the Contract.

Page 44 of GHI’s 2009 FEHBP benefit brochure states that nutritional supplements are only covered for the treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria. All other vitamins, nutrients and food supplements are not covered, even if a physician prescribes or administers them.

Because GHI was unable to show that these nutritional supplements were prescribed as treatment for one of the four covered diseases, we were unable to determine if these claims were allowable charges to the FEHBP.

GHI’s Comment:

GHI agrees with this finding.

Recommendation 3

We recommend that the contracting office require GHI to credit back to the FEHBP \$29,814 for claim overpayments.

Recommendation 4

We recommend that the contracting office require GHI to implement new system controls to prevent the payment of pharmacy claims for nutritional supplements unless the carrier can verify that the patient is being treated for one of the four covered diseases.

3. Pharmacy Claim Pricing

\$19,252

We reviewed all 2009 pharmacy claims paid to the mail order pharmacy (Medco) and the top 5 largest retail pharmacies (Walmart, CVS, Duane Reade, Rite Aid, and Walgreens) to determine if each claim was appropriately priced based on the contract agreement. We identified 93 out of 145,193 sampled claims, totaling \$19,252 out of \$8,316,666, that were priced at least \$100 more than the contracted agreement. All pharmacies, except for Walmart, had one or more claims priced incorrectly. The breakdown of claims per pharmacy is listed below:

- Medco overpriced 10 claims for a total overcharge of \$3,463;
- CVS overpriced 22 claims for a total overcharge of \$3,700;
- Duane Reade overpriced 30 claims for a total overcharge of \$5,136;
- Rite Aid overpriced 3 claims for a total overcharge of \$780; and
- Walgreens overpriced 28 claims for a total overcharge of \$6,173.

Contract CS 1056, Section 3.2(b), states that costs to the FEHBP must be actual, allowable, allocable, and reasonable. Additionally, when errors are identified, Section 2.3(g) of the Contract requires GHI to make a prompt and diligent effort to recover the overpayments.

Because GHI did not have proper controls in place to ensure that each claim is priced in accordance with its retail pharmacy contract, the FEHBP was overcharged \$19,252 in 2009.

GHI's Comment:

GHI's comments in its response to the draft report plus subsequent discussions with the audit staff show that it agrees with the amounts questioned.

Recommendation 5

We recommend that the contracting office require GHI to recover \$19,252 for the 93 claims that were overpriced, and return the full amount to the FEHBP.

Recommendation 6

We recommend that the contracting office require GHI to implement better system controls to ensure that all claims are priced at the agreed-upon rate listed in each retail pharmacy's contract.

4. Debarred Pharmacy Payments

\$3,789

As part of our debarment review, we compared GSA's Excluded Parties List to the 2009 pharmacy claims data in order to identify any claims paid to debarred pharmacies. During our review, we identified one pharmacy, Better Health Pharmacy, Inc., that filled

97 scripts and received \$3,789 in claim payments during 2009. This pharmacy was debarred by OPM in 2004. Once a provider is debarred, it is GHI's responsibility to ensure that the provider is flagged in its claims system to prevent future payments.

Chapter 2 of the Guidelines for Implementation of FEHBP Debarment and Suspension Orders requires FEHBP Carriers to establish a sanctions database that is updated monthly to include providers debarred by OPM. 5 CFR 890.1003 defines debarment as a decision by OPM's debaring official to prohibit payment of FEHBP funds to a health care provider. A health care provider includes any entity that, directly or indirectly, furnishes health care supplies including drugs and biologicals.

Because GHI did not identify Better Health Pharmacy, Inc. as being debarred by OPM in 2004, the pharmacy has continued to receive payment of FEHBP funds while in direct violation of federal laws and regulations. Additionally, the pharmacy's continued participation in the FEHBP has created a safety risk for the Plan's members.

GHI's Comment:

GHI agrees with this finding.

Recommendation 7

We recommend that the contracting office require GHI to recover all payments to Better Health Pharmacy, Inc. subsequent to the effective date of its debarment from the FEHBP. At a minimum, \$3,789 should be recovered and returned to the FEHBP for 2009.

Recommendation 8

We recommend that the contracting office require GHI to perform a monthly review of its provider databases to ensure that pharmacies currently filling scripts are not on the Excluded Parties List and have not been debarred by OPM.

5. Claims Paid after Member Termination \$1,439

Our review of the 2009 pharmacy claims data showed that GHI processed 14 claims for 5 members after their enrollment termination date. These five members incurred \$1,439 in prescription drug payments during 2009. GHI should have denied the claims since the members were no longer enrolled in the FEHBP.

Contract CS 1056, Section 3.2(b), states that costs to the FEHBP must be actual, allowable, allocable, and reasonable. Additionally, when errors are identified, Section 2.3(g) of the Contract requires the Plan to make a prompt and diligent effort to recover the overpayments.

Because GHI does not have proper controls in place to stop payments for members who terminate coverage, the FEHBP was overcharged \$1,439 in 2009.

GHI's Comment:

GHI agrees with this finding.

Recommendation 9

We recommend that the contracting office require GHI to credit back to the FEHBP \$1,439 for claim payments made on the behalf of the five members who were no longer enrolled in the FEHBP.

Recommendation 10

We recommend that the contracting office require GHI to implement additional system controls to identify members who are no longer enrolled in the FEHBP and prevent the payment of claims filed after the effective enrollment termination date.

B. DRUG MANUFACTURER REBATES

Our review showed that GHI returned to the FEHBP all drug rebates and the associated administrative fees that were received from the drug manufacturers based on 2009 FEHBP member utilization in compliance with Contract CS 1056 between GHI and OPM.

C. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The results of our review showed that GHI has policies and procedures in place to address the Health Insurance Portability and Accountability Act Standards for Electronic Transactions, Privacy Rules, and Security Rules.

D. FRAUD AND ABUSE PROGRAM

Our review of GHI's policies and procedures related to its Fraud and Abuse Program showed that GHI complied with section 1.9(c) of Contract CS 1056 and met all eight industry standards for fraud and abuse programs outlined in FEHBP Carrier Letter 2003-23.

E. LOST INVESTMENT INCOME

1. Lost Investment Income on Improper Payments **\$7,893**

In accordance with the FEHBP regulations and Contract CS 1056 between OPM and GHI, the FEHBP is entitled to recover lost investment income on improper payments made for prescription drug benefits, which totaled \$108,020 for contract year 2009.

Contract CS 1056, Sections 3.4 (e) and (f), states that investment income lost as a result of failure to credit income due to the contract is due to the government based on a simple

interest formula from the date the funds should have been credited to the date the funds are returned.

We determined that the FEHBP is due \$7,893 for lost investment income, calculated through July 31, 2011 (see Schedule C). In addition, the FEHBP is entitled to recover lost investment income on amounts due beginning on August 1, 2011 until all questioned costs have been returned to the FEHBP.

Our calculation of lost investment income was based on the United States Department of Treasury's semiannual cost of capital rates.

GHI's Comment:

GHI agrees that there is lost investment income associated with each finding.

Recommendation 11

We recommend that the contracting officer require GHI to refund the FEHBP \$7,893 for lost investment income on improper payments related to the 2009 prescription drug benefits calculated through July 31, 2011.

Recommendation 12

We recommend that the contracting officer recover lost investment income on amounts due beginning August 1, 2011 until all questioned costs have been returned to the FEHBP.

IV. LACK OF AUDITEE COOPERATION DURING AUDIT

At the request of OPM's contracting office, we conducted this limited scope performance audit in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. However, throughout the course of this audit we experienced numerous difficulties in obtaining sufficient evidence from GHI to satisfy several of our audit objectives. In fact, after several attempts to obtain information from GHI yielded no results, we solicited the assistance of the Contracting Officer to encourage GHI's cooperation. These efforts were again, in most cases, unsuccessful. Because we were unable to obtain information from GHI, we could not initially complete our work in several audit areas.

Section 1.11(b) of the Contract states:

“The Contractor shall maintain and the Contracting Officer, or an authorized representative of the Contracting Officer, shall have the right to examine and audit all books and records relating to the contract for purposes of the Contracting Officer's determination of the Carrier's subcontractor or Large Provider's compliance with the terms of the contract, including its payment (including rebate and other financial arrangements) and performance provisions. The Contractor shall make available at its office at all reasonable times those books and records for examination and audit for the record retention period specified in the Federal Employees Health Benefits Acquisition Regulation (FEHBAR), 48 CFR 1652.204-70. This subsection is applicable to subcontract and Large Provider Agreements with the exception of those that are subject to the “Audits and Records – Negotiation” clause, 48 CFR 52.215-2.”

48 CFR 1652.204-70 states:

“The carrier will retain and make available all records applicable to a contract term that support the annual statement of operations and, for contracts that equal or exceed the threshold at FAR 15.403-4(a)(1), the rate submission for that contract term for a period of six years after the end of the contract term to which the records relate. This includes all records of Large Provider Agreements and subcontracts that equal or exceed the threshold requirements. In addition, individual enrollee and/or patient claim records will be maintained for six years after the end of the contract term to which the claim records relate. This clause is effective prospectively as of the 2005 contract year.”

Recommendation 13

We strongly encourage the contracting office to work with GHI to ensure it understands its responsibilities relating to the Contract's records retention and right to inspection requirements.

Recommendation 14

We also encourage the contracting office to explore whatever remedies are at its disposal to penalize GHI for its inability to meet its contractual requirements.

V. MAJOR CONTRIBUTORS TO THIS REPORT

Special Audits Group

██████████, Auditor-In-Charge

██████████, Staff Auditor

██████████, Group Chief ██████████

██████████, Senior Team Leader

Appendix

**Response to
The Draft Audit Report of Group Health Incorporated's
Pharmacy Operations
Federal Employee Health Benefit Program**

Report No. ID-80-00-10-062

Date: May 31, 2011

Group Health Incorporated
Plan Code 80
New York, New York

Contents

	Page
• Paid Claims with Zero Quantity Dispensed	3
• Dependent Eligibility	3
• Unallowable Charges for Nutritional Supplies	4
• Pharmacy Claim Pricing	4
• Duplicate Claim Payment	5
• Debarred Pharmacy	5
• Claims Paid after Member Termination	6
• Lack of Adequate Documentation Supporting Rebate Allocations	6
• Internal Control Policies and Procedures	7
• Required Patient Safety Improvement Program	7

I. Audit Findings And Recommendations

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

2. **Dependent Eligibility**

The plan processed 427 claims, totaling \$70,821, for 36 members age 22 and over, whose eligibility could not be verified. The plan should not continue covering dependents age 22 and over without proper documentation to show that these dependents remain eligible for FEHBP coverage

Response:

The Plan disagrees with this finding. The Plan's computerized membership records going back to 1988 reveal the enrollees to be classified as "permanently disabled". Their status has not, to the plan's knowledge, been changed and has not been questioned by OPM/OIG in previous (and now) closed audits. Does OPM have records that indicate otherwise? If so, please share them with the plan. In the event OPM's records do indicate otherwise (or are not conclusive), then the plan can search its offsite, paper records to document the basis for the permanent disability status.

3. **Unallowable Charges for Nutrition Supplements**

We reviewed the 2009 pharmacy claims data to identify prescriptions with quantities over 5,000 dispensed to determine if the identified drugs were covered program benefits. We identified 143 claims, totaling \$29,814 that were paid for nutritional supplements. We asked the Plan to provide documentation showing how it determined that these nutritional supplements were allowable program benefits. The Plan was unable to support that these claims were paid in accordance with the Contract.

Page 44 of the Plan's 2009 FEHBP benefit brochure states that nutritional supplements are only covered for the treatment of phenylketonuria, branched chain ketonuria, galactosemia, and homocystinuria. All other vitamins, nutrients and food supplements are not covered, even if a physician prescribes or administers them.

Response:

The Plan agrees with this finding. The plan will returned \$29,814 plus LII to the LOC and provide documentation of the draw by June 3, 2011.

4. **Pharmacy Claim Pricing**

We reviewed all 2009 pharmacy claims paid to the mail order pharmacy (Medco) and the top 5 largest retail pharmacies (Wal-Mart, CVS, Duane Reade, Rite Aid, and Walgreens) to determine if each claim was appropriately priced based on the contract agreement. We identified 98 claims, totaling \$20,090, that were priced at least \$100 more than the contracted agreement. All pharmacies, except for Wal-Mart, had one or more claims priced incorrectly. The breakdown of claims per pharmacy is listed below:

- Medco had 15 overpriced claims for a total overcharge of \$4,483;
- CVS had 22 overpriced claims for a total overcharge of \$3,678;
- Duane Reade had 30 overpriced claims for a total overcharge of \$4,941;
- Rite Aid had 3 overpriced claims for a total overcharge of \$796; and
- Walgreens had 28 overpriced claims for a total overcharge of \$6,192.

Contract CS 1056, Section 3.2(b), states that costs to the FEHBP must be actual, allowable, allocable, and reasonable. Additionally, when errors are identified, Section 2.3(g) of the Contract requires the Plan to make a prompt and diligent effort to recover the overpayments.

Response:

The Plan is in disagreement with the finding. However, the Plan is in agreement it overpaid 65 claims in the amount of \$12,919.94. The Plan will return this amount plus LII to the LOC and provide documentation of the draw by June, 3 2011. The

plan has also provided documentation on these claims showing the exact

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6. Debarred Pharmacy Payments

As part of our debarment review, we compared GSA's Excluded Parties List to the 2009 pharmacy claims data in order to identify any claims paid to debarred pharmacies. During our review, we identified one pharmacy, Better Health Pharmacy Inc., that filled 97 scripts and received \$3,789 in claim payments during 2009. This pharmacy was debarred by OPM in 2004. Once a provider is debarred, it is the Plan's responsibility to ensure that the provider is flagged in its claims system to prevent future payments.

Chapter 2 of the Guidelines for Implementation of FEHBP Debarment and Suspension Orders requires FEHBP Carriers to establish a sanctions database that is updated monthly to include providers debarred by OPM. 5 CFR 890.1003 defines debarment as a decision by OPM's debarring official to prohibit payment of FEHBP funds to a health care provider. A health care provider includes any entity that, directly or indirectly, furnishes health care supplies including drugs and biologicals.

Response:

The Plan is in agreement with this finding and will returned \$3,789.00 plus LII to the LOC and provide documentation of the draw by June 3, 2011.

7. **Claims Paid after Member Termination**

Our review of the 2009 pharmacy claims data showed that the Plan processed 14 claims for 5 members after their enrollment termination date. These 5 members incurred \$1,439 in prescription drug payments during 2009. The Plan should have denied the claims since the members were no longer enrolled in the FEHBP.

Contract CS 1056, Section 3.2(b), states that costs to the FEHBP must be actual, allowable, allocable, and reasonable. Additionally, when errors are identified, Section 2.3(g) of the Contract requires the Plan to make a prompt and diligent effort to recover the overpayments.

Response:

The Plan is in agreement with this finding and will returned \$1,439.00 plus LII to the LOC and provide documentation of the draw by June 3, 2011.

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Attachments
Pharmacy claims pricing spreadsheet
Duplicate claims payment claim detail
Patient safety improvement program
Duplicate claim verification
Zero quantity sample screen shots