



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

Final Audit Report

**Audit of the BlueCross BlueShield Association's Pharmacy
Operations as Administered by Caremark PCS Health LLC
for Contract Years 2012 and 2013**

**Report Number 1H-01-00-14-067
August 12, 2015**

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EXECUTIVE SUMMARY

Audit of the BlueCross BlueShield Association's Pharmacy Operations as Administered by Caremark PCS Health LLC for Contract Years 2012 and 2013

Report No.1H-01-00-14-067

August 12, 2015

Why Did We Conduct the Audit?

The main objective of the audit was to determine whether costs charged to the Federal Employees Health Benefits Program (FEHBP) and services provided to FEHBP members were in accordance with the terms of the contracts between the U.S. Office of Personnel Management (OPM) and the BlueCross and BlueShield Association (BCBSA), the BCBSA and Caremark PCS Health LLC (Caremark), and the Federal regulations.

What Did We Audit?

The Office of the Inspector General (OIG) has completed a performance audit of the responsibilities of Caremark in regards to administrative fees, pharmacy claims pricing, eligibility, contract performance standards, and rebates for contract years (CY) 2012 and 2013, along with fraud and abuse reporting for CY 2013. Our audit was conducted from September 15 through 26, 2014, at Caremark's offices in Scottsdale, Arizona.



Michael R. Esser
*Assistant Inspector General
for Audits*

What Did We Find?

With the exception of the following items, we found Caremark's administration of BCBSA's FEHBP pharmacy operations to be in compliance with the contracts and Federal regulations.

1. Duplicate Claim Payments Identified – Caremark did not identify and reverse 49 duplicate claim payments, resulting in a \$5,915 overcharge to the FEHBP.
2. Fraud and Abuse Cases Not Reported by BCBSA – The BCBSA did not report all of the suspected fraud and abuse cases that were reported to it by Caremark to the OPM's OIG for CY 2013. Additionally, of those cases reported to the OIG, approximately 54 percent were not reported within the 30 working day requirement.

ABBREVIATIONS

5 CFR 890	Title 5, Code of Federal Regulations, Chapter 1, Part 890
BCBS	Blue Cross and Blue Shield
BCBSA	BlueCross BlueShield Association
CAREMARK	Caremark PCS Health LLC
CS 1039	Contract between the Office of Personnel Management and BCBSA
CY	Contract Year
FEHB	Federal Employees Health Benefits
FEHBP	Federal Employees Health Benefits Program
FEP	Federal Employee Program
FIMS	Fraud Information Management System
HIO	Healthcare and Insurance Office
OI	Office of Investigations
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
PBM	Pharmacy Benefit Manager
[REDACTED]	[REDACTED]

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I. BACKGROUND

This report details the results of our audit of the BlueCross BlueShield Association's (BCBSA) pharmacy operations as administered by Caremark PCS Health LLC (Caremark) for contract years (CY) 2012 and 2013. The audit was conducted pursuant to the provisions of Contract CS 1039 (between the U.S. Office of Personnel Management [OPM] and BCBSA); the pharmacy contracts between BCBSA and Caremark; 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 OPM's Office of the Inspector General (OIG), as established by the Inspector General Act of 1978, as amended. The audit was performed at Caremark's office from September 15 through 26, 2014.

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 BCBSA, 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 BCBSA delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers.

The 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 coordinates the administration of contract CS 1039 with the BCBSA, BCBS plans, and OPM. Compliance with the laws and regulations applicable to the FEHBP is the responsibility of BCBSA's management, which includes establishing and maintaining a system of internal controls.

The 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 its 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 BCBSA 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.

Our previous audit of Caremark’s administration of BCBSA’s pharmacy operations (Report Number 1H-01-00-14-008, dated October 6, 2014) covered pharmacy claim pricing (on a limited basis), compliance with the Health Insurance Portability and Accountability Act, and program requirements for fraud and abuse for CY 2012. All recommendations from the prior audit have been satisfactorily resolved.

The results of our audit were discussed with Caremark and BCBSA officials throughout the audit. In addition, a draft report, dated December 9, 2014, was provided to BCBSA for review and comment. The BCBSA’s response to the draft report, dated February 11, 2015, was considered in preparing the final report and is included as an Appendix in this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of the audit were to determine whether costs charged to the FEHBP and services provided to FEHBP subscribers were in accordance with the terms of the contract and Federal regulations. We also verified that the contract between BCBSA and Caremark complies with the requirements of the transparency standards included in contract CS 1039, and the retail, mail order, and specialty drug pharmacy contracts between BCBSA and Caremark.

Our specific audit objectives by area were as follows:

1. Administrative Fees Review – To determine if administrative fees paid by BCBSA to Caremark were accurate.
2. Claim Payment Reviews
 - a. Debarment – To determine if any claims were paid to a debarred pharmacy.
 - b. Duplicate Claims – To determine if any duplicate claims were paid.
 - c. Non-Covered Drugs – To determine if claims were paid for any drugs excluded from coverage.
 - d. Mail Order Day Supply – To ensure that mail order prescriptions were filled within the allowable day supply as stated in the benefit brochure.
 - e. Transparency Pricing Review – To determine if the pricing elements were transparent and if the retail, mail order, and specialty claims were properly paid.
 - f. Zero Quantity Review – To determine if any claims were paid which had a zero quantity.
3. Fraud and Abuse Review – To determine if Caremark and BCBSA followed OPM guidance in reporting fraud and abuse cases for 2013.
4. Member Eligibility Reviews
 - a) Dependent Eligibility – To determine if any claims were paid for dependents over age 26.
 - b) Eldest Members – To determine if any claims were paid for members after the date of death.
 - c) Ineligible Group Number – To determine if any claims were paid for non-FEHBP members or members enrolled in alternate plan codes under BCBSA.
5. Performance Standards Review
 - a) Contract Performance Review – To determine if Caremark met the performance standards required by BCBSA and OPM.

- b) Policies and Procedures Review – To obtain an understanding of the policies and procedures that relate to the segregation of duties, claims processing and payments, claim system edits, etc., and to determine if those policies and procedures appear to be adequate.
 - c) Procurement Review – To review the process used by BCBSA to select Caremark as its current PBM and to determine if this selection was the most cost effective for the FEHBP and its members.
6. Rebate Review – To determine if rebates billed to manufacturers were accurate and if the rebates were returned to BCBSA.

Scope and Methodology

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

This performance audit covered administrative fees, pharmacy claims pricing, eligibility, contract performance standards and rebates for CYs 2012 and 2013, along with fraud and abuse reporting for CY 2013.

The BCBSA is responsible for providing FEHBP members with medical and prescription drug benefits. To meet this responsibility, BCBSA collected premium payments of approximately \$27.5 billion in CY 2012 and \$28.4 billion in CY 2013, of which two thirds was paid by the government on behalf of the Federal employees. In addition to the premium payments, program income was also generated from the investment of program funds. Total pharmacy claims paid were approximately \$6.1 billion in CY 2012 and \$6.7 billion in CY 2013. A breakdown by pharmacy type can be seen in the chart to the right.

Pharmacy Claims Paid



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.

We also conducted tests to determine whether BCBSA complied with contract CS 1039, 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.

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.

To determine whether costs charged to the FEHBP and services provided to FEHBP members were in accordance with the terms of the contract and Federal regulations, we performed the following steps:

1. Administrative Fees Review

- a. From a universe of 24 retail pharmacy administrative fee invoices, totaling \$127,815,047 for CYs 2012 and 2013, we selected the highest dollar invoice from each CY (2), totaling \$12,492,304, to determine if the fees charged were accurate.
- b. From a universe of 24 mail order pharmacy administrative fee invoices, totaling \$7,965,138 for CYs 2012 and 2013, we selected the highest dollar invoice from each CY (2), totaling \$728,693, to determine if the fees charged were accurate.
- c. From a universe of 24 specialty pharmacy administrative fee invoices, totaling \$188,740 for CYs 2012 and 2013, we selected the highest dollar invoice from each CY (2), totaling \$18,423, to determine if the fees charged were accurate.

2. Claim Payment Reviews

- a. We obtained a list of debarred pharmacies from our Sanctions and Debarment Group and ran a match to the pharmacies on our [REDACTED] ([REDACTED]) claims database to determine if any claim payments were made to debarred pharmacies.

- b. From a universe of 2,958 members, with potential duplicate claims totaling \$1,564,511, we used a random number generator in [REDACTED] to select 50 members, with claims totaling \$8,244 for CY 2012, to determine if any duplicate claims were paid.
- c. From a universe of 9,799 members, with potential duplicate claims totaling \$5,238,923, we used a random number generator in [REDACTED] to select 50 members, with claims totaling \$24,612 for CY 2013, to determine if any duplicate claims were paid.
- d. From a universe of 1,212 non-covered drugs, we performed a search to identify all those where claims were paid. Our review identified 47 non-covered drugs that had paid claims. Of the 47 non-covered drugs identified, we selected 45 non-covered drugs to review (2 drugs were inadvertently excluded from our sample). Rather than expand our sample to include the remaining 2 non-covered drugs, we relied upon the results of our review of the 45 drugs selected (96 percent). All claims for the 45 non-covered drugs were determined to be allowable because either the member had a prior authorization, the drug was allowable at the time of fill and became unallowable at a later date, or the drug was part of a discount program for which the drug was paid for entirely by the member. As no errors were identified in our review of the 45 non-covered drugs, we did not expand our sample.

From the 45 non-covered drugs, we selected the first claim from the first two members listed (by subscriber number) for each non-covered drug for a total of 73 claims, totaling \$22,728, selected out of a universe of 1,570 claims totaling \$359,645, to determine allowability. (Of the 45 drugs, 17 had only one member with paid claims. The remaining 28 drugs had two members with paid claims.)

- e. We performed a search to identify all mail order pharmacy claims with a days supply under 21 and identified a universe of 1,619 claims totaling \$165,330. Using the [REDACTED] random number generator, we selected 25 claims, totaling \$2,083, to determine if the claims were paid correctly.
- f. We performed a search to identify all mail order pharmacy claims with a days supply over 90 and identified a universe of 2,865 claims totaling \$1,011,496. Using the [REDACTED] random number generator, we selected 25 claims, totaling \$11,310, to determine if the claims were paid correctly.
- g. From a retail pharmacy universe of approximately 153 million claims, totaling approximately \$7.5 billion, we used the [REDACTED] random sample generator to select a random sample of 75 claims from each CY from the top 25 pharmacies (as provided by Caremark), for a total of 150 retail claims, totaling \$17,579, to determine if the claims were paid correctly.

- h. From a mail order pharmacy universe of approximately 15 million claims, totaling approximately \$2.9 billion, we used the [REDACTED] random sample generator to select a random sample of 75 claims from each CY for a total of 150 mail order claims, totaling \$58,800, for review to determine if the claims were paid correctly.
- i. From a specialty pharmacy universe of 383,328 claims totaling approximately \$2.3 billion, we used the [REDACTED] random sample generator to select a random sample of 75 specialty pharmacy claims from each CY, for a total of 150 specialty claims totaling \$945,783, for review to determine if the claims were paid correctly.
- j. From a universe of 538,854 claims with zero quantities dispensed in CY 2012, totaling \$39,068,952, we used the [REDACTED] random sample generator to select 50 claims totaling \$2,532, to review for allowability. No sample was selected from CY 2013 as the universe identified was determined to be immaterial.

3. Fraud and Abuse Review

- a. We coordinated with our Office of Investigations (OI) to review the information provided by Caremark on 2013 cases entered into BCBSA's Fraud Information Management System (FIMS) to determine if BCBSA reported all cases entered into FIMS to the OIG and if the cases were reported timely in accordance with contract CS 1039 Section 1.9(a) and FEHBP Carrier Letter 2011-13.

4. Member Eligibility Review

- a. Using the [REDACTED] random sample generator, we selected a sample of 25 dependents over the age of 26 from each CY, with claims totaling \$3,920, to determine whether they were eligible over-age dependents.
- b. We selected the 50 oldest members, out of a total universe of 1,268 members over the age of 100 for CY 2012, to determine if any claims were paid after the date of death.
- c. We compared the list of Group ID numbers generated from the pharmacy claims in the [REDACTED] database to a list of eligible BCBSA Group ID numbers provided by Caremark to determine if claims for any non-BCBSA groups were included in the [REDACTED] database.

5. Performance Standards Review

- a. We reviewed the performance standards reported in the Retail Pharmacy, Mail Order Pharmacy and Specialty Pharmacy's annual statements for CYs 2012 and 2013 to determine whether the PBM reported the performance standards required by BCBSA

and OPM and reconciled the penalty amounts reported to each Annual Statement's "Statement of Charges."

- b. We reviewed all of Caremark's policies and procedures that relate to claims processing, billing and payments, pre-payment reviews, and quality assurance to determine adequacy.
- c. We reviewed information from BCBSA on the process used to select a PBM for CYs 2012 through 2014.

6. Rebate Review

- a. From a universe of \$762,504,017 in drug manufacturer rebates from retail pharmacy sales, we judgementally selected the highest guaranteed and non-guaranteed rebate from the 1st quarter rebate summary report of each CY, for a total of four retail pharmacy rebates totaling \$20,020,299, to determine if the rebates were calculated properly and returned to the FEHBP.
- b. From a universe of \$427,677,105 in drug manufacturer rebates from mail order pharmacy sales, we judgementally selected the highest guaranteed and non-guaranteed rebate from the 1st quarter rebate summary report of each CY, for a total of four mail order pharmacy rebates totaling \$19,993,726, to determine if the rebates were calculated properly and returned to the FEHBP.
- c. From a universe of \$80,855,579 in drug manufacturer rebates from specialty pharmacy sales, we judgementally selected the highest guaranteed and non-guaranteed rebate from the 1st quarter rebate summary report of each CY, for a total of four specialty pharmacy rebates totaling \$3,696,825, to determine if the rebates were calculated properly and returned to the FEHBP.

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 taken 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.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. ADMINISTRATIVE FEES REVIEW

The results of our review showed that the administrative fees charged by Caremark complied with the terms of the contract between it and BCBSA.

B. CLAIM PAYMENT REVIEWS

1. Duplicate Claim Payments Identified **\$5,915**

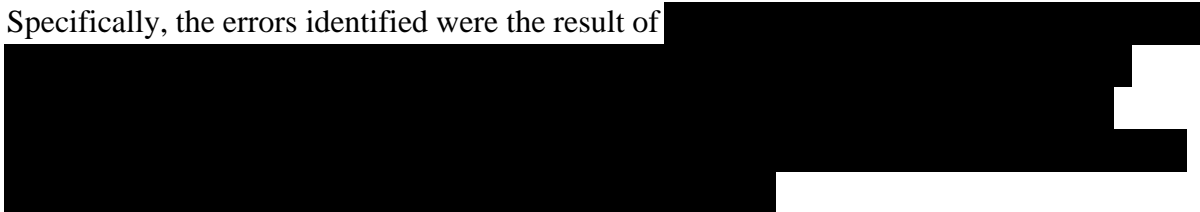
Caremark did not identify and reverse 49 duplicate claims, resulting in a \$5,915 overcharge to the FEHBP.

According to Contract CS 1039, Section 3.2(b), costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. Additionally, Section 2.3(g) states when “a Member’s claim has been paid in error ... the Carrier shall make a prompt and diligent effort to recover the erroneous payments”

Duplicate claims were not identified by Caremark’s system of edits.

We originally reviewed a sample of 100 members with potential duplicate claim payments to determine if the claims were properly paid. We identified eight claims, totaling \$310, that were duplicate claim payments. We then sent Caremark the entire universe of potential duplicate claims over \$50, which consisted of 2,875 claims, for review of proper payment. Caremark identified an additional 41 claims totaling \$5,605 that were duplicate claim payments.

Specifically, the errors identified were the result of



Upon review, Caremark stated that its system edits did not identify these claims as duplicate payments because they had different prescription numbers. Caremark currently runs a report of possible duplicate claims that match key items: Member ID, Date of Fill, Generic Code Number and Prescription Number. However, our review did identify one duplicate claim that had matching prescription numbers that Caremark’s system did not identify. Caremark stated that it has begun the process to enhance the system’s edits used to identify these types of duplicate payments.

As a result of Caremark's system's edits not identifying these types of duplicate payments, the FEHBP was overcharged \$5,915.

Recommendation 1

We recommend that the contracting officer direct BCBSA to start the recovery process for the duplicate claim payments identified and return \$5,915 to the FEHBP.

BCBSA's Response:

The BCBSA did not provide a response to this recommendation in its response to the draft audit report.

Caremark's Response:

Caremark concurs with the recommendation and stated that it had adjusted and returned monies to the FEP program for the 41 claims identified.

OIG's Response:

In its response, Caremark did not address the eight claims identified in the original finding, nor did it indicate if the monies for those claims had been returned. Additionally, Caremark did not provide documentation to demonstrate that the monies had been returned to the FEHBP. Caremark needs to ensure that it also adjusts and returns the monies for those eight claims, totaling \$310, that were initially identified and provide documentation to the contracting office to show that the entire \$5,915 has been returned to the FEHBP.

Recommendation 2

We recommend that the contracting officer and BCBSA ensure that Caremark updates its claim system edits to better identify [REDACTED] duplicate claims (especially for claims with different prescription numbers).

Caremark's Response:

Caremark concurs with the recommendation. Caremark currently runs a report for possible duplicate claims that is based off matching pharmacy prescription numbers. It was determined through this audit that the query logic should be updated to include all key fields (other than pharmacy prescription number). Caremark issued a Business Support Request on October 24, 2014, to update the query logic for the duplicate claims report to include [REDACTED]. This enhancement will

identify claims that do not have the same pharmacy prescription number but match on the remaining fields. This is scheduled to be implemented by [REDACTED].

BCBSA's Response:

The BSBSA stated that it will add a summary duplicate claims report to three of its current management reports reviewed by it to ensure that Caremark is reviewing the report timely and that the enhancements were implemented.

C. FRAUD AND ABUSE REVIEW

1. Fraud and Abuse Cases Not Reported by BCBSA

Procedural

The BCBSA did not report to the OPM's OIG all of the suspected fraud and abuse cases that were reported to it by Caremark for CY 2013. Additionally, of those cases that were reported to the OIG, approximately 54 percent were not reported within the 30 working day requirement.

Contract CS 1039, Section 1.9(a) requires the 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."

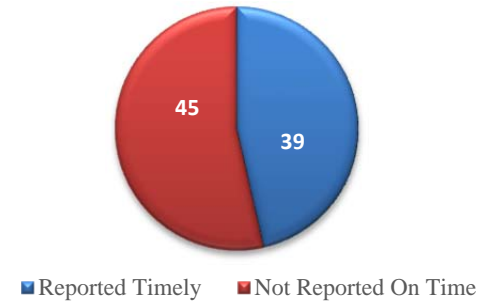
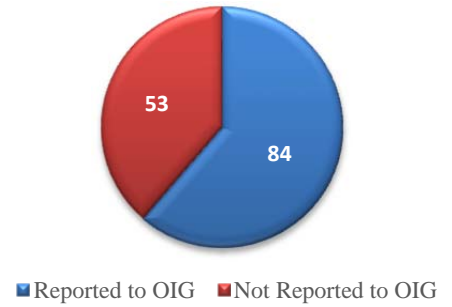
Additionally, FEHBP Carrier Letter 2011-13 (Carrier Letter) states that all FEHBP Carrier Special Investigative Units are required to submit a written notification to the OIG within 30 working days of becoming aware of a fraud, waste, or abuse issue where there is reasonable suspicion that fraud has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

Approximately 39 percent of suspected fraud and abuse cases were not reported to the OIG. Additionally, 54 percent of those reported were reported untimely.

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 FIMS for CY 2013. (CY 2012 was covered by a previous audit.) This information was then provided to the OIG's OI to compare to the pharmacy-related cases reported to it by BCBSA for CY 2013. Our review of the subsequent information provided by the OIG's OI determined that the BCBSA did not report all potential fraud, waste, or abuse cases entered into FIMS by Caremark. Additionally, of those reported, the OIG was notified untimely on approximately 54 percent of the cases.

Specifically, we identified the following:

- Cases Entered into FIMS but not Reported to the OIG: Of the 137 cases Caremark entered into FIMS, only 84, or approximately 61 percent, were reported to the OIG by BCBSA.
- Case Submitted After 30 Working Day Timeliness Guideline: Of the 84 cases reported to the OIG, 45 were reported untimely to OIG by BCBSA. On average, these cases were referred 57 working days after the case was entered into FIMS by Caremark (we assumed that the “Date Referred” in the 2013 Case Referral spreadsheet provided to the OIG is the date that the case was entered into FIMS).



This finding has been identified by the OIG in eight recently issued audit reports (since 2012) and has led BCBSA to institute new procedures (effective July 2014) to help alleviate the problem. However, these procedures (submitting a monthly report to the OPM Contracting Office on cases referred to and not referred to the OIG each month, and meeting with OIG OI staff weekly to review and search online FIMS entries at BCBSA) instituted by BCBSA were at best ineffective and inefficient. 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. Additionally, by not reporting all potential fraud cases reported to it by Caremark in a timely manner, BCBSA is further limiting the OIG’s investigative efforts.

To address our continuing concerns in this area, the BCBSA provided the OIG with remote read-only access to the FIMS on December 7, 2014. Therefore, no recommendation is included for this finding.

D. MEMBER ELIGIBILITY REVIEWS

Our member eligibility reviews of dependents over the age of 26, members aged 100 or greater, and non-FEHBP group numbers, determined that Caremark paid all claims in accordance with the contract between it and BCBSA.

E. PERFORMANCE STANDARDS REVIEW

The results of our review showed that Caremark properly reported its performance to the BCBSA in its 2012 and 2013 Annual Statements (for each pharmacy drug contract) without exception.

F. REBATE REVIEW

The results of our review determined that pharmacy drug rebates were calculated correctly and remitted to the BCBSA in accordance with the contract between the BCBSA and Caremark.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

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February 9, 2015

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**Reference: OPM DRAFT AUDIT REPORT
 BCBS Pharmacy Ops Caremark PCS Health LLC Audit
 Audit Report Number 1H-01-00-14-067
 (Dated December 9, 2014 and Received December 9, 2014)**

Dear ██████████:

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.

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

C. DUPLICATE CLAIMS REVIEW

1. Duplicate Claims

\$310

Recommendation 1

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

Caremark Response

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

Based on the results of this review, CVS Caremark agrees that 41 claims totaling \$5,605 were duplicate claim payments that had not been adjusted/voided by the OIG Audit Notification receipt date of July 23, 2014. CVS Caremark subsequently

adjusted the 41 identified claims and refunded monies to the FEP Program related to this error.

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

Recommendation 2

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

CVS Caremark Response

CVS Caremark currently reviews potential duplicate payment claims for accuracy. A duplicate claim report (CLTM51L103-01) is reviewed for claims with matching Pharmacy Prescription Numbers.

During the course of the OIG audit, it was determined that claims matching on all key data fields except Pharmacy Prescription Number should also be included in the query logic used to generate the CVS Caremark Duplicate Report. A Business Support Request (BSR) was opened on October 24, 2014 (BSRFE15637) to enhance the query logic used to identify claims for inclusion in the Caremark Duplicate report. The enhanced query logic will include claims that do not share a common Pharmacy Prescription number but otherwise match on the remaining key terms or fields.

The enhanced query logic will allow CVS Caremark to generate a report of claims that match on the following key terms other than Pharmacy Prescription Number:

1. [REDACTED]
2. [REDACTED]
3. [REDACTED]

With the implementation of the planned enhancement to the query logic, CVS Caremark anticipates a further reduction in potential duplicate payment claims. The enhancement is scheduled to be implemented by [REDACTED].

BCBSA Response

Effective for the 2nd Quarter 2015, a summary report of the duplicate claims review will be added to the existing management reports (RPP, MOP, and SDP) that are reviewed by FEP Pharmacy Programs to ensure that CVS Caremark reviews duplicate claims timely and that the enhanced duplicate post payment editing was completed.

D. FRAUD AND ABUSE

Procedural

1. Fraud and Abuse cases not Reported by BCBSA

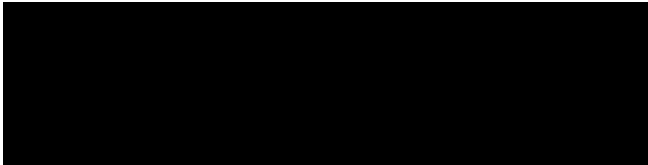
**Deleted by OIG
Not Relevant to the Audit Report**

BCBSA Response:



BCBSA provided read only access to the OPM-OIG on December 7, 2014.

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,

A large black rectangular redaction box covering the signature and name of the sender.

Attachments

cc: , Contracting Officer, OPM
Jena L. Estes, V.P. Government Program Integrity
, CVS Caremark



Report Fraud, Waste, and Mismanagement

Fraud, waste, and mismanagement in Government concerns everyone: Office of the Inspector General staff, agency employees, and the general public. We actively solicit allegations of any inefficient and wasteful practices, fraud, and mismanagement related to OPM programs and operations. You can report allegations to us in several ways:

By Internet: <http://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse>

By Phone: Toll Free Number: (877) 499-7295
Washington Metro Area: (202) 606-2423

By Mail: Office of the Inspector General
U.S. Office of Personnel Management
1900 E Street, NW
Room 6400
Washington, DC 20415-1100

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Report No. 1H-01-00-14-067