



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

Final Audit Report

**Audit of the American Postal Workers Union
Health Plan's Pharmacy Operations
as Administered by Express Scripts Holding Company
For Contract Years 2012 through 2014**

**Report Number 1H-04-00-15-053
September 28, 2016**

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EXECUTIVE SUMMARY

Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts Holding Company

Report No. 1H 04-00-15-053

September 28, 2016

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 its members were in accordance with the terms of the contracts between the U.S. Office of Personnel Management (OPM) and the American Postal Workers Union Health Plan (Plan), the Plan's agreement with Express Scripts Holding Company (PBM), and Federal regulations.

What Did We Audit?

The Office of the Inspector General has completed a performance audit of the Plan's pharmacy benefits operations as administered by the PBM. Our audit consisted of a review of administrative fees, claim payments, fraud and abuse, Health Insurance Portability and Accountability Act compliance, performance guarantees, and rebates related to the FEHBP for contract years 2012 through 2014. Our audit was conducted from September 8 through 29, 2015, at our office in Washington, D.C. Additional audit work was completed at our offices in Washington, D.C. and Cranberry Township, Pennsylvania.



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What Did We Find?

We determined that the Plan and/or the PBM needs to strengthen its procedures and controls related to the billing of administrative fees, pharmacy claim payments, and performance guarantee reporting and payment of penalties.

Our audit identified the following areas requiring improvement:

1. The PBM was unable to accurately support all of the line items it charged for administrative products and services.
2. The PBM failed to properly update pharmacy contract pricing information into its claims system, causing \$9,954 in erroneous claim payments.
3. The Plan paid \$16,847 in pharmacy claims on ineligible overage dependent children.
4. The Plan did not require the PBM to use OPM's debarred providers list, which resulted in claims paid to debarred providers.
5. The Plan paid 96 pharmacy claims incorrectly because override codes were not properly applied by either it or the PBM.
6. The Plan did not report all of the suspected pharmacy fraud and abuse cases to OPM.
7. The PBM failed to submit its 2014 performance report and a \$120,000 penalty to the Plan in a timely manner.

ABBREVIATIONS

5 CFR 890	Title 5, United States Code, Chapter 89; and Title 5, Code of Federal Regulations, Chapter 1, Part 890
Agreement	The Integrated Prescription Drug Program Master Agreement between the American Postal Workers Union Health Plan and Express Scripts Holding Company
Contract	OPM Contract CS 1370
CY	Contract Year
FEHB	Federal Employees Health Benefits
FEHBP	Federal Employees Health Benefits Program
FOIA	Freedom of Information Act
HIO	Healthcare and Insurance Office
HIPAA	Health Insurance Portability and Accountability Act
NPI	National Provider Identifier
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
PBM	Express Scripts Holding Company
Plan	American Postal Workers Union Health Plan
PMPM	Per Member Per Month
RRA	Retail Refill Allowance

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I. BACKGROUND

This report details the results of our audit of the American Postal Workers Union Health Plan's (Plan) pharmacy operations as administered by Express Scripts Holding Company (PBM) for contract years (CY) 2012 through 2014. The audit was conducted pursuant to the provisions of Contract CS 1370 (Contract) between the U.S. Office of Personnel Management (OPM) and the Plan; the pharmacy contract between the Plan and the PBM (Agreement); 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 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.

Pharmacy Benefit Managers are primarily responsible for processing and paying prescription drug claims. The services provided typically include retail pharmacy, mail order, and specialty drug benefits. For drugs acquired through retail, the PBM contracts 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, the PBM offers the option of mail order pharmacies. The PBM also provides specialty pharmacy services for members with rare and/or chronic medical conditions. Pharmacy Benefit Managers are used to develop, allocate, and control costs related to the pharmacy claims program.

The Plan contracted originally with Medco Health Solutions to provide pharmacy benefits and services to its members for CYs 2012 through 2014. On April 2, 2012, Medco Health Solutions and Express Scripts, Inc. merged and became wholly owned subsidiaries of the PBM. On the date of the merger, the PBM, located in St. Louis, Missouri, assumed the pharmacy operations and responsibilities under the Agreement and the Contract. Section 1.11 of the Contract includes a provision which allows for audits of the program's operations. Additionally, section 1.26(a) of the Contract outlines transparency standards that require the PBM to provide pass-through pricing based on its cost. Our responsibility is to review the performance of the PBM to determine if the Plan charged costs to the FEHBP and provided services to its members in accordance with the Contract, the Agreement, and the Federal regulations.

Compliance with the laws and regulations applicable to the FEHBP is the responsibility of the Plan's management. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

This was our first audit of the Plan's pharmacy operations as administered by the PBM.

The results of our audit were discussed with officials of the Plan and the PBM at an exit conference on October 15, 2015. In addition, a draft report, dated February 19, 2016, and a draft report addendum, dated June 10, 2016, were provided to the Plan and PBM for review and comment. The responses of the Plan and PBM to the draft report and addendum were considered in preparing the final report and are included as appendices in this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objective

The main objective of the audit was to determine whether the costs charged to the FEHBP and services provided to FEHBP subscribers were in accordance with the terms of the Contract, the Agreement, and applicable Federal regulations.

Specifically, our audit objectives were to determine if:

Administrative Fee Review

- The administrative fees incurred were compliant with the terms of the Agreement and supported by verifiable documentation.

Claims Payment Review

- Any claims were paid to debarred pharmacy providers;
- Any claims were paid with dispensing fees outside the contracted rates for mail order and specialty pharmacy;
- Any duplicate claim payments were made by the PBM;
- Any pharmacy claims were paid for deceased members;
- Any claims were paid for non-FEHBP members or members enrolled in an alternate plan code under the Plan;
- Any claims were paid with a days supplied exceeding the limits stated in the benefit brochures;
- Any claims were paid for non-disabled dependents over the age of 26;
- Claims coded as having a pre-authorization requirement were necessary for the drug and that the claim processed correctly; and
- The pricing elements for the retail, mail order, and specialty drug claims were transparent and if the claims were paid correctly.

Fraud and Abuse Review

- The Plan's fraud and abuse program was sufficient and if potential fraud cases were being reported to OPM.

Health Insurance Portability and Accountability Act (HIPAA) Review

- The Plan and PBM had policies and procedures in place to address HIPAA's Standards for Privacy, Security, and Electronic Transactions.

Performance Guarantee Review

- The PBM's performance reports, and any penalties, were properly calculated and submitted timely.

Rebates Review

- The pharmacy rebates were properly supported, accurately calculated, and remitted to the Plan.

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 included reviews of administrative fees, claim payments, the fraud and abuse program, HIPAA compliance, performance guarantees, and rebates related to the FEHBP for CYs 2012 through 2014. The audit fieldwork was conducted at our offices from September 8 through 29, 2015. Additional audit work was completed at our Cranberry Township, Pennsylvania and Washington, D.C. offices.

The Plan is responsible for providing FEHBP members with medical and prescription drug benefits. To meet this responsibility, the Plan collected premium payments of approximately \$3 billion in CYs 2012 through 2014, of which approximately two-thirds was paid by the government on behalf of Federal employees. Total pharmacy claims paid were approximately \$ [REDACTED] million in CYs 2012 through 2014 (See below).

Contract Year	Earned Premiums	Total Claims	Claims Paid
2012	\$936,333,550	[REDACTED]	\$ [REDACTED]
2013	\$994,780,915	[REDACTED]	\$ [REDACTED]
2014	\$1,075,996,204	[REDACTED]	\$ [REDACTED]
Total	\$3,007,110,669	[REDACTED]	\$ [REDACTED]

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

We also conducted tests of accounting records and other auditing procedures as we considered necessary to determine compliance with the Contract, the Agreement, and the applicable Federal

regulations. Exceptions noted in the areas reviewed are set forth in the “Audit Findings and Recommendations” section of this report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting the 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 our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

To determine whether the costs charged to the FEHBP and services provided to FEHBP subscribers were in accordance with the terms of the Contract, the Agreement, and applicable Federal regulations, we performed the following audit steps:

Administrative Fee Review

- For each CY, we selected the administrative fee invoices with the largest amounts due from the Plan. Specifically, we selected 3 invoices, totaling \$2,145,989, from a universe of [REDACTED] invoices, totaling \$ [REDACTED]. From the invoices selected, we judgmentally selected 69 line items (from a universe of [REDACTED] line items), totaling \$ [REDACTED], to determine if the fees were properly calculated and supported in accordance with the terms of the Agreement.

Claims Payment Reviews

Unless stated otherwise, the claim samples below were selected from the complete claims universe of [REDACTED] claims, totaling \$ [REDACTED], for CYs 2012 through 2014.

- Using the pharmacies’ National Provider Identifier (NPI), we reviewed all claims to determine if any payments were made to a pharmacy debarred by the OIG’s Administrative Sanctions Office.
- From CY 2014, we identified a universe of [REDACTED] claims, totaling \$ [REDACTED], where the dispensing fee was between \$11 and \$300 (which varied from the contractual dispensing fees for mail order or specialty drugs). From that universe, we selected a random sample of 15 claims, totaling \$27,619, to determine if claims were paid with the correct dispensing fee.
- We identified a universe of potential duplicate claim payments of [REDACTED] claims, totaling \$ [REDACTED]. From each CY, we judgmentally selected the top 10 members by total amount paid while ensuring that at least 5 samples included non-compounded drugs. If 5 members were not found in the top 10, we judgmentally selected the next members with non-compounded drugs so our sample totaled 5 in each CY. In total, we selected 32

members, with claims totaling \$3,405,820, for review to determine if duplicate claim payments were made by the PBM.

- We selected the 51 oldest members with paid claims from CY 2014 to determine if any of those members were deceased and if they had a claim paid after their date of death.
- We reviewed all claims to determine if any claims were paid for non-FEHBP members or members enrolled in an alternate plan code.
- From CY 2014, we identified a universe of [REDACTED] mail order claims, totaling \$ [REDACTED], where the days supplied was greater than 90 days. From that universe, we randomly selected 15 claims, totaling \$9,853, to determine if any were paid with a days supplied outside of the limits stated in the benefit brochure.
- We identified and reviewed all ([REDACTED] dependents, with claims totaling \$ [REDACTED]) non-disabled dependents 26 years of age or older to determine if the claims were paid correctly.
- We identified a universe of [REDACTED] claims, totaling \$ [REDACTED], which were identified as pre-authorization claims by the PBM. From that universe, we randomly selected 5 claims from each CY for a total of 15 claims, totaling \$29,086, to determine if the claims actually required a pre-authorization and that the claim was processed correctly.
- We separately identified the universe of brand and generic claims paid to the top 25 retail pharmacy chains (as identified by the PBM). Specifically, we identified [REDACTED] brand claims, totaling \$ [REDACTED], and [REDACTED] generic claims, totaling \$ [REDACTED]. From those universes, we randomly selected 20 brand and 20 generic claims from each CY (60 brand claims, totaling \$11,304, and 60 generic claims, totaling \$2,319) to determine if the pricing elements were transparent and that the claims were paid correctly.
- We identified a universe of [REDACTED] specialty pharmacy claims, totaling \$ [REDACTED]. From that universe, we randomly selected 20 claims from each CY (60 claims, totaling \$347,734) to determine if the pricing elements were transparent and that the claims were paid correctly.
- We separately identified the universe of mail order brand and generic claims paid. Specifically, we identified [REDACTED] brand claims, totaling \$ [REDACTED], and [REDACTED] generic claims, totaling \$ [REDACTED]. From those universes, we randomly selected 20 brand and 20 generic claims from each CY (60 brand claims, totaling \$19,374, and 60 generic claims, totaling \$1,466) to determine if the pricing elements were transparent and that the claims were paid correctly.

Fraud and Abuse Review

- We reviewed all (47) potential fraud and abuse cases reported by the PBM to the Plan to determine if those cases were reported to OPM.

HIPAA Review

- We reviewed the Plan's and the PBM's responses to our HIPAA questionnaires to determine if they had policies and procedures in place to ensure compliance with HIPAA's Standards for Privacy, Security and Electronic Transaction requirements.

Performance Guarantees Review

- From CY 2014, we judgmentally selected the top 4 performance guarantees (out of a universe of 20) with the most dollars at risk to determine if the guarantees were met, reported accurately, and that any associated penalties were reported accurately and paid to the Plan.

Rebates Review

- We judgmentally selected the pharmacy rebate report related to the first quarter of CY 2012, from a universe of 12 quarters, for review. From that report, we then judgmentally selected the top 5 therapeutic groups, with rebates due totaling \$3,200,791, from a universe of [REDACTED] groups, totaling \$[REDACTED]. As each therapeutic group contained many drugs, we then judgmentally selected all drugs where the total net rebate due was \$100,000 or more (five drugs with total rebates of \$1,529,807) to determine if the rebates were properly supported, accurately calculated, and remitted to the Plan.

The samples mentioned above, that were selected and reviewed in performing the audit, 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.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. ADMINISTRATIVE FEES REVIEW

1. Unsupported Administrative Fees

Procedural

The PBM was unable to accurately support all of the line items it charged to the Plan for administration of the pharmacy benefits.

According to Section 9 of the Agreement, the Plan agreed to pay the PBM for administrative products and services provided by the PBM in accordance with the provisions in Schedule B of the Agreement. It is the responsibility of the PBM to accurately charge the Plan for products and services actually provided.

The supporting documentation provided by the PBM did not match the quantities billed to the Plan.

We reviewed 69 administrative fee line items from three invoices to determine if the base fee amount matched the Agreement and if the quantities billed were supported by accurate documentation. Of the invoices reviewed, we found 13 line items that were not supported with accurate documentation. Specifically, we identified the following:

- 10 line items related to products or services offered by the PBM (Rationalized Med, Fraud Waste and Abuse, and Utilization Management) were charged to the Plan on a per member per month (PMPM) basis. For each line item questioned, the member counts for the services provided (as identified by the PBM) did not match the quantity charged on the invoice.
- Three line items related to a member program (Personalized Med) charged based on member participation. In all cases the list of members participating did not match the member counts listed on the administrative fee invoice.

For items charged on a PMPM basis, the PBM stated that the Plan provides routine eligibility files, often on a daily basis. Due to a merger, the PBM was having difficulty identifying the exact eligibility file that would accurately tie to the administrative fee invoice. For those items charged based on member participation, the PBM only provided spreadsheets listing more members than were charged on the invoices without an explanation of the differences.

Because the supporting documentation provided by the PBM did not accurately reflect the quantities charged to the Plan in its administrative fee invoices, we were unable to determine if the PBM administrative fee invoices were an accurate representation of the products and services provided to the Plan.

Recommendation 1

We recommend that the contracting officer and the Plan require the PBM to maintain complete and accurate documentation to support administrative fees and invoices billed (both the fees charged and quantities).

Plan Response:

The Plan agrees with this recommendation.

Recommendation 2

We recommend that the contracting officer require the Plan to implement policies and procedures for reviewing the administrative fees, including the verification of invoices to supporting documentation to ensure that invoices related to the FEHBP are paid accurately and in accordance with the Agreement.

Plan Response:

The Plan agrees with this recommendation and states that it will review the administrative fee invoices to verify them to supporting documentation.

B. PHARMACY CLAIM PAYMENTS REVIEW

1. Pharmacy Pricing Errors

\$9,954

The PBM incorrectly paid 4,162 claims as a result of not properly updating pharmacy contract information in its claim system. This error resulted in overpayments of \$9,954.

The PBM paid claims dispensed to a particular pharmacy chain incorrectly for over six months due to an incorrect discount in its claims system.

Section 1.26(a)(2) of the Contract states that the “PBM agrees to provide pass-through transparent pricing based on the PBM’s cost for drugs ... in which the [Plan] receives the value of the PBM’s negotiated discounts, rebates, credits or other financial benefits.” Similarly, the Agreement states that the Plan will pay the contracted rate with the pharmacy less the discount plus the dispensing fee and any applicable taxes.

During our review of retail pharmacy claim payments, we identified one claim where the Plan indicated that the claim was priced incorrectly because it did not properly update a change to the pharmacy discount and dispensing fee in its claims system between

April 1, 2013 and November 15, 2013. The PBM stated that the pharmacy contact information was updated in its system on November 15, 2013.

From this, we identified all claims paid to the pharmacy (located in Burlington, Massachusetts) related to the one erroneous claim and found that all 18 claims dispensed between April 1, 2013 and November 15, 2013 were paid incorrectly. Additionally, we reviewed five claims dispensed after November 15, 2013, and determined that all were paid correctly by the PBM, supporting its statement that its system was updated with the correct discount on that date. The common factor that we identified between the claims (both generic and brand name drugs) was that most were overpaid by a \$1.42 difference in the dispensing fee (\$2.50 – \$1.08). We noted that between April 1, 2013 and November 15, 2013, the dispensing fee was \$2.50 and after November 15 it changed to \$1.08 (as stated in the pharmacy contract). Claims for brand name drugs were also paid incorrectly because the pharmacy's discount rate was not updated as well.

We performed a search of claims dispensed by that pharmacy chain and found a similar change in dispensing fees in all claims dispensed in the state of Massachusetts, but not elsewhere. Our review of the claims dispensed by this pharmacy chain in Massachusetts determined that all claims dispensed between April 1, 2013 and November 15, 2013, were paid incorrectly. Our pharmacy-specific review found most claims (632 of 640) dispensed after November 15, 2013, were paid correctly. Specifically, we identified 4,162 claims paid in error with overpayments totaling \$9,954 (\$5,064 in overpayments by the FEHBP, and \$4,890 in overpayments by members).

A question to the PBM regarding why this error occurred and what steps were being taken to correct the error was not answered by the PBM during our audit.

As a result of not timely updating pharmacy discount information in its claims system, the PBM made claim overpayments of \$9,954 (overcharging the FEHBP by \$5,064 and Plan members by \$4,890) to the FEHBP.

Recommendation 3

We recommend that the contracting officer direct the Plan to reimburse \$5,064 to the FEHBP and \$4,890 to the affected Plan members.

Plan Response:

The Plan agrees with the recommendation and requests that the PBM reimburse the Plan and the affected members.

PBM Response:

The PBM will work with the Plan to reach resolution on this recommendation.

Recommendation 4

We recommend that the contracting officer and the Plan direct the PBM to institute and/or update its procedures to ensure that pharmacy contract changes are entered into its claims system so that those changes are effective on the date in the contracts with the pharmacies.

Plan Response:

The Plan agrees with this recommendation and states that it will direct the PBM to implement procedures to ensure that pharmacy contract changes are entered into its claims system timely.

PBM Response:

The PBM stated that implementation of a new pharmacy contract takes time and that the process is not exclusive to the Plan, but to its entire commercial book of business and that a number of factors impact the timing of contract implementation. However, the PBM agrees to explore areas for improvement as it moves to a new contracting system and provided a corrective action plan.

OIG Comments:

We understand that the implementation of new pharmacy contracts, or simple pharmacy contract modifications for that matter, require extensive work on the PBM's part. However, that does not excuse the PBM from not having its systems prepared to accurately price claims on the date when the discount and dispensing fee changes were effective.

The PBM's response does not explain why these claims were paid incorrectly for seven-and-a-half months, which seems more than the result of simple implementation. Nor does it explain why, once the pharmacy discount and dispensing fee were updated, it did not research and correct all claims paid between that date and the date when those changes should have been implemented.

Recommendation 5

We recommend that the contracting officer and the Plan direct the PBM to provide an explanation as to how this error occurred, and then take the necessary steps to ensure it does not happen again.

PBM Response:

The PBM states that an incorrect rate for the pharmacy contract in question was not set-up with this pharmacy. It states that the pharmacy rates for the Plan are guaranteed through an annual average rate and that the time period of the error in implementation did not impact the guarantee under the Plan's contract with it.

OIG Comments:

Based on the PBM's response to the previous recommendation we can ascertain that the error related to these claims was the result of delays in its implementing the contract changes in a timely manner. This again is inexcusable in the PBM's business practice and as it stated the contract was not exclusive to the Plan, but to its entire book of business. Therefore this error not only affected the Plan and its members, but all claims processed for the pharmacies in the state of Massachusetts over that period.

What we find alarming in its response is that the PBM states that the error was of no impact due to the pharmacy guarantee in its contract with the Plan. This is alarming because it showcases the PBM's lack of understanding of its agreement to comply with pharmacy standards in the Plan's contract with OPM (Section 18 of the Agreement). Those standards require the PBM to provide pass-through or transparent pricing based on the PBM's contracted rate. This is not an overall guarantee, but a contract by contract, claim by claim price, meaning that the PBM is required to pay all claims accurately and at the contracted rate established at the date the prescription is filled. So, although the claims identified in error did not cause the PBM to miss its pricing guarantee in the Agreement, those claims are of importance and do, in fact, impact the FEHBP and its members because they were not accurate and transparently priced by the PBM.

2. Claims Paid for Overage Dependents **\$16,847**

The Plan paid 124 pharmacy claims, for 16 dependent children, that were ineligible for coverage due to being age 26 (or older) on the dates of service. As a result, the FEHBP was overcharged \$16,847.

The Plan paid claims on 16 ineligible dependents.

Public Law 111-148, Section 2714 extends health insurance coverage for unmarried dependent children until age 26.

Additionally, section 2.3(g) of the Contract states that “It is the Carrier’s responsibility to proactively identify overpayments through comprehensive, statistically valid reviews and a robust internal control program.”

Finally, section 2.3(g)(12) of the Contract states, “In compliance with the provisions of the Contracts Dispute Act, the Carrier shall return to the Program an amount equal to the uncollected erroneous payment where the Contracting Officer determines that (a) the Carrier’s failure to appropriately apply its operating procedure caused the erroneous payment”

To determine if claims were paid for dependent children age 26 and older, we searched the claims database and identified claims paid for 41 dependent children over the age of 25. We asked the Plan to review and determine the eligibility status of those dependents and it confirmed that 16 dependents had not been properly terminated upon turning age 26 in its eligibility database.

As a result of our review, the Plan stated that it identified a gap in its procedures for dependents added to coverage who exceeded the allowable age limits. The Plan indicated that it had implemented a new manual process to identify dependent children age 26 and older who are shown as eligible for benefits. It also states that it changed the criteria for reporting these overpaid claims to ensure that all claims paid after termination are captured. While we acknowledge the Plan’s efforts to identify these errors, a manual process is inadequate because it permits the payment of unallowable claims and would only identify those claims after payment was made.

By not having system edits in place to automatically terminate dependents at age 26, the FEHBP has been overcharged \$16,847.

Recommendation 6

We recommend that the contracting officer direct the Plan to return \$16,847 to the FEHBP for erroneous claim payments on ineligible overage dependents.

Plan Response:

The Plan disagrees with this recommendation. It stated that it has made efforts to recover the funds through a third party recovery group and to date \$57 has been recovered. Three

recovery letters have been sent to the members and the Plan believes that it has performed its required due diligence in trying to recover the funds.

OIG Comments:

Although the Plan has started the recovery efforts related to the claims paid in error, it has yet to exhaust the efforts it must undertake according to section 2.3(g) of the Contract. Section 2.3(g)(3) states that the Plan may off-set future benefit payments to the member or to a provider on behalf of the member to satisfy the debt if it remains unpaid and undisputed after 120 days. For the members still enrolled in the Plan, this course of action should be undertaken before any overpayments are allowed.

Additionally, the Plan is financially responsible for all claims incurred prior to January 1, 2013 that were paid as a result of its failure to apply its operating procedures and controls appropriately (28 claim lines, totaling \$8,568). Effective January 1, 2013, the Contract allows such overpayments after the Plan has made its due diligent effort to recover them (Contract Section 2.3(g)(12)). It is our opinion that each of these claim errors identified were the result of the “inconsistencies” in the Plan’s eligibility system that it stated have since been identified and fixed.

Lastly, it should be noted that the amount originally questioned in the draft audit report (\$16,845) was adjusted due to rounding problems identified in preparing this report.

Recommendation 7

We recommend that the contracting officer direct the Plan to implement system edits that automatically identify and notify eligible dependents approaching their 26th birthday of their pending ineligibility. Additionally, the system edits should also terminate dependents upon reaching age 26.

Plan Response:

The Plan disagrees with this recommendation and states that prior to the OIG audit it had identified inconsistencies in its eligibility programs related to dependents reaching 26 years of age. As a result, it already has placed additional edits to identify all dependents over age 26 that could have questionable eligibility.

OIG Comments:

We were not provided the edits and therefore cannot make any comment regarding them.

3. Claims Paid to Debarred Pharmacies

Procedural

The Plan did not require the PBM to use the OPM OIG debarment/suspension list to ensure that payments are not made for FEHBP claims submitted by debarred providers. Consequently, two debarred pharmacies inappropriately received claim payments.

5 CFR 890.1043(a) states that “A debarred provider is not eligible to receive payment, directly or indirectly, from FEHBP funds for items or services furnished to a covered individual on or after the effective date of the debarment.”

The Plan did not require the PBM to utilize OPM OIG’s debarred provider listing.

Additionally, the OPM OIG’s Guidelines for Implementation of FEHBP Debarment and Suspension Orders instructs FEHBP carriers to only use OPM OIG’s data for debarments when dealing with FEHBP members and enrollees.

During our review of the PBM’s debarment verification process, the PBM stated that it uses the Department of Health and Human Services OIG’s List of Excluded Individuals and Entities in its system edits to ensure that payments are not made for claims submitted by debarred providers.

The Plan stated that it was not aware that the PBM was not using the OPM OIG list and indicated that it will work with the PBM to incorporate the OPM OIG’s list into the PBM’s editing system.

As a result of the Plan not requiring the PBM to utilize the correct debarment/suspension list, payments were inappropriately made to two debarred pharmacies.

Recommendation 8

We recommend that the contracting officer direct the Plan to ensure that the PBM uses the required OPM OIG debarment/suspension list for excluding FEHBP claim payments to debarred providers.

Plan Response:

The Plan agrees with the recommendation and states that the OIG debarred provider file was installed on the PBMs claims system on July 15, 2015, and that updated files are provided to the PBM by the Plan as they become available.

4. Override Codes Applied Incorrectly

Procedural

Override codes were incorrectly applied by either the PBM or the Plan, resulting in 96 claim payment errors for contract years 2012 through 2014. Although the overpayments identified were immaterial, if the underlying cause is not corrected, significant overpayments may occur in the future.

Section 2.2(a) of the Contract states that the Plan will provide benefits to its members that are in accordance with the benefit brochure.

According to the 2014 Plan benefit brochure, coinsurance on prescriptions purchased at network pharmacies was \$8 for covered generic drugs and 25 percent of cost for brand name drugs.

Coinsurance on prescriptions purchased at non-network pharmacies was 50 percent of cost.

**Override codes
incorrectly allowed
claims to be paid
without coinsurance.**

During our review of retail pharmacy claim payments, we identified one claim where the Plan indicated that a claim overpayment was made due to the incorrect application of a coinsurance override. As a result, we selected a targeted sample to identify claims similar to the one identified in error. Specifically, we selected a sample that included all claim lines where a coinsurance override was present and the coinsurance amount paid was zero dollars. We then reviewed the first claim line for all patients whose out of pocket expense for the claim was zero dollars and who had a coinsurance override present to determine if the claims were paid correctly.

Our review determined that no coinsurance was paid by the member on 96 claim lines for 19 patients due to overrides being applied incorrectly, causing the amount paid by the FEHBP to be overstated. Specifically, we found:

- Seven patients (15 claim lines) were unable to purchase their prescriptions through mail order due to residing in either a skilled nursing or assisted living facility. Members of the Plan are subject to a retail refill allowance (RRA) penalty if they receive more than one refill of a maintenance medication at retail rather than mail order. The Plan granted an override to permit these patients to obtain medications from retail locations without being charged an RRA penalty.
- Five patients (six claim lines) were unable to purchase their prescriptions through mail order due to delays or the drug being out of stock. The Plan granted overrides so that these patients could have their prescriptions filled at a retail pharmacy and not be charged an RRA penalty.
- Three patients (63 claim lines) where neither the Plan nor the PBM have any information why a coinsurance override was present.

- Three patients (11 claim lines) requiring medications to be refilled early were granted these overrides due to their need (two were traveling extensively overseas).
- One patient (one claim line) required a one-time RRA penalty override. The Plan granted a courtesy override to the patient due to confusion related to a pharmacy lock. (Patient could only receive certain drugs from one specific pharmacy. However, the patient thought the lock applied to all prescription medications and could not use mail order.)

The PBM stated that based on the information maintained in its systems, the overrides were applied correctly for all of the claims questioned. It did state that for most of the claim lines (14) associated with those residing in skilled nursing or assisted living facilities, that the Plan entered those overrides directly and not the PBM. Additionally, the PBM stated that it does not review overrides unless directed by the Plan. The Plan stated that it does not normally review short term or one-time overrides. However, for longer term overrides (where a patient is in a skilled nursing or assisted living facility) the facility normally sends a letter to advise the Plan if the patient is still in the facility and requires an override.

Apparent errors in either entering or applying overrides resulted in FEHBP claim payment errors for contract years 2012 through 2014.

Recommendation 9

We recommend that the contracting officer direct the Plan to ensure that all overrides, especially effecting coinsurance, are entered and applied correctly so that claims are paid correctly. Additionally, the Plan should institute procedures to review the initial paid claims with overrides to ensure that the coinsurance is paid correctly.

Plan Response:

The Plan agrees with this recommendation and states that it will develop procedures to define how and why overrides may be entered and will identify a process to validate that they are correctly applied.

PBM Response:

The PBM states that it did not receive a report to identify the overrides found in error. It was provided a list of 81 claim examples and it identified 9 overrides that did not contain enough detail to justify the override approval. It stated that currently all overrides are submitted through a dedicated team to ensure consistent documentation is maintained.

OIG Comments:

We disagree with the PBM’s statement that it only received a list of 81 claim examples in relation to this finding. We sent a list of all 96 claim lines questioned in this finding on June 13, 2016 via email to the PBM.

Recommendation 10

We recommend that the contracting officer direct the Plan to obtain from the PBM a list of all claim overrides in place and to review those overrides to ensure that they are still necessary. This should be done on an annual basis.

Plan Response:

The Plan agrees with the recommendation and states that it will review all overrides currently in place and perform an annual review going forward.

C. FRAUD AND ABUSE REVIEW

1. Fraud and Abuse Cases Not Reported by the Plan

Procedural

For CYs 2012 through 2014, the Plan did not report to the OPM OIG all of the suspected fraud and abuse cases that were received from the PBM.

According to Carrier Letter 2011-13, the “FEHBP Carrier Special Investigative Units (Carrier) are required to submit a written notification to the OPM OIG ... within 30 working days of becoming aware of a fraud, waste or abuse issue where there is a reasonable suspicion that a fraud has occurred or is occurring against the [FEHBP]. Reportable fraud, waste or abuse issues include the identification of emerging fraud schemes; suspected internal fraud or abuse by Carrier employees, contractors, or subcontractors; suspected fraud by providers who supply goods or services to FEHBP members; suspected fraud by individual FEHBP members; issues of patient harm, and Carrier participation in class action lawsuits. There is no financial threshold for these initial case notifications.”

All suspected fraud and abuse cases were not reported to the OPM OIG.

To determine if the Plan had reported to OPM OIG all cases of suspected fraud and abuse it received from the PBM, we requested that the PBM provide a listing of all FEHBP fraud and abuse cases reported to the Plan during CYs 2012 through 2014. We also requested from the OIG’s Office of Investigations a list of all fraud and abuses cases reported by the Plan. Our review determined that the Plan did not report all potential fraud and abuse issues submitted

by the PBM during CYs 2012 through 2014. We determined that out of 47 cases reported by the PBM to the Plan, only 3 were reported to OPM OIG during this time period.

The Plan stated that beginning in February 2014, patients who were restricted to using one pharmacy due to drug-seeking or doctor shopping behaviors were reported to OPM. Prior to this time, the Plan did not identify these cases as fraud and abuse and therefore they were not reported to OPM OIG.

By not reporting all potential fraud and abuse cases to the OPM OIG, the Plan adversely affected OPM OIG's ability to investigate these cases and increased the risks of possible overcharges to the FEHBP.

Recommendation 11

We recommend that the contracting office ensure that the Plan has updated its policies and procedures so that all potential cases of fraud, waste, and abuse reported to the Plan by the PBM are referred to the OPM's OIG, in compliance with the most recent FEHBP Carrier Letter (CL 2014-29).

Plan Response:

The Plan agrees with this recommendation and states that it has implemented procedures so that it is in compliance with the Carrier Letter.

OIG Comments:

We were not provided with the new procedures and therefore cannot make any comment regarding them.

D. HIPAA REVIEW

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

E. PERFORMANCE GUARANTEE REVIEW

1. Performance Guarantee Reporting and Penalty Payment **\$120,000**

The PBM did not submit the required 2014 annual performance report to the Plan by the due date in the Agreement. Furthermore, the PBM did not timely credit the Plan \$120,000 related to a performance standard that it failed to meet in CY 2014. Additionally, the Plan

was not aware that the report was not submitted and a penalty was due until after we identified the oversight in our audit.

Section 6.4 of the Agreement states that annual performance standards will be reported to the Plan within 75 business days from the close of the CY. Additionally, Section 6.6 states that any penalties will be credited to the Plan against the next billing following receipt of the annual performance report.

The PBM did not timely credit a performance penalty to the Plan.

We reviewed the PBM's performance standard reports for CYs 2012 through 2014 to determine if they were calculated correctly, if the performance standards were attained, and whether any applicable penalties were paid by the PBM. Our review found that the Claims Adjudication Accuracy Rate was not attained by the PBM in CY 2014. According to Schedule F of the Agreement, the PBM is assessed a \$120,000 penalty when this standard is not achieved.

We requested that the PBM provide supporting documentation to demonstrate the penalty was credited to the Plan. We found that the \$120,000 credit was not made until after we identified the error. According to the PBM, staffing changes in CY 2014 caused the report deadline of April 15, 2015, to be missed. The PBM sent the report to the Plan on August 15, 2015, and credited the Plan \$120,000 on October 13, 2015.

According to the Plan, it was unaware that the performance report was not submitted by the PBM because the manager responsible for oversight of the Agreement terminated employment in June 2015, and no follow-up request was made to obtain the missing report.

As a result of staffing changes at both the PBM and the Plan, the 2014 performance standard report and related penalty were not conveyed to the Plan in a timely manner.

Recommendation 12

We recommend that the contracting officer confirm that the PBM credited the Plan \$120,000 related to performance penalties in 2014.

Plan Response:

The Plan agrees with the recommendation and states that a credit for the amount in question was applied to its October 13, 2015 invoice by the PBM.

Recommendation 13

We recommend that the contracting officer require the Plan and the PBM to develop policies and procedures to ensure that the annual performance report and any associated penalties are submitted to the Plan within the required deadlines.

Plan Response:

The Plan agrees with the recommendation and states that it has put procedures in place to review the PBM's performance regularly.

F. PHARMACY REBATES REVIEW

The results of our review showed that the PBM properly returned all pharmacy rebates due to the Plan in accordance with the Agreement.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Special Audits Group

██████████, Auditor-In-Charge

██████████, Auditor

██████████, Auditor

██████████, Group Chief, ██████████

██████████, Group Chief (former)

██████████, Senior Team Leader

APPENDICES

APPENDIX A



799 Cromwell Park Drive, Suite K-2
Glen Burnie, MD 21061

American Postal Workers Union, AFL-CIO

Health Plan Department

April 14, 2016

Chief Operating Manager
[REDACTED]

**Health Plan
Board of Directors**

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Director, Industrial Relations

William J. Kaczor, Jr.
Director, Health Plan

Clint Burselson
Director, Clerk Division

Steven G. Raymer
Director, Maintenance Division

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Stephen R. Brooks
Director, Support Services Division

Regional Coordinators

Sharyn M. Stone
Central Region

Mike Gallagher
Eastern Region

John H. Dirzius
Northeast Region

Kennith L. Beasley
Southern Region

Omar M. Gonzalez
Western Region

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

Dear [REDACTED]:

We were asked by your audit staff to revise our response to the draft audit report to notate the Plan's agreement or disagreement for each recommendation. We have enclosed a revised response to the draft audit report 1H-04-00-15-053 dated February 19, 2016, issued by the Office of Inspector General. Where appropriate we have noted our agreement or disagreement with the recommendation.

Since the findings and recommendations in the draft report may change based on additional information provided, the APWU Health Plan reserves the right to review and modify its responses prior to the issuance of the final report.

I would like to reaffirm the American Postal Workers Union's commitment to responsible administration of the FEHB Program. If you have any questions, please contact [REDACTED], CFO at the APWU Health Plan, at [REDACTED].

Cordially,
American Postal Workers Union Health Plan

[REDACTED]
[REDACTED]
Chief Operating Manager

Attachments

cc: [REDACTED], Contracting Officer Health Insurance Group II
[REDACTED], Contracts Specialist

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

A. ADMINISTRATIVE FEES REVIEW

1. Unsupported Administrative Fees \$595,272

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

Recommendation 1

We recommend that the contracting officer and the Plan require ESHC to maintain complete and accurate documentation to support administrative fees and invoices billed (both the fees charged and quantities).

APWU Health Plan's Response to Draft Report

APWU Health Plan agrees with this recommendation.

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

Recommendation 2

We recommend that the contracting officer require the Plan to implement policies and procedures for reviewing ESHC's administrative fees, including the verification of invoices to supporting documentation to ensuring that invoices related to the FEHBP are paid accurately and in accordance with the Agreement.

APWU Health Plan's Response to Draft Report

APWU Health Plan agrees to review the monthly administrative fees to verify the invoices to supporting documentation.

B. PHARMACY CLAIM PAYMENTS REVIEW

1. Claims Paid to Debarred Pharmacies Procedural

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

Recommendation 8

We recommend that the contracting officer direct the Plan to ensure that ESHC uses the required OPM OIG debarment/suspension list for excluding FEHBP claim payments to debarred providers.

APWU Health Plan's Response to Draft Report

The APWU Health Plan has implemented the recommendation and ensured that ESHC is using the OPM OIG debarment/suspension list. As stated in the audit report, the APWU Health Plan was not aware that Express Scripts was using the HHS/CMS debarred provider file to edit claims instead of the OPM/OIG debarred provider file. Express Scripts installed the OPM/OIG debarred provider file for editing on July 15, 2015. Updated files are sent from APWU Health Plan to Express Scripts as they become available from OPM.

2. Claims Paid for Overage Dependents

\$16,845

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

Recommendation 6

We recommend that the contracting officer direct the Plan to return \$16,845 to the FEHBP for erroneous claim payments on ineligible overage dependents.

APWU Health Plan's Response to Draft Report

The APWU Health Plan disagrees with this recommendation. The Health Plan has taken the appropriate due diligent steps to recover these funds as outline in the contract and is not required to return the \$16,845 if considered unrecoverable. The APWU Health Plan has requested overpayment recovery for the individuals in question. The overpayments were sent to a third party recovery group for collection. There have been at least 3 overpayment recovery letters sent to these individuals since September 2015. To date the APWU Health Plan collected \$56.65 of the Rx overpayments. The APWU Health Plan has performed due diligence in trying to recover these funds.

Recommendation 7

We recommend that the contracting officer direct the Plan to implement system edits that would automatically identify and notify eligible dependents approaching their 26th birthday

of their pending ineligibility. Additionally, the system edits should also terminate dependents upon reaching age 26.

APWU Health Plan's Response to Draft Report

The APWU Health Plan disagrees that additional system edits are necessary because The APWU Health Plan has system edits in place that trigger notification to the dependent 90 days before their 26th birthday. At that time, the future termination date is placed on the dependent. There were some inconsistencies to this program identified by APWU Health Plan prior to the OIG audit and additional edits were put in place to identify all dependent over 26 that could have questionable eligibility.

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

C. FRAUD AND ABUSE REVIEW

1. Fraud and Abuse Cases Not Reported by the Plan

Procedural

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

Recommendation 11

We recommend the contracting officer ensure that the Plan has updated its policies and procedures so that all potential cases of fraud and abuse reported to it by ESHC are referred to the OPM OIG in compliance with the most updated FEHBP Carrier Letter 2014-29.

APWU Health Plan's Response to Draft Report

APWU Health Plan has implemented this recommendation. As stated in the audit report above beginning in February 2014 the Health Plan starting reporting the patient restrictions to OPM/OIG and has installed steps to be in compliance with the new CL 2014-29 issued on December 19, 2014.

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

E. PERFORMANCE GUARANTEES REVIEW

1. Performance Guarantees Reporting and Penalty Payment

\$120,000

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

Recommendation 12

We recommend that the contracting officer confirm that ESHC credited the FEHBP \$120,000 related to performance penalties in 2014.

APWU Health Plan's Response to Draft Report

The APWU Health Plan provided proof to OPM/OIG auditor that the \$120,000 performance penalty was applied as an offset to the Express Scripts invoice on 10/13/2015. The credit reduced the amount of the bi-weekly payment for pharmacy claims. A copy of this transaction was provided to the OPM/OIG on March 25, 2016.

Recommendation 13

We recommend that the contracting officer require the Plan and ESHC to develop policies and procedures to ensure that the annual performance report and any associated penalties are submitted to the Plan within the required deadlines.

APWU Health Plan's Response to Draft Report

APWU has implemented this recommendation. The APWU Health Plan has put a performance check list together for each vendor. This check list will be reviewed quarterly to determine that all vendors are reporting their performance timely and that penalties are paid as outline in the contracts.

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

June 24, 2016

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

**Health Plan
Board of Directors**

Mark Dimondstein
President

Deborah "Dabby" Szarety
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Director, Maintenance Division

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Regional Coordinators

Sharyn M. Stone
Central Region

Nike Gallagher
Eastern Region

John H. Dirzius
Northeast Region

Kennith L. Beasley
Southern Region

Omar N. Gonzalez
Western Region

Dear [REDACTED]

Enclosed is the APWU Health Plan's response to the addendum of the draft audit report 1H-04-00-15-053 dated June 10, 2016, issued by the Office of Inspector General. We have incorporated our response within the text of the audit report to provide continuity for the reader. If after you review the enclosed responses, you are not in agreement with the Plan's stated position, we respectfully request that the APWU Health Plan be afforded the opportunity to meet with you or the OIG staff regarding those items on which we disagree. We believe that this will assure fair resolution of differences at the lowest cost to all parties and allow for the final report to be complete, accurate, fair and as free from errors of fact or omission as our combined efforts can make them.

Since the findings and recommendations in the draft report may change based on additional information provided, the APWU Health Plan reserves the right to review and modify its responses prior to the issuance of the final report.

I would like to reaffirm the American Postal Workers Union's commitment to responsible administration of the FEHB Program. If you have any questions, please contact [REDACTED], CFO at the APWU Health Plan, at [REDACTED].

Cordially,
American Postal Workers Union Health Plan

[REDACTED]
[REDACTED]
Chief Operating Manager

CEMT:Wmaf
af-cio
opsta #2

Attachments

cc: [REDACTED] Contracting Officer Health Insurance Group II
[REDACTED] Contracts Specialist

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

B. PHARMACY CLAIM PAYMENTS REVIEW (AMENDED)

5. Override Codes Applied Incorrectly

Procedural

Recommendation 9

We recommend that the contracting officer direct the Plan to ensure that all overrides, especially effecting coinsurance, are entered and applied correctly so that claims are paid correctly. Additionally, the Plan should institute procedures to review the initial paid claims with overrides to ensure that the coinsurance is paid correctly.

APWU Health Plan's Response to Draft Report

APWU Health Plan agrees that it should establish procedures to ensure that all overrides effecting coinsurance are entered and applied correctly. The APWU Health Plan will develop procedures defining how and when overrides may be entered and will identify a process to validate correct adjudication.

Recommendation 10

We recommend that the contracting officer direct the Plan to obtain from the PBM a list of all claim overrides in place and to review those overrides to ensure that they are still necessary. This should be done on an annual basis.

APWU Health Plan's Response to Draft Report

APWU Health Plan agrees with this recommendation. The APWU Health Plan will review all overrides currently in place and perform this function at least annually going forward.

6. Pharmacy Pricing Errors

\$9,954

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

Recommendation 3

We recommend that the contracting officer and the Plan direct the PBM to reimburse \$5,064 to the FEHBP and \$4,890 to the effected Plan members.

APWU Health Plan's Response to Draft Report

APWU Health Plan agrees with this recommendation. The Health Plan will request that the PBM reimburse the Plan and the affected members.

Recommendation 4

We recommend that the contracting officer and the Plan direct the PBM to institute and/or update procedures to ensure that pharmacy contract changes are entered into its claims system so that those changes are effective on the date in the contracts with the pharmacies.

APWU Health Plan's Response to Draft Report

APWU Health Plan agrees with this recommendation. The APWU Health Plan will direct the PBM to implement or update procedures to ensure that pharmacy contract changes are entered into its claims system timely.

Recommendation 5

We recommend that the contracting officer and the Plan direct the PBM to provide an explanation as to how this error occurred.

APWU Health Plan's Response to Draft Report

APWU Health Plan will direct the PBM to provide an explanation as to how the error occurred.



24 June 2016
1H-04-00-15-053

██████████
Group Chief Special Audits
Office of Personnel Management
Office of Inspector General
1900 E Street, NW – Room 6400
Washington, DC 20415

Dear ██████████,

Express Scripts, Inc. (ESI) has completed its response to the draft audit report, addendum 1H-04-00-15-053. A response was provided to each of the OIG findings, in addition to the response from the APWU Health Plan.

Express Scripts is committed to supporting the Prescription Drug Program for the APWU Health Plan. We will continue to partner with the Health Plan provide resolutions to the recommendations provided by the OIG.

Questions regarding this matter may be addressed to the undersigned at ██████████ or via email at ██████████@express-scripts.com

Best regards,

██████████
Senior Manager, Government Audit
Express Scripts, Inc.

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

B. PHARMACY CLAIM PAYMENTS REVIEW (AMENDED)

5. Override Codes Applied Incorrectly

Procedural

Recommendation 9

We recommend that the contracting officer direct the Plan to ensure that all overrides, especially effecting coinsurance, are entered and applied correctly so that claims are paid correctly. Additionally, the Plan should institute procedures to review the initial paid claims with overrides to ensure that the coinsurance is paid correctly.

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

Express Scripts' Response to Draft Report

Express Scripts has not received a report to identify the overrides found in error. The OIG provided Express Scripts with a list of 81 claim examples between Information Requests 65 and 66. Express Scripts identified 9 overrides that did not contain enough detail to justify the override approval. Currently, all client initiated authorizations are being submitted through a dedicated team to ensure consistent documentation of the override is retained.

Recommendation 10

We recommend that the contracting officer direct the Plan to obtain from the PBM a list of all claim overrides in place and to review those overrides to ensure that they are still necessary. This should be done on an annual basis.

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

Express Scripts' Response to Draft Report

Express Scripts agrees with APWU Health Plan's response.

6. **Pharmacy Pricing Errors**

\$9,954

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

Recommendation 3

We recommend that the contracting officer and the Plan direct the PBM to reimburse \$5,064 to the FEHBP and \$4,890 to the effected Plan members.

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

Express Scripts' Response to Draft Report

Express Scripts will work with APWU Health Plan to reach a resolution on this recommendation.

Recommendation 4

We recommend that the contracting officer and the Plan direct the PBM to institute and/or update procedures to ensure that pharmacy contract changes are entered into its claims system so that those changes are effective on the date in the contracts with the pharmacies.

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

Express Scripts' Response to Draft Report

A signed pharmacy contract requires an implementation period for any changes identified within the new contract. The pharmacy contract implementation is a commercially accepted process that is not exclusive to APWU Health Plan. There are a number of factors that impact the timing of the contract implementation. We seek to operate our business process as quickly and efficiently as possible. Express Scripts agrees to explore areas for improvement as we move to a new contracting system. As part of the current process; when the team receives a new request/contract, a team member will review and provide an analysis of the changes. The analysis period is dependent on the complexity of the contract.

The documentation is submitted to a secondary party for Quality Review (QR). The reviewer validates the analysis with the contract. The QR person then returns the work to the initial team member and any needed corrections are made. The contract changes are then submitted for update. Each month the Retail Network Triage team will pull a random sample for additional review.

Recommendation 5

We recommend that the contracting officer and the Plan direct the PBM to provide an explanation as to how this error occurred.

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

Express Scripts' Response to Draft Report

Based on the standard contract implementation, an incorrect rate was not set-up for this pharmacy. Pharmacy rates are guaranteed through an annual average rate. The implementation period did not impact the performance guarantee for this period.



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:

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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

-- CAUTION --

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Report No. 1H-04-00-15-053