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

Final Audit Report

Subject:

LIMITED SCOPE AUDIT OF BLUE CROSS AND BLUE SHIELD'S PRICING OF PHARMACY CLAIMS AS ADMINISTERED BY CAREMARK PCS HEALTH LLC FOR CONTRACT YEAR 2012

Report No. 1H-01-00-14-008

Date: October 6, 2014

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

Office of the
Inspector General

AUDIT REPORT

LIMITED SCOPE AUDIT OF BLUE CROSS AND BLUE SHIELD'S PRICING OF PHARMACY CLAIMS AS ADMINISTERED BY CAREMARK PCS HEALTH LLC FOR CONTRACT YEAR 2012

CONTRACT CS 1039
PLAN CODES 10 AND 11

Report No. 1H-01-00-14-008 **Date:** October 6, 2014

Michael R. Esser
Assistant Inspector General
for Audits

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Washington, DC 20415

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Inspector General

EXECUTIVE SUMMARY

LIMITED SCOPE AUDIT OF BLUE CROSS AND BLUE SHIELD'S PRICING OF PHARMACY CLAIMS AS ADMINISTERED BY CAREMARK PCS HEALTH LLC FOR CONTRACT YEAR 2012

CONTRACT CS 1039 PLAN CODES 10 AND 11

Report No. 1H-01-00-14-008 **Date:** October 6, 2014

The enclosed audit report details the results of our limited scope audit of Blue Cross and Blue Shield's (BCBS) pricing of pharmacy claims as administered by Caremark PCS Health LLC (Caremark) for contract year 2012.

New pharmacy transparency standards for all Federal Employees Health Benefits Program carriers came into effect in January 2011 for new carrier/Pharmacy Benefit Manager Contracts. Contract year 2012 was the first where those transparency standards were included in the contracts between the BCBS Association (BCBSA) and Caremark. Therefore, the primary objective of our audit was to verify, on a limited basis, if the pharmacy claims processed and paid by Caremark on behalf of BCBSA were transparent and accurately priced. The audit was performed in our Washington, D.C. office from March 10, 2014 to April 18, 2014.

Additionally, we also determined if Caremark and BCBSA were in compliance with the Health Insurance Portability and Accountability Act and Fraud and Abuse requirements of the contract between the U.S. Office of Personnel Management (OPM) and BCBSA. This audit identified one procedural finding related to fraud and abuse.

The results of our audit have been summarized below.

TRANSPARENCY AND PRICING

The results of our review, based on our limited sample size of 120 pharmacy claims (40 claims each from retail, mail order, and specialty pharmacy; retail was further limited to four high volume pharmacies), found that the pricing calculations utilized by Caremark in its administration of the BCBSA's Federal Employees Health Benefits Program's pharmacy claims were transparent and accurately priced.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The results of our review show that Caremark and BCBSA have policies and procedures in place to address the Health Insurance Portability and Accountability Act's Standards for Electronic Transactions, Privacy Rule, and Security Rule.

FRAUD AND ABUSE

1. **Fraud and Abuse Cases Identified by Caremark but not Reported by BCBSA** — **Procedural**

   The BCBSA did not report to OPM's Office of the Inspector General (OIG) all of the suspected fraud and abuse cases that were reported to it by Caremark for contract year 2012. Additionally, of those cases that were reported to the OIG, 50 percent were not reported within the 30 working day requirement.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This report details the results of our limited scope audit of Blue Cross and Blue Shield's (BCBS) pricing of pharmacy claims as administered by Caremark PCS Health LLC (Caremark) for contract year 2012. 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 March 10, 2014 to April 18, 2014.

BACKGROUND

The Federal Employees Health Benefits Program (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 BCBS Association (BCBSA), on behalf of participating 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. BCBSA delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers.

BCBSA 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 (FEPDO) coordinates the administration of the contract with BCBSA, BCBS plans, and OPM. Compliance with the laws and regulations applicable to the FEHBP is the responsibility of BCBS's management, which includes establishing and maintaining a system of internal controls.

BCBSA 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 BCBSA 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, 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. PBMs are used by the Plan to develop, allocate, and control costs related to the pharmacy claims program.

Pharmacy operations and responsibilities under contract CS 1039 are carried out by 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. Additionally, section 1.26(a) of contract CS 1039 outlines transparency standards related to PBM arrangements (effective January 2011) that require PBMs to provide pass-through pricing based on the PBM's cost. Our responsibility is to review the performance of Caremark to determine if BCBSA charged costs to the FEHBP and provided services to its members in accordance with this contract.

This is our first audit of BCBSA's pharmacy pricing under the new transparency standards.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

New pharmacy transparency standards for all FEHBP carriers came into effect in January 2011 for new carrier/PBM Contracts. Contract year 2012 was the first where those transparency standards were included in the contracts between the BCBSA and Caremark. Therefore, the primary objectives of this audit were to:

- Obtain an understanding of Caremark's claims adjudication process and how CS 1039's transparency standards have been implemented.
- Determine if pharmacy claims for Federal subscribers were processed and priced in a transparent manner as required by CS1039, section 1.26, on a limited basis.

Additionally, we also included the following objectives:

- Determine if BCBSA's and Caremark's policies and procedures address the Health Insurance Portability and Accountability Act's (HIPAA) Standards for Electronic Transactions, Privacy Rule, and Security Rule and are in compliance with this regulation.
- Determine if BCBSA's and 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 Letters 2003-23 and 2011-13.

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 a limited review of pharmacy pricing and adherence to transparency pricing standards for contract year 2012. The audit scope also included compliance with HIPAA and program requirements for fraud and abuse for contract year 2012.

In 2012 BCBSA paid $6,068,584,781 in prescription drug charges (claims and administrative costs) to Caremark. A summary of those costs by pharmacy type for the contract year is below:

Contract Charges by Pharmacy Type	
Retail Pharmacy	$3,593,022,713
Mail Order Pharmacy	$1,421,440,966
Specialty Pharmacy	$1,054,121,102
Total	$6,068,584,781

In planning and conducting the audit, we obtained an understanding of BCBSA's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was

determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Additionally, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on BCBSA's system of internal controls taken as a whole.

In conducting our audit, we relied to varying degrees on computer-generated data provided by Caremark. 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 BCBSA complied with the Contract, Service Agreements, applicable procurement regulations (i.e., Federal Acquisition Regulations and FEHB 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 BCBSA and Caremark had not complied, in all material respects, with those provisions.

METHODOLOGY

To test whether pharmacy claims were priced accurately under the new transparency standards for contract year 2012, we identified a claims universe of 84,480,990 claim lines, totaling $6,068,584,781.

Due to the fact that the new transparency standards implemented by OPM would institute a much more complex pricing formula for pharmacy claims, we planned this limited scope audit to understand the new methods of pricing claims and to ensure that we can obtain all necessary documentation. As a result, we performed the following audit steps as a precursor to a more thorough review to be completed at a later date:

Transparency Pricing Review

- We identified a retail pharmacy universe of 76,215,108 claims totaling $3,593,022,713 for contract year 2012. We selected a random sample of 40 claims totaling $3,962 for review to determine if the claims were priced in accordance with CS 1039's transparency standards.

- We identified a mail order pharmacy universe of 8,085,445 claims totaling $1,421,440,966 for contract year 2012. We selected a random sample of 40 claims totaling $12,572 for review to determine if the claims were priced in accordance with CS 1039's transparency standards.

- We identified a specialty pharmacy universe of 180,437 claims totaling $1,054,121,102 for contract year 2012. We selected a random sample of 40 claims totaling $128,224 for

review to determine if the claims were priced in accordance with CS 1039's transparency standards.

The samples selected during our review were not statistically based. **Consequently, the results could not be projected to the universe since it is unlikely that the results are representative of the universe as a whole.** We used Contract CS 1039 to determine if claims charged to the FEHBP were in compliance with the terms of the Contract.

Health Insurance Portability and Accountability Act

- We obtained BCBSA's and Caremark's updated 2012 policies and procedures that address the HIPAA Standards for Electronic Transactions, Privacy Rule, and Security Rule for review to determine if the carrier has documented its compliance with this regulation.

Fraud and Abuse

- We reviewed BCBSA's and Caremark's updated 2012 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 Letters 2003-23 and 2011-13.

The results of our audit were discussed with Caremark and BCBSA officials throughout the audit. In addition, a draft report, dated April 24, 2014, was provided to BCBSA for review and comment. BCBSA's response to the draft report, dated May 23, 2014, was considered in preparing the final report and is included as an Appendix to this report.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. TRANSPARENCY AND PRICING

The results of our review, based on our limited sample size of 120 pharmacy claims (40 claims each from retail, mail order, and specialty pharmacy; retail was further limited to four high volume pharmacies), found that the pricing calculations utilized by Caremark PCS Health LLC (Caremark) in its administration of the Blue Cross and Blue Shield Association's (BCBSA) Federal Employee Health Benefits Program's (FEHBP) pharmacy claims were transparent and accurately priced.

B. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILTY ACT

The results of our review show that Caremark and BCBSA have policies and procedures in place to address the Health Insurance Portability and Accountability Act's Standards for Electronic Transactions, Privacy Rule, and Security Rule.

C. FRAUD AND ABUSE

1. Fraud and Abuse Cases Identified by Caremark but not Reported by BCBSA — Procedural

The BCBSA did not report to Office of Personnel Management's (OPM) Office of the Inspector General (OIG) all of the suspected fraud and abuse cases that were reported to it by Caremark for contract year 2012. Additionally, of those cases that were reported to the OIG, 50 percent were not reported within the 30 working day requirement.

Contract CS 1039 Section 1.9(a) requires BCBSA to "operate a system designed to detect and eliminate fraud and abuse . . . by providers providing goods or services to FEHB Members, and by individual FEHB Members."

Additionally, FEHBP Carrier Letter 2011-13 (Carrier Letter) states that all FEHBP Carrier Special Investigative Units are required to submit a written notification to the OIG within 30 working days of becoming aware of a fraud, waste, or abuse issue where there is reasonable suspicion that fraud has occurred or is occurring against the FEHBP. It also states that, in order to meet the 30 working day requirement, the carriers may provide notification on cases where their investigation is still in the early stages and it has not yet determined if there is sufficient evidence to substantiate the allegation. There is no dollar threshold for this Carrier Letter requirement.

During our audit we requested that Caremark provide a listing of all of its FEHBP fraud cases related to BCBSA which were entered into BCBSA's Fraud Information Management System (FIMS) for contract year 2012. This information was then provided to the OIG's Office of Investigations (OI) to compare to the pharmacy-related cases reported to it by BCBSA for calendar year 2012. Our review of the subsequent information provided by the OIG's OI determined that BCBSA did not report all

potential fraud, waste, or abuse issues entered into FIMS by Caremark and that half of the issues reported to the OIG were untimely. Specifically, we identified the following:

- Cases Entered into FIMS but not Reported to the OIG: Of the 61 cases that Caremark entered into FIMS (all of which met the Carrier Letter's criteria for reporting), only 18, or 30 percent, were reported to the OIG by BCBSA.

- Cases Submitted After the 30 Working Day Timeliness Guideline: Of the 18 cases that were reported to the OIG, only 9 were submitted within the 30 working day requirement. The nine cases reported late were referred to the OIG an average of 126 working days after the cases were entered into FIMS by Caremark (we assumed that the "Date Referred" in the notification information provided to the OIG is the date the case was entered into FIMS).

The BCBSA's Federal Employee Program Directors Office (FEPDO) has established vast anti-fraud activities with over 500 investigators at 53 local Blue Cross and Blue Shield (BCBS) anti-fraud units contained within the 37 BCBS companies. Additionally, it utilizes a dedicated fraud unit at Caremark, and employs 12 FEPDO staff and consultants. The cost of the FEPDO anti-fraud activities in 2012 was $5,845,156. Additionally, Caremark's anti-fraud activities charged to the FEHBP totaled $1,905,366 in 2012. (Please note that these amounts were provided to us by BCBSA and have not been verified by our office.) **However, as noted in this finding, and in three final BCBS audit reports issued by our office since March 2012, the costs charged by BCBSA for its anti-fraud activities have not led it to comply with the Carrier Letter requirement of reporting all of its fraud cases to the OIG in a timely manner, while Caremark, charging approximately one-third the costs, provided the information timely to the FIMS system.** It should also be noted that the OIG has no remote access to FIMS, a system that OPM has paid to create and maintain, and, therefore, relies solely on the FEPDO to provide FIMS case notifications and referrals.

By not reporting all potential fraud and abuse cases to the OIG, BCBSA is adversely affecting the OIG's ability to investigate those potential fraud cases and potentially recover FEHBP monies charged fraudulently. Additionally, by not reporting all potential fraud cases reported to it by Caremark in a timely manner, BCBSA is further limiting the OIGs investigative efforts. Finally, by not adhering to the requirements of the Carrier Letter, the FEHBP is paying BCBSA's anti-fraud units significant amounts each year for services that are not being provided as required by the contract and Carrier Letter.

Recommendation 1

We recommend that the contracting officer require BCBSA to implement changes to ensure that all cases reported in FIMS are referred to the OIG and that those cases are reported within 30 working days of being entered as required by the Carrier Letter.

BCBSA Response:

BCBSA partially disagrees with this recommendation.

It stated that Carrier Letter 2011-13 requires that all Carrier Special Investigation Units (SIU) submit a written notification, where there is a reasonable suspicion that fraud has occurred or is occurring in the FEHBP and indicated that it felt that not all cases reported by Caremark met this requirement.

Additionally, BCBSA stated that when Caremark enters a case into FIMS, its SIU staff reviews the entire entry in the activity log and the recommendations made by Caremark before choosing a course of action. BCBSA states that it is sometimes necessary to conduct a preliminary investigation to determine if there is sufficient information to support a reasonable suspicion that fraudulent activity may be occurring. If reasonable suspicion is determined, at that point it notifies the OPM-OIG of the allegations.

Out of the 61 cases identified, BCBSA provided the following disposition of the cases:

Pharmacy Referrals (submitted to OPM)	7
Pharmacy Notifications (Submitted to OPM)	11
Provider Shopper Case Management Referral Program (PSCMRP)	20
Not Fraud	7
Member Termed Out of Program	2
Referred to Plans for Further Investigation	6
Request for Information	4
Ongoing Investigations	3
Other Law Enforcement	1

The PSCMRP is a means of altering abusive behavior and has been in effect for many years. The OIG is aware that PSCMRP is an opportunity for intervention made available to members and the OIG has even requested Caremark use this program for other FEHBP Carriers.

After further analysis BCBSA determined that of the 18 cases that met its "reasonable suspicion" requirement, 9 were submitted within the 30 day requirement and 1 was a day late. Its objective is 100 percent compliance, but it feels that further investigation is necessary to determine if "reasonable suspicion" of fraud exists.

To improve the timeliness of reporting Caremark cases, BCBSA stated that it would develop additional processes and procedures by June 30, 2014.

OIG Response:

BCBSA's response only focused on one portion of Carrier Letter 2011-13 and did not account for the additional requirements that state "in order to meet the 30 day notification requirement, Carriers may provide notification on cases where their investigation is still

in the early stages and the Carrier has not yet determined whether there is sufficient evidence to substantiate the allegation."

The OIG believes that if a local plan or PBM investigator enters the case into FIMS and makes a recommendation, there is already "reasonable suspicion" in place; if not the case wouldn't have been entered into FIMS. If non-fraud related cases are entered into FIMS, then BCBSA should train its local plans and PBMs as to what should and should not be entered into FIMS. Nowhere is it stated that the FEPDO must perform further investigation or confirm fraud has occurred before notifying the OIG of the case. If the FEPDO is further investigating a case it may state that in the notification to the OIG. BCBSA consultants should not be applying their own standards to determine when a case entered into FIMS should or should not be reported to the OIG.

The OIG is aware of PSCMRP. However, those cases should be reported as well and noted that the member has agreed to enter the program. The program was designed as an intervention of possible prescription drug abuse.

We acknowledge that 9 of the 18 cases reported to the OIG were reported in the 30-day notification requirement. BCBSA did not provide any documentation showing the one case was a day late, but nonetheless it would still be considered late.

The non-reporting and late reporting of cases to OPM hinders the OIG's ability to investigate potential cases in a timely manner and to determine if any of the cases affect other areas of the FEHBP.

Recommendation 2

We recommend that the contracting officer require BCBSA to provide the OIG with access to all of the data entered into or contained in FIMS. That being said, we believe that direct (read-only) access to the FIMS system is the most efficient means of making the data available to the OIG.

BCBSA Response:

BCBSA will continue to work with the OIG to provide any specific data needed.

However, BCBSA disagrees with the OIG's opinion regarding access to the FIMS system. It states that FIMS is an internal management reporting system used by BCBSA and local plans to report fraud, waste, and abuse cases and resides on a secured proprietary platform accessible to Blue Plan employees only. Furthermore, BCBSA states "it would be physically impossible for the OPM/OIG to have access to FIMS." BCBSA stated that before cases can be fully accepted into FIMS, they must be reviewed and evaluated by its consultants. BCBSA then works with the local plans to ensure all of the proper data elements are entered. Access to FIMS by the OIG would result in potential inefficiencies to the FEP.

OIG Response:

We continue to recommend that the contracting officer direct BCBSA to provide OPM and the OIG with full access to FIMS data. We disagree with BCBSA's reasons for not providing this access, and in fact feel that providing this access would be the most efficient and cost effective way to provide the data to the OIG.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Office of Investigations

[redacted], Special Agent-In-Charge

Special Audits Group

[redacted], Auditor-In-Charge

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[redacted], Auditor

[redacted], Group Chief [redacted]

[redacted], Senior Team Leader

AUDIT OF BLUE CROSS AND BLUE SHIELD'S
TRANSPARENT PHARMACY PRICING
FOR CONTRACT YEAR 2012

REPORT NUMBER 1H-01-00-14-008

SCHEDULE A - CONTRACT CHARGES

PHARMACY CLAIMS		
2012 Retail Prescription Drug Claim Payments	**$**	**3,593,022,713**
2012 Mail Order Prescription Drug Claim Payments		**1,421,440,966**
2012 Specialty Prescription Drug Claim Payments		**1,054,121,102**
TOTAL CONTRACT CHARGES	**$**	**6,068,584,781**

APPENDIX

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

Federal Employee Program
1310 G Street, N.W.
Washington, D.C. 20005
202.942.1000
Fax 202.942.1125

May 23, 2014

Ms. [redacted], Group Chief
Special Audits Group
Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, Room 6400
Washington, D.C. 20415-11000

Reference: OPM DRAFT AUDIT REPORT
CVS Caremark Transparency Audit
Audit Report Number 1H-01-00-14-008
(Dated April 24, 2014 and Received April 24, 2014)

Dear [redacted]:

This is the BCBSA response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees Health Benefits. BCBSA would first like to take the opportunity to address the overall tone of the OIG Draft Audit Report. After close examination of the comments that were made in the draft report, BCBSA is concerned that some statements are not objective. For example, comments such as "**vast anti-fraud activities," "the *exorbitant* costs," "the *simple* requirement," "*significant amounts* each year for services that are *not* being provided" and "reporting the cases *in the first place*".**

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Not Relevant to the Audit Report

These comments are not objective and undermine the professional and cooperative relationship FEP has always experienced with OIG. Additionally, many statements as described are demonstrably false and do not facilitate productive resolutions of audit issues.

The FEP SIU has extensively re-assessed their processes and provided focused training to Plans since 2012. Consequently, BCBSA respectfully requests that these types of comments be removed from the Final Audit Report.

Deleted by OIG
Not Relevant to the Audit Report

APPENDIX

Our comments concerning the findings in the report are as follows:

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Not Relevant to the Audit Report

Recommendation 1

We recommend that the contracting officer require the BCBSA to implement changes to ensure that all cases reported on FIMS are referred to the OIG and that those cases are reported within 30 working days of being entered as required by the Carrier Letter.

BCBSA Response:

BCBSA partially disagrees with this recommendation. FEHBP Carrier Letter 2011-13 states that all Carrier SIUs are required to submit a written notification, where there is a reasonable suspicion that fraud has occurred or is occurring in the FEHBP. Based upon the analysis below, not all the cases reported by CVS met this requirement.

Upon receiving a new CVS Caremark case submitted in FIMS, the BCBSA SIU staff reviewed the entire entry in the activity log before considering any recommendations made by CVS. The CVS recommendations are just that, a recommendation that is taken into consideration when choosing a course of action.

A review of the actual 61 cases cited in the recommendation identified the following disposition:

Pharmacy Referrals	7
Pharmacy Notifications	11
Provider Shopper Case Management Referral Program (PSCMRP)	20
Not Fraud	7
Member Termed Out of Program	2
Referred to Plans for Further Investigation	6
Request for Information (RFI)	4
Ongoing Investigations	3
Other Law Enforcement	1
Total Cases:	61

Deleted by OIG
Not Relevant to the Audit Report

The OPM-OIG has been aware of the process of enrolling members into the PSCMP as a means of altering abusive behavior. The PSCMP enrollment process which has been in effect for many years enables BCBSA to provide an opportunity for intervention that

the member may not have had, but often is willing to accept. In fact, the OIG has even requested that CVS Caremark use this program for other FEHBP Carriers.

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Not Relevant to the Audit Report

Eighteen (18) cases were ultimately submitted to OPM as referrals and notifications after all other options were considered. Seven (7) of the remaining cases were examined and additional information was obtained to determine that no evidence of fraud existed. Two (2) members terminated the network, Six (6) were referred back to their Plans for specific follow-up, Three (3) are considered ongoing preliminary investigations, and four (4) were requests for information (RFI). The one (1) remaining case was referred to another Law Enforcement agency.

In order to determine that there is a "reasonable suspicion" that a fraud was occurring, it is often necessary to conduct a preliminary investigation. Once sufficient information has been obtained to support a reasonable suspicion that fraudulent activity may be occurring, then that would be the appropriate time to notify the OPM-OIG of the allegations of wrongdoing.

In further analyzing the above results, BCBSA did determine that 9 of the 17 cases identified as meeting the "reasonable suspicion" requirement were submitted within the 30 day requirement, and one case was one day late. Clearly, 100% compliance is our objective; however, at times cases are opened with the recommendation that additional investigation be conducted to determine whether there is a reasonable suspicion that fraud exists.

To improve the timeliness of reporting CVS Caremark cases, BCBSA will develop additional processes and procedures by June 30, 2014.

Recommendation 2

OPM recommended that the contracting officer direct the Association to provide OPM and the OIG full access to FIMS.

BCBSA Response:

BCBSA continues to disagree with the recommendation to provide the OPM OIG full access to FIMS. FIMS is an internal management reporting system used by BCBSA and Local Plans to report Fraud, Waste and Abuse cases. The FIMS system resides on a secured proprietary platform accessible to Blue Plan employees only. It would be physically impossible for the OPM/OIG to have access to FIMS. Before cases can be fully accepted into FIMS, they must be reviewed and evaluated by BCBSA consultants, who then work with Local Plans to ensure the proper data elements are entered. As

APPENDIX

such, unlimited access by the OIG to the system would result in potential inefficiencies for FEP.

BCBSA continues to be open to alternative processes to provide OPM-OIG with any specific data elements they desire.

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

Sincerely,

[redacted], CISA, CRMA, PMP, CRISC
Managing Director, FEP Program Assurance