



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

Final Audit Report

Subject:

AUDIT OF BLUECROSS AND BLUESHIELD'S RETAIL PHARMACY MEMBER ELIGIBILITY IN 2006, 2007, AND 2011

Report No. 1H-01-00-12-072

Date: November 8, 2013

--CAUTION--

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

AUDIT REPORT

**AUDIT OF BLUE CROSS AND BLUESHIELD'S
RETAIL PHARMACY MEMBER ELIGIBILITY
IN 2006, 2007, AND 2011**

**CONTRACT CS 1039
PLAN CODES 10 AND 11**

Report No. 1H-01-00-12-072

Date: November 8, 2013



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Assistant Inspector General
for Audits**

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EXECUTIVE SUMMARY

AUDIT OF BLUE CROSS AND BLUESHIELD'S RETAIL PHARMACY MEMBER ELIGIBILITY IN 2006, 2007, AND 2011

CONTRACT CS 1039 PLAN CODES 10 AND 11

Report No. 1H-01-00-12-072

Date: November 8, 2013

The enclosed audit report details the results of our member eligibility-focused audit of the BlueCross and BlueShield's (Plan) retail pharmacy claims in 2006, 2007, and 2011. The primary objective of our audit was to determine if the Plan complied with the regulations and requirements contained within Contract CS 1039, between the Plan and the Office of Personnel Management (OPM), and the requirements within its contract with CVS Caremark, its Pharmacy Benefit Manager. The audit was performed in our Washington, D.C. office from September 27, 2012 to May 22, 2013.

In addition to a review of member eligibility for contract years 2006, 2007, and 2011, the audit also covered compliance with the Health Insurance Portability and Accountability Act (HIPAA) and program requirements for fraud and abuse for contract year 2011. A previous audit (Report Number 1H-01-00-11-063, dated August 8, 2012) covered HIPAA and fraud and abuse compliance for contract years 2006 and 2007. Our current audit identified improper claim payments in regards to member eligibility. As a result, the FEHBP was overcharged \$2,305,973, which includes \$6,465 for lost investment income calculated through August 31, 2013.

We used statistical sampling software to select a statistical sample for each year. A statistical sample is selected randomly from a universe using random numbers, in which each item has an equal chance of being selected. The use of statistical sampling allows us to project the error rates identified in our samples to the universe of claims. Since, as mentioned above, each claim had

an equal chance of being selected, it is reasonable to expect that the error rate occurs consistently throughout the universe and not solely within the selected sample. Therefore, we decided to project the results of our review of claims for 2011 to the entire 2011 universe of potential errors. We did not project our error rates for 2006 and 2007 to the respective universes due to the significant time elapsed since the claims were paid, the fact that the claims have reached or are approaching the end of the contractual limitation for records retention (although our intention to audit these records was announced to the Plan well in advance of that date), and because claims of that age are unlikely to be recovered.

Additionally, we are concerned that the Plan's responses to the recommendations in this report convey an attitude that erroneously paid claims are allowable as long as it has made a recovery effort, no matter the cause of the error. The Plan shows no sign of being disturbed that its weak internal controls are the root cause of the overpayments. This should clearly be a major priority for a carrier that covers over half of the FEHBP membership. We are also concerned that the Plan appears to rely upon our audits to identify erroneous claim payments rather than act proactively to identify and begin recovery efforts in a timelier manner on its own, as is required by its contract with OPM.

The results of our audit have been summarized below.

MEMBER ELIGIBILITY REVIEW

• **Member Eligibility Problems Identified** **\$2,299,508**

We identified 1,617 claims for contract years 2006, 2007, and 2011, totaling \$680,093, paid by the Plan for members that were ineligible due to retroactive member eligibility changes received by the Plan after the date of the claim (making them ineligible for coverage after the claim was originally processed). After projecting the 2011 results to the 2011 universe, we are also questioning an additional \$681,496 in claim payments.

We also identified 912 claims, totaling \$386,497, for contract years 2006, 2007, and 2011 where the Plan's claims system indicated that recovery (off-set) had not been initiated. For these claims we are questioning an additional \$478,133 after projecting the 2011 results to the 2011 universe.

Lastly, for contract years 2006, 2007, and 2011 we identified 142 claims, totaling \$49,089, which were unallowable for payment because the Plan's claims system indicated that the member was ineligible for coverage at the date of service. The 2011 results were projected to the 2011 universe resulting in additional questioned costs of \$24,200.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The results of our review showed that CVS Caremark 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

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

LOST INVESTMENT INCOME ON FINDINGS

- **Lost Investment Income** **\$6,465**

As a result of the questioned claims for ineligible members who were ineligible at the time of service, the FEHBP is due lost investment income of **\$6,465** through August 31, 2013 (interest will continue to accrue after that date until all questioned costs are returned to the FEHBP).

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This report details the results of our audit of BlueCross and BlueShield's (Plan) Federal Employees Health Benefits Program (FEHBP) retail pharmacy claims related to member eligibility, in 2006, 2007, and 2011. The audit was conducted pursuant to the provisions of Contract CS 1039; Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890 (5 CFR 890). The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended. The audit was performed in our Washington, D.C. office from September 27, 2012 to May 22, 2013.

BACKGROUND

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office (HIO) has overall responsibility for administration of the FEHBP, including the publication of program regulations and agency guidance. As part of its administrative responsibilities, the HIO contracts with various health insurance carriers that provide service benefits, indemnity benefits, and/or comprehensive medical services. The provisions of the FEHB Act are implemented by OPM through regulations codified in 5 CFR 890.

The BlueCross and BlueShield Association (Association), on behalf of participating Blue Cross and Blue Shield (BCBS) plans, entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers.

The Association established a Federal Employee Program (FEP) Director's Office in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, BCBS plans, and OPM. Compliance with the laws and regulations applicable to the FEHBP is the responsibility of the Plan's management, which includes establishing and maintaining a system of internal controls.

The Association also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BCBS, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

Pharmacy Benefit Managers (PBMs) are primarily responsible for processing and paying prescription drug claims. The services typically include both retail and mail order drug benefits.

For drugs acquired through the “local” drugstore, the PBMs contract directly with the approximately 50,000 retail pharmacies located throughout the United States. For maintenance prescriptions that typically do not need to be filled immediately, PBMs offer the option of mail order pharmacies. The PBM is used by the Plan to develop, allocate, and control costs related to the pharmacy claims program.

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

Although the Plan’s pharmacy operations and responsibilities are carried out by CVS Caremark, the responsibilities related to maintaining and updating member eligibility are the responsibility of the Plan. The Plan provides CVS Caremark with the membership eligibility data and updates when changes occur. It is the responsibility of CVS Caremark to initiate recovery efforts if claims have been paid in error due to retroactive membership eligibility changes. However, it is the Plan’s responsibility to notify them of these changes and of the claims effected by the changes before the refund requests can be sent.

All findings identified in our previous audit of the Plan (Report # 1H-01-00-11-063, dated August 8, 2012) have been resolved.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary objectives of this audit were to:

- Determine whether costs charged to the FEHBP and services provided to its members were in accordance with the terms of the FEHBP contract and Federal regulations.
- To determine if CVS Caremark’s policies and procedures address the Health Insurance Portability and Accountability Act (HIPAA) Standards for Electronic Transactions, Privacy Rules, and Security Rules and are in compliance with this Federal regulation.
- To determine if CVS Caremark’s policies and procedures for fraud and abuse complied with section 1.9(c) of Contract CS 1039 and met all eight industry standards for fraud and abuse programs outlined in FEHBP Carrier Letter 2003-23.

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 an eligibility review of retail pharmacy claims and the Plan’s adherence to its contractual requirements regarding claims for contract years 2006, 2007, and 2011. The audit scope also included compliance with HIPAA and program requirements for fraud and abuse for contract year 2011. A previous audit (Report Number 1H-01-00-11-063, dated August 8, 2012) covered HIPAA and fraud and abuse compliance for contract years 2006 and 2007.

In 2006, 2007, and 2011 the Plan paid \$8,831,464,251 in prescription drug charges (claims and administrative costs) to CVS Caremark. A summary of those costs by contract year is below:

Contract Charges by Year	
2006	\$2,616,272,544
2007	\$2,740,947,608
2011	\$3,474,244,099
Total	\$8,831,464,251

In planning and conducting the audit, we obtained an understanding of the Plan’s internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we identified internal control deficiencies within the Plan’s claims and eligibility systems

which resulted in the payment of claims for ineligible members. This issue is addressed in the “Audit Findings and Recommendations” section of this report. 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.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the Plan. Due to time constraints, we did not verify the reliability of the data generated by the various information systems involved. However, while utilizing the computer-generated data during audit testing, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve the audit objectives.

We also conducted tests to determine whether the Plan complied with the Contract, Service Agreements, applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP. Exceptions noted in the areas reviewed are set forth in the “Audit Findings and Recommendations” section of this report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan and CVS Caremark had not complied, in all material respects, with those provisions.

METHODOLOGY

To test whether the Plan accurately charged the FEHBP for 2006, 2007, and 2011 prescription drug benefits and complied with its contractual requirements, we identified potential error universes within the full claims universe of 197,261,689 claim lines, totaling \$8,831,464,251.

We used statistical sampling software to select a statistical sample for each year. A statistical sample is selected randomly from a universe using random numbers, in which each item has an equal chance of being selected. The use of statistical sampling allows us to project the error rates identified in our samples to the universe of claims. Since, as mentioned above, each claim had an equal chance of being selected, it is reasonable to expect that the error rate occurs consistently throughout the universe and not solely within the selected sample. Therefore, we decided to project the results of our review of claims for 2011 to the entire 2011 universe of potential errors. We did not project our error rates for 2006 and 2007 to the respective universes due to the significant time elapsed since the claims were paid, the fact that the claims have reached or are approaching the end of the contractual limitation for records retention (although our intention to audit these records was announced to the Plan well in advance of that date), and because claims of that age are unlikely to be recovered. The use of statistical sampling also requires the selection of confidence levels and precision rates. For the samples selected, we used a confidence level of 90 percent and a maximum precision rate of \$37,500, which means we are 90 percent sure that the difference between the projected questioned claims and the actual questioned claims is no more than \$37,500.

The following audit steps were performed:

Member Eligibility Review

- We identified a potential eligibility error universe of 6,860 claims totaling \$1,196,126 for contract year 2006. The universe contains all claims over \$100 and claims that were not previously reviewed on prior audits. We selected a statistical sample of 804 claims totaling \$206,086 for review to determine if the member was eligible for services at the time of the claim.
- We identified a potential eligibility error universe of 8,202 claims totaling \$1,465,678 for contract year 2007. The universe contains all claims over \$100 and claims that were not previously reviewed on prior audits. We selected a statistical sample of 912 claims totaling \$264,933 for review to determine if the member was eligible for services at the time of the claim.
- We identified a potential eligibility error universe of 10,233 claims totaling \$2,496,291 for contract year 2011. The universe contains all claims over \$100. We selected a statistical sample of 1,857 claims totaling \$985,648 for review to determine if the member was eligible for services at the time of the claim.

Health Insurance Portability and Accountability Act

- We obtained CVS Caremark's updated 2011 policies and procedures that address the HIPAA Standards for Electronic Transactions, Privacy Rules, and Security Rules for review to determine if the carrier has documented its compliance with this Federal regulation.

Fraud and Abuse

- We reviewed CVS Caremark's updated 2011 policies and procedures for fraud and abuse to determine if the Plan complied with section 1.9 (c) of Contract CS 1039 and met all eight industry standards for fraud and abuse programs outlined in FEHBP Carrier Letter 2003-23.

As mentioned previously, our selected samples were statistically based. Consequently, we projected the results of our review of 2011 claims to the universe since it is likely that the results were representative of the universe as a whole. We used Contract CS 1039 to determine if claim processing and administrative fees charged to the FEHBP were in compliance with the terms of the Contract.

The results of our audit were discussed with Plan officials throughout the audit. In addition, a draft report, dated May 22, 2013, was provided to the Plan for review and comment. The Plan and CVS Caremark's responses to the draft report, dated July 15, 2013, were considered in preparing the final report and are included as an Appendix to this report.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MEMBER ELIGIBILITY REVIEW

In a previous audit (Report Number 1H-01-00-11-063, dated August 8, 2012) we identified a high error rate in our sample of potential member eligibility errors. As a result, we decided to perform a separate audit to expand our review of member eligibility.

Using the universe of potential member eligibility errors for 2006 and 2007 identified in the previous audit, we selected a statistical sample (separate samples each year) of the remaining claims (removing those member claims that were previously reviewed). We then compared the Plan's enrollment data to the claims paid by CVS Caremark in 2006 and 2007 to determine if any claims were paid when a member was ineligible for FEHBP benefits with the Plan. During the audit we expanded the scope to include 2011 claims, which was the most recent year of claims available in our claims warehouse, to see if improved internal controls would result in fewer eligibility errors.

To complete our review, we were provided access to the Plan's claims system ("FEP Direct") which gave us current information related to member eligibility, claims, and any related refunds. Rather than provide the Plan with 3,573 claims and ask if the members were eligible or not, we manually reviewed each claim by looking up the member in FEP Direct and reviewing their eligibility. For claims which we determined had eligibility errors, we printed all of the FEP Direct screens used in determining that the member was not eligible at the time of service.

Before issuing a draft report, we electronically sent the Plan a spreadsheet with all of the claims in question along with all of the screen prints from our review. We asked the Plan to respond to each claim indicating whether or not they agreed with our findings, and if they did not, explain why they disagreed with our determination. If recoveries had not been initiated we asked the Plan to provide a reason why it was not done, and if recoveries had been initiated to provide supporting documentation for a selected number of recoveries. The Plan did not review the information timely and requested an extended time frame to complete its review. When responses were received from the Plan, they were generic, blanket responses covering many of the claims instead of the detailed claim by claim responses that we requested. We met with the Plan prior to issuance of our draft report and stressed to it the importance of a detailed claim by claim review of our questioned costs. However, responses provided to the draft report were again generic, blanket responses following another extension of time to respond.

Additionally, the Plan had CVS Caremark respond to the findings even though we made it clear to the Plan in discussions that our concerns were not with CVS Caremark but with the Plan's internal claims system and internal controls (as such, none of the recommendations in the draft report were addressed to CVS Caremark).

The claims reviewed in this audit were statistically sampled and are representative of the universe. A statistical sample is selected randomly from a universe using random numbers,

in which each item has an equal chance of being selected. The use of statistical sampling allows us to project the error rates identified in our samples to the universe of claims. Since, as mentioned above, each claim had an equal chance of being selected, it is reasonable to expect that the error rate occurs consistently throughout the universe and not solely within the selected sample. Therefore, we decided to project the results of our review of claims for 2011 to the entire 2011 universe of potential errors. We did not project our error rates for 2006 and 2007 to the respective universes due to the significant time elapsed since the claims were paid, the fact that the claims have reached or are approaching the end of the contractual limitation for records retention (although our intention to audit these records was announced to the Plan well in advance of that date), and because claims of that age are unlikely to be recovered.

1. Member Eligibility Problems Identified \$2,299,508

We identified 1,617 claims for contract years 2006, 2007, and 2011, totaling \$680,093, paid by the Plan for members that were ineligible due to retroactive member eligibility changes received by the Plan after the date of the claim (making them ineligible for coverage after the claim was originally processed). After projecting the 2011 results to the 2011 universe, we are questioning an additional \$681,496 in claim payments. The Plan's claim system indicates that recovery (off-set) has been initiated on these claims.

We also identified 912 claims, totaling \$386,497, for contract years 2006, 2007, and 2011 where the Plan's claims system indicated that recovery (off-set) had not been initiated. For these claims we are questioning an additional \$478,133 after projecting the 2011 results to the 2011 universe.

Finally, for contract years 2006, 2007, and 2011 we identified 142 claims, totaling \$49,089, which were unallowable for payment because the Plan's claims system indicated that the member was ineligible for coverage at the date of service. The 2011 results were projected to the 2011 universe resulting in additional questioned costs of \$24,200.

During our review of the 2006, 2007, and 2011 claims, we identified the following problems:

Recoverable Claims with Off-Set Process Begun by Plan

We identified 1,617 claims for contract years 2006, 2007, and 2011, totaling \$680,093, that were paid by the Plan for members that were ineligible due to retroactive member eligibility changes received by the Plan after the date of the claim. Our review determined that the Plan's claims system indicated that it had identified the claims as overpaid and marked them for recovery (off-set) against the next claim submitted for payment. However, we could not determine if the required recovery letters were sent. Consequently, we projected error rates for the 2011 review to the 2011 universe and questioned an additional \$681,496 in claim payments.

Year	Number of Questioned Claims	Dollar Amount of Questioned Claims	Projected Amount	Total Questioned Amount
2006	360	\$100,390	N/A	\$100,390
2007	404	\$125,230	N/A	\$125,230
2011	853	\$454,473	\$681,496	\$1,135,969
Total	1,617	\$680,093	\$681,496	\$1,361,589

The Plan contracts with CVS Caremark to administer its pharmacy benefit and to pay the member’s claims on its behalf. As CVS Caremark is the party that is the primary payer, the Plan relies upon it to make the initial recovery efforts from the members. Upon learning of an eligibility change for a member that would make a claim ineligible for payment, the Plan informs CVS Caremark to begin recovery efforts. CVS Caremark sends out letters at 30, 60, and 90 days requesting a refund from the member. If no recovery is made by CVS Caremark, it notifies the Plan and then it updates its system to off-set the amount from the next claim submitted for payment.

Contract CS 1039, Section 2.3(g) Erroneous Payments states, “If the carrier or OPM determines that a Member’s claim has been paid in error for any reason (except fraud and abuse), the Carrier shall make a prompt and diligent effort to recover the erroneous payment to the member from the member or, if to the provider, from the provider.”

Section 2.3(g) continues to outline the process for notifying the member of the overpayment, including the sending of the 30, 60, and 90 day letters, and allowing the Plan to begin an off-set of claims after 120 days of the first notice. The Plan may cease recovery efforts if it is deemed more cost effective to do so. However, the Plan is required to maintain “records that document individual unrecovered erroneous payment collection activities for audit for future reference.”

Finally, Section 2.3(g)(11) states “In compliance with the provisions of the Contract Disputes 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 and (b) that the Carrier failed to make a prompt and diligent effort to recover an erroneous payment.”

When our initial review was provided to the Plan in advance of our draft report, we requested it to provide copies of the recovery letters sent for a subset of the claims questioned (304 in total). However, the Plan did not provide this information until it was requested again in the draft report. Our review of the letters found that each of them (initial recover letter, as well as the 30, 60, and 90 day follow-up letters) had the same date.

This is a concern to us because the process could allow CVS Caremark to show the recovery process as completed when the initial letter is generated. Additionally, if the

letters are all generated simultaneously, partial recoveries received within the 90 day follow-up process would not be accounted for in the letters.

Prior to preparing this report we made numerous attempts to obtain an explanation as to why the recovery letters for each claim had identical dates. However, the Plan did not respond to any of our requests. As a result, we could not determine if the Plan met its due diligence requirements, which resulted in our questioning \$1,361,589.

Recommendation 1

We recommend that the contracting officer direct the Plan to return \$680,093 to the FEHBP for eligibility errors for 2006, 2007, and 2011, as it could not document its prompt and diligent efforts to recover the overpayments.

Plan's Comments:

The Plan disagrees with our finding. CVS Caremark agrees that the questioned claims had retroactive changes made to the enrollment records after adjudication and states that recovery letters were sent to members upon receipt of termination notices and that overpayments have been setup for off-set in the FEP claims system. The FEP Claims System has recovered \$1,790 of these overpayments as of August 8, 2013. Copies of the refund letters were provided to the OIG on July 15, 2013, and as a result the due diligence requirements of CS 1039 have been met.

OIG's Comments:

As stated previously in the finding, because the recovery letters provided had identical dates and the Plan did not respond to our questions, we could not determine if the Plan met its due diligence requirements. Additionally, the Plan did not provide evidence to support the recovery and return of the \$1,790 (out of the \$680,093 questioned). Therefore, we did not reduce the amount questioned by those potential recoveries.

Recommendation 2

We recommend that the contracting officer direct the Plan to return \$681,496 to the FEHBP for the projected eligibility errors for 2011.

Plan's Comments:

The draft report did not include this recommendation.

OIG Comments:

Although the draft report did not include this recommendation, we did inform the Plan in the draft report that the samples from this audit were statistically based and that we planned on projecting the error rates to the claims error universe. The Plan, in its

response to the draft report, did not object to this valid audit approach. In the resolution process we suggest that the Plan has two options to address the questioned amount (unless a settlement is reached): it may either return the full amount questioned, or it may review the entire universe of claims to determine the specific claims paid in error, provide supporting documentation to OPM, and begin the recovery process.

Recoverable Claims Where the Off-Set Process was not Begun by Plan

Our review also identified 912 claims, totaling \$386,497, for contract years 2006, 2007, and 2011 that were paid by the Plan for members that were ineligible due to retroactive member eligibility changes received by the Plan after the date of the claim and where the Plan’s claims system did not show the off-set recovery process was begun. We are questioning an additional \$478,133 in claim payments after projecting the 2011 error rate to its corresponding universe.

Year	Number of Questioned Claims	Dollar Amount of Questioned Claims	Projected Amount	Total Questioned Amount
2006	166	\$39,108	N/A	\$39,108
2007	207	\$64,219	N/A	\$64,219
2011	539	\$283,170	\$478,133	\$761,303
Total	912	\$386,497	\$478,133	\$864,630

Discussion with the Plan indicated that as a result of our previous audit, Report Number 1H-01-00-11-063, it had identified a systematic error in its claims system that caused many of these errors. According to the Plan, when a “file correction” is manually made to a member’s eligibility information, the system is unable to retroactively determine if claims were paid after the date eligibility was terminated. As a result of this system error, the claims were not sent to CVS Caremark to initiate recovery efforts.

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.”

It is our opinion that the Plan’s lack of proper internal controls to identify any and all changes to member eligibility, no matter how the change was made, resulted in its failure to identify and potentially recover these claims when they could have been more readily recovered. Therefore, these claims should be deemed unallowable and the funds questioned should be returned to the FEHBP.

In addition, it should be noted that this type of error is not limited to pharmacy claims, but most likely also can be found across all of the Plan’s many medical claims where “file corrections” were made.

Finally, the Plan indicated that recoveries were not initiated on many claims because they were over three years old when the eligibility update was received. However, according to the contract there is no time limitation on recovery efforts. The contract does allow the Plan to cease recovery efforts if it is more cost effective to do so, but the contract requires an effort to be made.

As the Plan did not comply with the contract's requirements to make a prompt and diligent effort to recover these payments that it should have identified (or in some cases did identify, but did not attempt to recover due to age), these claims should be deemed unallowable and the amounts questioned should be returned to the FEHBP.

Recommendation 3

We recommend that the contracting officer direct the Plan to return \$386,497 to the FEHBP for eligibility errors for 2006, 2007, and 2011, as it did not make a prompt and diligent effort to recover the overpayments.

Plan's Comments:

The Plan disagrees with our finding. CVS Caremark agrees that the questioned claims had retroactive changes made to the enrollment records after adjudication. Many of these retroactive changes were made by a manual file correction for which no notification is issued. The Plan developed a process during 2012 to send periodic listings of potential payment errors due to file corrections to CVS Caremark for overpayment recovery, ensuring timely initiation. Copies of the refund letters were provided to the OIG on July 15, 2013, and as a result, the due diligence requirements of CS 1039 have been met. In addition we provided select copies of file corrections that occurred and show CVS Caremark initiated recovery. Some of the documentation could not be provided due to the age of the files being beyond our records retention requirements.

Finally, medical claims that have file corrections are included in the FEP Claims System Claims Audit Monitoring Tool, which is used by Plans to initiate recovery on potential payment errors.

OIG's Comments:

In its response, the Plan provided us with copies of the refund letters for the claims in question that were all dated July 8, 2013. This date was after the issuance of our draft report. We would have to, therefore, disagree that the procedures implemented by the Plan in 2012 to initiate recovery on potential payment errors involving manual file corrections is effective or ensuring timely initiation. It appears that these claims were identified solely as a result of our audit as the letters were dated after issuance of our draft report.

In response to this recommendation, CVS Caremark provided comments pertaining to its internal control system. These comments were not included in the Plan's Comments, as

they are irrelevant to the finding. Our finding identifies the Plan's lack of internal controls as a cause for untimely recovery initiation of these claims, not CVS Caremark's. Throughout our audit process, the Plan often sought a response from CVS Caremark when we repeatedly asked for its response.

Our scope for this audit was a review of member eligibility at the time a claim was paid. Eligibility files are maintained by the Plan and updates to member eligibility are received by the Plan. Determination that a recovery is to be initiated due to a retroactive eligibility change is a responsibility of the Plan. CVS Caremark only initiates recoveries when notified by the Plan to do so. CVS Caremark was not notified in a timely manner to initiate recoveries for these claims due to the Plan's claims system not identifying the claims to be recovered. The responsibility for this oversight lies solely with the Plan.

Recommendation 4

We recommend that the contracting officer direct the Plan to return \$478,133 to the FEHBP for projected eligibility errors for 2011.

Plan's Comments:

The draft report did not include this recommendation.

OIG Comments:

Although the draft report did not include this recommendation, we did inform the Plan in the draft report that the samples from this audit were statistically based and that we planned on projecting the error rates to the claims error universe. The Plan, in its response to the draft report, did not object to this valid audit approach. In the resolution process we suggest that the Plan has two options to address the questioned amount (unless a settlement is reached): it may either return the full amount questioned, or it may review the entire universe of claims to determine the specific claims paid in error, provide supporting documentation to OPM, and begin the recovery process.

Recommendation 5

We recommend that the contracting officer direct the Plan to make immediate improvements to its internal control system so that it is able to identify all changes to a member's eligibility information when they are made and identify all potentially overpaid claims as a result of the change.

Plan's Comments:

The FEP Claims System is transaction driven and when a change is made to a member's enrollment records a Retro Enrollment Change Notification is generated. Manual file corrections are not transactions. Therefore, a notification is not generated. The FEP Director's Office and the FEP Operations Center are working on a resolution to identify

and automate the notifications for manual file corrections. In the meantime, the FEP Director's Office has developed a manual process to identify and generate file correction changes to send to CVS Caremark on a periodic basis. CVS Caremark manually generates overpayment recovery notices upon notification of the file correction.

OIG's Comments:

We acknowledge that the Plan is working on a solution to automate manual file corrections. However, as stated in our response to the previous recommendation, the manual process that has been implemented to identify file corrections and generate notifications is not entirely effective. The claims identified in our audit were not previously identified by the Plan for recovery initiation.

Recommendation 6

We recommend that the contracting officer direct the Plan to follow all aspects of Section 2.3(g) in its recovery efforts on all claims identified as overpaid in the future no matter the age of the claim.

Plan's Comments:

CVS Caremark disagrees with our recommendation. It stated that because manual file corrections do not automatically generate notifications, it did not initiate recovery on these overpayments until it received the list of claims from the OIG. Recovery was initiated upon receiving the information. Therefore, the due diligence requirements were met and they are in compliance with Section 2.3(g) of contract CS 1039.

OIG's Comments:

While we would agree with CVS Caremark's statements regarding its not being notified of these overpayments, the focus of this recommendation was not on the manual file corrections, but on those claims for which the Plan stated no recovery attempt was made because the claim was over three years old. These claim recoveries are not the responsibility of CVS Caremark, but of the Plan who, of its own accord, decided that the claims were too old to attempt recovery and never notified CVS Caremark to initiate recovery. As a result, we feel that the due diligence requirements for these claims were not met by the Plan.

Unallowable Claims for Ineligible Members

Additionally, we identified 142 claims for contract years 2006, 2007, and 2011, totaling \$49,089, which were unallowable for payment because the Plan's claims system indicated that the member was ineligible for coverage at the date of service. We have questioned an additional \$24,200 in claim payments after projecting the 2011 results to its universe.

Year	Number of Questioned Claims	Dollar Amount of Questioned Claims	Projected Amount	Total Questioned Amount
2006	68	\$15,140	N/A	\$15,140
2007	36	\$7,073	N/A	\$7,073
2011	38	\$26,876	\$24,200	\$51,076
Total	142	\$49,089	\$24,200	\$73,289

FEHBAR 1652.216-71(b) and Contract CS 1039, Section 3.2(b) Definition of costs (1) state, “The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable.” Additionally, Contract CS 1039, Section 3.2(b)(1)(i) states that the Carrier must “on request, document and make available accounting support for the cost to justify that the cost is actual, reasonable and necessary.”

Again, it is our opinion that the Plan’s internal control system is not sufficient to meet the requirements of the contract. All claims identified and questioned clearly showed that the member was ineligible for coverage prior to and at the date of the service. Consequently, these claims should be deemed unallowable as they never should have been paid, and the amounts questioned should be returned to the FEHBP.

Recommendation 7

We recommend that the contracting officer direct the Plan to return \$49,089 for contract years 2006, 2007, and 2011 to the FEHBP for eligibility errors where it did not make a prompt and diligent effort to recover the overpayments.

Plan’s Comments:

The Plan disagrees with our finding. Upon notification of the errors during the OIG audit and confirmation of the overpayments, recovery was initiated by CVS Caremark. As a result, the due diligence requirements of contract CS 1039 were met. The OIG was provided copies of the recovery letters on July 15, 2013.

OIG’s Comments:

The Plan fails to recognize that the claims questioned in this finding were due to the members being ineligible at the time of payment and that the Plan’s own claims system showed that these members were ineligible prior to the services incurred. The Plan provided no further documentation from its eligibility database to show that these members were eligible or, if ineligible, it did not provide an explanation or steps to correct the problem.

Additionally, it is our opinion that the \$73,289 in payments questioned does not meet the definition of “good faith payments.” We base this opinion on the fact that a reasonable

business person would not pay a claim for an individual with terminated coverage. As stated above, the Plan's own eligibility database shows that the members questioned were ineligible at the time the claims were incurred. It is then our assumption that the Plan was aware of the eligibility status of these individuals at that time. However, this information was apparently not communicated to CVS Caremark by the Plan. As a result, we have determined that these payments are unreasonable and unallowable charges against the contract which must be returned immediately, regardless of the Plan's recovery efforts, and are subject to lost investment income (LII).

Lastly, it is of great concern to us that the Plan's responses to this, and other recommendations in this report, convey an attitude that erroneously paid claims are allowable as long as a recovery effort has been made. The fact that the Plan's weak internal controls were the cause of the problem, or that years have passed without the Plan ever determining that an error (and in many cases repeated errors) have occurred, does not seem to be a concern to the Plan. It clearly should be, especially for a carrier that covers over half of the FEHBP membership. The Plan continually requested time extensions to review claims provided to it both prior to and after issuance of our draft report. Yet in spite of being granted this additional time, the documentation provided to support its review and recovery efforts did not demonstrate due diligence. Additionally, the Plan relies upon our audits to identify erroneous claims rather than act proactively to identify and recover monies on its own as is required in its contract with OPM.

Recommendation 8

We recommend that the contracting officer direct the Plan to return \$24,200 to the FEHBP for projected eligibility errors for 2011.

Plan's Comments:

The draft report did not include this recommendation.

OIG Comments:

Although the draft report did not include this recommendation, we did inform the Plan in the draft report that the samples from this audit were statistically based and that we planned on projecting the error rates to the claims error universe. The Plan, in its response to the draft report, did not object to this valid audit approach. In the resolution process we suggest that the Plan has two options to address the questioned amount (unless a settlement is reached): it may either return the full amount questioned, or it may review the entire universe of claims to determine the specific claims paid in error, provide supporting documentation to OPM, and begin the recovery process.

Recommendation 9

We recommend that the contracting officer require the Plan to obtain the eligibility error universe for contract years 2009, 2010, and 2012 from the OIG and to report to OPM, at

least quarterly, on the status and recovery efforts made on the identified improperly paid claims.

Plan's Comments:

The draft audit report did not include this recommendation.

Recommendation 10

We recommend the contracting officer direct the Plan to institute internal controls and edits to the eligibility system that would reject or suspend a claim for which no eligibility exists at the time of the claim.

Plan's Comments:

The draft audit report did not include this recommendation.

B. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

C. FRAUD AND ABUSE

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

D. LOST INVESTMENT INCOME ON FINDINGS

1. Lost Investment Income **\$6,465**

The FEHBP is due \$6,465 for LII related to the \$73,289 in questioned claims for members who were ineligible at the time of service.

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

We computed LII that would have been earned using the rates specified by the Secretary of Treasury and determined that the FEHBP is due \$6,465 for LII, calculated from erroneous claim payments made in 2006, 2007, and 2011.

Recommendation 11

We recommend that the contracting officer require the Plan to credit the FEHBP \$6,465 for LII calculated through August 31, 2013 (interest will continue to accrue after that date until all questioned costs are returned to the FEHBP).

Plan's Comments:

The draft audit report did not include LII on audit findings.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Special Audits Group

██████████, Auditor-In-Charge

██████████, Auditor

██████████, Group Chief ██████████

██████████, Senior Team Leader

**AUDIT OF BLUECROSS AND BLUESHIELD'S
RETAIL PHARMACY MEMBER ELIGIBILITY
IN 2006, 2007, AND 2011**

REPORT NUMBER 1H-01-00-12-072

SCHEDULE A - CONTRACT CHARGES

PHARMACY CLAIMS

2006 Retail Prescription Drug Claim Payments	\$2,616,272,544
2007 Retail Prescription Drug Claim Payments	2,740,947,608
2011 Retail Prescription Drug Claim Payments	3,474,244,099

TOTAL CONTRACT CHARGES	\$8,831,464,251
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SCHEDULE B - QUESTIONED COSTS

A. MEMBER ELIGIBILITY REVIEW

1. Member Eligibility Problems Identified

Recoverable Claims with Off-Set Process Begun by Plan	\$1,361,589
Recoverable Claims Where the Off-Set Process was not Begun by Plan	864,630
Unallowable Claims for Ineligible Members	73,289
Total Member Eligibility Claims Questioned	\$2,299,508

B. LOST INVESTMENT INCOME (See Schedule C)	\$6,465
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TOTAL QUESTIONED COSTS	\$2,305,973
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AUDIT OF BLUECROSS AND BLUESHIELDS'S
RETAIL PHARMACY MEMBER ELIGIBILITY
IN 2006, 2007, AND 2011

REPORT NUMBER 1H-01-00-12-072

LOST INVESTMENT INCOME CALCULATION

LOST INVESTMENT INCOME	2006	2007	2008	2009	2010	2011	2012	2013	TOTAL
A. QUESTIONED CHARGES (Subject to Lost Investment Income)									
Unallowable Claims for Ineligible Members	\$15,140	\$7,073	\$0	\$0	\$0	\$51,076	\$0	\$0	\$73,289
TOTAL	\$15,140	\$7,073	\$0	\$0	\$0	\$51,076	\$0	\$0	\$73,289
B. LOST INVESTMENT INCOME CALCULATION									
a. Prior Years Total Questioned (Principal)	\$0	\$15,140	\$7,073	\$0	\$0	\$0	\$51,076	\$0	
b. Cumulative Total	<u>\$0</u>	<u>\$0</u>	<u>\$15,140</u>	<u>\$22,213</u>	<u>\$22,213</u>	<u>\$22,213</u>	<u>\$22,213</u>	<u>\$22,213</u>	<u>\$73,289</u>
c. Total	\$0	\$15,140	\$22,213	\$22,213	\$22,213	\$22,213	\$73,289	\$73,289	
d. Treasury Rate: January 1 - June 30	5.125%	5.250%	4.750%	5.625%	3.250%	2.625%	2.000%	1.375%	
e. Interest (d * c)	\$0	\$397	\$528	\$625	\$361	\$292	\$733	\$504	\$3,440
f. Treasury Rate: July 1 - December 31	5.750%	5.750%	5.125%	4.875%	3.125%	2.500%	1.750%	1.750%	
g. Interest (f * c)	\$0	\$435	\$569	\$541	\$347	\$278	\$641	\$214	\$3,025
Total Interest By Year (e + g)	\$0	\$832	\$1,097	\$1,166	\$708	\$570	\$1,374	\$718	\$6,465



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

Federal Employee Program
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Washington, D.C. 20005
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July 15, 2013

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

**Reference: OPM DRAFT AUDIT REPORT
CVS/CAREMARK Expanded Retail Pharmacy Operations
Audit Report Number 1H-01-00-12-072
(Dated May 22, 2013 Received May 23, 2013)**

Dear ██████████:

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

A. MEMBER ELIGIBILITY REVIEW

1. Member Eligibility Problems Identified **\$1,115,679**

The OIG Auditors identified 2,671 claims, totaling \$1,115,679 paid for members that were ineligible due to retroactive member eligibility changes after the drugs were dispensed:

Recommendation # 1 **\$630,618**

CVS/Caremark agrees that claims for drugs totaling \$630,618 were dispensed prior to receiving retroactive enrollment changes that terminated the coverage for the questioned members identified in this finding. However, the claims were paid in error because termination information was submitted by the Federal Payroll Offices and or members to FEP after the claims had already been paid. Recovery letters were sent to the members immediately upon receipt of the retro-active termination notices. As of the date of this response, the overpayments have also been setup for off-set in the FEP claims system. As of August 8, 2013, the FEP Claims System has recovered \$1,790 of these overpayments. Copies of the refund letters were provided to OIG on July 15,

2013. As a result, CS1039 Due Diligence requirements were met and evidence has been provided to the OIG.

Recommendation # 2

\$435,972

We disagree with the OIG's statement that the internal controls over the overpayment recovery efforts at CVS/Caremark are not adequate.

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

CVS/Caremark agrees that claims for drugs totaling \$435,972 were dispensed before the termination dates were loaded to the FEP System or retroactive enrollment notices were received. A number of these changes were the result of FEP Operations Center (FEPOC) manually processed enrollment changes (File Corrections) for which no notification is generated.

During 2012, the FEP Director's Office developed a process to send periodic listings of potential payment errors due to File Corrections to CVS/Caremark for initiation of overpayment recovery. This new procedure ensures timely initiation of recovery for potential overpayments. Copies of the refund letters sent to members once Caremark became aware of the overpayments were provided to OIG on July 15, 2013. In addition, on July 15, we provided select copies of documentation that File Corrections occurred for claims in this category and that Caremark initiated recovery once the impact of these File Corrections were documentation. As a result, CS1039 Due Diligence requirements were met. The remaining documentation of the File Corrections cannot be provided because the ages of the changes are beyond our record retention requirements.

Medical claims related to termination file corrections are included in the FEP Claims System Claims Audit Monitoring Tool (CAMT), which is used by Plans to initiate recovery on potential terminated member claims.

Recommendation # 3

Procedural

The FEP Claims System generates Retro Enrollment Changes Notifications for transactions that make changes to the members' enrollment records. The FEP Claims System is a transaction driven system. Because these changes are not transactions, the system does not generate notifications for File Corrections. The FEPDO and the FEPOC continue to research how to identify and automate the notifications for File Corrections. However, to minimize the impact of this issue, the FEP Director's Office has developed a manual process to generate File Correction changes to CVS/Caremark on a periodic basis. Once received, Caremark manually generates overpayment

July 15, 2013
Draft Report Response

recovery notices. Medical claims impacted by file corrections are included on the FEPDO online CAMT, used by Plans to initiate recovery on terminated member claims.

Recommendation # 4

Procedural

CVS/Caremark is in compliance with all aspects of Section 2.3(g) of CS1039 in its recovery efforts on all claims identified as overpayments. Because retro-termination notices are not generated for File Corrections, Caremark did not initiate recovery for these overpayments until they received the OIG listing. Once Caremark was informed of the overpayments, recovery letters were sent to these members. As a result, CS1039 Due Diligence requirements were met. Copies of the refund letters were provided to the OIG on July 15, 2013.


Recommendation # 5

\$49,089

When Caremark was notified of the error during the OIG audit, upon confirmation of the overpayments, recovery was initiated. As a result, CS1039 Due Diligence requirements were met. Copies of the refund letters to support Caremark's overpayment recovery activities were provided to the OIG on July 15, 2013.

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

Sincerely,


Managing Director
Program Assurance