



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

Final Audit Report

Subject:

AUDIT OF THE MAIL HANDLERS BENEFIT PLAN'S PHARMACY OPERATIONS AS ADMINISTERED BY CAREMARKPCS HEALTH FOR 2009 AND 2010

Report No. 1B-45-00-12-017

Date: December 13, 2012 -- --

--CAUTION--

This audit report has been distributed to Federal officials who are responsible for the administration of the audited program. This audit report may contain proprietary data that 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 THE MAIL HANDLERS BENEFIT PLAN'S
PHARMACY OPERATIONS AS ADMINISTERED BY
CAREMARKPCS HEALTH FOR 2009 AND 2010**

**CONTRACT NO. CS 1146
PLAN CODES 41, 45, AND 48**

Report No. 1B-45-00-12-017

Date: December 13, 2012



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

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EXECUTIVE SUMMARY

**AUDIT OF THE MAIL HANDLERS BENEFIT PLAN'S
PHARMACY OPERATIONS AS ADMINISTERED BY
CAREMARKPCS HEALTH FOR 2009 AND 2010**

**CONTRACT NO. CS 1146
PLAN CODES 41, 45, AND 48**

Report No. 1B-45-00-12-017

Date: December 13, 2012

The enclosed audit report details the results of our audit of the Mail Handlers Benefit Plan's (Plan) pharmacy operations as administered by CaremarkPCS Health [a subsidiary of CVS Caremark Corporation], the Plan's pharmacy benefit manager (PBM), for 2009 and 2010. The primary objective of our audit was to determine if the Plan complied with the regulations and requirements contained within Contract CS 1146, between the Plan and the Office of Personnel Management (OPM), and the requirements within its contract with the PBM. The audit was performed at the PBM's location in Northbrook, Illinois, from February 13, 2012 to March 2, 2012.

The audit covered mail and retail pharmacy claims and the Plan's adherence to its contractual requirements for contract years 2009 and 2010. The results of our audit have been summarized below.

MEMBER ELIGIBILITY REVIEW

The results of our review showed that the Plan had the appropriate procedures in place to verify member eligibility prior to pharmacy claims being paid.

COVERED DRUG REVIEW

The results of our review showed that the Plan had the appropriate procedures in place to ensure that excluded drugs, specialty drugs, and high quantity prescriptions were only covered when members received prior authorization.

ADJUDICATION REVIEW

The results of our review showed that the Plan and the PBM had appropriate procedures in place to deny duplicate claims, claims from debarred pharmacies, and claims with zero quantities dispensed.

PRICING REVIEW

The results of our review showed that the Plan and the PBM priced pharmacy claims according to the agreed-upon rate and returned all rebates that were due to the Federal Employees Health Benefits Program.

PRESCRIPTION REVIEW

The results of our review showed that the Plan and the PBM had policies and procedures in place to properly handle high dollar prescriptions, drug refills, and expired prescriptions.

COMPLIANCE REVIEW

- **Annual Fraud and Abuse Reporting Requirements** **Procedural**

The Plan's 2009 annual fraud and abuse report was missing a costs and benefits analysis of the Plan's fraud and abuse program, and it did not include the number of cases referred to OPM's and the Office of the Inspector General.

PERFORMANCE REVIEW

The results of our review showed that the PBM was held accountable for the performance standards outlined in its contract with the Plan. We also identified several value based benefits and drug utilization reviews implemented by the Plan to help reduce member costs and improve performance.

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I. INTRODUCTION AND BACKGROUND

INTRODUCTION

This report details the results of our audit of the Mail Handlers Benefit Plan's (Plan) pharmacy operations as administered by CaremarkPCS Health [a subsidiary of CVS Caremark Corporation], the Plan's pharmacy benefit manager (PBM), for 2009 and 2010. The audit was conducted pursuant to the provisions of Contract CS 1146; 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 at the PBM's location in Northbrook, Illinois, from February 13, 2012 to March 2, 2012.

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 Plan began participating in the FEHBP in 1963 under Contract CS 1146 between OPM and the National Postal Mail Handlers Union, a division of the Laborers International Union of North America. The Plan is open to all federal employees, postal employees, and annuitants who are eligible to enroll in the FEHBP. The Plan is an experience rated fee-for-service plan underwritten by First Health Life & Health Insurance Company and Cambridge Life Insurance Company [Coventry Health Care, Inc.].

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 1146 are carried out by the PBM, which is located in Northbrook, Illinois. Section 10 of Contract CS 1146 includes a provision that allows for audits of the program's operations. Our responsibility is to review the performance of this PBM to determine if the Plan charged costs to the FEHBP and provided services to its members in accordance with this contract. This was our first audit of the Plan's pharmacy operations.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVES

The primary objectives of this audit were to:

- Obtain reasonable assurance that the Plan complied with the provisions of the FEHB Act and regulations that are included, by reference, in the FEHBP contract.
- Obtain reasonable assurance of the Plan's compliance with the provisions of the contract with the PBM.
- Determine whether costs charged to the FEHBP and services provided to its members were in accordance with the terms of the FEHBP contract and federal regulations.

SCOPE

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our audit findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on the audit objectives.

This performance audit covered pharmacy claims and the Plan's adherence to its contractual requirements for contract years 2009 and 2010. The audit scope included a review of the PBM's compliance with the Health Insurance Portability and Accountability Act (HIPAA), its fraud and abuse program, and internal controls related to its claim processing system. In 2009 and 2010, the Plan paid \$792,077,332 in prescription drug charges (claims net of rebates and adjustments) to the PBM (see Schedule A).

In planning and conducting the audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its operation. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

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

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

METHODOLOGY

To test whether the Plan accurately charged the FEHBP for 2009 and 2010 prescription drug benefits and complied with its contractual requirements, we performed the following audit steps. The 2009 and 2010 claims universe used in the audit steps below included 14,317,837 pharmacy claims totaling \$845,724,503. The Plan reported 367,699 members enrolled for 2009 and 332,284 members enrolled for 2010.

Member Eligibility Review

- We reviewed all claims to determine if the member was eligible in the Plan’s system at the time the prescription was filled.
- To determine if the Plan properly enrolled dependent members, we identified all 833 dependents age 23 and over (760 disabled and 73 non-disabled) that had claims paid in 2009 and 2010. We verified the eligibility of all 73 non-disabled dependents and selected a judgmental sample of 32 members, out of 760 disabled dependents, to determine if the Plan could support each member’s disability status. The judgmental sample was picked by selecting every 25th member from the list of 760 disabled dependents.
- We reviewed all claims to determine if any payments were made to non-FEHBP members, or members enrolled in another group or plan code.

Covered Drug Review

- We reviewed all claims to determine if the Plan and the PBM denied payments for drugs that were excluded from coverage.
- We reviewed all 391 claims, totaling \$1,296,161, which had a quantity dispensed of 8,000 or more to determine if the large quantities of drugs were allowable.
- We reviewed all claims to determine if the Plan and the PBM documented its authorization of drugs requiring prior approval.
- We conducted a meeting with the Plan and the PBM to obtain detailed information on system edits, prior authorizations, excluded drugs, etc.

Adjudication Review

- We reviewed all claims to determine if any payments were made for duplicate claims or zero quantities dispensed.
- We reviewed all claims to determine if any payments were made to debarred pharmacies.

Pricing Review

- We tested the validity of our claims data by observing queries within the PBM's claims system to ensure that the totals matched.
- We reviewed prior audit reports from both internal and external auditors that tested the Plan's pricing of pharmacy claims and determined if the appropriate discounts were given to the FEHBP.
- We reviewed rebate reports and account credits to determine if rebates, recoveries, settlements, and adjustments were properly returned to the FEHBP.
- We obtained the Plan's annual accounting statements and compared them to the PBM's billings to determine if the Plan added any additional administrative fees or profit to the pharmacy claims.

Prescription Review

- We reviewed all 58 claims that were \$35,000 or greater, totaling \$2,696,963, to determine if the high dollar claims were properly supported by the original scripts.

Compliance Review

- We reviewed our prior audits of the PBM's HIPAA policies to determine if there were any changes during the past year and if the policies still comply with federal regulations.
- We reviewed the Plan's and the PBM's policies and procedures for fraud and abuse to determine if they complied with all eight industry standards for fraud and abuse programs as outlined in the FEHBP Carrier Letter 2003-23.
- We reviewed the information provided by the PBM in response to our Claims Processing Questionnaire to determine what edits and controls were used in its claims processing system.
- We reviewed the PBM's internal control policies and procedures to ensure that there were segregation of duties, physical safeguards, management review of high dollar claims, and controls to limit the risks associated with data entry.
- We held a meeting with the Plan and the PBM to discuss what internal controls they had in place related to the processing and payment of claims.
- We reviewed the Plan's annual fraud and abuse reports that were submitted to OPM to determine if the Plan complied with all of the reporting requirements listed in the Contract.

Performance Review

- We reviewed the Plan's value-based benefit initiatives that were implemented for the FEHBP to determine if the initiatives reduced costs or increased benefits for FEHBP members.
- We reviewed the 2009 and 2010 Performance Guarantee Reports to determine if the PBM met the performance requirements of the Plan and OPM.
- We reviewed the PBM's Drug Utilization Reports and met with the Plan to determine how it used the reports to help reduce or contain pharmacy costs.

Only those samples specifically identified as such were statistically based. Consequently, the results of the non-statistical samples could not be projected to the universe since it is unlikely that the results are representative of the universe as a whole. We used Contract CS 1146 to determine if claim processing and administrative fees charged to the FEHBP were in compliance with the terms of the Contract.

The results of our audit were discussed with Plan officials throughout the audit and at an exit conference. We also issued a draft report to the Plan on June 14, 2012, for review and comment. The Plan's response and comments to our draft report were considered in preparing the final report and are included as an Appendix.

III. AUDIT FINDINGS AND RECOMMENDATION

A. MEMBER ELIGIBILITY REVIEW

The results of our review showed that the Plan had the appropriate procedures in place to verify member eligibility prior to pharmacy claims being paid.

B. COVERED DRUG REVIEW

The results of our review showed that the Plan had the appropriate procedures in place to ensure that excluded drugs, specialty drugs, and high quantity prescriptions were only covered when members received prior authorization.

C. ADJUDICATION REVIEW

The results of our review showed that the Plan and the PBM had appropriate procedures in place to deny duplicate claims, claims from debarred pharmacies, and claims with zero quantities dispensed.

D. PRICING REVIEW

The results of our review showed that the Plan and the PBM priced pharmacy claims according to the agreed-upon rate and returned all rebates that were due to the FEHBP.

E. PRESCRIPTION REVIEW

The results of our review showed that the Plan and the PBM had policies and procedures in place to properly handle high dollar prescriptions, drug refills, and expired prescriptions.

F. COMPLIANCE REVIEW

1. Annual Fraud and Abuse Reporting Requirements

Procedural

The following exceptions were identified during our review of the Plan's fraud and abuse program:

- The Plan's 2009 annual fraud and abuse report, which was submitted to OPM on March 31, 2010, was missing a costs and benefits analysis of the Plan's fraud and abuse program; and
- The Plan's 2009 annual fraud and abuse report did not address the number of cases referred to OPM and the OIG.

Contract CS 1146, paragraph 1.9(a), Detection of Fraud and Abuse, states that the Carrier must submit annual fraud and abuse reports to OPM addressing an annual analysis of

costs and benefits for its fraud and abuse program and the number of cases referred to OPM and the OIG.

Because the Plan submitted its 2009 annual fraud and abuse report without several critical elements required by OPM, the effectiveness of the Plan's fraud and abuse program was unable to be assessed.

The Plan's Comments:

The Plan agrees that Section 1.9 of the Contract requires carriers to submit annual fraud and abuse reports to OPM addressing an annual analysis of costs and benefits for its fraud and abuse program. However, it pointed out that the fraud and abuse template issued by OPM on January 31, 2011, does not include a corresponding line item for the costs incurred by the fraud and abuse program. For the OIG to properly analyze the effectiveness of the Plan's fraud and abuse program, the Plan has provided the OIG with support to show what costs were incurred by the fraud and abuse program for 2009 through 2010. Based on the total amounts provided, the Plan shows an average savings of \$8 for every \$1 expended on its efforts to detect and prevent fraud, waste, and abuse.

In response to the second part of the finding, the Plan has already begun addressing the number of cases referred to OPM and the OIG using the January 31, 2011 fraud and abuse template issued by OPM. Therefore, the Plan requests that this finding be dropped.

OIG Comments:

While we acknowledge the Plan's position and the missing information that was provided to support the claimed costs of its fraud and abuse program during our audit, the fact remains that this information should have been included in the annual fraud and abuse report submitted to OPM for 2009. Contract provisions under section 1.9 spell out the Plan's responsibilities regarding fraud and abuse reporting and are enforceable until such time that the Contract's requirements are modified. That being said, we commend the Plan for taking action to ensure that the number of cases referred to OPM is documented in future fraud and abuse reports and would encourage them to continue this practice going forward.

Recommendation 1

We recommend that the Contracting Office ensure that the Plan's annual fraud and abuse reports contain all of the information required by section 1.9 of the Contract. This includes providing a costs and benefits analysis of the Plan's fraud and abuse program, and addressing the number of cases referred to OPM and the OIG.

G. PERFORMANCE REVIEW

The results of our review showed that the PBM was held accountable for the performance standards outlined in its contract with the Plan. We also identified several value based

benefits and drug utilization reviews implemented by the Plan to help reduce member costs and improve performance. These programs include managed drug dispensing limitations, specialty drug management, generic equivalent alerts, member utilization summaries (I-Benefits), and extra healthcare savings cards.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Special Audits Group

██████████, Auditor-In-Charge

██████████, Staff Auditor

██████████, Group Chief ██████████

██████████, Senior Team Leader

SCHEDULE A**AUDIT OF THE MAIL HANDLERS BENEFIT PLAN'S
PHARMACY OPERATIONS
AS ADMINISTERED BY CAREMARKPCS HEALTH
FOR 2009 AND 2010****CONTRACT CHARGES
REPORT NUMBER 1B-45-00-12-017****PRESCRIPTION DRUG BENEFITS****A. PHARMACY CLAIMS**

2009 PRESCRIPTION DRUG CLAIM PAYMENTS	\$408,114,347
2010 PRESCRIPTION DRUG CLAIM PAYMENTS	\$383,962,985

TOTAL CONTRACT CHARGES	<u>\$792,077,332</u>
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**AUDIT OF THE MAIL HANDLERS BENEFIT PLAN'S
PHARMACY OPERATIONS
AS ADMINISTERED BY CAREMARKPCS HEALTH
FOR 2009 AND 2010**

**SUMMARY OF FINDINGS
REPORT NUMBER 1B-45-00-12-017**

AUDIT FINDINGS

A. COMPLIANCE REVIEW

- | | |
|---------------------------------------------------------------------------|-------------------|
| 1. Annual Fraud and Abuse Reporting Requirements | Procedural |
| - 2009 Fraud and Abuse Report Missing Costs and Benefits Analysis | |
| - 2009 Fraud and Abuse Report Missing Number of Cases Referred to OPM-OIG | |

TOTAL PROCEDURAL FINDINGS

1



July 30, 2012

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

Re: OPM OIG Draft Audit Report No. 1B-45-00-12-017
Audit of the Mail Handlers Benefit Plan's Pharmacy Operations
as Administered by CaremarkPCS Health for 2009 and 2010

Dear [REDACTED]

Attached please find the response of Coventry Health Care ("Coventry") management to U.S. Office of Personnel Management Office of Inspector General Draft Audit Report No. 1B-45-00-12-017, Audit of the Mail Handlers Benefit Plan's Pharmacy Operations as Administered by CaremarkPCS Health for 2009 and 2010. Coventry looks forward to discussing the contents of this response at your convenience, and to a prompt and mutually satisfactory resolution of this audit. Please contact me if you have any questions or require additional information regarding this response.

Sincerely,

[REDACTED]
Vice President – Federal Programs
Coventry Health Care, Inc.

Enclosures

cc: [REDACTED]

Pages 1 through 10 deleted by the OIG

Not relevant to the Final Report

Deleted by the OIG

Not relevant to the Final Report

Recommendation 4

We recommend that the Contracting Office require the Plan to include an analysis of costs and benefits of its fraud and abuse program with each annual fraud and abuse report submitted to OPM.

Coventry Response: The OPM OIG bases this recommendation on the same compliance review described in Coventry's response to Recommendation 3 above. Generally speaking, the OIG's observation is, again, correct in that Section 1.9 of the FEHB Standard Contract requires plan carriers to furnish OPM with an annual cost-benefit analysis of their fraud and abuse program. Coventry notes, however, that while the fraud and abuse report template transmitted in OPM's above-referenced January 31, 2011, e-mail contains line items for several factors that enable OPM to identify the *benefits* attributable to that program (*i.e.*, the line items denoted Dollars Recovered, Actual Savings, and Prevented Loss), that template does not include a corresponding line item for quantifying the *costs* incurred to achieve these considerable benefits. That said, enclosed as Exhibits C and D to this response are copies of (i) the MHBP's 2009 and 2010 fraud and abuse reports submitted timely to OPM, and (ii) Coventry's March 2, 2012,

response to OPM OIG Information Request #35 from this audit specifying the costs Coventry charged the MHBP Contract in those years for its fraud and abuse program.

Review of those documents together reveals that during Contract Years 2009-2010, the MHBP realized approximately \$16.2 million in cumulative fraud and abuse recoveries and actual/projected savings. It further evidences that during that same time period the costs that Coventry charged just over \$2.1 million in costs to the MHBP Contract for the activities of its Special Investigative Unit (SIU) team. Accordingly, during those years the MHBP realized benefit savings of nearly \$8 for every \$1 Coventry expended on its efforts to detect and prevent fraud, waste, and abuse.

For these reasons, the OPM OIG should withdraw this Recommendation 4.

Recommendation 5

We recommend that the Contracting Office require the Plan to include the number of cases referred to OPM-OIG with each annual fraud and abuse report submitted to OPM.

Coventry Response: As noted in the discussion of Recommendation 3 above, OPM furnished FEHB plan carriers with a fraud and abuse reporting template by e-mail dated January 31, 2011. That template, which Coventry has utilized in the years following (*i.e.*, Contract Years 2010 and 2011) contains a line item – Cases Referred to OPM's OIG – which serves that very function. In other words, Coventry already has begun to furnish OPM with this information, and it continues to do so. See Exhibit C hereto. Accordingly, the OPM OIG should withdraw this Recommendation 5.

Deleted by the OIG

Not relevant to the Final Report

Sincerely,



Vice President – Federal Programs
Coventry Health Care, Inc.

Enclosures

cc:

