Report on the

STATE OF ALABAMA RECOVERY AUDIT

Employee Insurance Boards

January 1, 2008 through December 31, 2011

CONDUCTED BY
RECOVERY AUDIT SPECIALISTS, LLC

Filed: December 26, 2014

Department of Examiners of Public Accounts

50 North Ripley Street, Room 3201
P.O. Box 302251
Montgomery, Alabama 36130-2251
Website: www.examiners.alabama.gov

Ronald L. Jones, Chief Examiner

15X-003

Table of Contents

	Page
Chief Examiner's Transmittal Letter	1
Alabama Public Employee Benefit Plans 2014 Recovery Audit Management Report – Final Report	2
State Employees' Insurance Board's (SEIB) Response to Recovery Audit	3
Public Education Employees Insurance Plan's (PEEHIP) Response to Recovery Audit	4

State of Alabama
Department of
Examiners of Public Accounts

Telephone (334) 242-9200
FAX (334) 242-1775

Ronald L. Jones
Chief Examiner

Mailing Address:
P.O. Box 302251
Montgomery, AL 36130-2251

Location:
Gordon Persons Building
50 North Ripley Street, Room 3201
Montgomery, AL 36104-3833

December 15, 2014

Dear Members of the Legislature and Citizens of the State of Alabama:

In accordance with the ***Code of Alabama 1975***, Section 41-5-6.1, the Chief Examiner of Public Accounts hereby releases the following Final Recovery Audit Report prepared by Recovery Audit Specialist, LLC (RAS) and responses from the State Employees Insurance Board (SEIB) and Public Education Employees Insurance Plan (PEEHIP) who provided their response when draft copies of the report were furnished to them by this Department.

ALABAMA PUBLIC EMPLOYEE BENEFIT PLANS 2014 RECOVERY AUDIT MANAGEMENT REPORT - RECOVERY AUDIT SPECIALISTS, LLC
Response – State Employees Health Insurance Plan
Response – Public Education Employees Health Insurance Plan

Any views, opinions or findings in the recovery audit report are solely those of the contractor. The Examiners of Public Accounts makes no representations or warranties of any kind, express or implied about the completeness, accuracy, or reliability with respect to its content. Any reliance placed on such information is therefore strictly at the users' risk.

Readers of the report are encouraged to read any corresponding responses from the applicable agencies to gain a better understanding and perspective of the matters included in the recovery audit report.

The report and responses may be obtained by visiting our website www.Examiners.State.Alabama.gov and clicking the **Information and Other Resources** Icon and then clicking "**Other**" or by contacting us at Department of Examiners of Public Accounts, P.O. Box 302251, Montgomery, Alabama, 36130-2251, (334) 242-9200.

The report and corresponding responses have been reproduced as submitted and are being released by this office to comply with applicable statutes. The Department of Examiners of Public Accounts did not participate in the preparation of the report and responses.

Sincerely,

Ronald L. Jones
CHIEF EXAMINER.

Alabama Public Employee Benefit Plans 2014 Recovery Audit Management Report

RECOVERY AUDIT SPECIALISTS, LLC ALABAMA PUBLIC EMPLOYEE BENEFIT PLANS 2014 RECOVERY AUDIT MANAGEMENT REPORT

Final Report

Prepared for the State of Alabama
Department of Examiners of Public Accounts
Ronald L. Jones, Chief Examiner
September 2014

Recovery Audit Specialists

Accountability ▪ Transparency ▪ Recovered Funds

Executive Member Advisory Board

General (Retired) Wesley Clark
CEO, Wesley K. Clark & Associates, Former Supreme Allied Commander & Commander in Chief US European Command, NATO

Clark Kent Ervin
Partner, Patton Boggs LLP, former first Inspector General US Department of Homeland Security & Inspector General of the US Department of State

Bob J. Nash
President, Bob J. Nash & Associates; former Assistant to the President and Director of Presidential personnel for the White House & former Undersecretary U.S. Department of Agriculture

Dr. Raymond Scalettar
MD, DSc, FACP, MACR
Practicing Physician; Clinical Professor of Medicine George Washington University & former Chair of the American Medical Association Board of Trustees

Alan B. Smith
Senior Fellow, Heartland Institute & former Executive Director, American Legislative Exchange Council (ALEC)

James Lee Witt
CEO Witt Associates & former Director U.S. Federal Emergency Management Agency

Brenda Russell
President/CEO, Recovery Audit Specialists, LLC

September 3, 2014

Ronald L. Jones
Chief Examiner
Alabama Department of Examiners of Public Accounts
P.O. Box 302251
Montgomery, AL 36130-2251

Dear Mr. Jones:

Recovery Audit Specialists (RAS) is pleased to provide you with the Final Recovery Audit Management Report for the Public Education Employees' Insurance Plan (PEEHIP) and the State Employees' Health Insurance Plan (SEHIP) as specified by Alabama Act 2011-703. The report includes RAS' observations and recommendations to strengthen both the programs financial integrity and recovery audit procedures.

RAS sincerely appreciates the support provided by you and other officials in the Examiners Office; in particular, Sharon Russell, Christine Harden, and Alice Martin, with whom RAS closely worked.

It has become clear that without incentives for compliance and enforcement mechanisms in the law, the legislature's vision to recover all overpayments for the state will not be realized. As you know, RAS was unable to perform the full medical recovery audits that your office contracted it to conduct. Despite your best efforts and those of RAS, we were not able to obtain the cooperation of the State's Third Party Administrator, Blue Cross Blue Shield of Alabama (BSCBSAL), which only agreed to a small sample audit.

To date, no funds have been recovered for the small sample of medical claims RAS was allowed to examine. PEEHIP has 23 undocumented claims outstanding in the amount of $87,694 and three documented overpayments totaling $10,321. SEHIP has 17 undocumented medical claims in the amount of $424,136 and one documented overpayment for $100.

Despite numerous delays and challenges, RAS did recover $5,408,190 in unauthorized fees and prescription overcharges in the SEHIP pharmacy benefits program.

RAS appreciates the opportunity to perform our services for the State and the confidence and trust you placed in us to conduct this recovery audit.

Sincerely,

Brenda Russell

Brenda Russell
President/CEO

1455 Pennsylvania Avenue, NW ▪ Suite 400 ▪ Washington, DC 20004
800-690-3622 ▪ Fax (202) 521-3461 ▪ www.RAS-DC.com

Table of Contents

Executive Summary Recovery Audit Management Report 1

Summary of Medical Claims Overpayments for PEEHIP and SEHIP 3

Financial Summary of Undocumented PEEHIP Medical Claims & Overpayments 4

Financial Summary of Undocumented SEHIP Medical Claims & Overpayments 5

Alabama Pharmacy Recovery Audit Key Findings 6

PEEHIP & SEHIP Pharmacy Benefit Overpayments & Non-Recoverable Lost Savings 7

Conclusion 8

PEEHIP & SEHIP Recovery Audit Management Report 1

Scope of the Recovery Audit 2

PEEHIP & SEHIP Medical Claims Recovery Audits 3

Recovery Audit Methodology Overview 3

Overview of PEEHIP and SEHIP Audits 6

PEEHIP Medical Claims Audit Results 12

Agreed upon PEEHIP Overpayment Findings for Recovery 13

Undocumented PEEHIP Overpayment Findings Recommended for Recovery 13

Financial Summary of Undocumented PEEHIP Claims & Overpayments 14

Details of Undocumented Overpayment Findings for Recovery 15

Disputed PEEHIP Hospital Claims Details 15

Disputed PEEHIP Physician Claims Details 16

SEHIP Medical Claims Audit Results 23

Agreed upon Overpayment Findings for Recovery 24

Undocumented BCBSAL Overpayment Findings for Recovery 24

Financial Summary of Undocumented SEHIP Medical Claims & Overpayments 25

Details of Undocumented Overpayment Findings for Recovery 26

Disputed SEHIP Hospital Claims Details 26

Disputed SEHIP Physician Claims Detail 30

Pharmacy Audits for PEEHIP and SEHIP 31

Pharmacy Audit Methodology 31

Public Education Employees' Health Insurance Board (PEEHIP) 33
Overview 33
MedImpact 34
Express Scripts 34
AWP Amendment that Reduced PEEHIP's Discounts 35
State Employees' Insurance Board (SEHIP) 37
Overview 37
Undisclosed Administrative Fee 38
Unfavorable Contract Provisions 39
Eliminating Unrestricted Pharmacy Audit Rights 40
Missing or Corrupted Data and Documentation 40
Verbal, Undocumented Amendment Reducing Discounts Related to AWP Settlement 42
Problems Encountered in Medical and Pharmacy Audits 45
Inability to Enforce the Recovery Audit Law 45
Lack of Incentives to Cooperate 46
Inaccurate and Incomplete Information Provided to Auditors 46
Unfavorable Contract Terms 46
Average Wholesale Price (AWP) Discount Reduction 49
SEHIP Verbal Amendment 54
Major Obstacles to Pharmacy Recovery Audits - Lack of Transparency and Cooperation with Audits 54
Undisclosed, Unauthorized Administrative Fees 54
Absence of Authorizing Language 55
Redundant Non-Disclosure Agreements Required 57
HIPAA Obstacle – Unnecessarily Halts Pharmacy Audit Also 57
Lack of Cooperation 59
Sample Audit VS. Recovery Audit 59
On-Site Audit Concerns 60
Follow-up after On-Site Audit 60

Remote Read Only Access Denied 61
Request for Electronic Copies of Necessary Documentation Denied 62
Restrictive Audit Limitations Hinder Recovery Audit 62
Audit Observations and Recommendations 64
Overview 64
Strengthen Master Contract Language for All State Contracts 64
Disclose Detailed Plan Costs and TPA/PBM Revenue in ASAs 65
Strengthen Master Contract Provisions for State Healthcare Plans 66
Modernize ASAs to Conform to Alabama Act 2011-703 Requirements 68
Increase Efficiency, Eliminate Duplication and Consolidate Purchasing Power 68
Encourage Competition in Alabama's Employee Health Benefits Program 69
Conclusion 70

Executive Summary
Recovery Audit Management Report

The Alabama legislature led the nation by enacting the most comprehensive statewide recovery audit law to date, Act 2011-703 (AL Code § 41-5-6.1 (2012). By enactment of its law and initiation of a program of recovery audits, Alabama has taken the lead in providing transparency and accountability and ensuring public resources are being prudently managed.

The law authorizes the Chief Examiner of Public Accounts to enter into contracts for recovery audits to recover overpayments made by state agencies to individuals, vendors, service providers and other entities. The Department of Examiners of Public Accounts (EPA) contracted Recovery Audit Specialists, LLC (RAS), through an open Request for Proposal (RFP) process, to conduct comprehensive statewide recovery audits of state expenditures made during Fiscal Years 2009 through 2011.

The Alabama law established a special fund within the State Treasury for the deposit of all funds generated from the recovery audits. All recovered funds are paid directly to the state.

The value of this independent recovery audit exceeds the funds Alabama will recapture as a result of the audit work. Stronger protections for the State and its taxpayers that may result from this work and the issues it uncovered may provide value to Alabama for years going forward.

The information gleaned from this independent audit provides Alabama with an opportunity to take a fresh look at the structure of its health benefit programs and the companies that administer those benefits on behalf of the state and its taxpayers. The American Medical Association recently ranked Alabama as the state with the least amount of health insurance competition in America.

Putting Alabama Taxpayers First

Requires Transparency & Accountability

Every company under contract to the State must be accountable for 100% of its financial transactions made with taxpayers' dollars and must operate in a transparent manner.

In the auditor's opinion, transparency and accountability in the administration of Alabama's public employee healthcare benefit programs by outside administrators need to be strengthened. Implementation of the recovery audits in the healthcare sector faced challenges from the start. Procedural delays and negotiations with outside administrators regarding the full recovery audit vs. a sample audit—and the limited size of the sample—consumed 2012 and 2013 and were never resolved.

Those challenges thwarted the full recovery audits envisioned by the state legislature. A *recovery audit* examines all transactions that appear likely to have an overpayment. Instead, Blue Cross Blue Shield of Alabama (BCBSAL) would only allow sample audits, where a small number of transactions are examined, to be performed. Even then, BCBSAL did not provide all the required documentation for those limited number of claims.

Performing the medical and pharmacy fraud analysis was prevented due to RAS being unable to obtain the necessary medical data points originally requested in November 2011 from the Third Party Administrator (TPA) retained by the insurance plans, BCBSAL. Failure to provide complete and accurate pharmacy and medical benefits information for all eight of Alabama's public employees benefit plans prevented performance of a comprehensive analysis. Without all the necessary data points, accurate analytical work simply could not be performed for a fraud analysis.

Throughout 2012, EPA and RAS encountered so many barriers to completion of the medical and pharmacy audits that the Examiners office capacity was enhanced in January 2013 by the addition of a Deputy Attorney General to provide legal support to the recovery audit.

While acknowledging that RAS was not privy to the negotiations surrounding selection of Alabama's Third Party Administrators (TPA) and Pharmacy Benefit Managers (PBMs) and their contract provisions, RAS' audit observations and many years of industry experience suggest that Alabama's employee benefits programs would benefit from strengthened contract provisions that better protect the State financially and foster improved accountability and transparency.

This report includes auditors' observations and specific recommendations to strengthen the financial integrity and management of Alabama's employee benefits programs and better support program integrity through recovery audits**.**

The following charts provide a brief summary of the outcome of the limited medical claims sample review RAS was allowed to perform for the Public Employees' Health Insurance Board and the State Employee' Health Insurance Board. Under Alabama Law 2011-703, the definition of an overpayment includes "failure to provide adequate documentation or necessary signatures, or both, on documents, or any other inadvertent error resulting on overpayment."

The majority of the disputed medical claims are due to lack of documentation being provided to auditors—despite repeated requests--in order to validate the accuracy and appropriateness of the expenditure.

In brief, a recovery audit is a process of elimination. All transactions are examined electronically by powerful algorithms that separate clean transactions from those with potential overpayments. For PEEHIP and SEHIP, approximately ninety-five percent of transactions were deemed accurately paid. Auditors then needed to examine the remaining transactions and supporting documentation for

potential overpayments. Examination of the supporting documentation typically eliminates additional transactions as having an overpayment. The remaining subset is those claims with a documented overpayment or claims where the documentation was not provided in order for auditors to validate whether the payment was accurate or not. Undocumented claims are considered overpayments by auditors under Alabama Act 2011-703 and are submitted to EPA as such with this report.

An important lesson learned from these first recovery audits is that the law needs some incentives for cooperation and some enforcement mechanisms for compliance with the law in order for the Legislature's vision of recovering overpayments to be fully realized.

The following summary charts show the overall status of the limited review auditors were allowed to perform.

Summary of Medical Claims Overpayments for PEEHIP and SEHIP

Insurance Benefit Plan	Amount
PEEHIP	
BCBSAL Agreed upon Overpayments for Recovery	$10,321.58
Undocumented Payments	$87,694.00
PEEHIP Total that Auditors Recommend for Recovery	**$98,015.58**
SEHIP	
BCBSAL Agreed upon Overpayment for Recovery	$100.00
Undocumented Payments	$424,136.64
SEHIP Total that Auditors Recommended for Recovery	**$424,236.64**

The following two charts for PEEHIP and SEHIP itemizes the outstanding claim amounts for health care benefits where the documentation was not provided (or only partially provided) to auditors to enable them to validate the accuracy and appropriateness of the expenditure.

Financial Summary of Undocumented PEEHIP Medical Claims & Overpayments

Final PEEHIP Outstanding Claims			BCBSAL Agreed as Overpayments	
Claim #	**Amount**	**Notes**	**Claim #**	**Amount**
PEEHIP Hospital				
10	$27,172.97	Undocumented	2	$6,472.58
50	$60.00	Undocumented		
78	$25.00	Undocumented		
82	$5,225.24	Unbundled Billing		
86	$5,782.94	Duplicate Claim		
Sub Total	**$38,266.15**	**5 claims**	**1 claim**	**$6,472.58**
PEEHIP Physician				
5	$55.00	Undocumented	49	$729.00
14	$4,906.00	Undocumented	81	$3,120.00
17	$2,378.00	Undocumented		
19	$903.00	Need Additional Documentation		
32	$924.50	Need Additional Documentation		
38	$3,336.50	Undocumented		
41	$6,139.00	Undocumented		
42	$4,310.00	Need Subrogation Documentation		
45	$3,947.50	Undocumented		
46	$1,295.50	Undocumented		
47	$2,920.50	Undocumented		
50	$169.50	Duplicate Claim		
52	$6,149.00	Third Party Liability		
57	$2,770.50	Triplicate Claim		
60	$2,722.00	Undocumented		
62	$1,449.50	Undocumented		
76	$2,547.50	Need Subrogation Documentation		
93	$2,504.35	Need Subrogation Documentation		
Sub Total	**$49,427.85**	**18 claims**	**2 claims**	**$3,849.00**
PEEHIP Total Overpayments & Undocumented Claims				**$91,543.00**

Financial Summary of Undocumented SEHIP Medical Claims & Overpayments

SEHIP Undocumented Claims			BCBSAL Agreed as Overpayments	
Claim #	**Amount**	**Notes**	**Claim #**	**Amount**
SEHIP Hospital				
2	$210.00	Co-payment	79	$100.00
2a	$363,808.94	Undocumented		
3	$2,920.77	Undocumented		
5	$5,000.00	Need Subrogation Documentation		
7	$1,117.28	Overpaid bill		
15	$15,983.40	Need 3rd Party Liability Documentation		
22	$6,528.16	Undocumented		
24	$0	Procedural Error		
25	$25.00	Co-payment		
40	$25.00	Co-payment		
41	$10,000.00	Third Party Liability		
44	$2,701.92	Dental Exclusion		
48	$880.00	Overpaid bill		
67	$358.95	Inpatient vs. Outpatient Co-pays		
97	$7,590.00	Claim Exceeded Time Limit		
Sub-Total	**$417,149.42**	**15 claims**	**1 claim**	$100.00
SEHIP Physician				
6	$95.32	Undocumented	**None**	$0.00
11	$6,891.50	Undocumented		
Sub Total	**$6,986.82**	**2 claims**	**None**	$0.00
TOTAL Undocumented Claims	**$424,136.24**		**TOTAL Approved Claims**	**$100.00**
SEHIP Total Overpayment & Undocumented Claims				**$424,236.24**

Alabama Pharmacy Recovery Audit Key Findings

- Each contract (ASA) specifies the allowed administrative fees. None of Alabama's eight health plans' ASAs contained language allowing the TPA/PBM to impose any additional—or undisclosed—fees.
- In an 18 month period, BCBSAL/Prime withheld almost $5.1 million in unauthorized and undisclosed, additional administrative fees due to SEHIP from its drug manufacturer's rebates.
- It took six months for BCBSAL to repay Alabama the almost $5.1 it withheld from SEHIP.
- BCSAL initially said it was entitled to keep the funds since its ASAs did not expressly prohibit it from charging additional, undisclosed fees.
- SEHIP ***verbally*** accepted an amendment from BCBSAL to diminish the discounts it received on prescriptions filled by its members, which increased its costs by approximately $7.33 million for FY 09 - 11.
- SEHIP was overcharged $316,475 for its members' prescriptions for fiscal years 09 - 11. These funds were recovered.
- An amendment that was presented as "cost neutral" to PEEHIP from Express Scripts diminished PEEHIP's guaranteed prescription discount price. Agreed upon contract language allowed its PBMs, Express Scripts and MedImpact, to average out individual prescription costs on an annual basis and offset discounts /overcharges, which, together, totaled approximately $15.7 million in unrealized savings that otherwise, could have been achieved. Requiring the PBM to meet or exceed the accurate price on each prescription and not accepting the discount price reduction would have yielded significant cost-savings.
- PEEHIP and SEHIP stated that they accepted the amendment diminishing their discounts due to an industry settlement of a lawsuit (none of the Alabama entities were a party to the suit). The parties to the settlement received $350 million in damages and the settlement rolled back improperly inflated wholesale drug prices to compensate Third Party Payers (similar to PEEHIP and SEHIP) and consumers for past overcharges from the improperly inflated drug prices. Third Party Payer payouts, however, were limited to non-governmental self-insured plans even though governmental plans had been negatively impacted by the higher prices as well.
- Combining documented overpayments and unrealized savings due to less than favorable contract language and contract amendments, the State of Alabama potentially lost more than $30 million in savings it might have otherwise achieved in its pharmacy benefit programs for fiscal years 2009 – 2011 for PEEHIP and SEHIP.

PEEHIP & SEHIP Pharmacy Benefit Overpayments & Non-Recoverable Lost Savings

Plan	Explanation	Amount
PEEHIP	**Express Scripts:** Overcharges netted out against discounts and underpayments and prescriptions averaged together on an annual basis, plus accepting the amendment that diminished the discount price rate for the plan.	Potential Unrealized Savings Lost: $15,724,974
	MedImpact: Overcharges netted out against discounts and underpayments and prescriptions averaged together on an annual basis.	Potential Unrealized Savings Lost: $1,901,338
PEEHIP OVERPAYMENTS RECOVERED	**Claims paid in accordance with ASA provisions.**	**NO RECOVERIES**
SEHIP	**BCBSAL / Prime Therapeutics:** Undisclosed, unauthorized Administrative Fee;	**$5,091,715**
	Accepting ***verbal*** amendment that diminished discount price rate for the plan.	Potential Unrealized Savings Lost:-$7,330,563
	Individual prescription claims overpayments.	**$316,475**
SEHIP OVERPAYMENTS RECOVERED	**SEHIP Overpayment for Administrative Fees**	**$5,091,715**
	SEHIP Overpayments for Prescription Costs	**$316,475**
	TOTAL	**$5,408,190**

The following report provides details on the process and outcomes of these recovery audits, Including observations and recommendations on ways to strengthen the process for the benefit of Alabama taxpayers.

Conclusion

It has become clear that without incentives for compliance and enforcement mechanisms in the law, the legislature's vision to recover all overpayments for the state will not be realized. The statewide recovery audit to return overpayments to the state is only partially fulfilled. Without clear enforcement power, the EPA and the auditors wasted excessive amounts of time just trying to move the healthcare audits forward—to no avail. It is three years after enactment of the law and medical recovery audits were not able to be performed on the expenditures for the state's eight self-insured employee health benefit plans since the TPA would only agree to a small sample audit.

The Act does not provide any mechanism to collect overpayments if a vendor/service provider does not repay the funds timely. It took six months for the state to recover approximately five million dollars owed Alabama for funds its TPA/PBM withheld, without authorization or notification, for an additional administrative fee from the SEHIP. Likewise, BCBSAL withheld another million dollars from the universities without authorization or notification, for the same additional administrative fee it imposed on SEHIP. BCBSAL made it clear to auditors and the EPA that it intends to use all means at its disposal to retain that million dollars.

Alabama employee benefit plans pay their TPA/PBM significant funds each month, yet EPA was powerless to legitimately withhold any of those payments to help recapture the funds owed the state, thus, enabling an interest free loan at taxpayers' expense to the TPA/PBM.

Without defined timelines, incentives for cooperation and sanctions for non-compliance in the law, the EPA had no mechanisms to ensure that accurate and complete data and documentation necessary to perform the audits was provided to auditors. Significant time and effort were taken from the EPAs daily responsibilities and redirected towards attempts to fully implement the recovery audit law.

RAS has included its audit observations, including problems identified, and recommendations on opportunities for the state to strengthen its recovery audit law in the full report.

PEEHIP & SEHIP
Recovery Audit Management Report

The Alabama legislature led the nation by enacting the most comprehensive statewide recovery audit law to date, Act 2011-703 (AL Code § 41-5-6.1 (2012). By enactment of its law and initiation of a program of recovery audits, Alabama has taken the lead in providing transparency and accountability and ensuring public resources are being prudently managed.

Recovery audits are a strong management tool that can help control costs, strengthen financial systems and encourage state vendors and service providers to operate in a transparent manner, as well as document the State's achievement in being prudent managers of state resources.

The law authorizes the Chief Examiner of Public Accounts to enter into contracts for recovery audits to recover overpayments made by state agencies to individuals, vendors, service providers and other entities. The Department of Examiners of Public Accounts (EPA) contracted Recovery Audit Specialists, LLC (RAS) through an open Request for Proposal (RFP) process to conduct comprehensive statewide recovery audits of state expenditures made during Fiscal Years 2009 through 2011.

The Alabama Statute established a special fund within the State Treasury for the deposit of all funds generated from the recovery audits. All recovered funds are paid directly to the state.

RAS performed the audits on a contingency fee basis. This means that auditors identify, document and recover the overpayments for the State. Auditors are then compensated by a percentage of the amount recovered after funds have been deposited into the special fund established by the state legislature for receipt of the overpayments.

The law stipulates that auditors shall be provided with any and all payment-related information necessary to perform the audit, including any confidential information as determined by the Chief Examiner. The final success of a recovery audit depends on compliance with the audit requirements, transparency and accountability by vendors and service providers.

Putting Alabama Taxpayers First

Requires Transparency & Accountability

Every company under contract to the State must be accountable for 100% of its financial transactions made with taxpayers' dollars and must operate in a transparent manner.

RAS did not receive the medical data and documentation to perform the full recovery audits it was contracted to do, only a small sample of claims were allowed to be fully examined for accuracy and appropriateness of the payment.

The RFP issued by the Examiner's Office for comprehensive recovery audits required the auditor to examine expenditures for the state's health insurance benefits plans. The healthcare expenditures are processed by outside vendors, called Third Party Administrators (TPA) and Pharmacy Benefit Managers (PBM), but the plans remain fully responsible to cover all healthcare benefit costs for employees.

This report is focused on the transactions made by the Public Employees' Health Insurance Plan (PEEHIP) and the State Employees' Health Insurance Plan (SEHIP). It documents the process used, challenges encountered, overpayments documented and recovered, as well as auditors' observations and recommendations arising from the audit.

An important lesson learned from these first recovery audits is that the law needs timelines and incentives for cooperation and some enforcement mechanisms for compliance with the law in order for the Legislature's vision of recovering overpayments to be fully realized.

Scope of the Recovery Audit

Alabama provides medical and pharmacy benefits as part of a comprehensive program of healthcare offered to more than 400,000 state employees, teachers and their covered dependents, and retirees. The state employee health benefit plans (plans) provide their employee benefit programs on a self-funded basis. This means Alabama pays all the bills and hires Third Party Administrators (TPAs) and Pharmacy Benefit Managers (PBMs), as claims administrators, to manage the benefit programs and process state payments properly on its behalf, and on behalf of the people who pay for and receive coverage under the plans.

Blue Cross and Blue Shield of Alabama (BCBSAL) serves as the TPA administering the medical benefits for PEEHIP and SEHIP and the PBM administering the pharmacy benefits for SEHIP under a contract called an Administrative Service Agreement (ASA) for each plan. Express Scripts and MedImpact served as the PBMs for PEEHIP.

Auditors were contracted to perform comprehensive recovery audits to identify, document and recover overpayments or inappropriate disbursements of state expenditures made during Fiscal Years 2009 -2011 (October 1, 2008 through September 30, 2011). Alabama law specifies that these recovery audits are complementary to financial management processes and do not replace existing or future state audit or program integrity activities.

This report focuses on the state's two large health benefit insurances plans: PEEHIP and SEHIP. It complies with the Alabama Act 2011-703 requirements that auditors provide a detailed report to the EPA that will be posted on EPA's website that contains:

- the methodology used to conduct the recovery audit component,

- the results of the recovery audit for that component, including
  - problems found,
  - overpayments identified,
  - actual amounts collected, and
- recommendations to correct any problems identified.

PEEHIP & SEHIP Medical Claims Recovery Audits

Recovery Audit Methodology Overview

To begin the audit, EPA and RAS held meetings with key leadership of the Public Education Employees' Health Insurance Board (PEEHIP), the State Employees' Insurance Board (SEHIP) and Blue Cross and Blue Shield of Alabama (BCBSAL) in October and November 2011 respectively, to educate them about the recovery audit requirements and engage them in the process.

RAS provided BCBSAL, PEEHIP and SEHIP with its *Alabama Employee Benefits Audit Guide*. The guide specified the data (down to the level of each required individual data field) and supporting documentation required to conduct the full medical and pharmacy recovery audit. RAS also provided the same Guide to PEEHIPs PBMs: Express Scripts and MedImpact.

Recovery audits are a unique and comprehensive process that examines the totality of financial transactions and produce a precise analysis of state expenditures relative to overpayments. Recovery audits are distinguished from traditional sample audits, which are more common in the medical field and are performed on a fee-for-service basis, requiring a client to pay upfront for review of only a small sample of claims instead of reviewing all potential overpayments made on behalf of the State.

RAS was not engaged by the State to perform sample audits and never agreed to perform sample audits on a contingency-fee basis. Examining a small sample of 200 claims is not financially feasible on a contingency fee basis. RAS performs sample audits on a set fee basis; not a contingency basis.

Recovery auditing is a process of elimination, whereby, the initial electronic analysis culls out all clean payments that do not indicate a potential error, which is the vast majority of payments. For medical audits RAS' powerful software algorithms and data analysts analyze the raw data for potential overpayments and flag those for further review by medical auditors.

Approximately ninety-five percent of claims for PEEHIP and SEHIP were eliminated from further review by this electronic analysis. Highly trained medical auditors (medical directors, clinical nurses, certified medical coders and data analysts) then review the remaining claims for accuracy and appropriateness of payment.

A *recovery audit* fully examines all claims that are flagged as having a potential overpayment from the original data analysis, not a small sample of only 200 out of hundreds of thousands of claims. For example, the software analysis eliminated approximately ninety-five percent (95%) of the SEHIP claims from additional examination. The remaining five percent (5%), approximately 20,000 SEHIP claims, were flagged for further examination. BCBSAL, however, would only agree to allow 200 of those 20,000 claims to be examined in order to validate that they were appropriately paid.

A sample audit might discover an overpayment that turns out to be a systemic issue covering many errors, such as a certain procedure is coded into the TPAs payment software inaccurately, causing all such payments to contain that error and be improperly paid. In that case, the TPA would agree to all such overpayments, thereby broadening the impact of the sample audit.

The overwhelming majority of overpayments, however, are individual errors, not systemic errors. For example, of the 200 PEEHIP and 200 SEHIP claims RAS was able to review, none of the claims contained a systemic error.

At the beginning of the medical audit the software assigns a unique audit number to each claim as the primary identifier for the recovery audit process. It is used throughout the audit instead of name, social security number, place of employment or any other personal identifiers. This limits Personal Health Information (PHI) from being routinely viewed, even by the medical auditors.

Medical auditors do not need to know the patient's name or social security number in order to examine the documentation. Since medical claims, especially medical necessity issues, require medical expertise to properly evaluate them, claim disputes are handled first between the RAS medical audit team, which consists of certified medical coders, clinical nurses and a medical director and BCBSAL.

Auditors examine the claim and review supporting documentation that validates the transaction and determine whether an overpayment occurred. A formal preliminary report is prepared and presented to the claims administrator, BCBSAL, each insurance plan and the EPA. Each individual claim is numbered and specifies the documentation needed to validate the legitimacy of that specific payment.

Typically, the TPA returns the report with its claim by claim responses to the auditor, either with agreement on the finding or with additional information to document the claim. If auditors are able to validate the appropriateness of the payment based on the additional documentation provided by the TPA, that claim is removed from the list (No Finding). Each claim where there is a finding is presented to EPA (without any personal information) for approval prior to recovery.

EPA would determine whether to approve any claims for recovery based on the documentation provided to support the legitimacy of the payment. This is the way the process *typically* works, not how it worked this time.

BCBSAL did not provide a written response to the report. Even though RAS has only been able to perform a sample audit on PEEHIP and SEHIP, BCBSAL has not provided the necessary documentation to verify the validity for each of those limited claims.

RAS medical auditors were on-site at BCBSAL for one week to address the initial 200 medical claims each for PEEHIP and SEHIP and they performed extensive work before going onsite and afterwards. The 200 claims each is a very small proportion of the claims flagged for further review.

A *recovery audit* is an effective financial management tool and is far more reliable than a sample audit because it requires examination of *all potentially erroneous transactions for accuracy and appropriateness of the expenditure* This means the audit firm performs the audit, documents overpayments and errors, and recovers the overpayments, which are repaid directly to the State. Auditors are then compensated solely from a portion of the recovered funds.

The objectives of Alabama Act 2011-703 were to identify and recover overpayments, including:

- Any payment of in excess of amounts due;
- failure to meet eligibility requirements;
- failure to identify third party liability where applicable;
- payment for an ineligible good or service;
- payment for a good or service not received;
- duplicate payments;
- invoice and pricing errors;
- failure to apply discounts, rebates or other allowances;
- failure to comply with contracts or purchasing agreements, or both;
- failure to provide adequate documentation or necessary signatures, or both, on documents;
- or any other inadvertent error resulting in overpayment.

In order to accomplish those objectives RAS auditors perform the following:

- Assess processes and procedures employed by the third party administrator
- Provide an objective assessment of payment accuracy levels
- Ensure proper interpretation, documentation and administration of plan provisions with respect to both system operations and claim data processing by claim personnel
- Ensure proper application of utilization review provisions
- Identify, document and recover overpayments for the State

A sample audit can provide a plan with an estimation of its TPAs error rate. A recovery audit provides an exact measure of the overpayments and recovers those misspent funds for the state.

Fraud Analysis

In November of 2011, RAS provided PEEHIP, SEHIP and BCBSAL with its *Alabama Employee Benefits Audit Guide.* The Audit Guide which detailed the information and data required to perform the recovery audit, including a listing of each data field needed.

Once all the medical transactions were run through the initial electronic analysis process, RAS planned that further analyses would be performed by RAS' teaming partner, SAS, at its Advanced Analytics Lab using its Fraud Framework for State and Local Government.

The SAS fraud detection system would have combined the Alabama data for all eight of the state employee health plans for medical, pharmacy and dental and used advanced analytics, predictive modeling and social network analysis to detect and prevent fraud in Alabama's employee benefits programs. Patterns that emerge from interrogation of the integrated data connect the dots for seemly unrelated individuals and providers.

If RAS had received all the data elements specified in the *Audit Guide* for medical claims for all eight of the state's employee benefit plans and had been able to conduct pharmacy and medical audits simultaneously, as planned, this advanced analytical process could have identified any potentially fraudulent activity by providers for further investigation.

The advanced analytics might also have helped narrow the number of medical claims that required a complex review. SAS, however, was only able to review a limited amount of data from PEEHIP and SEHIP transactions. SAS' analysis of the data provided by BCBSAL revealed that numerous data fields were missing some, or all, of the necessary data.

There was not enough complete data to run the Fraud Framework. The EPA determined that RAS should focus on completing the medical recovery audit and afterward could work to secure the additional data necessary to perform the fraud analysis.

Since RAS was prevented from conducting the full recovery audit, it was unable to progress to the Fraud Framework analysis for the benefit of Alabama.

Overview of PEEHIP and SEHIP Audits

BCBSAL is the TPA for all eight of Alabama's employee health benefit plans. EPA and RAS held meetings with key leadership of the Public Education Employees Health Insurance Board (PEEHIP) and the State Employees Insurance Board (SEHIP) in October 2011 to educate them on the recovery audits authorized by Alabama Act 2011-703 and initiate the audits. EPA, PEEHIP, SEHIP and RAS met with

Blue Cross and Blue Shield of Alabama (BCBSAL) at its headquarters in Birmingham in November of 2011 regarding the recovery audit requirements, and to engage them in the process.

BCBSAL officials stated they would support an audit as contained in their ASA with the insurance plans (a limited sample audit), but protested major aspects of the recovery audit authorized under Alabama law. BCBSALs position was that its ASA agreements with the plans governed any audit, not the state law. Specifically, BCBSAL objected to the following key recovery audit components:

- Allowing auditors to review and pursue all overpayments of medical or dental claims in accordance with the Act rather than be limited to pursuing recovery of only a statistical sample of claims and claims which are indicative of a systematic problem.
- Allowing auditors to contact providers directly about potential overpayments, if needed.
- Allowing auditors to perform credit balance reviews at all hospitals which received payments from PEEHIP and SEHIP.
- Allowing auditors to examine all overpayments made from January 1, 2008 through December 31, 2011 rather than limit the audit to the immediately preceding two year period.

EPA reminded BCBSAL that the expanded access outlined above was necessary in order for the Recovery Audit to comply with the provisions of Act No. 2011-703, which were to provide for the greatest identification and recovery of overpayments of state funds. Alabama Act 2011-703 governed the recovery audits and the law authorized the audit to be performed.

EPA notified PEEHIP and SEHIP that their assistance to facilitate the requests outlined above and secure cooperation from BCBSAL would be greatly appreciated. EPA requested that each insurance board let EPA know as soon as possible if each was agreeable to making the request of BCBSAL.

On November 28, 2011, SEHIP forwarded the November 16, 2011 EPA letter seeking cooperation with the mandated recovery audit to BCBSAL with a cover letter. PEEHIP did the same on November 29, 2011.

EPA sent PEEHIP and SEHIP follow-up letters on January 4, 2012 since EPA had not received any response to its November 16, 2011 request. EPA still did not receive a response from BCBSAL.

In a February 19, 2013 letter, again seeking cooperation with the recovery audit, EPA reminded BCBSAL that Alabama Act 2011-703 governed the recovery audits and the law mandated that it be performed (emphasis added).

> ***"The recovery audit is being conducted under the broad authority granted this office by the Legislature.*** *The Code of Alabama 1975, Section 41-5-6.1 permits the Chief Examiner to obtain any payment related information as determined by the Chief*

*Examiner, including any confidential information, that is necessary for the performance of the audit or the recovery audit of an overpayment". **We disagree with your position that the recovery audit scope is limited by the terms of the Administrative Services Agreement [ASA] entered with the SEHIP. T**he legislative intent of cost containment, aimed at reducing improper payments and identifying process improvements where state monies are expended, is clear and unimpeded by private contract provisions. **It is well established law in Alabama that a contract "adverse to the enactments of the legislature, is illegal and void"** Perdue v Green, 2012 WL 887492 (Ala. 2012), citing Carrington v Caller, 2 Stew. 175, 192 (Ala. 1829) (citing Wheeler v. Russell, 17 Mass. 258 (1821). **Therefore, please consider this a formal production demand for SEHIP [Plan] data, an asset owned by the Plan, which is in BCBSAL's custody by virtue of its role as the third-party administrator.** By copy of this demand letter we are also notifying the Plan which has previously issued the appropriate Letters of Authority requesting your assistance. If the data is not produced directly to RAS, the responsibility will fall to your client – the SEHIP – to make the documents available to RAS. We wish to avoid further production delays and complete this audit, and thank you in advance for your continued cooperation."*

The law stipulates that auditors *shall* be provided with any and all payment-related information necessary to performance of the recovery audit, including any confidential information as determined by the Chief Examiner.

It took from November 2011 until May 20, 2012 for RAS to obtain the initial raw data from BCBSAL; although agreement still had not been reached on whether BCBSAL would cooperate with the recovery audit and allow examination of all potential overpayments, which continued to hold up performance of the audit.

Procedural delays included: BCBSAL requiring multiple and redundant Non-Disclosure Agreements (NDAs), objections raised over whether federal HIPAA law would allow the audit; and negotiations with BCBSAL regarding the full recovery audit vs. a sample audit—and the limited size of the sample BCBSAL was willing to allow. These challenges significantly delayed the audit process and ultimately prohibited the full recovery audit.

Typically, it would take an audit team four to five months to complete a sample audit of 400 medical claims from start to finish. In this case, it took longer than that for auditors to even receive the initial raw data for the state plans.

If RAS had been permitted to perform the full recovery audit it would have assigned additional audit teams to the project.

The ASAs between PEEHIP and SEHIP stipulate that the records belong to the plan, which means that they belong to the state. The ASAs also provide that if PEEHIP or SEHIP hires its own independent auditors, there are certain limitations on the scope of that audit.

This was not a situation, however, where PEEHIP and SEHIP arranged for a sample audit per their respective ASA with BCBSAL. This was a situation where the Department of Examiners, per a statute of authorization, arranged for a comprehensive audit of state programs and was requesting records/data which belongs to a state agency, but is in the hands of its contractor.

Initial Set of Claims

Since BCBSAL continued to only agree to an examination of 200 claims each for PEEHIP and SEHIP, the Examiner requested RAS move forward on analysis of those *initial* limited claims in the summer of 2013 as a way to start the recovery audit, while being clear that the full examination was authorized and comprehensive audits were specified under the RFP issued by the Examiner.

RAS conducted the electronic analysis of the raw data for PEEHIP and SEHIP, which eliminated approximately ninety-five percent of the claims from further examination. RAS selected a subset of 200 each for PEEHIP and SEHIP from those remaining claims for the *initial* examination by the RAS audit team.

RAS provided the list of the initial selected sample claims for PEEHIP and SEHIP to BCBSAL June 11, 2013. BCBSAL requested four weeks of time to prepare the documentation for these selected claims before auditors came on site, which was granted. In July of 2013, BCBSAL stated in writing that it would provide the necessary documentation for auditors. BCBSAL had two months, double the time it requested, to assemble the materials before auditors arrived at BCBSAL on August 12, 2013. Auditors expected all the documentation to be ready for them upon arrival; it was not.

In June of 2012, RAS identified 200 PEEHIP claims and 200 SEHIP claims for initial review of potential errors and submitted a spreadsheet for each plan to BCBSAL in June of 2013, with each claim numbered chronologically 1 -200 for PEEHIP and SEHIP respectively. The documentation was to be waiting for the auditors upon their arrival at BCBSAL's office at 8:00 am Monday August 12, 2013.

RAS was explicit in detailing the exact documentation the auditors needed to confirm the payment for each claim with BCBSAL before auditors went onsite. In July of 2013, BCBSAL agreed in writing to provide the documentation necessary for complex review of 200 PEEHIP and 200 SEHIP medical claims. EPA and RAS retained the position that the full recovery audit needed to be conducted, however, and that this sample was a first step.

The audit team expected to have the assistance of the Senior Internal Auditor they had been working with for an extended period. She was familiar with the audit as she had been involved for quite some time. A few days prior to arrival, the audit team was advised that she had been removed as the audit coordinator and replaced by another coordinator (who was not familiar with the project).

On-Site Audit Review

Upon arrival the auditors discovered, for reasons that were unclear, that the sample audit selections had been renumbered by BCBSAL, with no notice to RAS auditors. BCBSAL did not provide a crosswalk for the revised numbers and said they could not do so when one was requested. This created unnecessary delay and confusion for the auditors. Before auditors could begin to conduct any reviews, they had to spend considerable time manually searching the claim number and cross checking it with the printed BCBSAL renumbered list in order to pair the claim with its corresponding documentation.

The auditors have performed numerous audits across the country, including at many Blue Cross and Blue Shield organizations. The BCBSAL system training by the new audit coordinator was found by the members of the audit team to be fragmented, inconsistent, and haphazard.

Specific documentation the audit team expected to be ready upon its arrival was not provided until requested by the audit team. Even then, some documentation items were not provided at all.

Auditors had to repeatedly reiterate that one example for an entire category of overpayments was not sufficient; auditors needed the specific documentation the specific claim that was being validated.

After each completed review, claims believed to contain errors were submitted to BCBSAL for review.

An operational overview was performed utilizing BCBSAL's responses to RAS' Audit Questionnaire, on-site evaluations of policies and procedures and on-site interviews with key personnel.

Our onsite auditors attempted to review a variety of plan administrative protocols including:

- Eligibility Management
- Coordination of Benefits
- Third Party Recovery Procedures and Cost Controls
- Claim Adjudication

RAS is concerned with the obstacles placed by the onsite audit coordinator and the multiple interruptions to the audit team during the course of the audit. For example, the audit coordinator informed the audit team on the second day of the audit that documentation regarding the Maternity Management Program could be found in the claim system. This prompted a high number of objections by the audit team. On the fourth day of the five-day on-site audit work, the coordinator

corrected her statement and advised the audit team that the documentation regarding the Maternity Management Program could not be found in the audit system.

For claims where the medical necessity of the claim is in question, it is routine for the medical auditors to review medical records to validate the appropriateness of the claim. For example, cosmetic procedures are not covered by the plan and certain procedures typically performed for cosmetic reasons might also be performed due to injury or illness, which might be covered by the plan. Review of medical records would reveal whether injury or illness was the reason for the procedure.

Follow-up Review of Claim Documentation

Since certain documentation was not provided on-site as promised, BCBSAL agreed to provide the missing documentation on a thumb drive for the auditors by their departure on Friday. This discussion took place in front of the Deputy Attorney General for the Department of Examiners of Public Accounts who was on-site Monday through Thursday of the audit.

When Friday arrived, the last day of the on-site audit, no thumb drive containing the necessary documentation was provided. BCBSAL later denied saying they would provide a thumb drive containing the documentation. The audit team spent a full week at BCBSAL reviewing the 400 claims for PEEHIP and SEHIP. Upon their departure auditors were still missing certain requested documentation that was supposed to be waiting for them at the beginning of the week.

Auditors requested the missing documentation repeatedly once back at the operations center. In response, auditors received approximately eighty emails sent securely from BCSBSAL. The majority of the information in the messages was duplicates of items that had already been provided to auditors on-site and therefore, had not been requested again.

Auditors had to cull through all the attachments in order to determine whether any new documentation might be included. Instead of just sending the missing documentation requested, the eighty messages were resent numerous times from August 2013 to January 2014, frequently with the message that the documentation requested had been provided. Only part of the missing documentation has been provided since the auditors were on-site in August 2013, but RAS has received multiple copies of the same documentation. This process created significant redundant, unproductive work for auditors.

Initial Medical Audit Reports

RAS submitted the audit reports on its findings for PEEHIP and SEHIP on December 3, 2013 to BCBSAL, PEEHIP, SEHIP and EPA. Both PEEHIP and SEHIP received a cover letter with the report requesting that each insurance board obtain the missing documentation for the audit. Not all of the missing documentation requested was provided, therefore, each plan still has outstanding claims that have

not been documented as valid. **Neither the December 2013 report nor this final report contains any personally identifiable information.** Following are the specific findings for each health plan.

PEEHIP Medical Claims Audit Results

RAS submitted the audit findings report to BCBSAL, PEEHIP and EPA on December 3, 2013. Out of the sample of 200, there were still twenty-eight (28) claims in disputed status (primarily due to lack of documentation being provided); eleven (11) hospital claims and seventeen (17) physician claims. As previously stated, RAS had made repeated requests to BCBSAL since August 2013 for the documentation on these specific claims.

The RAS report presented these claims in detail, designating the specific documentation needed to validate each claim, as is presented again in this final report. When RAS submitted its findings reports to BCBSAL for PEEHIP, BCBSAL did not provide a written response to the report as is customary.

Our audit teams have performed medical audits across America for major insurers, including many Blue Cross and Blue Shield organizations and for Medicaid and Medicare. This is the first time in fifteen years of medical auditing that the audit team did not receive a written response from the TPA on the audit findings report.

Given that RAS had been unable to obtain the complete documentation from BCBSAL, the transmittal letter to PEEHIP for the December report contained the following paragraph.

> **"In accordance with Alabama Code § 41-5-6.1 (c)(1) the Chief Examiner has determined that additional payment related information is necessary for the performance of the audit and PEEHIP shall provide the necessary information in order for RAS to finalize the disputed claims within fifteen (15) days; no later than December 18, 2013."**

PEEHIP requested an extension until January 6, 2014 to obtain the missing documentation from BCBSAL, which was granted. PEEHIP transmitted the documentation it obtained from BCBSAL to RAS on the initial sample claims on January 6, 2014, as promised.

The documentation provided by BCBSAL to PEEHIP, however, was primarily the same information BCBSAL had repeatedly re-sent to RAS each time it requested the ***missing*** **documentation. Very little new documentation was included.** This created needless work for auditors, again, who had to cull through the documents and repeatedly compare materials to determine whether and what, new information might be included. Having the same materials re-sent repeatedly was not useful and it further hampered completion of the recovery audit.

Out of all the materials obtained by PEEHIP from BCBSAL, RAS was able to reduce the number of undocumented claims from (28) twenty-eight down to (23) twenty-three; (5) five hospital claims and seventeen (18) physician claims remain undocumented. In other words, BCBSAL only provided documentation for five additional hospital claims in the month it had from December 3, 2013 until January 6, 2014 to produce the missing documentation.

Auditors have completed their audit review and **recommend** these unsubstantiated claims as overpayments that should be repaid to the State of Alabama. One of the definitions of an overpayment in Alabama Law 2011-703 is *"failure to provide adequate documentation or necessary signatures, or both, on documents, or any other inadvertent error resulting on overpayment."*

Agreed upon PEEHIP Overpayment Findings for Recovery

Out of the 200 PEEHIP claims with potential overpayments that RAS examined, BCBSAL and the auditors agreed that 174 claims were correctly paid and that the following three overpayments are subject to recovery.

PEEHIP Hospital Claim Agreed as Overpayment

- Sample Selection 2 – An overpayment of $6,472.58 for a cosmetic procedure was allowed for reimbursement. The plan does not cover cosmetic procedures.

PEEHIP Physician Claims Agreed as Overpayment

- Sample Selection 49 – An overpayment of $729.00 because the claim was manually processed in error causing an overpayment for an unbundled separate procedure.
- Sample Selection 81 – An overpayment of $3,120.00 provided for routine dental procedures, which are not covered by the plan.

Total Agreed PEEHIP Overpayment Findings Subject to Recovery from BCBSAL: $10,321.58

Undocumented PEEHIP Overpayment Findings Recommended for Recovery

BCBSAL did not provide the documentation to validate the following medical claims. Auditors consider undocumented claims as overpayments per Alabama law 2011-703 and recommended for recovery.

BCBSAL Undocumented PEEHIP Overpayments

- 5 Undocumented Hospital Claims for an Overpayment of: $38,266.15
- 18 Undocumented Physician Claims for an Overpayment of: $49,427.85

Undocumented PEEHIP Overpayment Findings Recommended for Recovery from BCBSAL: $87,694.00

TOTAL PEEHIP Amount Recommended for Recovery from BCBSAL: $98,015.58
Amount recovered to date: $0.00

Financial Summary of Undocumented PEEHIP Claims & Overpayments

Final PEEHIP Outstanding Claims			BCBSAL Agreed as Overpayments	
Claim #	**Amount**	**Notes**	**Claim #**	**Amount**
PEEHIP Hospital				
10	$27,172.97	Undocumented	2	$6,472.58
50	$60.00	Undocumented		
78	$25.00	Undocumented		
82	$5,225.24	Unbundled Billing		
86	$5,782.94	Duplicate Claim		
Sub Total	**$38,266.15**	**5 claims**	**1 claim**	**$6,472.58**
PEEHIP Physician				
5	$55.00	Undocumented	49	$729.00
14	$4,906.00	Undocumented	81	$3,120.00
17	$2,378.00	Undocumented		
19	$903.00	Need Additional Documentation		
32	$924.50	Need Additional Documentation		
38	$3,336.50	Undocumented		
41	$6,139.00	Undocumented		
42	$4,310.00	Need Subrogation Documentation		
45	$3,947.50	Undocumented		
46	$1,295.50	Undocumented		
47	$2,920.50	Undocumented		
50	$169.50	Duplicate Claim		
52	$6,149.00	Third Party Liability		
57	$2,770.50	Triplicate Claim		
60	$2,722.00	Undocumented		
62	$1,449.50	Undocumented		
76	$2,547.50	Need Subrogation Documentation		
93	$2,504.35	Need Subrogation Documentation		
Sub Total	**$49,427.85**	**18 claims**	**2 claims**	**$3,849.00**
PEEHIP Total Overpayments & Undocumented Claims				**$91,543.00**

Details of Undocumented Overpayment Findings for Recovery

After culling through all the material provided to PEEHIP in 2014, auditors were able to process six (6) additional claims based on new information from BCBSAL. The following Twenty-three (23) claims remain undocumented and consequently, recommended for recovery by the State.

The "BCBSAL Information" column in the following chart reflects information gleaned from the various BCBSAL emails since August 2013 and the information provided to PEEHIP in January 2014.

The audit team and BCBSAL did not agree on the following findings due to lack of documentation. The specifics are separated by hospital and physician claims.

Following is a detailed claim by claim report specifying precisely what was required to validate each disputed claim and each agreed upon overpayment from the initial PEEHIP sample audit. This is the same report provided to BCBSAL in December 2013, minus the five additional claims for which BCBSAL provided the documentation to PEEHIP in January 2014.

Disputed PEEHIP Hospital Claims Details

#	Sample Selection	BCBSAL Information	Required Action
10	**$27,172.97 Overpaid-** Documentation was not provided onsite, or to date, to support the medical necessity for the elective procedures performed.	BCBSAL indicated they were considering supplying criteria and documentation of medical necessity requested by the auditor. Subsequent correspondence by BCBSAL advises that the auditor was provided records and criteria while onsite.	The requested documentation was not provided and was re-requested by the auditor 8-16-13 prior to departing the onsite. The criteria for coverage of this elective procedure and medical records showing that the criteria were met are required for the finding to be removed.
50	**$60.00 Overpaid-** No documentation was provided showing that the network discount adjustment had been credited to PEEHIP.	BCBSAL responded that the claim processed correctly based on the pricing in effect at the time services were rendered.	No documentation provided. No additional refunds or adjustments are applicable at this time. A PEEHIP override is required to remove the finding.

#	Sample Selection	BCBSAL Response	Required Action
78	**$25.00 Overpaid-** No documentation has been provided showing that the network discount adjustment has been credited to the client.	BCBSAL did not respond to this objection.	The auditor viewed a network pricing adjustment while onsite. A PEHIP override is required to remove the finding.
82	**$5,225.24 Overpaid -** A duplicate claim was allowed for reimbursement.	BCBSAL did not respond to this objection.	A review of all claims considered for these dates of service are required for the finding to be removed.
86	**$5,782.94 Overpaid-** A duplicate claim was allowed for reimbursement	BCBSAL provided documentation showing that the primary diagnosis for the newborn claim is V30.00.	The RAS auditor is aware that this code is used exclusively for a well newborn. The baby's claim should not be reimbursed separately, but should be included in the per diem reimbursement allowed for the member's claim.

Disputed PEEHIP Physician Claims Details

#	Sample Selection	BCBSAL Response	Required Action
5	**$55.00 Overpaid -** BCBSAL did not provide documentation to support payment of the procedure that is often performed for cosmetic purposes.	BCBSAL did not respond to this objection.	The documentation used for the determination to allow the current surgical procedures is required for the finding to be removed.

#	Sample Selection	BCBSAL Response	Required Action
14	**$4,906.00 Overpaid -** Documentation to show that the injury to the member was not the responsibility of another party was not provided. In addition, BCBSAL did not supply the documentation to support coverage of multiple procedures that were billed.	BCBSAL did not respond to this objection.	Documentation showing that the injury was not the responsibility of other party liability or worker's compensation needs to be provided for the finding to be removed.
17	**$2,378.00 Overpaid -** BCBSAL did not provide documentation to support payment of the procedure that is often performed for cosmetic purposes.	BCBSAL did not provide documentation for this claim.	Documentation showing that the procedure was not performed for cosmetic reason is required to remove the finding.
19	**$903.00 Overpaid-** The plan excludes coverage of services or expenses related to sexual dysfunctions, sexual inadequacies.	BCBSAL responds that the treatment was not provided for sexual dysfunction but for impotence of organic nature.	Documentation of the criteria and medical necessity or a PEEHIP override is required to remove the finding.
32	**$924.50 Overpaid-** The plan excludes coverage of services or expenses related to sexual dysfunctions, sexual inadequacies.	BCBSAL responds that the prosthesis was not provided for sexual dysfunction but for impotence of organic nature.	Documentation of the criteria and medical necessity or a PEEHIP override is required to remove the finding.

#	Sample Selection	BCBSAL Information	Required Action
38	**$3,336.50 Overpaid-** The documentation to show that this injury was not due to other party liability or possible product liability was not provided. In addition, the requested medical records and operative report were not provided to support coverage for repetitive procedures.	BCBSAL responds that this item was one of several for which the requested medical records and criteria were provided to the onsite auditors.	The requested medical records and criteria were not provided to the onsite auditor. The criteria and medical records showing that the mesh replacement was not subject to a product liability recall are required for the finding to be removed.
41	**$6,139.00 Overpaid-** The documentation to show that this injury was not due to other party liability or possible product liability was not provided. In addition, the requested medical records and operative report were not provided to support coverage for repetitive procedures.	BCBSAL responded that the mentioned documentation would not have been requested or required.	The plan requires that the covered services be medically necessary. The supporting medical records, including the operative report, are required to remove the finding.
42	**$4,310.00 Overpaid-** Documentation that injury was not due to other party liability or possible product liability was not provided. Requested medical records and operative report were not provided to support coverage for repetitive procedures.	BCBSAL responded that they provided documentation showing where procedure 49565 is being considered as the primary procedure for 49568, thus allowing codes to be reimbursed separately.	The objection was based on the auditor's knowledge that codes 44120 and 49565 cannot be billed together. Subrogation documentation and/or a PEEHIP override are required to remove the finding.

#	Sample Selection	BCBSAL Information	Required Action
45	**$3,947.50 Overpaid-** Per the BCBSAL, the member fell from their personal vehicle. BCBSAL did not provide documentation showing that the medical payment from the member's automobile coverage was exhausted.	BCBSAL stated that Subrogation was not involved.	Documentation showing that the claim was not reimbursed to the provider or the member by the auto carrier or a PEEHIP override is required for the finding to be removed.
46	**$1,295.50 Overpaid -** The documentation was not provided to support the medical necessity for the elective procedures performed.	BCBSAL responded that standard documentation was provided showing the claim was reviewed by Blue Cross' medical review department and the claim was deemed medically necessary.	The documentation was not provided to the onsite auditor. The criteria and documentation used to support medical necessity for the elective procedure or a PEEHIP override are required for the finding to be removed.
47	**$2,920.50** Overpaid - Documentation showing that the injury was not the responsibility of another party was not provided.	BCBSAL responded that according to their investigation by the Subrogation area, the diagnosis does not have criteria that would warrant subrogation investigation.	Complete medical records showing that the complete rupture of rotator cuff were not the responsibility of another party or a PEEHIP override are required for the finding to be removed.

#	Sample Selection	BCBSAL Information	Required Action
50	**$169.50 Overpaid -** The same procedure code was billed and reimbursed two times for the same date of service. The operative report requested was not provided for review.	BCBSAL responded to Current Procedural Terminology (CPT) code 30420, which was not a disputed charge by the auditor. The requested operative report was not provided to support coverage for repetitive procedures. The provider billed code 30140-51 and 30140-50-51. The second procedure signifies a bilateral multiple surgery procedure. The first charge should have been disallowed as a duplication of service since the provider also billed as a bilateral procedure.	The requested operative report was not provided to support coverage for repetitive procedures.

#	Sample Selection	BCBSAL Information	Required Action
52	**$6,149.00 Overpaid -** The operative report requested was not provided for review. The member responded that the intestines were cut by the surgeon while performing a hysterectomy.	BCBSAL responded with claims payment and subrogation documentation stating that this particular CPT code (49002-78) does not require subrogation, however the accident code associated with the facility claim was subrogated and our investigation is now closed.	The member provided a statement indicating that the surgeon cut the intestine while performing a hysterectomy. This confirms that another party is liable for the claim and PEEHIP has the right to expect to be reimbursed for associated costs.
57	**$2,770.50 Overpaid -** The same procedure code was billed and reimbursed three times for the same date of service. The operative report requested was not provided for review. In addition, the requested completed claim form and subrogation documentation were not provided.	BCBSAL responded that per processing guides there is no limit to the number of times this procedure can be performed on the same day. The modifiers indicate multiple procedures (50), distinct procedure (59) and repeat procedures (76). This procedure code is considered an add-on procedure and is payable at 100% of the allowance. This claim was submitted electronically and the operative notes and claim form are not available. This diagnosis does not warrant subrogation review as it is not accident related.	Per industry standard, the procedure is allowable once and supporting documentation is required when modifiers (59) and (76) are applied. The diagnosis may be related to another party liability. The operative report and documentation showing that another party was not liable for the claim are required for the finding to be removed.
60	**$2,722.00 Overpaid -** The requested claim form and subrogation documentation has not been provided for	BCBSAL responded that this selection was currently being subrogated.	Documentation showing that PEEHIP is reimbursed for the claim is required for the finding to be removed.

	review.		
#	**Sample Selection**	**BCBSAL Information**	**Required Action**
62	**$1,449.50 Overpaid -** Reimbursement was provided for a global maternity delivery charge with the onset of care occurring prior to the member's effective date. The overpayment is estimated to be 50 percent of the billed charge.	BCBSAL responded that payments on global maternity codes are reduced by the paid amount of fragmented codes reported within the global period.	No fragmented codes were submitted for payment under this contract. The global delivery charge on 2-28-12 should have been denied and a breakdown of charges required from the provider. The charges incurred for the 6 months prior to the member's effective date of 10-1-11 should have been denied. A PEEHIP override is required for the finding to be removed
76	**$2,547.50 Overpaid -** BCBSAL did not provide documentation to support the payment of the procedure that is often done for cosmetic reasons.	BCBSAL provided the medical records and supporting documentation on 10-25-13 and again on 01-06-14 for auditor review. The documentation shows that the procedure is not performed for cosmetic reasons. It also shows that the procedure is performed due to repeated injuries to the 19 year old male's nose in 2007 & 2010.	Based on the new information provided to the auditor, completed claim form and subrogation documentation is required for the finding to be removed.
93	**$2,504.35 Overpaid -** Documentation showing that the injury was not the responsibility of another party was not provided.	BCBSAL provided documentation showing that the injury to the member's teeth was due to a fall in a kitchen.	The subrogation documentation showing that this fall occurred in the member's kitchen and was not the responsibility of another party is required for the finding to be removed.

SEHIP Medical Claims Audit Results

Out of the 200 SEHIP initial claims with potential overpayments that RAS examined, auditors determined that 183 claims were correctly paid. BCBSAL agreed that one (1) overpayment of $100.00 is subject to recovery.

When RAS submitted the audit findings report to BCBSAL on December 3, 2013, out of the sample of 200 SEHIP claims, there were still twenty-two (22) claims in disputed status; sixteen (16) hospital claims and six (6) physician claims.

The RAS report presented these claims in detail, designating the specific documentation needed to validate each claim, as is presented again in this final report. When RAS submitted its findings reports to BCBSAL for SEHIP, BCBSAL did not provide a written response to the report as is customary.

Our audit teams have performed medical audits across America for major insurers, including many Blue Cross and Blue Shield organizations and for Medicaid and Medicare. This is the first time in fifteen years of medical auditing that the audit team did not receive a written response from the TPA on the audit findings report.

Given that RAS had been unable to obtain the complete documentation from BCBSAL, the transmittal letter to SEHIP for the December report contained the following paragraph.

> **"In accordance with Alabama Code § 41-5-6.1 (c)(1) the Chief Examiner has determined that additional payment related information is necessary for the performance of the audit and SEHIP shall provide the necessary information in order for RAS to finalize the disputed claims within fifteen (15) days; no later than December 18, 2013."**

SEHIP transmitted the documentation to RAS that it was able to obtain from BCBSAL in order for auditors to be able to finalize the audit on these initial sample claims.

The documentation provided by BCBSAL to SEHIP, however, was primarily the same information BCBSAL repeatedly re-sent to RAS each time it requested the *missing* documentation, with some new documentation mixed in. This was not useful and it further hampered the completion of the recovery audit. This non-responsive activity by BCBSAL created needless work for auditors who had to cull through the documents and repeatedly compare materials to determine whether, and what, new information might be included.

In response to the request from SEHIP, BCBSAL provided documentation for eleven (11) additional claims in December. Out of all the materials obtained by SEHIP from BCBSAL, RAS was able to reduce

the number of undocumented claims from (22) twenty-two down to (17) seventeen; (15) fifteen hospital claims and two (2) physician claims remain undocumented.

RAS has completed its audit discovery work. Th**e remaining findings on undocumented SEHIP claims are in the amount of $424,136.64.** Since BCBSAL has not provided documentation to validate these payments, **auditors recommend these unsubstantiated claims as overpayments according to the criteria contained in Alabama Act 2100-703** definitions for overpayments of: "*failure to provide adequate documentation or necessary signatures, or both, on documents, or any other inadvertent error resulting on overpayment.*"

Agreed upon Overpayment Findings for Recovery

SEHIP Hospital Claim Agreed as Overpayment

- Sample Selection 79 – An overpayment of $100.00 because the inpatient copayment was applied twice in error.

SEHIP Physician Claims Agreed as Overpayment

- None

Total Agreed SEHIP Overpayment Findings Subject to Recovery from BCBSAL: $100

Undocumented BCBSAL Overpayment Findings for Recovery

BCBSAL did not provide the documentation to validate the following medical claims. These undocumented claims are therefore, recommended for recovery.

- 15 Undocumented Hospital Claims for an Overpayment of: $417,149.82
- 2 Undocumented Physician Claims for an Overpayment of: $6,986.82

TOTAL SEHIP Undocumented Claims from BCBSAL: $424,236.64

Amount recovered to date: $0.00

Financial Summary of Undocumented SEHIP Medical Claims & Overpayments

SEHIP Undocumented Claims			SEHIP Approved Claims	
Claim #	**Amount**	**Notes**	**Claim #**	**Amount**
SEHIP Hospital				
2	$210.00		79	$100.00
2a	$363,808.94			
3	$2,920.77			
5	$5,000.00			
7	$1,117.28			
15	$15,983.40			
22	$6,528.16			
24	$0.00	Procedural Error		
25	$25.00			
40	$25.00			
41	$10,000.00			
44	$2,701.92			
48	$880.00			
67	$358.95			
97	$7,590.00			
Sub-Total	**$417,149.42**	**14 claims**	**1 claim**	$100.00
SEHIP Physician				
6	$95.32		**None**	$0.00
11	$6,891.50			
Sub Total	**$6,986.82**	**2 claims**	**None**	$0.00
TOTAL Undocumented Claims	**$424,136.24**		**TOTAL Approved Claims**	**$100.00**
SEHIP Total Approved & Undocumented Claims for Recovery				**$424,236.24**

Details of Undocumented Overpayment Findings for Recovery

After culling through all the material provided to SEHIP, auditors were able to process five (5) additional claims based on new information from BCBSAL. The following seventeen (17) claims remain undocumented and consequently, recommended for recovery by the State.

The "BCBSAL Information" column in the following chart reflects information gleaned from the various BCBSAL emails since August 2013 and the information provided to SEHIP in December 2013.

The audit team and BCBSAL did not agree on the following findings due to lack of documentation. The specifics are separated by hospital and physician claims.

Following is a detailed claim by claim report specifying precisely what was required to validate each disputed claim and each agreed upon overpayment from the initial SEHIP sample audit. This is the same report provided to BCBSAL in December 2013, minus the five additional claims for which BCBSAL provided the documentation to SEHIP.

Disputed SEHIP Hospital Claims Details

#	Sample Selection	BCBSAL Information	Required Action
2	**$210.00 Overpaid** - The plan handbook indicates that the copayment is not applied to the member's out-of-pocket.	BCBSAL states that copayments apply to the member's out-of-pocket costs, which was satisfied, explaining why copayment was not applied.	The plan document indicates that copayments do not apply to the member's out-of-pocket costs. A SEHIP override is required to remove the finding.
2a	**$$363,808.94 Overpaid-** The documentation requested to verify the payment was not provided.	This selection was not responded to by BCBSAL.	A review of all correspondence specific to this selection, full calculations of discounts including Diagnosis Related Group (DRG) weights and pricing contract details, the high-dollar worksheet, and precertification documentation is required to remove the finding.

#	Sample Selection	BCBSAL Information	Required Action
3	**$2,920.77 Overpaid-** The documentation requested to show that the criteria were met was not provided. In addition, pre-admission testing should have been included in the per-diem payment for this inpatient stay.	BCBSAL provided partial documentation while the auditor was onsite. The documentation showed that BCBSAL medical criteria for coverage of bariatric surgery required participation in a weight loss program. In addition, the auditor objected to the reimbursement of pre-admission testing along with full coverage of the inpatient stay. BSBSAL subsequently responded that inpatient bariatric surgery/admission does not require medical review or weight loss program.	Documentation showing that the member participated in a weight loss program, as well as a SEHIP override, to allow pre-admission testing is required to remove the finding. Pre-admission testing is inclusive to an inpatient stay, per industry standard, and is not to be considered separately. The auditor requested the documentation onsite specific to this selection. If the criteria provided were incorrect, the documentation of criteria and medical necessity review or a SEHIP override is required for the finding to be removed.
5	**$5,000.00 Overpaid-** BCBSAL did not provide documentation showing that the member's medical payment provision on their automobile insurance was recovered for this injury. Without supporting documentation, the overpayment is estimated.	BCBSAL provided documentation showing that this was a single-car accident.	The documentation showing that the member's auto carrier MedPay coverage did not reimburse SEHIP for this claim is required to remove the finding.
7	**$1,117.28 Overpaid-** The plan excludes expenses for which no charge would have been made if no health coverage was in force.	BCBSAL indicated that reimbursing the provider $1,117.28 more than the billed charge is based on the network contract with the hospital.	The Plan excludes charges for expenses for which no charge would be made if no health coverage was in force. A SEHIP override is required to remove the finding.

#	Sample Selection	BCBSAL Information	Required Action
15	**$15,983.40 Overpaid-** BCBSAL did not provide documentation to verify that this claim was not related to other party liability due to product defect or recall.	BCBSAL stated that their research has determined this claim is processed according to BCBSAL guidelines based on the codes submitted by the provider of service. Currently there are no indications or necessity for medical records. The claim is processed based on services rendered.	The claim was for the placement of a cardiac pacemaker, a device with a known FDA product liability recall. Documentation showing that this was the initial placement or medical records, including the manufacturer and serial / model number of the device, indicating that the replacement was not due to recall or a defective product is required to remove the finding
22	**$6,528.16 Overpaid-** The plan excludes coverage of services or expenses related to sexual dysfunctions / inadequacies.	BCBSAL states that the treatment was not provided for sexual dysfunction but for impotence of organic nature.	Documentation of the criteria for medical necessity or a SEHIP override is required to remove the finding.
24	**Procedural Error –** BCBSAL confirmed this provider is in-network. The per-admission deductible should not have been applied.	BCBSAL provided the operative report to show that the claim is billed appropriately.	The error did not cause an overpayment at this time, but it could result in future overpayments. The accident details / subrogation for this spouse's claim are required or a SEHIP override is required to remove the finding.
25	**$25.00 Overpaid-** The claim is overpaid as the facility copayment for hemodialysis was not applied.	BCBSAL indicates that services are provided under Major Medical Benefits and are subject to the member's out-of-pocket maximum.	The plan provisions indicate that copayments do not apply to the member's out-of-pocket maximum. A SEHIP override is required to remove the finding.
40	**$25.00 Overpaid-** The claim is overpaid as the facility copayment for hemodialysis was not applied. The plan provisions indicate that copayments do not apply to the member's out-of-pocket	BCBSAL indicates that services are provided under Major Medical Benefits and are subject to the member's out-of-pocket maximum.	The plan provisions indicate that copayments do not apply to the member's out-of-pocket maximum. A SEHIP override is required to remove the finding.

	maximum.		
	Sample Selection	**BCBSAL Information**	**Required Action**
41	**$10,000.00 Overpaid-** BCBSAL did not file a lien on the member's medical payment coverage on his own insurance, this is considered other party liability.	BCBSAL indicated they do not have recovery rights for the member's auto carrier. The plan protects the client with subrogation language that includes any person, organization, or insurer even if the payment you receive is for your personal injury.	A SEHIP override is required to remove the finding.
44	**$2,701.92 Overpaid-** The plan excludes coverage for routine dental services.	BCBSAL responded that, per BCBSAL policy, claims for this type of dental treatment for members under the age of eight are reimbursed without a medical review.	A SEHIP override is required to remove the finding.
48	**$880.40 Overpaid-** The plan excludes expenses for which no charge would have been made if no health coverage was in force.	BCBSAL indicated that reimbursing the provider $880.40 more than the billed charge is based on the network contract.	The Plan excludes charges for expenses for which no charge would be made if no health coverage was in force. A SEHIP override is required to remove the finding.
67	**$358.95 Overpaid-** An inpatient claim was considered without applying the per-admission and per-day copayments.	BCBSAL indicated that the corrected claim was received without room and board charges and therefore, the services are considered at the outpatient level.	The auditor is aware that the Bill Type found on both the initial and corrected claim, 111, identifies an inpatient claim. A SEHIP override is required to remove the finding.
97	**$7,590.00 Overpaid-** The plan excludes coverage for claims received after 365 days from the date of service. The corrected claim was received outside of the timely filing limit and should not have been considered.	BCBSAL responded that they use the original receipt date to determine if the claim was filed in a timely manner, in this case 8/30/10.	A corrected claim for the 2010 hospital stay submitted by the provider on 4/12/12 is not filed timely. A SEHIP override is required to remove the finding.

Disputed SEHIP Physician Claims Detail

#	Sample Selection	BCBSAL Information	Required Action
6	**$95.32 Overpaid-** BCBSAL did not provide documentation to support the payment of the procedure that is often done for cosmetic reasons	BCBSAL responded that when 36478 meets the medical criteria outlined in the medical policy, 36479 and 36471 also meet medical criteria for coverage. We cover 36471 for 6 months after the primary procedures are completed before a new review is done.	Injections of sclerosing solution into the veins are a cosmetic procedure per industry standard, and a SEHIP override is required to remove the finding.
11	**$6,891.50 Overpaid-** The documentation supporting medical necessity for this reconstructive service was not provided.	BCBSAL responded that medical review is not required for any of the procedures on the claim.	The documentation supporting criteria and medical necessity for the reconstructive procedure or a SEHIP override are required to remove the finding.

Pharmacy Audits for PEEHIP and SEHIP

Pharmacy Audit Methodology

Millions of prescriptions are processed daily across America. The pharmacy industry established the National Council for Prescription Drug Programs' (NCPDP) uniform data transaction standards, commonly referred to as NCPDP. Every pharmacy and PBM uses the NCPDP standards to process prescription claims, which is an all-electronic process.

RAS updates its pharmaceutical costs daily and has data for every drug price on a daily basis for the previous ten years. Once the PBM contract compliance analysis is complete, RAS programs all contract and program parameters into its audit software and creates an identical claims processing system as the PBM uses. Since pharmaceutical costs vary frequently, algorithms investigate the validity of each prescription for accurate pricing on the day each prescription was filled.

RAS' robust system examines every facet of the pharmacy program requirements. In order to conduct a valid pharmacy audit, RAS requires that the complete, raw NCPDP data be transmitted directly to it from the PBM along with relevant pricing and benefits design information of the health plan, all of which were examined as part of the Alabama recovery audits. Below are some of the documents that we require from a PBM and the relevant plan in order to perform a valid audit.

- **Pharmacy Benefit Contract and all amendments** from both the PBM and the plan, including all changes, so RAS can compare and verify that documents are identical and it has received all
- **Set-Up Sheet/Document** that is negotiated after the PBM contract is signed
- **Claims Data** containing the full NCPDP raw data without any additions or deletions to the data
- **Claim File Layout** that deciphers and identifies the data elements within the claim file
- **Current and Historical Maximum Allowable Cost (MAC) list,** which is the generic internal pricing structure created by the PBM
- **Pricing Lists,** including historical changes to the unit prices with corresponding dates of change during the term of the audit request, including the Generic Price Index (GPI) for each drug
- **National Association of Boards of Pharmacy (NABP) Numbers,** which is a listing of any specific or Specialty and Mail Service Pharmacies
- **Specialty Drugs and Associated National Drug Code (NDC) Number,** which is an electronic list that includes all Average Wholesale Price (AWP) discount rates for both mail service and retail providers
- Excluded Drugs
- Clinical Program Descriptions and Procedures for each health plan

These documents contain necessary information to enable RAS to construct a claims adjudication process identical to what the PBM uses to process claims.

RAS undertakes a complete forensic audit on 100 percent of the data. Once the millions of pharmacy transactions are processed, a preliminary analysis is prepared for the PBM and the plans with representative examples of overpayments in a spreadsheet, including the formula used to process the claims.

This report is provided to the PBM along with a disk containing the detail for every claim in question, including the reason for the overpayment. The PBM usually has thirty (30) days to review the data and respond to the auditor with its concurrence with the findings or its adjustments, and documentation supporting any adjustment. Auditors finalize the findings and present the total findings to EPA for approval before proceeding to recovery.

Again, this is the typical process for a PBM audit, but not how things proceeded for these audits.

Fraud Analysis

Once all the pharmacy transactions were run through the adjudication process and complete, it was planned that further analyses would be performed by RAS' teaming partner, SAS, at its Advanced Analytics Lab using its Fraud Framework for State and Local Government. This analysis would have included the data from all eight of Alabama's employee benefit plans for medical (including dental) and pharmacy.

In order to conduct a fraud analysis, one wants as much data as possible so that a comprehensive view can be obtained that enables connecting seemingly unrelated transactions and points out unusual patterns that might emerge. RAS/SAS would have combined the data from all eight of Alabama's public employee health benefit plans for medical, dental and pharmacy for the fraud analysis.

If RAS had received all the data elements specified in the *Audit Planning Guide* provided to BCBSAL in November 2011, for medical claims and had been able to conduct pharmacy and medical audits simultaneously, as planned, this advanced analytical process could have identified any potentially fraudulent activity by providers or individuals for further investigation. Further, having all the data run through the Fraud Framework might have helped narrow the number of claims flagged for additional examination.

The fraud-detection system uses advanced analytics, predictive modeling and social network analysis to detect and prevent fraud in public programs. Patterns that emerge from interrogation of the integrated data help target areas requiring additional review and raise additional questions for examination.

For example, if a pharmacy appears to be filling an extraordinarily large number of narcotic prescriptions, it might be flagged as a possible "pill mill." Further research might reveal, however, that the pharmacy is located in a hospital or a medical building having many surgeons, and, hence, would be expected to fill more prescriptions for narcotic pain medications than a neighborhood pharmacy. If the pharmacy does not have any mitigating factor that would explain its high number of narcotics dispensed however, it would be referred for further investigation.

Similarly, researching a situation in which a doctor appears to be over-prescribing narcotic drugs might reveal the doctor is a surgeon who would be expected to issue strong pain medications for patients recovering from surgery as opposed to a general practitioner running a family practice that would be expected to issue few prescriptions for narcotics.

This advanced analysis couples the medical and pharmacy claims together (does the prescription match medical the condition?) along with additional data sets available to take a broad view of the circumstances to identify patterns that do not fit expected norms.

Since RAS was not able to obtain all the data from BCBSAL to conduct the full medical recovery audit, it was not possible to conduct this additional fraud analysis for the benefit of Alabama.

Public Education Employees' Health Insurance Board (PEEHIP)

Overview

PEEHIP administers Alabama's largest state employee health benefit plan, serving 282,846 employees, dependents and retirees. PEEHIP informed RAS that it has changed PBMs several times seeking better cost containment and value; moving from BCBSAL to Express Scripts to MedImpact, its current PBM since October 1, 2010.

Express Scripts and MedImpact served as the PBMs during the audit period (Express Scripts 10/1/08 to 9/30/10 and MedImpact 10/1/10 to 9/30/11). RAS, therefore, conducted an audit on each PBM. There were no recoveries for PEEHIP pharmacy transactions due to contract provisions that enabled both PBMs to offset any overpayments.

While RAS was not privy to the contract negotiations and realizes many factors influence such matters, it would like to recommend that PEEHIP secure more favorable contract language that is commonly used, which states that the PBM must "meet or exceed" specified discounts/pricing, thus requiring the PBM to be accountable for pricing each prescription accurately.

Each prescription should be filled at the accurate price by the PBM. If the PBM gets a better price from a pharmacy the savings should be passed on to the plan, which is responsible for all costs, not

the PBM. Likewise, if the PBM overcharged the plan it should not benefit by being able to offset overcharges against better discounts or undercharges and average the costs out over the year as Express Scripts and MedImpact were able to do.

"Meet or exceed" guarantees provide incentives to the PBM to accurately price each prescription. Whereas, averaging out costs on an annual basis and being able to offset undercharges against overcharges and better discounts diminishes the incentive to make sure each prescription is accurately priced by the PBM.

This provision works by averaging out the price paid for all 5.5 million prescriptions annually before determining if there are any funds due back to the State. Averaging the cost of discounted prescriptions in with higher priced prescriptions and deducting any undercharges, enables the PBM to reap the advantage of a discounted prescription instead of the state plan.

If the PBM gets better pricing or employees' purchase their prescription at a better discount (for example the four dollar prescriptions offered by a large discount retailer), the savings shuld be passed on to the plan.

MedImpact

Of the two PBMs engaged by PEEHIP, MedImpact cooperated with the recovery audit with the typical exchange of information between the auditors and PBM. The amount shown as a result of the audit before the offsetting and averaging of all transactions was approximately $1.9263 million. There were no recoveries from MedImpact due to the provisions that allowed it to average out all prescription costs and offset discounts and undercharges from overpayments.

Express Scripts

PEEHIP accepted an amendment from Express Scripts that diminished its guaranteed prescription discounts as a result of an industry lawsuit settlement, to which PEEHIP was not a party. Express Scripts and PEEHIP failed to provide auditors with this significant pricing amendment that diminished the prescription drug discount guarantee in the original ASA.

Express Scripts presented the pricing amendment as "cost neutral" to PEEHIP. This amendment is more fully explained in the "Problems Encountered" section of the report under "Average Wholesale Price Reduction Amendment."

The results of the first audit based on the original pricing provided to auditors showed $15.7 million in overpayments.

It wasn't until RAS had performed the audit and submitted its findings to Express Scripts and PEEHIP that RAS was informed it had been given the wrong pricing. PEEHIP's executive emailed RAS to apologize for the error from PEEHIP. RAS, therefore, had to redo the audit based on the new pricing.

The second audit based on the diminished discount pricing amendment eliminated the $15.7 million overpayment from the original audit, even though Express Scripts had informed PEEHIP the discount pricing amendment would be "cost neutral" to the plan.

The materials Express Scripts presented to PEEHIP regarding the amendment were prepared for the benefit of Express Scripts, not PEEHIP. It was not based on an impact analysis of the amendment on PEEHIP. It showed that the "cost neutrality" applied to the *ingredient costs for the drugs,* not that it was cost neutral for Express Scripts clients. The impact of the amendment was to increase the price PEEHIP paid for prescriptions. Express Scripts provides a major mail order prescription program, whereby it buy drugs wholesale and dispenses them retail to its mail order clients. PEEHIP does not use Express Scripts mail order prescription service. Express Scripts, however, benefited by implementing an across-the- board amendment that shifted the loss to its clients instead of absorbing the cost reduction for having used an inflated mark-up on wholesale drugs for years.

The industry lawsuit settlement's impact on the PBM industry was not meant to be cost neutral; it required improperly inflated drug price markups to be rolled back and provided $350 million in compensation to the lawsuit's Third Party Payers and consumers for being overcharged for years.

In the auditor's opinion, requiring its PBM to price each prescription accurately would have produced better cost-savings for PEEHIP and is something to consider when negotiating future PBM agreements.

AWP Amendment that Reduced PEEHIP's Discounts

PEEHIP engaged Express Scripts as its PBM from October 1, 2008 until September 30, 2010. It was during that time that a settlement on the Average Wholesale Price (AWP) lawsuit occurred. Express Scripts plainly states in its ASA that it operates in the best interest of Express Scripts (not its clients').

PEEHIP stated that they accepted the amendment diminishing their discounts due to an industry settlement of a lawsuit (none of the Alabama entities were a party to the suit). The parties to the settlement received $350 million in damages and the settlement rolled back wholesale drug prices to compensate third party payers (PEEHIP is a Third Party Payer) and consumers for past overcharges from improperly inflated drug prices. Settlement payouts to Third Party Payers, however, were limited to non-governmental self-insured plans even though governmental plans had been negatively impacted by the higher prices as well. **The bottom line is that wholesale drug prices went down by five percent, but drug costs to PEEHIP did not.**

In its ASA with PEEHIP, Section 6.3 Pricing Benchmarks, Express Scripts specifies that historical pricing (used as the basis for its Agreement from First DataBank) may change or be eliminated due to industry, legal or other external factors. Further, the ASA stated that the parties agreed that should the pricing change Express Scripts would provide (90) ninety days' notice of the change, or if not practicable, as much notice as is reasonable under the circumstances.

Express Scripts also stated that it would provide written illustration of the financial impact of the pricing source or index change with the mutual intent to maintain pricing stability as intended and not to advantage either party to the detriment of the other.

To support its case, Express Scripts provided PEEHIP with a January 29, 2009 report prepared for it by Milliman regarding the *AWP Rate Adjustment Process Validation.* Milliman states that *"This report was prepared solely to provide assistance to Express Scripts, Inc. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this report."* This report was based on the April 18, 2007 report prepared by Milliman actuaries titled *Review of Express Scripts AWP Re-Contracting Process,* which was attached to the 2009 report. The report detailed how the *drug ingredient cost* was being maintained as cost neutral as a result of the settlement.

Specifically, this report details how the "cost neutrality" projections that are based on eleven sample Express Scripts clients (not including PEEHIP) would not increase or decrease the *ingredient costs of the drugs*. The lawsuit and subsequent settlement, however, was over the *improperly inflated markup* on the drug ingredient costs charged to PBM clients. **The settlement required the 125% markup be lowered to 120% markup—not to keep costs the same—but to lower the costs to Third Party Payers and consumers.**

Express Scripts anticipated that the inflated markup might be changed and took precautions to protect its profits when the inflated markup was curtailed. Express Scripts included language in *Section 6.3 Pricing Benchmarks*, of the PEEHIP ASA that "their mutual intent has been and is to maintain pricing stability as intended and not to advantage either party to the detriment of the other. " The ASA specified that if changes were made to pricing indices that could alter the financial positions of the parties Express Scripts could undertake any or all of the following:

> *"(a) changes the AWP source across its book of business (e.g., from First DataBank to MediSpan); or*
> *(b) maintains AWP as the pricing index with an appropriate adjustment as described below, in the event the AWP methodology and/or its calculation is changed, whether by the existing or alternative sources; or*
> *(c) transitions the pricing index from AWP to another index or benchmark (e.g., to Wholesale Acquisition Cost),*

Participating Pharmacy, CuraScript and Mail Service Pharmacy rates, rebates and guarantees, as applicable, will be modified as reasonably and equitably necessary to maintain the pricing intent under this Agreement. ESI shall provide Sponsor with at least ninety (90) days notice of the change (or if such notice is not practicable, as much notice as is reasonable under the circumstances), and written illustration of the financial impact of the pricing source or index change (e.g., specific drug examples). If Sponsor disputes the illustration or the financial impact of the pricing source, the parties agree to cooperate in good faith to resolve such disputes."

Despite the Express Scripts ASA language stating that neither party should be disadvantaged, the cost for Express Scripts to purchase wholesale drugs diminished, while the costs to PEEHIP to purchase retail drugs for its members' increased.

State Employees' Insurance Board (SEHIP)

Overview

SEHIP, as the plan administrator for the second largest Alabama health insurance plan, serves 92,731 public employees, dependents and retirees. It entered into an ASA with BCBSAL to serve as the "Claims Administrator," acting as both the TPA and PBM. Charges to SEHIP for its administrative services (i.e., processing both medical and pharmacy claims) are specifically spelled out in the ASA between the parties.

RAS conducted a comprehensive recovery audit of BCBSAL's PBM services performed for SEHIP for the period January 1, 2008 through December 31, 2011. Beginning July 1, 2010, BCBSAL entered into a subcontract with Prime Therapeutics (Prime), in which BCBSAL had recently acquired a 17% ownership interest. Until then, BBSAL had subcontracted with Preferred Care Services Inc. (PCSI) to provide PBM services to BCBSAL clients. PCSI is a wholly owned subsidiary of BCBSAL. This new agreement allowed Prime to function as the BCBSAL PBM instead of PCSI. SEHIPs agreement is with BCBSAL, not PCSI or Prime.

Due to the fact that SEHIP had not been receiving all of its drug manufacturer rebates, RAS performed a rebate audit and spent two days at BCBSAL headquarters reviewing drug manufacturers' rebate contracts followed by two more days reviewing drug manufacturers' rebate contracts at Prime Therapeutics headquarters in Minnesota.

Auditors found the pharmacy audit of SEHIP to be particularly challenging. The following narrative details the extensive process that RAS had to go through in order to complete the pharmacy audit.

This audit should have only taken a few months, but instead, it took two years—and auditors had to perform the audit six times. While SEHIP represents approximately 23 percent of Alabama's eight pharmacy benefits programs it consumed 80 percent of the time auditors' spent on Alabama's

pharmacy recovery audits—and that is with RAS performing two separate PBM audits for PEEHIP on Express Scripts and MedImpact.

Undisclosed Administrative Fee

The terms of the Administrative Services Agreement (ASA) effective January 2007 through December 31, 2011 between SEHIP and BCBSAL provided that **100 percent** of the drug rebates received from manufacturers would be provided to SEHIP. **Effective July 1, 2010 Prime began withholding an administrative fee based on manufacturers' drug rebates; it did not disclose this fact to SEHIP.**

BCBSAL *did not reduce* the administrative fee it collected (that was specified in its ASA with SEHIP) when it transferred the PBM services from BCBSAL/PCSI to BCBSAL/Prime and began withholding the additional, unauthorized, undisclosed administrative fee. In addition, BCBSAL *did not transfer* the administrative fees (specified in the ASA) it received from SEHIP for pharmacy services to Prime as payment for its PBM services. Instead, **BCBSAL *(NOT SEHIP)* allowed Prime to withhold a significant percentage of drug manufacturers' rebates due to SEHIP as an additional administrative fee for Prime without informing SEHIP.**

Drug manufacturers pay a rebate to benefit plans based on the volume of drugs the plan's member's purchase. These rebate payments are used to offset prescription costs for SEHIP members. Not receiving a significant portion of the rebates it was due increased prescription costs for SEHIP.

The first completed audit resulted in a finding of an SEHIP overpayment to BCBSAL of $4,974,061 as a result of the undisclosed, unauthorized administrative fee charged SEHIP by BCBSAL. This was discovered in July 2012. In email exchanges to RAS, BCBSAL denied owing the funds to the State.

The Examiner, SEHIP and RAS contend that the retention of this undisclosed administrative fee by Prime Therapeutics was not authorized in the ASA. Initially claiming that it was entitled to withhold the rebate funds from SEHIP, BCBSAL delayed six months before it repaid the almost $5.1 million in unauthorized administrative fees to Alabama it had withheld over an eighteen month period.

BCBSAL's stated position was that nothing in the ASA explicitly prohibited it from retaining the funds. Further, BCBSAL kept responding with its standard phrase: *"We believe our transition to Prime put our customers in predominantly the same or better financial position."* Whether that statement is accurate or not, it does not authorize BCBSAL to unilaterally withhold additional funds from its clients. Based on BCBSAL records provided to RAS, **these undisclosed and unauthorized retained fees from SEHIP totaled $5,091,715 for drug rebates received for the period July 1, 2010 through December 31, 2011,** including the "true-up" to include additional rebate funds that were paid in the last two quarters of 2011.

Had RAS' audit not discovered the undisclosed fees, the overpayments most likely would have continued indefinitely, resulting in mounting costs to Alabama and its taxpayers.

SEHIP, the Examiner and RAS disagreed with the BCBSAL position and requested that BCBSAL repay the State the funds. The letter of request for repayment of this overcharge was sent to BCBSAL on September 26, 2012. BCBSAL responded on October 5, 2012 with a letter stating that EPA and RAS had agreed to wait until a final audit report for medical and pharmacy until BCBSAL had an opportunity to respond to the final report, which was BCBSAL's position during a meeting held on September 5, 2012. EPA and RAS, however, had never agreed to wait until the full audit was complete.

In a recovery audit, once an overpayment is documented and approved by the state, recovery of the funds proceeds. The report on that specific finding is contained in the detailed letter provided to BCBSAL on September 27, 2012 with supporting documentation in four exhibits. All other recoveries as a result of the statewide audit are recovered upon documentation and State approval.

It took from the summer of 2012 until February 1, 2013, for Alabama to receive repayment of the funds due. Beginning January 2013, a Deputy Attorney General was assigned to the Examiners of Public Accounts office to provide legal support for the recovery audit effort. One of the Deputy Attorney General's initial tasks was to contact BCBSAL regarding repayment of the unauthorized, undisclosed fees.

Unfavorable Contract Provisions

Although SEHIP stated it was unaware of the administrative fee, it also stated that, had it been notified of the fee in advance, it probably would have approved inclusion of the fee in the contract. In 2012 SEHIP renegotiated a new ASA with BCBSAL. The new ASA language provides a set rebate amount for drugs that provide rebates for years 2012 – 2014.

The amount of rebate guaranteed to SEHIP decreases in 2014, while industry rebates have steadily increased each quarter. In 2015, the SEHIP guaranteed rebate amount disappears, meaning Prime could retain an unspecified amount as it so chooses. **SEHIP will only receive what Prime passes on to BCBSAL in rebate funds**. Instead of specifying that SEHIP will receive 100% of the *manufacturers' drug rebates it has earned*, the revised ASA language specifies that *SEHIP will receive 100% of the funds that BCBSAL receives from Prime for the drug rebates.* The language is silent on how much Prime may retain before it sends funds to BCBSAL. This vague language effectively means Prime could withhold any amount it chooses above the minimum rebate amount specified in Exhibit 2 of the ASA, which declines for year 2014 and disappears in 2015—at a time when drug manufacturer rebates amounts paid have been steadily *increasing* every quarter. The actual ASA language follows (emphasis added).

> *"4. Prescription Drug Rebates —* ***The Claims Administrator contracts with a Pharmacy Benefit Administrator (PBM) to provide PBM services. For Contract Years January 1, 2012 through December 31, 2014, refer to Exhibit 2 for specific prescription drug rebates.*** *While there is no guarantee that the rebates will continue, as long as the rebate programs exist during Contract Years January 1, 2015 through December 31, 2016,* ***100% of the rebates received by Claims Administrator from the PBM*** *will be credited towards the Cost of Claims in the next billing cycle after the Claims Administrator receives them. In no case will the rebates alter the paid amount of any individual Claim."*

Further, SEHIP increased the fee it pays BCBSAL for filling each prescription by more than 800 percent (percent is used instead of actual amount to maintain confidentiality of BCBSALs proprietary information). When millions of prescriptions are filled even small amounts adds up quickly. The fill fees paid BCBSAL increased from $300,000 plus to more than $3 million annually.

SEHIP's counsel was aware of the contract renegotiation. The effective date of the renegotiated contract signed in April 2012 was made retroactive to January 1, 2O12, the day after the end of the period covered by the recovery audit.

Eliminating Unrestricted Pharmacy Audit Rights

The renegotiated 2012 ASA eliminated the provision for unrestricted audit rights on pharmacy transactions found in the 2007 ASA. **Given that SEHIP and BCBSAL are well aware of the recovery audit law enacted in 2011, eliminating the pharmacy audit rights is contrary to the legislative intent of Act 2011-703.** Pharmacy audits are an all-electronic process; the data is provided by the PBM, which should be able to provide an exact copy of the data contained in its system to the auditors. All documents requested for the audit already exist. What justification is there to eliminate pharmacy audit rights and prevent the state from verifying the accuracy of the payments made on its behalf?

Missing or Corrupted Data and Documentation

At the November 2011 meeting RAS provided BCBSAL with its *Alabama Employee Benefits Audit Guide,* which delineated in detail all the specific data and documents (e.g., all contracts and amendments, data dictionary, pricing schedules, etc.) needed to conduct the pharmacy audit. BCBSAL had processed nearly seven million pharmacy transactions electronically, spanning multiple years, on behalf of SEHIP. RAS needed an exact copy of the SEHIP data in the PBMs system. RAS did not need, or want, the PBM to make any alterations to the data, merely provide a copy, sent securely to RAS.

Although the State law and Examiner's office required production of the information, the information received from BCBSAL for the pharmacy claims audit was routinely found to be inaccurate and incomplete.

Providing inaccurate and incomplete information to the auditors required RAS to conduct the analysis on almost seven million prescriptions six times. This is the first audit where RAS has had to perform the same audit so many times.

It was not possible to just "look" at the data to analyze or identify problems with it. Each year's data file consisted of over one million rows and 101 columns, with some fields containing as many as 60 characters. It took several hours to get each data file imported and days just to determine if all seven million SEHIP transactions had all the required fields populated, before analytical work on the data could begin.

For example, BCBSAL provided a CD that contained only data and no data dictionary. The data dictionary identifies what the columns and rows represent in the millions of lines of data. Unless one knows what type of data is contained in a given column or row, it is impossible to conduct an analysis on that unknown data. Without having *both* the accurate data and an accurate data dictionary together, no analysis can be performed. Another time auditors received a data disk from BCBSAL and after reviewing the data discovered that Row 5 and Row 84 were completely missing.

RAS had to reprogram its software and perform the SEHIP audit six times as a result of multiple data inaccuracies and missing documentation from BCBSAL, including a *verbal* amendment to the ASA that diminished the discounts due SEHIP and, therefore, increased costs to the State.

Comparing the first audits RAS performed that were based on the pricing in SEHIP's ASA, with the subsequent audits based on the *verbal* amendment that diminished discounts, revealed accepting the amendment cost SEHIP approximately an additional $7.3 million.

Had BCBSAL provided timely, full and accurate information, the SEHIP pharmacy audit would have been completed in the Spring of 2012 rather than Fall 2013.

Following is a brief summary of the inadequate and problematic information auditors repeatedly received from BCBSAL. **RAS is perplexed why BCBSAL's sophisticated operation continued to provide files containing the errors and omissions noted below.**

- **BCBSAL's May 2012 Submission** - data fields were to have been in fixed length format, which would line up all the columns, but instead were comma delimited (meaning a comma separated each data element); four hundred and sixty thousand (460,000) ***extra*** commas existed in the data, which corrupted the data import.
- **BCBSAL's June 2012 Submission** – although BCBSAL has a calendar year contract (January 1 through December 31) with SEHIP, the data sent to RAS did not start and stop on these dates; the anomalous transactions were noted only after importing and running the data, thus requiring RAS to start over again with a new data set.

- **BCBSAL's July 2012 Submission** – RAS processed the data and submitted the preliminary findings on prescription transactions to BCBSAL on July 8, 2012. BCBSAL responded on August 12, 2012 that RAS had not properly divided the Retail Brand from the Retail Generic claims. **This requirement was not previously communicated to RAS, as it should have been, prior to RAS programming plan requirements into its software.** BCBSAL then, provided RAS with the method to be used to divide those claims. **When RAS subsequently examined BCBSAL's July 2012 file, it discovered the data fields to be used to separate generic from brand drugs were blank.**
- **BCBSAL's July 2012 Second Submission – Failure to inform RAS of discount pricing change.** RAS was provided inaccurate pricing documentation. BSBSAL and SEHIP both failed to inform RAS that they had implemented a pricing change that reduced the amount of discount SEHIP would receive on retail brand prescriptions through an ***undocumented verbal agreement.*** The amendment, and its financial impact on SEHIP, is discussed in the *Average Wholesale Price (AWP) Discount Reduction* section of this report. The verbal amendment is discussed in the following section.
- **BCBSAL's February 2013 Submissions – two data sets were received.** The first data set contained some records with blank fields that, instead, should have contained a character(s) identifying the "transaction type" consistent with July 2012's instructions. The second data set provided to RAS still had blank data fields.
- **BCBSAL's March 2013 Submission** – RAS finally received a properly structured data file that had all fields populated, enabling RAS to run the data with all pertinent parameters.

It took ten months and six data submissions before RAS received a complete and accurate data set for the SEHIP pharmacy audit from BCBSAL.

Verbal, Undocumented Amendment Reducing Discounts Related to AWP Settlement

In November 2011, RAS provided SEHIP and BCBSAL specific guidance on required data and documentation. RAS subsequently received contract documentation (ASA's, amendments and benefit changes, etc.) from both SEHIP and BCBSAL over an extended period of time. RAS requests contractual and benefit information from both the plan and the TPA/PBM for comparison, since the documents don't always match, and to ensure that auditors receive all pertinent information to enable them to accurately program audit software to mirror the claims adjudication system used by the PBM.

There were numerous interchanges between the parties about corrupt data and documentation issues. **RAS performed the audit on the data and documentation provided by BCBSAL and SEHIP.** On August 27, 2012, RAS presented the preliminary audit findings to SEHIP and BCBSAL showing that BCBSAL owed the State $7,647,030 in overpayments. BCBSAL disputed the findings because the data

was not run based on current pricing discounts. **RAS was not informed by BCBSAL until October 5, 2012 that these diminished discount rates, not the ones provided to RAS eight months earlier, were to be used in the audit.**

BCBSAL objected to the finding, asserting, along with SEHIP, the existence of a previously undisclosed oral and undocumented discount rate modification to the contractual guarantees in the ASA. It was only then, that RAS was informed that a *VERBAL* amendment had diminished the price discounts for SEHIP. Citing this undocumented amendment that neither SEHIP nor BCBSAL had previously disclosed to RAS, BCBSAL countered with an overpayment due of $316,474 based on BCBSAL's analysis using the revised rate changes as a result of the verbal amendment.

The Average Wholesale Price (AWP) lawsuit settlement that required the inflated price markup on wholesale drug prices be rolled back by five percent did not involve BCBSAL or SEHIP. BCBSAL stated the settlement was the reason it implemented a global price amendment with all its customers. This amendment lessened the discount amount provided to SEHIP, thereby increasing SEHIPs costs to cover prescriptions.

M**any opportunities had occurred over the prior year for SEHIP and BCBSAL to bring the existence of the modification to RAS' attention; this happened only after RAS had conducted the audit and presented its findings to SEHIP and BCBSAL.**

It took many requests before RAS learned *how* the change had occurred and who at SEHIP and BCBSAL had verbally agreed to the rate change since no one could produce the amendment. SEHIP's CEO later stated that he had verbally approved the amendment. On March 26, 2013 BCBSAL identified the person they believed spoke to SEHIP regarding the price change. This was also the first time BCBSAL provided RAS with a contact person at Prime Therapeutics. RAS had been requesting to speak to a Prime representative for more than a year regarding the pharmacy audit.

No documentation memorializes the ASA amendment or even any correspondence concerning a meeting or phone request to discuss the price change. BCBSAL and SEHIP both stated it was an oral agreement and that neither party has any documentation on the amendment. Likewise, BCBSAL could not provide any internal written documentation instructing its personnel to alter the pricing in its electronic claims system.

Article V. General Provisions, Section D. Changes in Agreement of the 2007 SEHIP / BCBSAL ASA stipulates that:

> **" … This Agreement may be amended by written agreement duly executed by the Claims Administrator and the SEHIP. … "**

RAS inquired whether SEHIP sought any advice from its Counsel or from its consultants (who advised on the earlier contract) regarding the verbal amendment that diminished the SEHIP prescription drug discounts. SEHIP responded that it had not sought any advice or recommendation regarding accepting such a discount reduction amendment.

In a subsequent meeting with SEHIP officials and the Deputy Attorney General, SEHIP's CEO said SEHIP felt compelled to accept the diminished discount rate because otherwise BCBSAL stated it would void its contract, which would create a disaster for the plan participants.

Contrary to the contract in place, SEHIP and BCBSAL had verbally agreed on the discount pricing change. Both parties stated that amendment was made subsequent to settlement of the AWP lawsuit to which SEHIP and BCBSAL had not been a party and to which they were not bound. The settlement required drug wholesalers to reduce the improperly inflated markup on drugs and compensated members of the class action suit that had been overcharged for years.

RAS did not receive an answer as to why it had not been told of this change when SEHIP and BCBSAL respectively sent their original package of documents to RAS for review.

To summarize, no one could:

- explain to RAS how and why the decision was reached to shift the reduction from the TPA/PBM to its client, losses that would cost the State taxpayers millions of dollars;
- initially identify for RAS who had approved the verbal amendment, although ultimately the CEO of SEHIP took responsibility;
- provide RAS with a copy of the contract modification or any document memorializing the change. SEHIP and BCBSAL both stated that the change had been made through a verbal agreement, not a written and signed contract amendment as required by the ASA;
- provide RAS with any general communique between SEHIP and BCBSAL arranging for or recording the results of any discussion of a proposed change to the contract;
- provide RAS with evidence that, as part of BCBSAL's claimed universal adjustment of all its public and private clients' rates, BCBSAL had formally notified its clients of the change; and
- no one could provide RAS with any documentation from BCBSAL even showing any change order directing that its internal information and financial systems be modified to implement the rate adjustments.

BCBSAL continues to state that the ASA governs the recovery audit instead of the State law. The ASA, however, requires amendments to be written and duly executed; not executed verbally.

RAS then ran the data again using the new rates it had been given, which reduced the amount BCBSAL owed the State from $7,647,030 to $316,474. This shows the approximate discount savings SEHIP lost as a result of the verbal amendment that reduced SEHIP discounts on certain drugs.

Problems Encountered in Medical and Pharmacy Audits

Procedural delays and negotiations with BCBSAL regarding the full recovery audit vs. a sample audit—and the limited size of the sample—delayed the audit during 2012 and 2013, and prevented a full medical claims recovery audit from being conducted. BCBSAL protested aspects of the recovery audit from the start and stated that under its ASA agreements with the various plans, RAS could only undertake a sample audit. BCBSALs position is that its agreements with the plans govern any audit, not the provisions authorized in Act 2011-703.

Inability to Enforce the Recovery Audit Law

It has become clear that without enforcement mechanisms in the law, the legislature's vision to recover all overpayments for the state will not be realized. Recommendations at the end of this report include incentives and sanctions to strengthen the law. Without clear enforcement power, the EPA and the auditors wasted excessive amounts of time just trying to move the healthcare audits forward—to no avail.

It is three years after enactment of the law and recovery audits were unable to be performed on the expenditures for the state's eight self-insured employee health benefit plans since the TPA would only agree to a small sample audit.

Likewise, the Act does not provide any mechanism to collect overpayments if a vendor/service provider does not repay the funds timely. It took six months for the state to recover approximately five million dollars owed Alabama for funds its TPA/PBM withheld, without authorization or notification, for an additional administrative fee from the SEHIP.

Significant time and effort were taken from the EPAs daily responsibilities and redirected towards efforts to get BCBSAL to pay its debt. There is another million dollars BCBSAL withheld from the universities without authorization or notification, for the same additional administrative fee it imposed on SEHIP. BCBSAL made it clear to auditors and the EPA that it intends to use all means at its disposal to retain that million dollars.

Alabama employee benefit plans pay their TPA/PBM significant funds each month, yet EPA was powerless to legitimately withhold any of those payments to help recapture the funds owed the state, thus, enabling an interest free loan at taxpayers' expense to the TPA/PBM.

Lack of Incentives to Cooperate

There were no incentives in Act 2011-703 that might have encouraged better compliance with the recovery audits. It took six months for RAS to receive the medical claims data from BCBSAL for PEEHIP and SEHIP. RAS was never able to obtain the documentation to conduct the full recovery on PEEHIP and SEHIP expenditures. Act 2011-703 does not contain any mandated timeframes in which TPA/PBMs must comply, or a requirement that PBM/TPAs provide accurate and complete data and documentation in a timely manner or face sanctions.

TPAs and PBMs are not required to pay lost interest income to the state on overpayments not repaid to the state within thirty days of notification. It took six months for Alabama to receive the $5.1 million overpayment for the undocumented, undisclosed additional administrative fee withheld from SEHIPs pharmacy rebates. The TPA/PBM for SEHIP was able to use taxpayer funds, interest free, for an additional six months. There are no penalties imposed on TPAs/ PBMs for delaying the recovery audits, not providing accurate and complete data and documentation or not repaying the State timely.

It appears that even the Alabama Department of Insurance also does not have the ability to counter non-compliance with audits by BCBSAL (with which BCBSAL has been registered since 1936 but Prime is not).

Inaccurate and Incomplete Information Provided to Auditors

RAS encountered missing documentation for both the PEEHIP and SEHIP medical audits. RAS did not receive the complete documentation required to perform the full recovery audit, or even all the documentation required to validate some of the claims in the initial sample medical audit for PEEHIP and SEHIP.

Due to repeated inaccurate or incomplete data and pricing information being given to auditors, RAS had to perform the prescriptions claims audit on SEHIP pharmacy expenditures six times.

Due to inaccurate pricing information being provided to auditors, RAS had to perform the PEEHIP prescription claims audit on Express Scripts twice.

Unfavorable Contract Terms

SEHIP

As previously noted, EPA made a presentation to SEHIP officials in October 2011 on the new recovery audit Act requirements. SEHIP top officials also were present at the November 2011 meeting with BCBSAL regarding the audit requirements.

Unrestricted Pharmacy Audit Rights

Despite SEHIPs and BCBSALs knowledge of the Act, the new ASA they executed in April 2012 (and made retroactive to January 2012) conflicted with the Act's provision for recovery audits. The SEHIP 2007 ASA contained unrestricted rights to audit pharmacy transactions. **The new ASA with BCBSAL eliminated the unrestricted pharmacy audit rights for the State from the 2012 ASA**—even though both BCBSAL and SEHIP were well aware of the recovery audit provisions in Alabama Act 2011-703.

The 2012 ASA continues the limits on examination of medical claims and the language infers that the pharmacy claims might be included as part of the medical claims sample audit limitations. Alabama pays millions of dollars to provide medical and prescription benefits for state employees, their dependents, and retirees. Restricting the number of pharmacy claims that can be audited for accuracy to a couple hundred, out of millions of prescription transactions, directly conflicts with the intent of the Act. Prescriptions are an all-electronic process and auditors do not know of any valid reason that all claims should not be examined for accuracy.

Rebates

Under the 2012 ASA, SEHIP will receive a set rebate amount for each brand name prescription filled from the respective drug manufacturer that has a signed contract with Prime for 2012 through 2014. Receiving a set amount for each rebate is a good ASA provision (providing the plan is receiving the current market rate), because it is a transparent pricing model and easy for the plan to verify the amount it should be receiving. The set amount SEHIP received for 2012, however, was lower than the market rate for rebates according to the Pharmacy Benefit Manager Institute's (PBMI) industry report. Industry wide, drug manufacturer rebate amounts have been increasing more than a dollar every quarter. The set rebate amount to be paid to SEHIP *decreases* in 2014 and the rebate guarantee disappears in 2015.

In the 2007 BCBSAL ASA, SEHIP only allowed 30 day retail prescriptions. Rebates for 90 day prescriptions are substantially higher and the costs for 90 day prescriptions are substantially lower. This eliminated SEHIP's eligibility for substantial rebates. Since our audit began to examine this low amount of rebates, SEHIP has now begun allowing 90 day prescriptions and receiving the higher 90 day retail rebates. The contractual minimum rebate amounts that SEHIP is to receive is still substantially low from the 2012 agreement that we have examined. SEHIP has stated that they receive more than that minimum. However, SEHIP does not have a mechanism in its ASA to verify that they receive all that it is due.

If SEHIP is not going to be receiving 100 percent of drug manufacturer rebates from its prescriptions filled, the ASA should specify the set rebate amounts that will be transferred to the plans and those rebate amounts should be documented and adjusted annually to reflect current market rates for the

industry. Any amounts above the minimum retained by the TPA/PBM should be reported to SEHIP so that the plan can determine the actual full cost to SEHIP of the PBM services it is paying for.

Prescription Filling Fees

In addition to the other fees paid for PBM services, SEHIP agreed to dramatically increase the amount it pays BCBSAL for each prescription filled. Based on the approximate number of prescriptions filled in 2010 and 2011, this means SEHIP will be paying BCBSAL almost $3 million more annually compared to the $300,000 plus in fill fees it had previously been paying.

SEHIP is paying a combination of other fees, some of which are partially based on pharmacy expenditures. With a combination of different fees, some based on percentages of an activity and others on a flat fee per activity and/or per member, it is challenging for a plan to know what it will actually be paying in total for its PBM services. **Real transparency in pricing requires all fees and revenue sources to be clearly, accurately and fully delineated so that the client knows precisely the total amount it is paying for its PBM services.**

Prompt Payment

Given that the overpayments are from fiscal years 2009 - 2011, and that the contract contains no penalty clauses to encourage prompt payment, the practical effect is that the TPA/PBM received a no-interest loan from the State. RAS recommends that ASA s must contain clear and transparent pricing and that overpayments are returned promptly to the state.

Lost Interest Income

Further, the state would benefit from requiring repayments to include lost investment income (LII). For example, the audit of BCBSAL on the Federal Employees Health Benefit Plan (FEHBP) conducted by the U.S. Office Of Personnel Management, Office of The Inspector General, (report issued November 21, 2011) required BCBSAL to pay $574,995 in drug rebates that were not paid timely and also required BCBSAL to pay lost investment income of $72,428 to the FEHBP. **Alabama would benefit from requiring timeliness of payments and lost investment income charges for funds due to the state in all of its state contracts, including ASAs.**

PEEHIP

Netting Out and Averaging Prescription Costs

While PEEHIP's contract contains price guarantees, the language allowed both of its PBMs, Express Scripts and MedImpact, to net out any overcharges against prescriptions where it received a better price. This is inconsistent with common—and more favorable—language found in PBM contracts that

require the PBM to "meet or exceed" a specified price guarantee in the contract (e.g. when the PBM gets a better price the plan benefits, not the PBM).

There is no incentive for the PBM to price each prescription accurately because as a self-insured plan PEEHIP pays all costs for its member's prescriptions. Overcharges are wiped out by other discounts received or costs are passed on to the plan, as the following scenario illustrates. Moreover, according to the contract language, no transaction can be deemed overcharged until the millions of pharmacy transactions for the year are individually and collectively calculated and then averaged together. This is another way the plan can lose prescription discounts from which it could benefit.

For example, a member fills a prescription at a discount pharmacy that offers an array of medications at a standard $4 rate. That same prescription would cost more at a regular drug store. For example, the cost at a regular pharmacy might be $20. So instead of the plan saving $16, the PBM can now overcharge $16 on a different prescription and owe the plan nothing for that overcharge because the PBM "netted out" the overcharge against the discounted prescription savings. In self-funded plans like those in Alabama, the plan covers any added cost and, likewise, should also benefit from any savings. The PBM is not held accountable for accurately pricing each prescription and is not incentivized to do so. RAS recommends that this material contract weakness of netting out overcharges be corrected in PEEHIP's ASA.

Drug Manufacturer Rebates

Rebates from drug manufacturers help PEEHIP offset the costs of its member's prescriptions. PEEHIP's ASA that RAS examined specifies a set rebate amount PEEHIP will receive per drug manufacturer. RAS observed that the Express Script agreement guaranteed rebate amount is low in comparison to industry standards published by The Pharmacy Benefit Management Institute (PBMI), our experience with other plans, and even what SEHIP is stated to be receiving.

Need to Identify all Revenue Sources to PBM

RAS recommends a complete analysis of compensation and costs for all current State agreements. It would benefit the state if all ASAs required the PBM to report all income it receives or retains for its pharmacy benefit services so that the plan can determine the full cost of its PBM services.

Average Wholesale Price (AWP) Discount Reduction

As self-funded plans, Alabama's benefit plans are Third Party Payers (TPP) that engage a TPA/PBM to administer payments for the plan, while the state plan remains responsible for covering all costs.

The most common pricing benchmark used to reimburse brand prescription drugs is the Average Wholesale Price or "AWP." Several companies, including First DataBank, Medi-Span and Micromedex published the AWP for prescription drugs in printed and electronic databases.

A Class Action Lawsuit of non-governmental organizations claimed that First DataBank and McKesson (a major prescription drug wholesaler) unlawfully conspired to inflate the prescription drug mark-up factor, thereby wrongfully increasing the published AWP for certain drugs. According to the lawsuit, this in turn, increased the prices paid by self-funded health plans whose PBM used First Data Bank as its pricing source for AWP for certain drugs since August 1, 2001 until the settlement date of September 29, 2009.

First DataBank used an inflated prescription drug markup factor of 125% during the time period of the lawsuit. Some other publishers of AWP prices for the industry used a markup of 120%. The settlement required First DataBank to roll back its markup to 120% and cease publishing AWPs for the industry in two years.

The settlement also required a $350 million payout to non-governmental Third Party Payers (TPP) and consumers that had been harmed by paying the inflated prices. While all of Alabama's employee benefit plans are TPPs, they were not a party to the suit and, therefore, did not receive any payout. **The settlement was not designed to make the impact "cost neutral" to PBM clients. It was designed to lower the costs for PBM clients, self-funded plans and consumers, who had been paying the improperly inflated prices, many of them for years.**

The lawsuit was well known in the PBM industry and PBMs that chose to continue using First DataBank were well aware of the inflated pricing issue and the lawsuit for several years. The inflated prices were beneficial to PBMs using First DataBank in three ways.

1. The PBM could provide a competitive advantage in bidding for business because they could offer a larger drug price discount to potential clients, since they were using a higher price base than a PBM not using the inflated prices from First DataBank. This made it appear that PBMs using the inflated markup were offering better value to the client than PBMs not using the inflated markup prices.
2. PBMs such as Prime and Express Scripts also function as pharmacies for certain of their clients' mail order programs. Mail order programs produce significant revenue for PBMs, which purchase drugs wholesale and sell them at retail to their clients' members. It was in the PBMs best interest to protect those higher profits it was receiving.
3. In the AWP settlement, the inflated prices for drugs were reduced, but the PBM's adjusted the relative price discounts to maintain their profit position.

<u>The ingredient cost of the prescription drugs were not altered by the settlement.</u> The extra five percent *markup* on wholesale drug costs was reduced from 125% markup down to a 120% markup.

PBMs using the First DataBank inflated markup were affected by the 5% price rollback on certain drugs required by the settlement. **PBMs that used AWP publishers that did not employ the inflated markups were not financially impacted by the settlement.**

The PBMs employed at the time by Alabama's plans, BCBSAL and Express Scripts were using the inflated markups and had to roll back the price markup on certain drugs. Instead of honoring their discount price agreements with the state plans, they amended their respective ASAs with SEHIP and PEEHIP respectively to lower the guaranteed prescription drug discounts.

The PBMs presented the amendment to the plans as "cost neutral." Lowering the price discounts to the state insurance plans increased the costs each plan paid for state employees' prescriptions.

Cost neutrality was not the intended outcome of the AWP settlement;
it was the rollback of inflated markups and compensation for Third Party Payers
and consumers that had been harmed by paying higher prices for years.

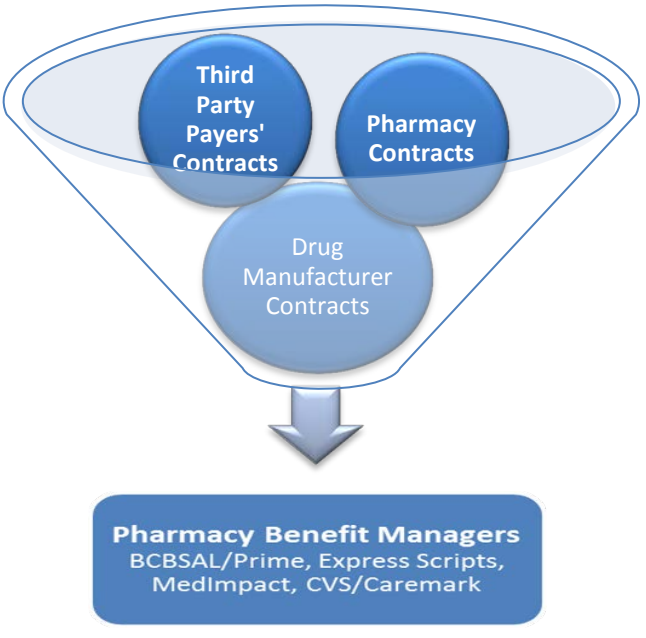
SEHIP stated that BCBSAL informed it that its pharmacy network would collapse; that pharmacies would refuse to fill SEHIP members' prescriptions and withdraw from the network if it did not accept the amendment. However, since this was a verbal agreement no documentation was presented to SEHIP to validate BCBSAL's statement. SEHIP stated that BCBSAL/Prime did not benefit from reducing SEHIPs discount guarantees.

SEHIP does not provide a mail order option to its members', but Prime operates a large mail order program whereby it functions as both the PBM and the pharmacy. Likewise, Express Scripts and MedImpact also operate large mail order programs. Implementing the discount price reduction across all clients maintained PBM's mail order profits.

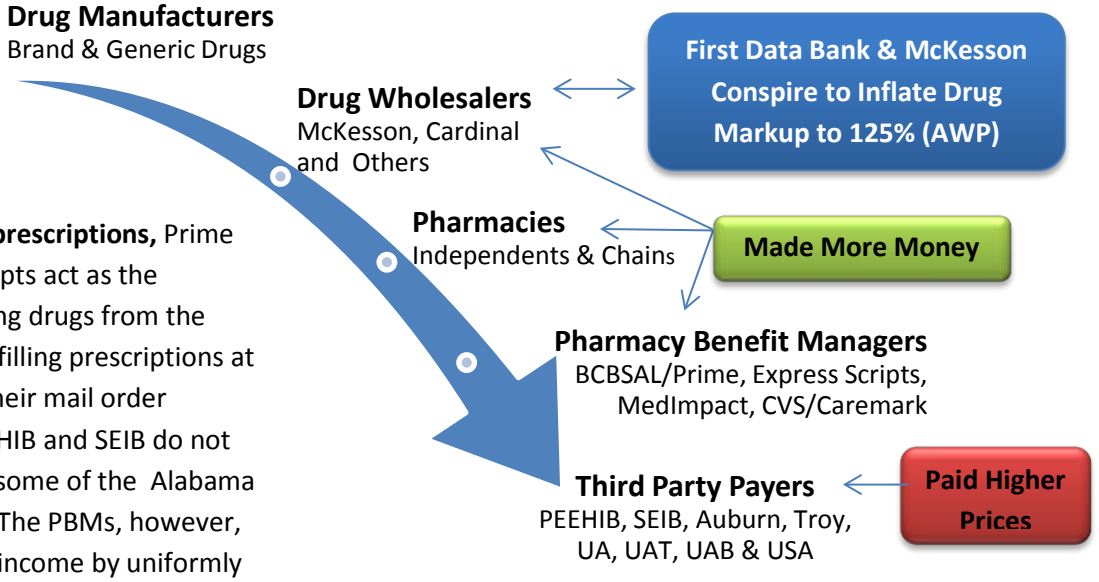
The graphic on the following page depicts how the process works.

AWP is Used by PBMs as Cost Basis for its Various Contracts

PBMs contract terms are kept very confidential and terms vary by each entity, each drug manufacturer, each chain drug store group, each independent pharmacy and, of course, each self-funded third party payer that actually foots the bill. This makes it challenging for the payer to determine the true coats.



For mail-order prescriptions, Prime and Express Scripts act as the pharmacy; buying drugs from the wholesaler and filling prescriptions at retail through their mail order programs. PEEEHIB and SEIB do not use mail order; some of the Alabama universities do. The PBMs, however, protected their income by uniformly reducing discounts to clients.



Wholesale Drug Prices Went Down—but Drug Costs to Alabama Plans Did Not

The Class Action Settlement intent was not to keep drug prices "cost neutral."

The settlement required the improperly inflated drug prices to be reduced by 5% and compensated self-funded plans and consumers $350 million in damages for being improperly overcharged since 2001. As a result of the settlement, instead of reducing drug costs for plans, Alabama's PBMs decreased the guaranteed discounts (cost-savings) to plans, which effectively eliminated the benefit of the reduction in the drug price markup and called it "cost neutrality."

Alabama's health plans are self-funded Third Party Payers who were improperly charged inflated drug prices, but were not a party to the suit and did not receive a payout from it.

Prime, Express Scripts, and MedImpact have large mail order programs that act as pharmacies for their clients by filling their mail order prescriptions directly—and reaping those profits. PEEHIP and SEHIP did not offer mail order prescriptions during the audit period.

Drug Prices

PBM's Protect Profits by Reducing Discounts to Plans as "Cost Neutral"

Instead of passing on the 5% mandated drug price rollback to clients and honoring their current ASAs, certain PBMs protected their income by reducing the cost-saving discounts plans had been guaranteed. **The lesser discounts increased drug costs paid by plans purchasing "cost neutral" drugs instead of reduced price drugs per the settlement.** This protected the PBMs, not the plans.

Reduced Plan Discounts Increased Costs

Example of a Pre & Post-Settlement Average Wholesale Drug Price Change with Same & Lesser Discount				
Situation	**Wholesale Drug Cost**	**Drug Cost Markup**	**AWP Discount***	**Cost to Alabama**
Pre-Settlement	$100	125%	-15%	$106.25
Post-Settlement	$100	120%	-15%	$102.00
Post-Settlement	$100	120%	-10%	$108.00

*AWP percentages are a representative example, *NOT* actual Alabama percentages due to required confidentiality.

SEHIP Verbal Amendment

Despite the fact that the ASA between SEHIP and BCBSAL states that amendments shall be written and duly executed, SEHIP accepted a *verbal* amendment to diminish its discount price on certain prescriptions as a result of an industry lawsuit settlement to which it was not a party. SEHIP informed RAS that it did so because BCBSAL informed SEHIP that it would cancel its ASA otherwise. No documentation was provided to SEIHIP to substantiate BCBSALs claim that pharmacies would refuse to fill SEHIP members' prescriptions unless it accepted the amendment. SEHIP, however, stated it felt compelled to accept the amendment in order to prevent disruption to its pharmacy benefit program for Alabama's public employees. **This undocumented amendment reduced the amount of the guaranteed discount price on drugs, and resulted in the loss to SEHIP of approximately $7 million in discounts for fiscal years 2009 - 2011.**

Major Obstacles to Pharmacy Recovery Audits - Lack of Transparency and Cooperation with Audits

The public expects transparency and accountability in the use of taxpayers' money. BCBSAL processes millions of taxpayer dollars for public employee medical and pharmacy benefits every year. Yet, BCBSAL failed to provide the complete documentation and data necessary to perform the full healthcare audit. Since it did not receive complete, accurate and timely medical claims information, RAS could not combine all medical data and documentation with the pharmacy data. This prevented RAS from being able to identify potential fraudulent activities and other circumstances for Alabama that might:

- cause the State to lose money,
- needlessly drive up the cost of Alabama's health benefit programs,
- waste precious public resources,
- compromise public services, and
- increase the financial burden on the public.

Undisclosed, Unauthorized Administrative Fees

In the Request for Proposal (RFP) submission by BCBSAL to SEHIP BCBSAL provides the following representations as it relates to its transparent pricing policy **for all of its clients** (emphasis added):

> ***"BCBS indicates they offer and administer fully transparent pricing arrangements for all of its groups and that their sole revenue source is the administrative fee that they will charge SEHIP,*** *which includes costs for administering their health related benefits* ***including pharmacy benefit management.*** *(See page 91, RFP Response to question #1)*

BCBSAL's response to question number two in that same proposal on page 91 is a statement on its business philosophy: (Emphasis added)

> ***"Supporting and administering a 100% open, fully transparent model is the cornerstone of our business philosophy.*** *We do not rely on ancillary revenue flows, spread pricing, and other miscellaneous revenues sources to offset or eliminate administrative fees. To do so is simply not in the best interest of our customers and members. We believe that competition on fair and honest administrative fees increases efficiency and allows for customized services. …"*

Transition to Prime

Except for SEHIP, which has the PBM fee broken out, BCBSAL references a combined administrative fee for its medical and pharmacy related services under the "health" category in its ASAs with PEEHIP and the five public universities. **BCBSAL continued to charge its full administrative fee to all the plans when it transitioned it clients from its then current PBM subcontractor, Preferred Care Services, Inc. to its new subcontractor, Prime Therapeutics.**

That meant the plans were knowingly paying BCBSAL the administrative fee specified in their ASAs to cover PBM services, and they were unknowingly being charged a second administrative fee by having a significant portion of the drug manufacturer rebates due to each plan withheld.

In just 18 months, this second, undisclosed administrative fee amounted to almost $5.1million dollars taken from SEHIP alone. The unauthorized withholding of funds due state health plans could have gone on indefinitely had the audit not uncovered it.

BCBSAL notified it clients about its partnership with Prime Therapeutics for PBM services through a press release issued April 5, 2010 and disclosed that as part of the deal it owned seventeen percent of Prime. There was no mention, however, that state plans would be charged additional fees as a result of the BCBSAL – Prime partnership.

Absence of Authorizing Language

Auditors routinely speak with the PBM during an audit of the PBM. **Each time RAS' auditors requested to speak with Prime, BCBSAL said questions should be addressed to BCBSAL and it would not provide contact information for a Prime contact. It was not until June 2012 when RAS was finally able to speak with representatives from Prime, with BCBSAL on the call, that RAS discovered the undisclosed, additional administrative fee withheld by Prime.**

Following the discovery of the undisclosed, additional administrative fee, RAS requested BCBSAL to provide the ASA language that BCBSAL believed authorized any additional fee. **RAS could not find any provision in the ASAs for SEHIP or the universities that allowed for a second administrative fee, or that permitted the withholding of rebate funds due to the plans.**

The prescription drug rebate provisions in each of the state health benefits plans' 2007 ASAs with BCBSAL were identical. **BCBSAL has never identified any ASA language that authorized an additional administrative fee.**

Instead, notwithstanding SEHIP and the universities' state plans' documented loss of rebate funds as a result of the additional undisclosed administrative fee, BCBSAL repeatedly replied in its emails: *"We believe our transition to Prime put our customers in predominantly the same or better financial position."* This is the premise BCBSAL initially used to defend its unauthorized, undocumented and undisclosed administrative fee of almost $5.1 million it withheld from SEHIP's pharmacy benefit plan, which BCBSAL eventually repaid.

In a July 27 email, SEHIP provided its position on BCBSAL's undisclosed administrative fee and the withholding of SEHIPs drug manufacturer rebates for that fee. In part, the email stated (emphasis added):

> "*… As part of their pharmacy management services,* ***BCBSAL agreed to pursue and pass along rebates it received from drug manufacturers based on the volume of drug claims incurred by the SEHIP.*** *The term of the 2007 ASA ran through December 31, 2011. …*
>
> Prior to July 1, 2010, the SEHIP was notified of BCBSAL's decision to subcontract with Prime Therapeutics. BSBSAL assured the SEHIP that since Prime Therapeutics dealt with larger drug volumes (20 million members nationwide) that the rebates for the SEHIP would be larger and could be obtained in a timelier manner.
>
> In response to the Examiner and RAS notifying SEHIP of the undisclosed withholding of an additional administrative fee, SEHIPs Counsel responded:
>
> *"Accordingly, the SEHIP did not object to BCBSAL's decision to subcontract with Prime Therapeutics provided that BCBSAL met its obligations under the ASA. …* ***During contract negotiations with BCBSAL in 2007, the SEHIP made it clear that it expected to receive 100% of the rebates and BCBSAL fully understood and accepted this premise. Nothing in the language of the ASA allows BCBSAL or Prime Therapeutics to retain a portion of the rebates before passing them along to the SEHIP. …***
>
> *Beginning in July of 2010, Prime Therapeutics began withholding* [redacted] *of the manufacturers' rebates. BCBSAL contends that it did not violate the terms of the ASA since the minimum pre claim rebate guarantee in the 2007 ASA was exceeded for each quarter since Prime Therapeutics began managing the pharmacy benefits. BCBSAL also contends that the 2007 ASA requires only that it pass through the rebates it receives directly from the manufacturers. Since it no longer receives rebates directly from the manufacturers there is no obligation under the 2007 ASA to pass on rebates to the SEHIP. Finally, BCBSAL contends that even if it had*

technically violated the terms of the ASA (which they do not concede), it had still complied with the spirit of the agreement and that the SEHIP had profited from an increase in rebates when Prime Therapeutics began managing the pharmacy benefits. …

It is the position of the SEHIP that it should have received 100% of the manufacturers' rebates for the period of July 1, 2010 through December 31, 2011 under the terms of the 2007 ASA."

Redundant Non-Disclosure Agreements Required

Act 2011-703 requires that the recovery auditor and its employees and agents are prohibited from disclosing confidential information obtained in the course of their audit work. Any disclosure is subject to prosecution by the Attorney General in any Alabama court. The Health Insurance Portability and Accountability Act (HIPAA) prohibits the disclosure of protected health information under Federal law.

In addition to disclosure being prohibited by federal and state law, RAS signed a Non-Disclosure Agreement (NDA) that covered RAS' employees and agents with each TPA/PBM, PEEHIP, SEHIP and five state universities In addition, BCBSAL required RAS to sign three-way and four-way duplicative NDAs—that had to be signed in sequential order with BCBSAL being last. BCBSAL is the TPA for all eight of Alabama's health plans and the PBM for six of the state's health plans. This statewide audit carried out under the auspices of the EPA could have been adequately covered under a single NDA between BCBSAL and RAS that covered all audit work that involved BCBSAL. Engaging in this a duplicative process for the eight state health plans consumed an inordinate amount of time and delayed initiation of the audit process.

It should be sufficient for the auditor under contract with the state to sign one NDA per entity that covers all of the auditor's work for the state with that specific TPA/PBM or state plan.

HIPAA Obstacle – Unnecessarily Halts Pharmacy Audit Also

In November 2011, at the start of the audit process, RAS signed a Business Associate Agreement (BAA) with each state plan as required by HIPAA, which prohibits the disclosure of protected health information under Federal law. Executing a BAA is standard practice for every healthcare related audit.

HIPAA law has specific provisions that provide for audits. RAS was informed that PEEHIP and SEHIP had conferred with attorneys from their respective health care benefit consultants regarding whether RAS could receive protected health information—and therefore, conduct the audit. As a result, RAS was informed by PEEHIP and SEHIP that it could not conduct the audit due to the HIPAA restrictions on RAS being able to receive protected health information. This was despite RAS having executed the Business Associate Agreements required under HIPAA with PEEHIP and SEHIP in November 2011, which allowed it to do so.

Months were lost due to PEEHIP, SEHIP and BCBSALs contention that HIPAA precluded auditor access to records because the auditor was engaged by the EPA instead of the plan.

The objection based on HIPAA also prevented the pharmacy audit from proceeding, even though a pharmacy claims audit does not involve any personal health information (PHI) that would be subject to HIPPA protections. PEEHIP, SEHIP and BCBSAL each conceded that no PHI was required for the pharmacy claims audit, but still would not allow the pharmacy audit to start.

In order to overcome this objection, RAS secured clarification from the federal office that administers and enforces HIPPA law. RAS contacted the General Counsel of U.S. Department of Health and Human Services (HHS) Office of Civil Rights, which administers and enforces HIPAA requirements, seeking clarification that RAS could provide to the insurance boards. RAS had never encountered a medical or pharmacy audit where HIPAA requirements had been raised as a prohibitive issue after executing the HIPAA required Business Associate Agreement.

On February 17, 2011 the HHS Civil Rights Division, Office of General Counsel provided an explanation on the HIPAA requirements, which, in part, included the following (emphasis added):

> *"You have inquired as to the application of HIPAA to certain disclosures by a state health plan to the Chief Examiner of Public Audits or its agents. …*
>
> ***1. A covered entity may**, under 45 CFR 164.506(c)(1), and consistent with its business associate agreement, **disclose protected health information (PHI) to its business associate for the covered entity's health care operations** purposes without the authorization of the individual whose PHI is being disclosed. **Health care operations includes conducting or arranging for auditing functions.***
>
> *2. A covered entity, under CFR 164.512(a), **may also disclose PHI as "required by law"** without the authorization of the individual whose PHI is being disclosed if the disclosure **complies with and is limited to the relevant requirements of such law.***
>
> ***"Required by law"** encompasses a state law that requires a state agency (that is a HIPAA covered entity) to provide a certain office or person with certain specific information or with certain types of information under certain circumstances. **Nothing in the HIPAA Privacy Rule would prevent a covered entity, in the circumstances described above, from disclosing the protected health information as required by such state law. …"***

Even after receiving this response from HHS, it took additional exchanges with HHS and additional time before RAS was allowed to begin even the pharmacy audits.

Lack of Cooperation

BCBSAL would not recognize that Alabama law governed the recovery audit, instead of its agreements with the various health plans. RAS therefore, was still precluded from performing the full audits on PEEHIP and SEHIP.

It took from November 2011 until May 2012 for RAS to obtain SEHIPs initial raw data from BCBSAL (PEEHIPs initial raw data was transmitted later) to analyze in order to determine the number of claims needing review for PEEHIP and SEHIP. RAS conducted a comprehensive electronic claims review process on PEEHIP and SEHIP claims, which evaluated approximately ninety-five percent of the hundreds of thousands claims as accurately paid. The remaining subset of claims was flagged for further review. BCBSAL, however, would only agree to provide documentation for 200 claims for each plan to be reviewed for accuracy and appropriateness of payment.

As of the writing of this report, BCBSAL has not provided the necessary information to enable the full recovery audit or the fraud analysis, or even provided the full documentation needed for the limited sample of 200 claims each for PEEHIP and SEHIP.

When RAS submitted its findings reports to BCBSAL, PEEHIP and SEHIP, BCBSAL did not respond to the reports as is customary. **Our audit teams have performed medical audits across America for major insurers, including other Blue Cross and Blue Shield organizations and for Medicaid and Medicare. This is the first time in fifteen (15) years of medical auditing that the audit team did not receive a written response from the TPA on submitted audit findings reports.**

Instead of providing a written response to the specific undocumented claims specified in the reports, BCBSAL stated that auditors had been given the documentation (they had not). BCBSALs response to PEEHIP and SEHIP in December 2014, produced some additional documentation, but the majority of documents BCBSAL sent were the same materials that had repeatedly been provided to auditors.

Sample Audit VS. Recovery Audit

Sample audits are performed on a fee-for-service basis, requiring a client to pay the auditing firm a guaranteed fee, plus expenses, to review a small sample of claims. Typically, a plan would be charged approximately $22,000 to $30,000, plus expenses, to examine approximately 200 claims. The audit firm would conduct the audit one time, review the documentation from the TPA; report its findings to the TPA for its comments/response; review the TPA response to the initial report and any additional documentation the TPA might provide that would validate a claim. The audit firm finalizes its report on the audit findings, including the response from the TPA, and presents the report to the plan on the completed audit.

In a sample audit, the audit firm usually is not involved in helping the plan recover any overpayments (for an additional fee, typically 35% on agreed and disagreed medical audit findings they may help with recoveries). It typically takes four to five months to conduct and finalize a sample audit.

A *recovery audit* firm may be willing to assume the financial risk of performing the recovery audit on a contingency-fee basis because it will be examining 100 percent of suspected overpaid claims, not just a small sample of claims. Because the scope of the audit is larger, the recovery audit firm has the opportunity to identify and document sufficient overpaid claims to compensate it for its work and cover its expenses.

Most firms will not perform a sample audit on a contingency-fee basis. In the case of Alabama, the state receives the vast majority of recovered funds and auditors are compensated from a small percentage of those recovered funds. To date, no overpayments have been recovered for the medical audits.

On-Site Audit Concerns

In June of 2012, RAS identified 200 PEEHIP claims and 200 SEHIP claims for initial review of potential errors and submitted a spreadsheet for each plan to BCBSAL in June of 2013, with each claim numbered chronologically 1 -200 for PEEHIP and SEHIP respectively. BCBSAL requested four weeks to prepare the documentation, which was to be waiting for the auditors upon their arrival at BCBSAL's office at 8:00 am Monday August 12, 2013.

As previously detailed, medical claims documentation was not ready for the auditors' on-site work; the BCBSAL audit coordinator was switched at the last minute; selected claims were renumbered without reason and BCBSAL could not provide a crosswalk to match the claim numbers with the new documentation numbers. The audit system training provided by the new BCBSAL audit coordinator was lacking and most importantly, auditors did not receive the full documentation required to validate the selected claims by the end of their on-site work as promised.

Follow-up after On-Site Audit

Following the onsite audit, requests for the missing documentation were responded to by multiple BCBSAL emails indicating incorrectly that the documentation had been provided onsite. RAS submitted a detailed list of precisely what it needed for each claim.

Instead of responding to the RAS report on missing documentation with the specifics for each claim, BCBSAL sent approximately 80 secure emails relating to the PEEHIP and SEHIP medical audits with some additional information or stating that the documentation had been provided, which it had not.

It is customary for auditors to submit its written findings to the TPA. The TPA then provides a written response to each finding. BCBSAL just re-sent all their emails, even though auditors had made it clear

that they had reviewed every email and had culled any relevant information from the emails into the written report it had submitted to BCBSAL under the "BCBSAL Information" column in the report. RAS was explicitly clear that the report reflected all information provided on-site and in all subsequent BCBSAL emails. Even after PEHIP and SEHIP requested the missing documentation in December 2013, only partial new documentation was received.

Certain missing documentation still has not been provided to date.

Remote Read Only Access Denied

To enable RAS to efficiently accomplish an audit of this scope, it requested remote read-only access to Alabama's medical claims data processed by BCBSAL.

Read-only access merely allows the audit team to review claims and supporting documentation contained in the system. Auditors cannot alter anything in the system nor can they access another part of the system that is beyond the access level they have been granted. In addition, for security and HIPAA reasons, large scale health care data systems commonly track who has accessed specific items in the system. In other words, the user typically leaves a trail that can be tracked.

Remote read-only access is commonly used by healthcare auditors for Medicaid and Medicare through a web-portal. RAS auditors have used remote read-only access to audit Medicaid and Medicare claims for other clients. This type of access would have enabled RAS to complete a medical audit and do the analysis on the combined pharmacy and medical data. Remote read-only access can also diminish the time commitment for the TPA being audited.

RAS learned that BCBSAL maintains a dedicated database for its Medicare members, which is accessible remotely for audits because BCBSAL is required to do so by the federal government.

Alabama state government deserves no less.

BCBSAL stated that it cannot segregate Alabama's state plans' claim data from its other clients, including commercial clients, as it has co-mingled its entire client population together in one database (except Medicare clients).

Each plan, whether public or private, must have a unique identifier; it is challenging to believe that with today's technological capabilities, BCBSAL could not devise a way to segregate its Alabama state plans from its other clients and enable system access to a state plan's claim information.

The TPAs database design should not impede an audit which is authorized by state law. This limitation, which poses a major obstacle to obtaining claims information necessary to performance of a recovery audit, should be corrected immediately in order to comply with Alabama's recovery audit law.

Remote read-only access is the most efficient way to conduct a large scale audit such as a recovery audit where all potential errors are examined —and least disruptive to a TPAs daily operations. This efficient process would have eliminated the need for auditors to be onsite in BCBSAL offices for an extended time, which is not feasible in a comprehensive audit due to the amount of time it takes to review a large volume of claims. In addition, remote read-only access enables the full medical audit team's resources to be available to validate the claims.

Request for Electronic Copies of Necessary Documentation Denied

With remote read-only access denied to the medical claims, RAS requested BCBSAL provide electronic copies of the documents contained in the database. BCBSAL stated that would not be possible, even though the information would be transmitted and received via a secure channel. RAS auditors have audited numerous other TPAs, including many BCBS organizations which have supplied electronic images of necessary documentation.

Restrictive Audit Limitations Hinder Recovery Audit

Alabama notified the contracted TPA/PBMs, through a Letter of Authority sent by each plan, to provide RAS with all information required to conduct the recovery audit. As the State and RAS learned, the ASAs between BCBSAL and the various Alabama plans includes language that restricts medical audits conducted by the health plans' to a very limited sample of the claims; typically a few hundred out of millions of claims.

BCBSAL tried to include pharmacy transactions in these limitations for the SEHIP audit, until RAS pointed out that its ASA provided for unrestricted audit rights on the pharmacy claims. When SEHIP and BCBSAL executed a new ASA in 2012, the unrestricted audit rights for pharmacy claims was eliminated, despite the provisions of Act 2011-703.

These audit restrictions between BCBSAL and the various plans have been used to prevent the verification that claims were properly paid under Alabama Act 2011-703. This restrictive language is commonly approved by TPA/PBM clients who may not understand the implications of the restriction or may have been informed by the TPA/PBM that having full audit rights would result in the TPA/PBM increasing its fees to the plan.

Increasing the fees charged to the plan for access to its own claims information amounts to the TPA or PBM charging the state plan to receive data and documentation that the state owns. The state plan, not the TPA or PBM, owns the claims data and supporting documentation, except for actual medical records, which belong to the patient and the healthcare provider. The TPA/PBM is retained by the state to manage the state benefits and accurately process each claim according to the plan's requirements.

The financial impact of limiting the state's ability to validate the accuracy of its expenditures means that costs to the plan may increase due to improper payments being charged or approved by the TPA/PBM.

SEHIP covers more than 92,700 individuals; to date, BCBSAL has only allowed RAS auditors to examine 200 medical claims. PEEHIP covers close to 283,000 individuals; to date, BCBSAL only allowed RAS to examine 200 medical claims.

The TPA/PBM bears no financial risk for any unidentified improper payments as all costs are borne by the plan—and ultimately the taxpayers of Alabama.

Audit Observations and Recommendations

RAS is sharing the following audit observations and recommendations based on its years of experience and industry knowledge for the benefit of the State of Alabama. We hope this information will serve to assist Alabama to strengthen the fiscal integrity of its employee healthcare benefits programs.

Overview

Government has a responsibility to manage its taxpayer's resources wisely. The State Legislature strengthened financial accountability when it enacted Alabama Act 2011-703 in 2011 to authorize recovery audits on expenditures for state agencies, institutions of higher education and the Public Employees' Health Insurance Plan and the State Employees' Health Insurance Plan.

The people of Alabama expect resources they entrust to the State to be properly handled by Alabama's contractors. They expect full accountably for the millions of taxpayer dollars spent annually on healthcare benefits for Alabama's public employees.

No private vendor or service provider under contract with the State, including Third Party Administrators and Pharmacy Benefit Managers, should be able to impede public accountability and transparency in the financial transactions it is paid to perform for government.

Due to auditors' inability to obtain the necessary documentation to complete the medical audits to date, three years later the financial findings and ancillary benefits envisioned by the Legislature are yet to be fully realized.

Based on our observations conducting recovery audits in Alabama over the past three years and our knowledge of industry practices, RAS recommends the following actions to strengthen Alabama's healthcare benefit programs and its recovery audit process be codified in state law to ensure the improvements are enforceable.

Strengthen Master Contract Language for All State Contracts

Canceling a contract for non-compliance, especially for healthcare benefits, could cause significant disruption for the State and its employees. Alabama plans' concern about program disruption for public employees provides significant leverage for the TPA/PBM with the State. Alabama could benefit from additional tools and incentives for contract and audit compliance in order to strengthen Alabama's recovery audit program requirements. To protect the State and strengthen its contracting process RAS recommends including the following mandatory master contract requirements in all State contracts:

- **Unrestricted Audit Rights for the State.** The State shall have full access, at any place of its choosing and for audit purposes, to any and all data and documentation in the contractor's possession or under its control that pertains to an expenditure of state funds.
- **State Ownership of Data and Documentation.** Except for employees' medical records, which are the property of the medical provider, all records pertaining to any expenditure made with State funds, remain the sole property of the State, and shall be producible and returnable to the State upon demand.
- **Production of Data and Documentation.** The contractor shall provide, within 30 calendar days, all data and documentation specified by the State as necessary to validate the accuracy and appropriateness of any expenditure made with State funds..
- **Repayment of Funds within 30 Days.** Any vendor or service provider owing funds to the State shall repay those funds within 30 calendar days. Failure to do so shall result in imposition of of lost interest income charges and financial penalties. If a vendor or service provider contests the repayment and wants to engage in mediation, the vendor shall first deposit the disputed funds in a non-interest bearing escrow account.
- **Penalties for Non-Compliance.** If the vendor or service provider fails to comply with a contract requirement for timely production of data and documentation or repayment of funds, financial penalties shall be imposed that escalate over time, up to and including contract termination.
- **Offset of Past Due Payment.** If a vendor or service provider fails to repay State validated overpayments due the State within 60 calendar days of written demand by the State, the Chief Examiner may offset, against any State funds otherwise due to the vendor or service provider, the amount due and payable to the State.
- **Written Documentation of all Contract (and ASA) Amendments.** Changes to contracts and Agreements shall be in writing and duly executed by the official authorized to bind the governmental unit and the vendor or service provider/TPA/PBM.
- **Undisclosed Fees are Prohibited.** All costs charged or withheld from any state entity, for any purpose, shall be clearly identified in any contract, agreement, invoice or purchase order with such state entity. Every vendor or service provider, including a TPA or PBM, shall fully disclose all revenues it receives from any source as a result of the state contract, and all costs, direct and indirect, to the state. Failure to provide this transparent pricing information shall subject the TPA or PBM to financial penalties and require the immediate repayment of any prohibited fees.

Disclose Detailed Plan Costs and TPA/PBM Revenue in ASAs

RAS recommends a complete analysis of revenue income related to its plans for TPA/PBMs and costs charged/funds retained for all current state TPA/PBM agreements. Current ASAs should be amended to require the PBM/TPA to report all sources of income and amounts it receives/retains for Alabama's

employee benefit plan. This will enable Alabama plans to determine the actual cost of its PBM/TPA services. Requiring all costs and revenues streams to be transparent enables the State to compare the true cost benefit of each potential PBM/TPA on an equal basis.

RAS recommends that the full transparency of revenue and costs for plans become a mandatory contract requirement in future RFPs and ASAs for the State of Alabama.

Strengthen Master Contract Provisions for State Healthcare Plans

In addition to modifying all state contracts, RAS recommends including the following provisions in all ASAs for Alabama's employee health benefit plans.

- **Require TPAs/PBMs to maintain State data in a separate database for Alabama State Plans** in a manner accessible to the State or its designated agents for audit purposes. The State's healthcare claims data shall be maintained in a separate data system through which the State can remotely access the database for audit and program integrity purposes. This requirement is similar to audit access requirements for the federal Medicare program and Federal-State Medicaid program. The access will be "read only" and must comply with HIPAA privacy requirements and State confidentiality requirements and protections.
- **Include language making it clear that all data, supporting documentation and work products belong to the State** (actual medical records belong to the patient and the medical provider). Clarify that medical records shall be made available when needed to determine the medical necessity and appropriateness of the claim for audit purposes.
- **Electronic Access to Data and Documentation.** All records the State deems necessary to performance or review of a contract shall be readily available to the State in electronic form.
- **Prohibit TPAs/PBMs from charging the State to access or receive claims for its data and documentation** that is needed to validate the accuracy of payments made with State funds.
- **Remove audit restrictions on claims,** whether medical or pharmacy, in all of the state's ASAs.
- **Explicitly prohibit TPAs/PBMs from charging any undisclosed, unauthorized fees.** All pricing and fees in contracts shall be explicit, transparent and easily verifiable.
- **Require fully transparent pricing and subject TPAs/PBMs to penalties for non-compliance with transparent pricing requirement.** Complex pricing arrangements are not easily transparent. The total cost to the plan cannot be calculated without knowing the full amounts that will be paid to and retained by the TPA/PBM. Real transparency in pricing requires all fees and revenue sources to be clearly, accurately and fully delineated so that the client knows precisely the total amount it is paying for its TPA and PBM services.
    - RAS recommends ASA contract language be rewritten to contain clear and transparent pricing; specifically prohibit undisclosed fees; require each prescription to be individually priced and require all funds retained or received by the PBM and/or

claims administrator, from any source, as a result of its contract with the state, to be reported quarterly to the plan.

  - This pricing transparency would enable the state to determine the full cost for its TPA/PBM services and accurately compare the cost benefit of various TPA/PMB proposals.
  - RAS recommends a complete analysis of compensation and costs for all current TPA/PBM agreements. This will enable the state to determine the most beneficial benefits program going forward.
  - Impose financial penalties for failure to provide explicit, clear and transparent pricing or for imposing any undisclosed, unauthorized fee or withholding of funds. Continued non-compliance shall trigger escalating penalties up to and including cancellation of contract and disbarment from government contracting.

- **TPAs/PBMs shall acknowledge the special standing of government plans.** Should new or modified statutory and or regulatory language have implications for and require changes to existing ASAs, those changes shall be made to cause the ASA contract to conform to and comply with state or federal law.
- **TPAs/PBMs shall acknowledge responsibility for accurate claims processing.** Failure to accurately process medical and pharmacy claims is a failure under the contract of the TPA/PBM, not the State. The TPA/PBM is responsible for its errors and shall not pass on any increased costs to the State as a result of errors. Claims shall not be aggregated, or averaged annually. Each transaction is expected to be accurately processed. Overpayments due the State shall not be offset by the TPA/PBM in any way. If the TPA/PBM overpays a claim, overcharges the State, withholds any funds due the State from any source or does not meet its price guarantees, the TPA/PBM shall make the State whole and promptly reimburse the state for those costs.
- **Standardize State Non-Disclosure Agreements for Audits.** Alabama should develop a standard statewide Non-Disclosure Agreement (NDA) that meets its reporting requirements and transparency needs while protecting the confidentiality of its healthcare TPA/PBMs proprietary information. The NDA should be included in the Request for Proposal as a standard requirement. TPA/PBMs desiring to do business with the state should conform to the state's requirements. When conducting an audit the state's chosen agent should need to sign only a single NDA with each TPA/PBM covering the full scope of work with that TPA/PMB on behalf of the state. As it stands today, the state must confirm to its contractors varying NDA requirements. Multiple 3-way and 4-way NDAs required by BCBSAL, delayed the audits and created unnecessary work for the Examiner and the auditors.
- In order to protect the state and its taxpayers, amend Act 2011-703 to incorporate the following incentives for compliance with the recovery audit by all vendors and service providers, including TPAs and PBMs:

- provide required data within thirty days of the written request;
- provide required documentation within thirty days of the written request;
- require the TPA/PBM to certify that the data and documentation provided for the recovery audit is accurate and complete;
- require repayment of overpayments within thirty days of the state approved written request, and;
- implement a Lost Interest charge on state funds not repaid timely.

Modernize ASAs to Conform to Alabama Act 2011-703 Requirements

Most of Alabama's Administrative Services Agreements with its State health benefit plans were originally drafted decades ago, before technology enabled full access to and accountability for the processing of millions of claim transactions. For example, ASAs were originally drafted in 1981 for SEHIP, and 1992 for PEEHIP. ASAs for the universities were drafted even earlier. While the ASAs have been amended over the years, RAS recommends the Agreements should be thoroughly reviewed and the language modernized to comply with the recovery audit process and to examine other contractual provisions that now may favor the TPA/PBM instead of the State of Alabama and its taxpayers.

- ASAs should be (re)drafted, by or under the direction, review and approval of State counsel, to meet the State's needs.
- Audit restrictions should be removed from ASAs. Sample audits of two or three hundred claims out of millions of transactions do nothing to validate the accuracy of the claims not examined. Most healthcare errors are made individually and are not system-wide errors. Applying a systemic error identified from a sample audit globally may sound encompassing, when in reality it does little to rectify the potential overcharges in a full audit. For example, of the 400 claims RAS was able to examine, the mistakes were all on an individual claim, none contained systemic errors.
- Contracts should be renewed at a regularly fixed time. ASAs should not be signed and made retroactive, as occurred with several ASAs. Effective dates of contracts should either be upon signature or at some future mutually agreed upon date.

Increase Efficiency, Eliminate Duplication and Consolidate Purchasing Power

Consolidation of the State's eight health benefit plans for public employees would simplify program and contractor oversight and accountability. It would increase the State's negotiation and purchasing power, particularly for its smaller plans. The State could enhance its position even further if it elected

to allow municipal and county employees in the plans, as some other states have done in order to benefit the state and the employees.'

Consolidation could also reduce on-going operating costs, as duplication of effort could be eliminated (e.g., multiple RFP development and contractor selection; engagement of multiple advisory consultants; staff to design plans and benefits and provide legal expertise). It would eliminate the current variation among each plan's pricing structure, where an inverse relationship exists in the cost of plan administration depending on the size of the plan. Consolidation would further strengthen accountability as the State would be able to standardize and streamline monitoring and auditing of its various entities.

- Medical, pharmacy and dental benefit claims and pricing structures are complex, requiring governing bodies and support staff with demonstrated experience and expertise to manage and oversee each of these complicated systems. Given the cost of health care benefits and the vulnerability of the State and taxpayers to increased costs, the employee health benefits plans and ASAs should be subject to regular and high level State oversight.
- Members of plans' governing bodies need to have extensive experience and expertise in health plan and benefit design, contract negotiation and administration, financial analysis and other technical areas critical to healthcare program management, or retain experts that possess those skills. They also need to possess a sophisticated, working knowledge of how PBM and TPA industries operate. Combining oversight of the plans might help a new authority/board to maximize the expertise it can bring to its governing body. It could also reduce consulting costs for industry expertise.

Encourage Competition in Alabama's Employee Health Benefits Program

The American Medical Association recently issued a report, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2013 Update*, revealing that Alabama has the least competitive healthcare market in the Nation for the second year in a row. With one dominant TPA, most providers need to align with it or risk losing patients. With the majority of providers aligned with the dominant TPA, it is difficult for an alternative TPA to offer sufficient scale and range of providers to compete.

Alabama has the least competitive health environment in the Nation according to the American Medical Association. Having one highly dominant TPA in the state, enables it to have disproportionate leverage with a state plan such as telling a plan it must accept a discount pricing reduction or it will cancel its contract as SEHIP reported that BCBSAL did.

With all employee groups under one authority the State would have sufficient scale to offer multiple provider options for its employees if it chose. Competition among TPA/PBMs could help contain health care costs and provide more options for the state and its employees.'

Conclusion

RAS worked closely with the EPA throughout the audits and appreciates the professionalism and support they provided. Unfortunately, Act 2011-703 did not provide any mechanisms the EPA could use to enforce compliance with the recovery audits. The major challenges and time delays occurred as a result of auditors not receiving timely, complete and accurate data and supporting documentation necessary to complete the recovery audits for the eight state employee health plans.

TPAs and PBMs must be accountable for their administration of state employee health plans, which expend millions of taxpayer dollars every year. The repeated provision of inaccurate and incomplete information created significant additional, and duplicative, work for both the auditors and the EPA.

The Legislature showed leadership in enacting the recovery audit law. The lessons learned from the challenges presented to the audits provide an opportunity for the Legislature to strengthen its recovery audit provisions for the benefit of the state and its taxpayers.

This Page Intentionally Blank

State Employees Insurance Board's (SEIB) Response to Recovery Audit

State of Alabama
STATE EMPLOYEES' INSURANCE BOARD
State Employees' Health Insurance Plan
Local Government Health Insurance Plan
Joe N. Dickson, Chairman
William L. Ashmore, CPA, Chief Executive Officer

October 31, 2014

Mr. Ron Jones
Chief Examiner
Department of Examiners of Public Accounts
50 North Ripley Street, Room 3201
Montgomery, AL 36104

Dear Ron:

Attached is the State Employees' Insurance Board's respond to the findings of the recovery audit of the State Employees' Health Insurance Plan conducted by Recovery Audit Specialists. We were generally pleased with RAS's audit results of the medical and pharmacy claims of the State Employees' Health Insurance Plan. However, we strongly disagreed with many of the opinions of RAS related to the management of the plan, most of which were outside of the scope of the audit and reflected their lack of expertise in health benefit management.

Please call me should you have any questions or need further information regarding our response. We look forward to working with you again in the future.

Sincerely,

William L. Ashmore
Chief Executive Officer

WLA/ks

201 South Union Street, Suite 200 • PO Box 304900
Montgomery, Alabama 36130-4900
334.263.8300 • Fax 334.263.8711
www.alseib.org

State Employees' Insurance Board

Response to Recovery Audit Specialists' 2014 Recovery Audit Management Report Of Alabama Public Employee Benefit Plans

October 31, 2014

Executive Summary

The State Employees' Insurance Board (SEIB) was generally pleased with the results of the recovery audit of medical and pharmacy claims of the State Employees' Health Insurance Plan (SEHIP).The overpayments identified by Recovery Audit Specialists (RAS) represented an infinitesimally small percentage of total claims of the SEHIP; confirming that the medical and pharmacy claims had been accurately processed by Blue Cross over the audit period.

The opinions expressed by RAS in their final report regarding the management of the SEHIP are unfounded and were thoroughly refuted by the facts:

- AWP Issue - While in retrospect it may have been the best practice to formally amend the Blue Cross Agreement in 2009 to allow Blue Cross to reimburse pharmacies at a lower discount, the bottom line is that the SEIB would have taken the same action whether or not the agreement was formally amended. Not only was the SEIB's decision in the best interest of state employees; it did not cost the State one cent.

- SEHIP Receives 100% of Rebates - RAS alleges that the 2012 Blue Cross agreement does not specify that the SEHIP will receive 100% of all rebates on brand name drugs. This is not correct. Starting in 2012 the SEIB pays an administrative fee of $1.50 per prescription and the SEHIP receives 100% of all brand name drug rebates.

- Rebates Exceed Industry Standards - The average rebate per prescription received by the SEHIP for the audit period continued to increase and were well above industry standards.

- 2012 Increase in PBM Fee Agreed to by the SEIB in Exchange for Higher Rebate Guarantees – The SEIB agreed to the increased fee in exchange for higher rebate guarantees. In 2012 under the new fee arrangement total rebates received by the SEHIP increased by $ 8 million, more than offsetting the increased fee.

- Strengthen Contract Language - Many of RAS's recommended changes to the Blue Cross agreement appear to be designed to force the claims administrator to comply with RAS's audit procedures; shifting the financial risk for the audit from RAS to the State of Alabama.

Based on the actual findings of the recovery audit the State of Alabama can rest assured that taxpayers' funds are being very well spent for state employee health benefits. Indeed, the findings confirm what many national studies have been finding for many years - the SEHIP provides state employees with some of the best benefits in the country at one of the lowest costs in the country.

Introduction

The State Employees' Insurance Board (SEIB) was generally pleased with the results of the recovery audit of medical and pharmacy claims of the State Employees' Health Insurance Plan (SEHIP). Based on Recovery Audit Specialists (RAS) own findings, even if all the disputed claims were accepted as overpayments, 99.6% of medical claims and 99.9% of pharmacy claims were properly processed and paid by Blue Cross. Accordingly, the State of Alabama can rest assured that taxpayers' funds are being very well spent for state employee health benefits. Indeed, RAS's findings confirm what many national studies have been finding for many years - the SEHIP provides state employees with some of the best benefits in the country at one of the lowest costs in the country.

The SEIB's response to RAS's final report will first address the actual and potential medical and pharmacy claims overpayments identified by RAS. The SEIB will then address the opinions expressed by RAS regarding the management of the SEHIP. Our response will also include an analysis of RAS's final report by Mercer Health and Benefits, a third party consultant recognized as one of the country's premier experts in the field of health benefit management.

Medical and Pharmacy Claims Recovery Audit

Assurances by RAS that its recovery audit of the SEHIP's claims over a three year period could save the State of Alabama up to $90 million was welcome news for our program which had experienced a reduction in funding over the last several years. Although it had been our experience that overpayments in the range that RAS was promising were unlikely, we were nonetheless more than happy to assist them in any way we could. Three years later RAS has released its final report and the anticipated overpayments did not materialize. What follows is a brief review of RAS's findings.

Medical Claims Recovery Audit Findings

RAS was provided with 100% of all medical claims for a three year period, totaling over $502 million in claims. Of this amount RAS's software analysis eliminated 95% of the claims from additional examination. Only 20,000 SEHIP claims of the millions of claims provided were flagged by RAS for further examination.

RAS contended that they were prevented from identifying overpayments within the 20,000 claims because of audit stipulations in Blue Cross's administrative service agreement with the SEIB, foremost of which was the limitation of a 200 claim sample size for more detailed audit analysis. The SEIB asked Mercer Health and Benefits to review RAS's position in relation to industry wide audit practices to determine if RAS's contentions were legitimate. Mercer concluded that:

- It is industry practice to spell out audit rights in the administrative service contract.
- A sample size ranging from 200 to 400 claims is standard.
- It is industry standard to charge a fee for sample sizes in excess of the contract limit (in this case $5,000 per 100 claims).
- It is typical for audit firms to identify thousands of claims believed to be in error for a carrier to review – industry experience has shown that the false positive rate on these errors often exceeds 95%.
- Most carriers have a standard data file that is sufficient for an audit firm to review its sample selection – deviation from the standard usually requires an additional fee.
- It is industry standard to require onsite review of claims.

A complete list of Mercer's findings is attached to our response as Attachment A.

From the 20,000 claims identified by RAS for further review, a sample of 200 claims was extracted. A sample size of 200 claims yields a 99% confidence level with 3.11% precision given the size of the claims population to be reviewed and an expected accuracy percentage of 97%. This sample size well exceeds the minimum requirements of a 95% confidence level with 3% precision which is commonly accepted in the industry for medical claims audits.

Of the 200 claims, only 17 claims were disputed by RAS, with a possible overpayment of $424,237. None of the disputed claims were systemic errors, making it highly unlikely that an expanded sample size would be of any additional value. (It should also be noted that the 200 claims chosen for review by RAS did not appear to be a random sample. The average dollar per claim for the 200 claims chosen for review by RAS was more than five times higher than the average for total claims reviewed.)

RAS contended that Blue Cross did not provide adequate documentation to support payment of these claims. Blue Cross contended that all necessary documentation was provided and that only one claim for $100 was correctly identified by RAS as an overpayment.

The SEIB submitted the 17 claims in question to Mercer Health and Benefits for an independent analysis to determine if the documentation provided by Blue Cross was sufficient and whether the claims were paid properly.

Attached to this document as Attachment B are Mercer's findings regarding the 17 disputed claims. Mercer confirmed that Blue Cross did not provide sufficient documentation for five of the 17 claims. This reduced the potential overpayment from $424,237 to $29,015. Extrapolating the results of Mercer's analysis of the claim sample, 99.9% of all claims processed were paid correctly. (This assumes that the sample selected by RAS was truly random and not targeted). Accordingly, the overpayments identified by RAS represent an infinitesimally small percentage of total claims confirming that the medical claims had been accurately processed by Blue Cross over the audit period.

Pharmacy Claims Recovery Audit findings

- Claims Audit - RAS was provided with 100% of all pharmacy claims for FY2008-2011. This totaled over $451 million in claims. RAS's review of these claims found only $316,474 in overpayments. The recovered overpayment represented an infinitesimally small percentage of total claims (less than 0.1%) confirming that the pharmacy claims had been accurately processed by Blue Cross over the audit period.

- Rebate Issue - RAS identified $5.1 million in brand name prescription drug rebates that were withheld by Blue Cross as an administrative fee when Prime Therapeutics became the Pharmacy Benefits Manager in 2010. Under the provisions of the Administrative Service Agreement (ASA) with Blue Cross, the SEHIP was to receive 100% of all rebates. Although the net rebates to the SEHIP increased when Prime became the Pharmacy Benefits Manager, the administrative fee should not have been retained by Blue Cross. To understand how this happened, a review of the rebate arrangement is necessary.

  In 2007 the SEIB entered into an ASA with Blue Cross to provide administrative services for the SEHIP. These services included the management of the SEHIP's pharmacy benefits for which Blue Cross received an administrative fee. As part of their pharmacy management services, Blue Cross agreed to pursue and pass along rebates it received from drug manufacturers based on the volume of drug claims incurred by the SEHIP. The term of the 2007 ASA ran through December 31, 2011.

  On July 1, 2010, Blue Cross entered into an agreement with Prime Therapeutics to manage the pharmacy benefits for the SEHIP. (Prime Therapeutics is a privately held corporation owned by 13 Blue Cross Blue Shield affiliates, including Blue Cross of Alabama.) Prior to July 1, 2010, the SEIB was notified of Blue Cross's decision to subcontract with Prime Therapeutics. Blue Cross assured the SEIB that since Prime Therapeutics dealt with larger drug volumes (20 million members nationwide) that the rebates for the SEHIP would be larger and could be obtained in a timelier manner. Accordingly, the SEIB did not object to Blue Cross's decision to subcontract with Prime Therapeutics provided that Blue Cross met its obligations under the ASA.

  Although Blue Cross informed the SEIB of its agreement with Prime Therapeutics, they did not disclose to the SEIB the details of their financial arrangement with Prime Therapeutics. As a result, the SEIB was unaware that Prime Therapeutics was withholding a percentage of the rebates it received from the manufacturers from July 1, 2010 through December 31, 2011. (Note: The Prime Therapeutics arrangement was no longer an issue as of January 1, 2012. Under the 2012 ASA, the SEIB has been receiving 100% of the rebates.)

  It was the position of the SEIB that it should have received 100% of the manufacturers' rebates for the period of July 1, 2010 through December 31, 2011 under the terms of the 2007 ASA. Had Blue Cross informed the SEIB of the details of its financial arrangement

with Prime Therapeutics in 2010 there is a probability that the SEIB would have approved of the arrangement with the stipulation that the rebates received by the SEIB would meet or exceed the amount of rebates received while BCBSAL was managing the SEHIP's pharmacy benefits (which they did).

Blue Cross contended that it did not violate the terms of the ASA since the minimum pre claim rebate guarantee in the 2007 ASA was exceeded for each quarter since Prime Therapeutics began managing the pharmacy benefits. Blue Cross also contended that the 2007 ASA required only that it pass through the rebates it receives directly from the manufacturers. Since it no longer received rebates directly from the manufacturers there is no obligation under the 2007 ASA to pass on rebates to the SEIB. Blue Cross further contended that even if it had technically violated the terms of the ASA, it had still complied with the spirit of the agreement and that the SEHIP had profited from an increase in rebates when Prime Therapeutics began managing the pharmacy benefits.

In reality Blue Cross could have refunded the administrative fee withheld by Prime Therapeutics and gone back and reprocessed the rebates under the terms of the ASA prior to July 1, 2010. This would have resulted in a substantial reduction in rebates to the SEHIP. Fortunately for the State of Alabama, Blue Cross agreed to refund the administrative fee without reprocessing the rebates.

Management Opinions of RAS

While the SEIB was pleased with the findings of the actual recovery audit, we strongly disagree with many of the opinions expressed by RAS regarding the management of the SEHIP, most of which were outside of the scope of the audit and reflected their lack of expertise in health benefit management. What follows is a brief summary of the SEIB's position regarding the management issues identified by RAS.

AWP Issue

RAS contends that a verbal amendment to the Blue Cross ASA by the SEIB to allow Blue Cross to reimburse pharmacies at a lower discount cost the SEHIP $7.3 million in prescription drug discounts. This opinion is completely unsubstantiated and shows a complete lack of understanding regarding the pharmacy market in 2009.

The Average Wholesale Price (AWP) of prescription drugs was intended to represent the average price at which wholesalers sell drugs to physicians, pharmacies, and other customers. In practice, it is a figure reported by commercial publishers of drug pricing data. Reimbursement amounts for prescription drugs are typically based on AWP minus some percentage. Because published AWPs often dramatically exceed the real prices of drugs, many lawsuits were brought alleging fraud and violations of consumer protection laws. In 2009 a settlement was reached in federal court that established new guidelines for establishing the AWP.

In 2006 when the SEIB and Blue Cross negotiated the terms of the 2007 ASA, the parties did not anticipate the 2009 federal court settlement and thus, did not include AWP neutrality language that would allow prescription drug pricing to be adjusted automatically after 2009 settlement. In 2009 the SEIB became aware of the changes to the AWP calculation methodology required under the 2009 federal court settlement and that Blue Cross's retail brand price guarantees for 2010 and 2011 would be affected.

The SEIB and Blue Cross discussed the implications of the court ruling and it was decided that Blue Cross would be allowed to reimburse the pharmacies at a lower discount off AWP that would correspond to the same dollar reimbursement or charge as before the court settlement. Had the parties not agreed to this arrangement it is very likely that pharmacies in Alabama would have refused to take the lower reimbursement and would have dropped out of the network. This would have resulted in a much smaller network of pharmacies that would not be able to handle the volume necessary to adequately serve the members of the SEHIP. It would also force SEHIP members to use non-network pharmacies which would substantially increase their out-of-pocket expenses.

In its report, RAS stated that the SEIB's CEO said that the SEHIP was compelled to accept the diminished discount rate or Blue Cross would void its contract with the SEIB. This is simply not true. The CEO was concerned that pharmacies would drop out of the network, not that Blue Cross would void its contract. We are at a loss as to where this allegation originated.

While in retrospect it may have been the best practice to amend the ASA to reflect the SEIB's decision, the bottom line is that the SEIB would have taken the same action whether or not the ASA was formally amended. Not only was the SEIB's decision in the best interest of the State of Alabama and its state employees; it did not cost the State one cent.

Contrary to RAS's contention, we are unaware of any other state employee health plan that benefited from lower prescription costs as a result of the AWP court settlement. For RAS to allege that this decision cost the State of Alabama $7.3 million shows a complete misunderstanding of the pharmacy market in 2009.

SEHIP Receives 100% of Rebates

RAS alleges that the 2012 ASA does not specify that the SEHIP will receive 100% of all rebates on brand name drugs. This is not correct. Starting in 2012 the SEIB pays an administrative fee of $1.50 per prescription; therefore the PBM does not withhold a percentage of the rebate received. Hence, the SEHIP receives 100% of all brand name drug rebates.

Rebates Exceed Industry Standards

RAS infers that since the rebate guarantees are not listed in the 2012 ASA after 2014 that the PBM will retain part of the rebates it receives. Once again, starting in 2012 the SEIB pays an administrative fee of $1.50 per prescription; therefore the PBM does not withhold a

percentage of the rebate received. The SEHIP receives 100% of all brand name drug rebates for the duration of the ASA.

It is not uncommon for PBM's to guarantee only three years of rebates. Guarantees beyond three years would prove risky and require an increase in fees to the SEHIP. Accordingly, future guarantees are usually renegotiated during the renewal process. What is more important are the actual rebates received. In 2009 under the old rebate arrangement with Blue Cross, the average rebate received by the SEHIP for brand name drugs was $15.30 per prescription. After Prime became the PBM, the average rebate per prescription received by the SEHIP increased to $16.51 in 2010, $18.21 in 2011 and $33.58 in 2012. Contrary to what RAS alleges, these rebate amounts have continued to increase and are well above industry standards.

During the renewal process subsequent to the release of RAS's final report, the SEIB negotiated rebate guarantees of $50.26 per prescription for 2015 and $49.81 per prescription for 2016. Accordingly, RAS's contention is no longer an issue.

2012 Increase in PBM Fee Was Agreed to in Exchange for Higher Rebate Guarantees

It is true that the SEHIP's PBM administrative fee increased in 2012 from $366,166 to $3,329,451. However, the SEIB agreed to the increased fee in exchange for higher rebate guarantees. In 2012 under the new fee arrangement total rebates received by the SEHIP increased by $ 8 million, more than offsetting the increased fee.

Prior to the change in the fee arrangement, in 2011 the SEHIP received rebates of $10.4 million. When the administrative fee of $366,166 is deducted, the net rebate is $10.1 million, for an average rebate per prescription of $18.21. In 2012 the PBM's fee per prescription was increased and the SEHIP began receiving increased rebates obtained by Prime Therapeutics. In 2012 the rebates received by the SEHIP increased to $18.6 million. When the administrative fee of $3,329,451 is deducted the net rebate is $15.3 million, for an average rebate per prescription of $33.58. Therefore, while the administrative fee went up by $3 million, the total rebates increased by $8 million.

Once again, RAS's inference that the increase in the PBM administrative fee was inappropriate is totally unsupported by the facts.

Strengthen Contract Language

Many of RAS's recommended changes to the ASA appear to be designed to force the claims administrator to comply with RAS's audit procedures; shifting the cost of their recovery audit from RAS to the SEIB. These recommendations would certainly allow RAS to at least attempt to meet the lofty recovery amounts it advertised before the audit, but at what cost to the State of Alabama? It is one thing to require stringent audit provisions when negotiating a contract with a claims administrator; it is quite a different thing in reality to find a claims administrator to agree to such provisions. Assuming that a claims administrator would agree to what RAS is proposing, the costs associated with the proposed contract

provisions would be passed along to the State. For instance, RAS wanted the claims administrator to review in detail over 20,000 claims in order for it to properly conduct its audit. At a cost of $5,000 per 100 claims, this totals $1,000,000 for this service. Based on the percentage of overpayments identified by RAS for the 200 claims that were reviewed in detail, it is unlikely that the overpayments identified in the 20,000 claims would exceed the $1,000,000 in additional costs required to review them. It appears that RAS is simply attempting to shift the financial risk for the audit from themselves to the State of Alabama.

Conclusion

The SEIB was generally pleased with the results of the recovery audit of the medical and pharmacy claims for the SEHIP. This was RAS's primary focus and represented the bulk of any savings to the State. However, the small number of overpayments identified by RAS represented an infinitesimally small percentage of total claims confirming that the medical and pharmacy claims had been accurately processed by Blue Cross over the audit period.

The opinions expressed by RAS in their final report regarding the management of the SEHIP are unfounded and were thoroughly refuted by the facts:

- AWP Issue - While in retrospect it may have been the best practice to amend the ASA to reflect the SEIB's decision to allow Blue Cross to reimburse Pharmacies at a lower discount, the bottom line is that the SEIB would have taken the same action whether or not the ASA was formally amended. Not only was the SEIB's decision in the best interest of state employees; it also did not cost the State one cent.

- SEHIP Receives 100% of Rebates - RAS alleges that the 2012 ASA does not specify that the SEHIP will receive 100% of all rebates on brand name drugs. This is not correct. Starting in 2012 the SEIB pays an administrative fee of $1.50 per prescription; therefore the PBM does not withhold a percentage of the rebate received. Hence, the SEHIP receives 100% of all brand name drug rebates.

- Rebates Exceed Industry Standards - RAS infers that since the rebate guarantees are not listed in the 2012 ASA after 2014 that the PBM will retain part of the rebates it receives. Once again, starting in 2012 the SEIB pays an administrative fee of $1.50 per prescription; therefore the PBM does not withhold a percentage of the rebate received. The SEHIP receives 100% of all brand name drug rebates for the duration of the ASA.

  Note: Subsequent to the release of RAS's final report, the SEIB executed a new enrollment agreement with Blue Cross that stipulated a rebate guarantee in 2015 of $50.26 per prescription and in 2016 of $49.81 per prescription. Accordingly, RAS's contention is no longer an issue.

- 2012 Increase in PBM Fee Was Agreed to in Exchange for Higher Rebate Guarantees - It is true that the SEHIP's PBM administrative fee increased in 2012 from $366,166 to $3,329,451. However, the SEIB agreed to the increased fee in exchange for higher rebate guarantees. In 2012 under the new fee arrangement total rebates received by the SEHIP increased by $ 8 million, more than offsetting the increased fee.

- Strengthen Contract Language - Many of RAS's recommended changes to the ASA appear to be designed to force the claims administrator to comply with RAS's audit procedures; shifting the cost of their recovery audit from RAS to the SEIB. These recommendations would certainly allow RAS to at least attempt to meet the lofty recovery amounts it advertised before the audit. It appears, however, that RAS is simply attempting to shift the financial risk for the audit from themselves to the State of Alabama.

Based on the actual findings of the recovery audit the State of Alabama can rest assured that taxpayers' funds are being very well spent for state employee health benefits. Indeed, the findings confirm what many national studies have been finding for many years - the SEHIP provides state employees with some of the best benefits in the country at the lowest cost in the country.

ATTACHMENT A

Dan Priga
Partner

Six PPG Place, Suite 400
Pittsburgh, PA 15222
412 355 8735
dan.priga@mercer.com
www.mercer.com

MERCER

Mr. William Ashmore
Chief Executive Officer
State Employee's Insurance Board
PO Box 304900
Montgomery, AL 36130

Mr. Jim Bradford, Esq.
General Counsel
State Employee's Insurance Board
PO Box 304900
Montgomery, AL 36130

September 30, 2014

Subject: Industry Audit Practices

Dear Mr. Ashmore and Mr. Bradford:

You asked Mercer to review documentation provided by both Recovery Audit Specialists, LLC (RAS) and Blue Cross Blue Shield of Alabama (BCBSAL). Our review of the documentation focused on what aspects of the process which initially appear to either conform or not conform to general industry health plan audit practices. After our review of the documentation, it is Mercer's opinion that BCBSAL's practices shown in this documentation appear generally consistent with those observed within the industry. Below is a list of practices that we have identified in the documentation.

1. Audit Rights/Sample Size – In our experience, it is industry practice to spell out the audit rights a self-funded plan sponsor has in the administrative service contract. This description typically details the time period required for notification of the audit, the sample size the carrier will allow, and expectations for how results will be provided to the carrier and plan sponsor. The sample size range that we have observed in contracts ranges from 200 to 400 claims. We find this language in contracts issued by both BCBS plans nationally and by commercial carriers.

2. Sample size larger than contracted limit – All carriers will typically charge plan sponsors if the sample size exceeds the limit shown in the contract. It is common for the fees associated with producing a sample larger than contracted limited to be prohibitively expensive. This is the result of the carrier not having staffing resources available to assist with large sample requests or the magnitude of requests that may occur if this became a precedent in the market with all their clients. In the past some audit firms would produce a list of thousands of claims believed to be in error and expect the carrier to review all of them. Commercial carriers and BCBS plans have studied this and determined that the false positive rate on these error listings often exceeded 95%. They put in place fees to discourage this approach.

3. Data files – BCBS and commercial carriers have a standard data file that they will produce for audit firms. Usually, the data contained in that file is sufficient for the audit firm to review and perform its sample selection. Deviation from the standard data file is usually negotiated with the audit firm and if a decision is made to produce a non-standard data file, it is usually accompanied by a fee for the production of the file. Given the current HIPAA requirements, carriers are very concerned about expansive requests to release non-standard data files.

4. Overpayment recovery – It is common for a carrier to only agree to pursue overpayments for those errors it has agreed to. Claims in dispute (not agreed to errors) are not pursued until some agreement is reached that an error actually occurred. We note that there are 17 disputed errors that BCBSAL believes the documentation provided justifies its actions and the accuracy of the claim payment. Mercer, separately, upon authorization from SEIB will review the documentation provided and provide an opinion on whether or not the documentation provided is sufficient to make a determination.

5. Unrestricted pharmacy audit rights – Mercer has encountered this issue with some BCBS plans and vendors where the contract limits the ability to conduct a 100% pharmacy audit. This is a contract matter where SEIB will need to negotiate with the pharmacy benefits manager to include this in the contract. We note that although RAS lists this as an issue with the conduct of the audit, it appears that they were able to conduct a 100% audit of pharmacy plans. The challenges with such contracting are further discussed in item 11 below.

6. Pharmacy Rebates – It is not uncommon to find rebates set that reflect a plan sponsor's unique business needs. Although it is not uncommon for plan sponsors to want to maximize the rebates it receives, there can be compelling business needs or program and contract trade-offs that may warrant accepting less than the maximum rebates.

7. AWP Lawsuit Settlement – The court required settlement of the class action lawsuits involving First DataBank, Medi-Span and McKesson Corporation in 2009 impacted the way that most self-funded plan sponsors contracted with pharmacy benefit providers. While a couple more common approaches were pursued to target economic neutrality for plan sponsors (between the pre-settlement and post-settlement pricing arrangements), most vendors indicated they would use the "adjusted discount" approach that decreased the AWP and the AWP discounts. Of course, similar to item 6, any specific employer might

have specific program, vendor and organizational considerations as part of being required to adopt the final vendor approach, including potential pharmacy network impacts.

8. Redundant Non-disclosure Agreements – it is not uncommon to have the auditor sign a non-disclosure agreement with a carrier. In our work with some states, we too have had to sign multiple non-disclosure agreements with carriers where multiple employee groups have separate contracts with the third party administrator. This is a common requirement with third party administrators. This would be an issue for legal counsel to review and/or negotiate with the third party administrator.

9. Lack of Cooperation – RAS has raised what we think may be a legal issue between state's or Alabama law and the contract terms or regulations governing conduct of an audit with self-insured employer health plans. Mercer is not a law firm and cannot comment on this potential legal issue.

10. Remote Read Only Access Denied – It is industry practice regarding audits of group health plans to require the onsite review of claims.

11. Incentives to Compel Compliance – Yes, the use of incentives/performance guarantees to compel compliance with data requirements to conduct an audit, sample size, on or off-site conduct of the audit can be included in any performance agreement assuming the carrier is willing to do so. We find that most carriers are not willing to do much more than agree to the timing of data release and in some rare cases the accuracy of such data. In addition, there can reasonably be a broader business concern for the carriers if they were to set a precedent in the market by offering broader and more detailed audits than their standard industry position. From our perspective, the mandatory inclusion of non-standard incentives/performance guarantees can result in the carrier refusing to bid or raising administrative service fees to off-set the risk. Ultimately, the ability to negotiate such contracts can be difficult and must consider the practical aspects of the carriers' total market positioning and possible responses to such requirements.

MERCER

We appreciate the opportunity to assist the State with this review. If you have questions regarding this, please feel free to contact me or other members of the team.

Sincerely,

Dan Priga
Partner

Copy:
Slate Taylor
Tony Holmes

ATTACHMENT B

Dan Priga
Partner

Six PPG Place, Suite 400
Pittsburgh, PA 15222
412 355 8735
dan.priga@mercer.com
www.mercer.com

MERCER

Mr. William Ashmore
Chief Executive Officer
State Employee's Insurance Board
PO Box 304900
Montgomery, AL 36130

Mr. Jim Bradford, Esq.
General Counsel
State Employee's Insurance Board
PO Box 304900
Montgomery, AL 36130

October 28, 2014

Subject: RAS Audit of SEIB – Audit Documentation Review

Dear Mr. Ashmore and Mr. Bradford:

Mercer Health and Benefits, LLC (Mercer) was engaged by the Alabama State Employee's Insurance Board (SEIB) to perform a documentation review of the audit findings of Recovery Audit Specialists (RAS) and the documentation provided by Blue Cross Blue Shield of Alabama (BCBSAL) in response to the audit findings.

The following documents were provided to Mercer by SEIB to conduct the review and make a determination of whether or not the documentation provided by BCBSAL appears sufficient to allow RAS to make a determination of error:

- RAS' Recovery Audit Findings Report on Initial 200 Medical Claims
- BCBSAL's 2013 SEIB Audit Report Responses
- SEHIP Handbooks 2007-2013
- BCBSAL's documentation for the 17 unresolved claim issues.

Below is Mercer's initial determination on each of the unresolved issues.

Hospital Claims Review

- ***Sample 2*** – Yes, documentation is sufficient to remove error. Services rendered in a free standing dialysis center are paid under Major Medical per the Handbook and not subject to the per test copayment. Remove overpayment of $210.00.
- ***Sample 2a*** – Yes, documentation is sufficient to remove error. BCBS provided the pricing details and pre-certification documentation. The high dollar worksheet was not provided but this documentation is not needed to verify pricing and pre-certification. Remove overpayment of $363,808.94.

- ***Sample 3*** – No, documentation is not sufficient to remove error. BCBS must provide documentation of questions answered by physician/surgeon during the online medical necessity review process. Additionally BCBS's response regarding inpatient procedures not requiring medical review or authorization is contrary to the Handbook language (page 50 of the 2012 Handbook). The Handbook states "This exclusion does not apply to Bariatric Surgical procedures if medically necessary and in compliance with BCBS's guidelines. Bariatric Surgical procedures are limited to one per lifetime, subject to prior authorization." Lastly, inclusion of preadmission testing in the pricing of the procedure is no longer an industry standard therefore, documentation is not required. Hold overpayment of $2,920.77. Update: On October 27, 2014 Mercer received additional documentation from SEIB. The documentation included responses to the online medical necessity review answered by the provider. The response indicates that the patient did not participate in any weight loss programs prior to seeking surgical intervention. The documentation provided does not change Mercer's initial opinion and the error should not be removed.
- ***Sample 5*** – No, documentation is not sufficient to remove error. Page 61 of the 2011 Handbook, under Right of Reimbursement, states "...you will pay to BCBS the amount of money recovered by you through judgment or settlement from the third person or his insurer, as well as from any person, organization, or insurer, up to the amount of benefits paid or provided by us." Hold estimated overpayment of $5,000.00. Update: On October 27, 2014 Mercer received additional documentation from SEIB. The documentation included an email from SEIB to BCBSAL confirming that SEIB did not want to exercise their right to recovery when the employees received payment from their own insurance. If this documentation was provided to RAS, it should be sufficient to remove the error.
- ***Sample 7*** – Yes, documentation is sufficient to remove error. Charges made by hospital did not change based on insurance coverage, the allowable expense was based on insurance coverage and the provider's contracted rate. DRG pricing is an industry common pricing strategy. Remove overpayment of $1,117.28.
- ***Sample 15*** – No, documentation is not sufficient to remove error. Diagnosis on the provider bill indicates: mechanical complication of cardiac device, implant and graft – breakdown (mechanical), displacement, leakage, obstruction (mechanical), perforation or protrusion of; due to automatic implantable cardiac defibrillator, due to cardiac pacemaker (electrode). BCBS should have requested medical records to determine if the device was replaced due to a product defect or recall. Hold overpayment of $15,983.40.

- ***Sample 22*** – No, documentation is not sufficient to remove error. The 2011 Handbook, page 48, states services related to sexual dysfunctions are not covered and does not include the wording "not related to organic disease." Hold overpayment of $6,528.16.
- ***Sample 24*** - Yes, documentation is sufficient to remove error. BCBSAL provided documentation showing the facility was not a SEIB approved mental health facility. Remove procedural error.
- ***Sample 25*** - Yes, documentation is sufficient to remove error. Services rendered in a free standing dialysis center are paid under Major Medical per the Handbook and not subject to the outpatient copayment. Remove overpayment of $25.00.
- ***Sample 40*** - Yes, documentation is sufficient to remove error. Services rendered in a free standing dialysis center are paid under Major Medical per the Handbook and not subject to the outpatient copayment. Remove overpayment of $25.00.
- ***Sample 41*** – No, documentation is not sufficient to remove error. Page 62 of the 2012 Handbook, under Right of Reimbursement, states "...you will pay to BCBS the amount of money recovered by you through judgment or settlement from the third person or his insurer, as well as from any person, organization, or insurer, up to the amount of benefits paid or provided by us." Hold overpayment of $10,000.00 (estimated?). Update: On October 27, 2014 Mercer received additional documentation from SEIB. The documentation included an email from SEIB to BCBSAL confirming that SEIB did not want to exercise their right to recovery when the employees received payment from their own insurance. If this documentation was provided to RAS, it should be sufficient to remove the error.
- ***Sample 44*** - No, documentation is not sufficient to remove error. SEIB should verify if they have agreed to follow all BCBS standard policies and procedures even if they conflict with the Handbook. Per page 47 of the 2011 Handbook, non-covered services include services or expenses to care for, treat, fill, extract, remove or replace teeth. Hold overpayment of $2,701.92.
- ***Sample 48*** - No, documentation is not sufficient to remove error. BCBS did not provide adequate documentation that the provider's contract does not include lessor of language. Hold overpayment of $880.40. Update: On October 27, 2014 Mercer received additional documentation from SEIB. The documentation included a template contract that BCBSAL uses for their participating hospitals. A template contract is not sufficient documentation to remove the error as it does not verify that the contract in place with this hospital has the exact same wording and provisions.

MERCER

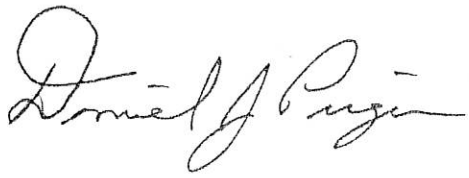
- ***Sample 67*** - Yes, documentation is sufficient to remove error, however BCBS should investigate this provider's corrected billing as it is very unusual for a patient to be in an observation status (considered outpatient) for a 3 day period (1/29-2/1). Three surgical procedures were performed on 2 separate dates according to the outpatient bill – 1/31 and 2/1. Remove overpayment of $358.95.
- ***Sample 97*** - Yes, documentation is sufficient to remove error. Timely filing is calculated on the original receipt date however, it is suspect when a provider resubmits a claim 20 months after the original submission and receives a higher benefit as the result of the corrected claim. Remove overpayment of $7,590.00.

Physician Claims Review

- ***Sample 6*** - Yes, documentation is sufficient to remove error. Online pre-determination information furnished by the physician was provided. Remove overpayment of $95.32.
- ***Sample 11*** - Yes, documentation is sufficient to remove error. Diagnosis of sleep apnea and congenital defect. Remove overpayment of $6,891.50.

We would be happy to discuss our determinations with SEIB, RAS and BCBSAL.

Respectfully submitted,



Dan Priga
Partner

Public Education Employees Insurance Plan's (PEEHIP) Response to Recovery Audit

PEEHIP Board of Control
Sarah S. Swindle, Chair
Susan W. Brown, Vice Chair

David G. Bronner, CEO
Donald L. Yancey. Deputy Director

PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN

Overview of PEEHIP's Response to the Draft Audit Report by Recovery Audit Specialists, LLC

(Submitted to the Alabama Department of Examiners of Public Accounts on October 31, 2014)

In the attached letter, PEEHIP responds to the draft audit report by Recovery Audit Specialists, LLC ("RAS"). Some of the main points of that response are highlighted below:

- The vast majority (**99.9%**) of PEEHIP medical claims were **accurately paid** according to RAS's purported sample.
- RAS found **no overpayments** in PEEHIP's pharmaceutical spend of nearly **$650 million**.
- PEEHIP provided RAS data for 100% of all medical claims, totaling approximately **$1.5 billion**. RAS found only **three (3)** undisputed overpayments, totaling only **$10,321.58**, out of the 200 medical claims RAS hand-selected to review.
- RAS lists 23 medical claims as "undocumented" overpayments, but an independent expert determined that there was **no evidence of overpayment** in any of the claims.
- PEEHIP would have had to spend **$2.8 million** to provide RAS the complete medical and procedural review it sought.
- If PEEHIP negotiated the pharmaceutical management terms RAS recommends, PEEHIP could not obtain its aggressive discount guarantees and would **incur higher pharmaceutical costs**.
- RAS **incorrectly asserts** that PEEHIP could have lowered its costs due to a lawsuit settlement that changed drug price calculations. An independent expert certified that PEEHIP's response was appropriate and that **no plan sponsors lowered costs** as a result of the settlement.
- The RAS draft report **exceeds the scope** of the audit review contemplated by the authorizing legislation, Ala. Code § 41-5-6.1.

(Mailing Address) P.O. Box 302150 ♦ Montgomery, AL 36130-2150
(Office Location) 201 South Union Street ♦ Montgomery, AL
334.517.7000 or 877.517.0020
www.rsa-al.gov

PEEHIP Board of Control
Sarah S. Swindle, Chair
Susan W. Brown, Vice Chair

David G. Bronner, CEO
Donald L. Yancey. Deputy Director

PUBLIC EDUCATION EMPLOYEES' HEALTH INSURANCE PLAN

October 31, 2014

Ronald L. Jones, Chief Examiner
State of Alabama Department of Examiners of Public Accounts
P.O. Box 302251
Montgomery, AL 36130-2251
(334) 242-9200

Re: Draft Audit Report by Recovery Audit Specialists, LLC

Dear Mr. Jones:

We respectfully submit this letter and the enclosed materials in response to the draft recovery audit management report from Recovery Audit Specialists, LLC ("RAS"), covering the time period from 2009 to 2011. We are pleased with the draft report's indication that over 99.9% of PEEHIP medical claims, and all known PEEHIP pharmaceutical claims, were paid correctly, reflecting an excellent accuracy rate. However, RAS's draft report also contains significant inaccuracies regarding the PEEHIP audit process, PEEHIP medical and pharmaceutical claims, PEEHIP's third-party-administrator arrangements, and relevant industry standards in the health benefits field.

With respect to PEEHIP's medical plan, the RAS report inaccurately faults PEEHIP for RAS's audit process and improperly seeks reimbursement for valid payments. With respect to PEEHIP's pharmaceutical plan, the RAS report misunderstands PEEHIP's contractual arrangements with its benefits managers. Finally, as a general matter, much of the draft report exceeds the scope of the audit review contemplated by the authorizing legislation, Ala. Code § 41-5-6.1, and has nothing to do with the validity of medical or pharmaceutical claims.

To ensure a thorough and accurate response to RAS's draft report, PEEHIP not only conferred with its third-party administrators regarding the relevant issues but also engaged Segal Consulting and Advanced Pharmacy Concepts, experienced health benefits consultants who are familiar with PEEHIP's health plan. Those consultants—who were not engaged by PEEHIP

(Mailing Address) P.O. Box 302150 ♦ Montgomery, AL 36130-2150
(Office Location) 201 South Union Street ♦ Montgomery, AL
334.517.7000 or 877.517.0020
www.rsa-al.gov

during the time period covered by the RAS audit—analyzed and refuted the central assertions in RAS's draft report, and their analyses are attached hereto as supporting exhibits.

A. PEEHIP's Medical Plan

In its draft report, RAS mischaracterizes the PEEHIP medical audit process and wrongly criticizes PEEHIP's extensive work facilitating that process. In addition, RAS errs in its substantive conclusions that numerous medical claims paid by Blue Cross Blue Shield of Alabama ("BCBS") should be rejected as "undocumented"—to the contrary, the information provided validates the claims and/or demonstrates proper documentation of the claims in accordance with BCBS policies (and none of the information evinces any overpayment). Each of those issues is addressed in turn below.

1. The Medical Audit Process

PEEHIP worked extensively, over the course of many months, to facilitate RAS's audit of PEEHIP's medical claims, at considerable resource expense. It is estimated that PEEHIP's work in relation to the RAS audit has consumed more than 200 hours of PEEHIP staff time, not including the time and resources expended by PEEHIP's contractors. PEEHIP worked diligently to provide relevant medical claims information, in coordination with BCBS, in response to reasonable requests from RAS.

In its draft report, RAS repeatedly distorts the nature and extent of PEEHIP's facilitation of the medical audit process. RAS insinuates, for example, that an unwarranted delay resulted from PEEHIP's need to determine whether federal regulations under the Health Insurance Portability and Accountability Act (commonly known as "HIPAA") would permit the audit to proceed as RAS wished. (Draft Report at page 8.) RAS fails to disclose that PEEHIP initially was told by federal regulators that the audit should not be permitted. While the regulators later changed their position and allowed the audit to proceed, the interim delay clearly was necessary for PEEHIP to ensure its compliance with applicable law. RAS also insinuates, without justification, that unwarranted delays resulted from the need to execute simple non-disclosure agreements to ensure that personal and confidential information would be protected. (Draft Report at page 8.)

As another example of RAS's misleading narration, RAS criticizes PEEHIP and BCBS for the data they provided to RAS. PEEHIP provided data for 100% of all medical claims (totaling over $1 billion), as RAS initially requested, and RAS's initial audit determined that 95% of PEEHIP's medical claims were accurately paid (demonstrating that BCBS "met industry expectations based on information available at the time a claim was processed"). (Exhibit 1 at page 4.) RAS notes in its draft report that BCBS provided additional supporting documentation on only 200 claims (hand-picked by RAS) for RAS's further review, rather than providing such additional documentation for the 5% of claims flagged by RAS's software (more than 55,000 claims total) which RAS sought to review further. (Draft Report at pages 3-5, 8-9.) RAS omits the critical fact that PEEHIP would have had to spend millions of dollars for BCBS to provide the complete body of additional data RAS sought. (See Exhibit 4, BCBS's cost estimate of $2.8 million to assimilate and produce the information RAS requested for 5% of PEEHIP claims.) PEEHIP has no provision in its current contract with BCBS for conducting a medical audit of the

magnitude RAS sought. Such a provision would require significantly higher administrative fees, and PEEHIP presently has no state funds dedicated for that purpose. PEEHIP worked diligently with RAS and BCBS, however, to provide information for RAS's audit. As noted by Mercer in relation to their review of RAS's draft report for the State Employees' Insurance Board, the rate of false positives in an initial audit review often exceeds 95%. (See SEIB Response to RAS Draft Report, Attachment A at page 1.) Segal, PEEHIP's own outside consultant, observed that a sample of 200 claims is appropriate and consistent with standard practices in health benefits audits. (Exhibit 2 at pages 3-4.) RAS found that none of the 200 claims reviewed contained any systemic errors. (Draft Report at page 4.)

Importantly, RAS's ostensible "sample" of 200 claims was skewed against PEEHIP, as the claims were not randomly selected but rather were specifically chosen by RAS from the subset of 5% of PEEHIP claims that RAS's software had already flagged as potentially inaccurate. (See Draft Summary at page 2; Draft Report at page 9.) Moreover, RAS selected 200 claims that were over six times as expensive, on average, as the average PEEHIP claim. It is therefore significant that RAS found only three (3) undisputed overpayments, totaling $10,321.58, in the entire purported "sample" of 200 claims. Based on that figure, even accepting RAS's "sample" of 200 claims as valid, the draft report indicates that BCBS accurately paid over 99.9% of PEEHIP claims during the audited time period.

2. <u>The Challenged Medical Claims</u>

Perhaps most fundamentally, RAS is simply incorrect in its assertions that 23 PEEHIP claims should be deemed "undocumented" and should be reimbursed based on the information available at this time. (Draft Report at pages 14-22.) RAS takes the position that reimbursement should be demanded for valid medical claims on which BCBS has properly followed its standard review procedures and as to which no evidence exists to demonstrate an overpayment. (Draft Report at pages 15-22.) That position is untenable, given that none of the information received from BCBS suggests that any of the 23 disputed claims involved any overpayment. PEEHIP's review of the information provided by BCBS, as well as an external review by PEEHIP's outside consultant, revealed that eleven (11) of those 23 claims should have been validated by RAS based on the information provided, with the remainder of the claims to be removed from "overpayment" status unless and until additional evidence is obtained that indicates an overpayment took place. (See Exhibit 2 for a claim-by-claim analysis of the 23 disputed claims; see also Exhibit 1 at pages 6-7.)

As an example, with respect to Claim 93, RAS received documentation showing that a PEEHIP member received appropriate treatment for an injury that resulted from a fall in the member's kitchen, and the health care provider was appropriately compensated in the amount of $2,504.35 for that treatment. (Draft Report at page 22.) RAS seeks further documentation to show that the injury "was not the responsibility of another party" who the member might have sued for compensatory damages (potentially yielding a subrogation claim by PEEHIP). Such confirmation could be worthwhile if easy enough to obtain. None of the information received from BCBS, however, suggests that the member's fall in their own home gave rise to a lawsuit, and that question hardly justifies RAS's recommended demand for reimbursement on the full claim. Notably, RAS does not suggest that BCBS failed to review and document the claim appropriately pursuant to its contractual obligations, internal policies, and industry standards.

RAS simply recommends a demand for reimbursement on a valid claim based solely on the unsubstantiated possibility of a lawsuit yielding a subrogation claim.

In sum, none of existing data concerning the 23 claims RAS deems "overpayments" suggests that BCBS has improperly documented the claims or that BCBS owes reimbursement for the claim payments. Indeed, RAS fails to point out any deficiencies in BCBS's claims review policies and procedures, and RAS makes no recommendations for any improvements thereto. (See Exhibit 1 at page 2.) Furthermore, RAS does not suggest that BCBS failed to follow its review and documentation policies appropriately with respect to any of the 23 disputed claims. (See Exhibit 1 at page 6 ("RAS appears to have requested many documents that were not required according to BCBSAL policy to determine the claim compensable under PEEHIP's plan.").)

B. PEEHIP's Pharmaceutical Plan

RAS found no overpayments by PEEHIP's pharmaceutical plan. Instead, RAS's draft report levies two criticisms against PEEHIP on the pharmaceutical side. First, RAS asserts that PEEHIP's contract with its pharmaceutical benefits manager (or "PBM"), MedImpact, departs from industry standards by allowing MedImpact to average the discounts it achieves on pharmaceutical transactions in order to meet its performance guarantees. Second, RAS asserts that PEEHIP should have received steeper discounts from its prior PBM, Express Scripts, as a result of a litigation settlement in which PEEHIP was not involved. As explained below, each of those incorrect assertions reflects RAS's misunderstanding of standard practices in pharmaceutical benefits management and of the arrangements between PEEHIP and its PBMs.

1. Offsetting in PBM Contracts

As PEEHIP's PBM, MedImpact negotiates pricing with retail pharmacies (both national chains and local independents). PEEHIP's contract with MedImpact provides that MedImpact must meet certain guaranteed average price discounts for PEEHIP members' aggregate pharmaceutical purchases within specified "channels," such as retail or specialty. Those average discounts are included as "performance guarantees" in MedImpact's contract, and discounts are calculated by comparing PEEHIP's prices with the Average Wholesale Price (or "AWP") for the purchased drug. AWPs are published by professional industry observers such as First DataBank.

Pursuant to its contract, MedImpact must pay penalties to PEEHIP if MedImpact fails to achieve its performance guarantees for average discounts below the AWP. MedImpact's performance guarantees apply at an aggregate level within each drug channel, so that MedImpact is penalized if it fails to achieve its guaranteed discount with respect to PEEHIP claims <u>on average</u> within a given channel. (Of course, the AWP from which the discounts are calculated is itself merely a published average.) Put simply, if MedImpact's negotiations with retailers result in PEEHIP paying an amount <u>above</u> its guaranteed discount on one transaction, MedImpact can avoid paying a penalty only if it makes up the difference by obtaining a price <u>beneath</u> the guaranteed discount for another transaction. Averaging the price discounts obtained among various transactions is commonly referred to as "offsetting". PEEHIP's contract with MedImpact provides for appropriately limited offsetting within specified channels. (See Ex. 1 at page 3 ("We note that the offset provision in the PEEHIP contract is limited to within a

particular channel (e.g. retail) which limits the extent to which the offset can be used by the PBM. We conclude that the offset provisions in the PBM contract within the context of the overall pricing guarantee between PEEHIP and its PBM are reasonable and consistent with industry norms.”).)

RAS claims that the allowance of offsetting in PEEHIP’s PBM contract does not reflect common practices in pharmaceutical benefits management. (Draft Report at pages 48.) That claim is false, as offsetting is a ubiquitous industry standard. (See Exhibit 1 at page 3; Exhibit 3 at pages 2-3; Exhibit 5.) RAS recommends that PEEHIP negotiate guaranteed price discounts at the individual claims level (Draft Report at 49), an unrealistic proposition that misunderstands the PBM arrangement. To include a price guarantee on each individual transaction (or at the “claims level”), as RAS suggests, would be administratively unfeasible for a plan of PEEHIP’s size and nature. According to PEEHIP’s consultants, such arrangements are rare in commercial benefit plans. (See Exhibit 3 at page 3.) Indeed, PEEHIP’s experience in dealing with claims-level discount guarantees for even a small subset of specialty drugs has been negative; to implement claims-level discount guarantees for the entirety of PEEHIP’s pharmaceutical transactions—totaling hundreds of millions of dollars annually—would be counterproductive.

Most importantly, PEEHIP could not possibly have negotiated the aggressive discount guarantees it has in place if those guarantees were not provided at the aggregate, rather than individual claims, level. (See Exhibit 1 at page 3 (“PBMs tend to set pricing guarantees based on whether or not offsets are in-place and to what degree they are in-place.”); Exhibit 3 at page 3 (“If the pricing condition had been per claim reconciliation, the pricing guarantees would have been less aggressive.”).) Therefore, if PEEHIP implemented RAS’s recommendation, it would result in higher pharmaceutical costs for the plan. (See Exhibit 3 at page 3 (“When a PBM is required to guarantee that no claim is adjudicated at a discount less favorable than the per claim guarantee, the PBM will present rates that are at or near their profit threshold for their most expensive pharmacy contract. … A guarantee by channel is recommended, which means that [various channels] would be reconciled within their own categories [as PEEHIP’s PBM contract provides].”).) In ignoring those realities, the RAS draft report fundamentally misunderstands the nature of pharmaceutical benefits management and PEEHIP’s PBM arrangements.

2. The AWP Lawsuit Settlement

A class action settlement in 2009 changed the calculation of AWP by First DataBank, a publisher of AWP data. (See Exhibit 1 at page 2; Exhibit 3 at pages 3-7.) RAS asserts that the settlement would have reduced PEEHIP pharmaceutical costs by 5% but for an adjustment of discount guarantees by PEEHIP’s PBM at the time, Express Scripts, and RAS claims that PEEHIP’s costs increased by $15.7 million as a result of Express Scripts’ adjustment to the guarantees. (Draft Report at pages 49-51.) Again, RAS misunderstands the nature of pharmaceutical benefits management. (See Exhibit 1 at page 2 (“In Segal’s experience working with hundreds of plan sponsors that provide prescription benefits through PBMs, as well as our knowledge of PBMs, retail pharmacies, and other plan sponsors, **we are not aware of any plan sponsor that benefited from lower actual prescription costs as a result of the AWP change in 2009**. Therefore, we disagree with the assertion that PEEHIP’s costs increased unnecessarily as a result of the AWP change amendment between PEEHIP and its PBM.”); Exhibit 3 at page 3

("We believe that **the RAS report conveys a misunderstanding of the AWP settlement** and of PBMs' handling of the implications of that settlement.") (emphases added).)

In short, RAS confuses AWP calculation with actual payment experience. (See Exhibit 3 at page 6 ("The RAS report to the State of Alabama states that wholesale drug costs decreased by 5% as a result of this settlement (page 35 of RAS report) and suggests that PEEHIP's cost should have decreased as well. This is a misconception.").) AWP is an abstract number used by PEEHIP to calculate discounts, whereas the dollar amounts actually paid for pharmaceutical products are a function of many other variables. That confusion leads RAS to assert incorrectly that the new AWP calculation equated with a change in PEEHIP's actual costs. RAS's confusion also underlies its unwarranted criticism of the 2009 adjustment to the Express Scripts discount guarantees, which was consistent with industry standards (see Exhibit 3 at page 6) and which was expressly contemplated in the governing contract (such that an attempt by PEEHIP to preclude the post-settlement adjustment would have been inconsistent with the explicit terms of its contract and the intent of the parties in negotiating the contract).

Due to its confusion regarding the AWP settlement, the assertions in RAS's draft report regarding alleged cost increases in connection with that settlement are simply wrong.

C. Scope of Audit

Finally, the RAS draft report exceeds the scope of the audit review contemplated by the legislation that authorizes RAS's audit, Ala. Code § 41-5-6.1. The draft report goes far beyond attempting to determine whether PEEHIP claims payments between 2009 and 2011 were valid and correct, as the authorizing legislation contemplates. Instead, as discussed above, RAS also presents opinionated critiques of standard contractual terms that reflect fundamental misunderstandings of the industry. In doing so, RAS exceeds the scope of the audit authorized by Ala. Code § 41-5-6.1, which purports specifically to uncover payments in excess of amounts due. See Ala. Code § 41-5-6.1(a)(3) (defining the authorized "recovery audit" as a "financial management technique used to identify overpayments made by a state agency . . . in connection with a payment activity"); id. at § 41-5-6.1(a)(2) (defining "overpayment" as a "payment in excess of amounts due" including "failure to meet eligibility requirements, failure to identify third party liability where applicable, any payment for an ineligible good or service, any payment for a good or service not received, duplicate payments, invoice and pricing errors, failure to apply discounts, rebates or other allowances, failure to comply with contracts or purchasing agreements, or both, failure to provide adequate documentation or necessary signatures, or both, on documents, or any other inadvertent error resulting on overpayment").

Similarly, RAS also includes in its draft report a number of broad-sweeping pontifications on policy matters, such as Alabama's allocation of responsibility among different state agencies for managing the health benefits of different populations of public employees. RAS cites no qualifications, much less any quantitative evidence or objective basis, for its conclusions, which have no bearing on the claims data it received and analyzed during its audit. The audit process was designed and statutorily contemplated to uncover overpayments, see id. at § 41-5-6.1(a)(3), rather than to assess state policy—a subject on which RAS appears to have inadequate expertise and insufficient experience.

Thank you for giving us the opportunity to highlight these important issues and to clarify PEEHIP's understanding of the topics discussed in RAS's draft report. Please let me know if I can provide any further information or be of any assistance.

Very truly yours,

Don Yancey
Deputy Director

Leura Canary
General Counsel

Diane Scott
Chief Financial Officer

List of Exhibits

Exhibit 1 – Analysis of RAS Draft Report by Segal Consulting
Exhibit 2 – Attachment to Analysis of RAS Draft Report by Segal Consulting
Exhibit 3 – Analysis of RAS Draft Report by Advanced Pharmacy Concepts
Exhibit 4 – Correspondence from Blue Cross Blue Shield of Alabama
Exhibit 5 – Correspondence from MedImpact

This Page Intentionally Blank

Exhibit 1

Segal Consulting

2018 Powers Ferry Road SE Suite 850 Atlanta, GA 30339-7200
T 678.306.3100 www.segalco.com

October 22, 2014

Ms. Diane Scott
Chief Financial Officer
Retirement Systems of Alabama
PEEHIP
201 South Union St.
Montgomery, AL 36130

Dear Diane:

Recovery Audit Specialists, LLC (RAS) recently conducted an audit and review of the pharmacy and medical benefits provided by The Public Education Employees' Health Insurance Plan (PEEHIP) and The State Employees' Health Insurance Plan (SEHIP). RAS reviewed past payment and claims processing practices, including the supporting contracts, for PEEHIP and SEHIP and their contracted vendors. The report contains RAS's findings and recommendations to both plans.

As an independent advisor to PEEHIP, Segal Consulting was requested to review and comment on RAS's report and its claims and recommendations relative to PEEHIP. For this review, we enlisted our National Pharmacy Practice Leader and our National Audit Practice Leader. This letter contains our comments, which are based on Segal's relationship with PEEHIP as its current health benefits consultant and our general knowledge and expertise in the health benefits area. We note that we were not engaged as PEEHIP's consultant during the period of time covered by the audit (FY 2009-2011).

Summary Findings

Segal's Pharmacy and Claims Administration experts have reviewed the respective RAS report sections in detail. Based on the information provided for our review, we disagree with certain findings and recommendations presented by RAS related to pharmacy benefit claims. We also cannot support the position presented by RAS with respect to certain medical claim disputes without further discussion and review of source data files and documentation. Further detail is provided within this document and attachment for the following observations.

- **Pharmacy Average Wholesale Price (AWP) Change -** We disagree with the assertion that PEEHIP's costs increased unnecessarily as a result of the AWP change amendment between PEEHIP and its pharmacy benefit manager (PBM). During the time period covered in RAS's review, PEEHIP's PBM was Express Scripts.

- **Pharmacy Offsets Between Pricing Shortfall and Surplus -** We conclude that the offset provisions in the PBM contract within the context of the overall pricing guarantee between PEEHIP and its PBM are reasonable and consistent with industry norms.

- **Medical Undocumented BCBSAL Payments –** Of the 23 claims in dispute, 11 should be removed ($55,687.50) and another 12 should be removed until further documentation is presented to establish an overpayment exists ($32,006.50).

Audits can be conducted to detect overpayments that may have been missed during claims adjudication and standard recovery processes. However, it is equally important to understand if established policies that were in effect at the time the claim was processed and reviewed were followed and if improvements are recommended to support timely recovery efforts. The RAS report lacks commentary on deficiencies in administrative procedures and/or recommendations for process improvement.

Pharmacy

Average Wholesale Price (AWP) Change

On page 35 of their report, RAS asserts that by PEEHIP agreeing to a contract amendment with their pharmacy benefit manager (PBM) related to AWP "neutrality", PEEHIP's costs increased unnecessarily by $15.7 million.

AWP is widely used in the pharmaceutical and pharmacy benefit industries as a benchmark or list price for pricing purposes. In 2009, First DataBank, the publisher of AWP data, reduced AWP by approximately four percent, for certain prescription drugs, based on the settlement terms of a class action suit. To our knowledge no manufacturer, wholesaler, or other seller of prescription drugs reduced the actual price charged for prescription drugs as a result of the change in AWP. Since PBMs are major purchasers of prescription drugs, in order to maintain the neutrality of their existing agreements with plan sponsors, PBMs initiated contract amendments in order to change the AWP discount guarantees to reflect the reduced AWP prices so that the overall economic terms between the PBM and plan sponsor would remain unchanged.

In Segal's experience working with hundreds of plan sponsors that provide prescription benefits through PBMs, as well as our knowledge of PBMs, retail pharmacies, and other plan sponsors, we are not aware of any plan sponsor that benefited from lower actual prescription costs as a result of the AWP change in 2009. Therefore, we disagree with the assertion that PEEHIP's costs increased unnecessarily as a result of the AWP change amendment between PEEHIP and its PBM.

Offsets Between Pricing Shortfall and Surplus

On page 48 of their report, RAS notes that the PBM is allowed to use surpluses (drugs for which the actual discount is greater than the guaranteed discount) to offset shortfalls (drugs for which the actual discount is less than the guaranteed discount) which RAS refers to as "overcharges". They indicate that without this offsetting feature costs to PEEHIP would have been approximately $1.9 million lower (page 34 of report). Further RAS states that "This is inconsistent with common – and more favorable – language found in PBM contracts that require the PBM to 'meet or exceed' a specified guarantee in the contract (e.g. when the PBM gets a better price, the plan benefits, not the PBM)".

We disagree with the assertion that "offsets", where a PBM may deduct shortfalls from one pricing category from surpluses in another category, are not common in the PBM industry. The majority of agreements between plan sponsors and PBMs include some variation of such offset provisions. We do agree that, all things being equal, it is beneficial to plan sponsors to negotiate the elimination or minimization of such offsets. However, it is important to note that PBMs tend to set pricing guarantees based on whether or not offsets are in-place and to what degree they are in-place.

For example, a PBM may be willing to provide guaranteed pricing without any pricing offsets, however in such cases the actual discount guarantee may be lower than in a case where offsets are allowed. Therefore, an assessment of whether contract terms are competitive or appropriate can only be made based on the entirety of the pricing guarantees as well as other related provisions such as those related to pricing offsets. We note that the offset provision in the PEEHIP contract is limited to within a particular channel (e.g. retail) which limits the extent to which the offset can be used by the PBM. RAS also neglects to reference the usual and customary (U&C) provision contained in the PBM contract which requires the PBM to charge PEEHIP the lessor of the contract discount price or the pharmacy's U&C or "cash" price. This provision provides PEEHIP the benefit of any claim level discount or reduced price offered by the pharmacy, ensuring PEEHIP receives the best price available.

We conclude that the offset provisions in the PBM contract within the context of the overall pricing guarantee between PEEHIP and its PBM are reasonable and consistent with industry norms.

Medical

Industry Standard Audits

Before commenting on the RAS report, we believe it is important to recognize industry standards relating to audits and overpayment recoveries. There are two industry audits that require distinction; each produces a sample of claims that require review of source documentation to determine if each sampled claim was paid according to plan provisions.

1. **Random sampling** (i.e., statistical, stratified) of 200-225 claims to determine overall processing performance with comparison to performance guarantees and/or industry standards. Claims are randomly selected to measure 99% or better financial accuracy and 95% or greater accuracy for the number of claims without payment or procedural error.

2. **Focused reviews** targeting claims with possible overpayment identified through a series of electronic analyses, which often includes classification of errors and a variety of claims sampled to identify patterns and/or large dollar claims for greater financial recovery. The methods employed and types of claims sampled vary based on the audit firm's area of expertise.

    a. **Coding edits** (i.e., unbundled and upcoded services, medical appropriateness, etc.) are based on AMA and CMS guidelines, but often vary based on the payer's own medical policy, provider contract provisions, and medical claim review of a patient's file.

    b. **Duplicate payments** for the same patient, provider, date of service and procedure. False positives may be sampled if the data file does not contain related adjustments, procedure code modifiers, and/or provider specialty codes that can assist in refining the query.

    c. **Third party recovery opportunities** which often review up to five years of data to gather patterns of care that require further investigation; selections are often based on diagnosis and/or procedure codes that reflect an injury or a combination of past services that suggest an opportunity for participation in product liability suits (i.e., complications following mesh implant, extended prescription use now known to present medical problems).

Most claim administrative service contracts contain audit provisions that limit the audit period, sampling methodology, number of claims selected, and onsite days; some contracts also require approval of the audit firm engaged to ensure a constructive approach that includes review of potential errors and discussion of any recommendations for improvement. These restrictions are in place to support random sampling audits that report on overall processing achievements for financial dollar, incidence, and timeliness of processing.

Industry standards allow for sampling of 200-250 claims during a 12-month period that requires no more than five onsite days; contingency arrangements are often prohibited. Many payers will permit a small focus sample as long as the larger number of claims are sampled for overall confidence levels (i.e., 150 statistical and 75 focus). Results are shared with the claims payer for comment and rebuttal prior to the report being shared with the client.

Segal was not provided the sampling methodology employed by RAS; however, their following statement would support that BCBSAL met industry expectations based on information available at the time a claim was processed. *"Approximately ninety-five percent of transactions were deemed accurately paid. Auditors then needed to examine the remaining transactions and supporting documentation for potential overpayments."*

Recovery Audit Specialists

Information provided for this review did not include a copy of the RAS contract with the Examiners of Public Accounts (EPA); however, the report outlines a recovery audit process approved by the Legislature. Their website offers the following audit benefits:

- *Recovery auditing is a complementary process that strengthens your existing financial system of checks and balances, enhances public accountability and improves your bottom line.*

- *Once improper payment claims are approved by you, Recovery Audit Specialists (RAS) helps you collect the improper payments due. Only once improper claims are collected, is RAS compensated from a percentage of the recovered funds that we identified.*

The industry standard practice for review of potential third party liability is after benefit payment has been made. Questionnaires are sent based on a combination of procedure and diagnosis codes that suggest another party may be at fault and financially responsible for some or all of the medical expenses. Ideally, such audits should comment on existing procedures and describe any missed opportunities identified with process improvement recommendations.

Evidence of subrogation investigation was provided by BCBSAL. Of interest would be RAS's summary of any claims they believe were not identified or satisfactorily pursued to recovery or closure and process improvements for discussion with BCBSAL. For example,

- Does BCBSAL identify expenses that may be reimbursed under class action suits such as mesh implants, faulty medical devices, illnesses caused by approved prescription drugs?

- Did BCBSAL follow their established subrogation policies and procedures?

- Are investigation and follow-up procedures appropriate and effective in maximizing recoveries to PEEHIP?

- Were large dollar closed claims reviewed with, or communicated to, PEEHIP?

- How can subsequent audits validate compliance with BCBSAL procedures and policies, explore missed opportunities in a timely fashion, and be coordinated in a fashion that minimizes the ongoing delays and rebuttals experienced during this first RAS review?

RAS Reported Obstacles

RAS reports several challenges that delayed their progress and successful completion of their proposed scope of services.

- *"Procedural delays and negotiation with outside administrators regarding the full recovery audit vs. a sample audit – and the limited size of the sample – consumed 2012 and 2013 and were never resolved."*

- *"These challenges thwarted the full recovery audits envisioned by the state legislature. A recovery audit examines all transactions that appear likely to have an overpayment."*

- *"Performing the medical and pharmacy fraud analysis was prevented due to RAS being unable to obtain the necessary medical data points originally requested in November 2011."*

The stated challenges appear to be due to the request for a non-standard audit, which extends beyond the measurement of benefit accuracy based on information obtained at the time of claims processing or available through standard post-payment subrogation review procedures. In addition, RAS appears to have requested many documents that were not required according to BCBSAL policy to determine the claim compensable under PEEHIP's plan. Such data requests included operative reports for claims coded with multiple and bilateral surgical procedures; accident details for diagnosis not identified by BCBSAL for investigation, and subrogation inquiry for new implants and devices.

RAS Observations

RAS reports 23 payment errors in dispute totaling $98,015.58 for 5 hospital and 18 physician claims; another 3 claims for $10,321.58 in overpayments were agreed to by BCBSAL (RAS reports 26 errors for 87% incidence accuracy within the 200-claim sample representing 5% of all claims). The report further states information requested for many of the claims in dispute was not made available, and that *"Undocumented claims are considered overpayments by auditors under Alabama Act 2011-703 and are submitted to EPA as such with this report."*

RAS Classification of Disputes	RAS Summary
BCBSAL Agreed upon Overpayments for Recovery	$10,321.58
Undocumented Payments	$87,694.00
Total RAS Recommended for Recovery	**$98,015.58**

PEEHIP requested missing documentation from BCBSAL and presented to RAS; the report states "*very little new documentation was included*." Segal was provided copies of the 23 disputed claims on September 26, 2014 for review; a column has been added to the attached RAS report tables to include our commentary, which is provided as an attachment to this letter.

Segal's review is not intended to determine when information became available to BCBSAL or RAS, rather our focus is on the current state of the suggested overpayments. We did not have an opportunity to question RAS or BCBSAL on the claims in dispute; however, we have based our comments on the documentation provided and our experience and knowledge of best practice administration procedures.

Segal understands medical decisions were addressed by BCBSAL on behalf of PEEHIP. Accordingly, claims paid in accordance with BCBSAL policy and/or medical review at the time of payment should be removed from the error classification until such time additional

documentation (i.e., subrogation inquiry, operative report) is provided to support the error assessed by RAS.

We found information supporting the benefit determination for 11 of the 23 disputed claims, 12 additional claims require further follow-up with BCBSAL, the provider, or the patient.

Segal Classification of Disputes	Number of Claims	RAS Overpayment Amounts
Remove	11	$55,687.50
Remove and Follow-Up	12	$32,006.50
Total Recommended for Recovery	**0**	**Pending above Follow-ups**

No systemic errors were identified; therefore, there is no indication that an expanded sample would produce additional value in ongoing review.

Future Audits

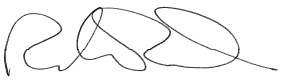
Segal does not dispute the potential value in the RAS post-payment audit process, however, efforts do need to take into consideration a workflow that minimizes time requirements from BCBSAL staff. The request for information not required to process a claim is outside the scope of a typical administrative contract; to request such cooperation without compensation beyond an agreed upon number of hours is unreasonable.

Any payment associated with the RAS or similar focused audits should be based on “recovered” dollars and not simply projected recoveries.

In Closing

Please feel free to contact us to discuss any of our comments or to discuss how we can be of additional service as PEEHIP determines how to respond to RAS’s recommendations.

Sincerely yours,



Richard Ward, FSA, FCA, MAAA
Senior Vice President
Atlanta Health Practice Leader

ATTACHMENT

8084843V1/96019.001

This Page Intentionally Blank

Exhibit 2

Disputed PEEHIP Hospital Claims Details

#/DOS	Sample Selection	BCBSAL Information	Required Action	Segal Comment
10 **Dec 2011**	**$27,172.97 Overpaid-** Documentation was not provided onsite, or to date, to support the medical necessity for the elective procedures performed.	BCBSAL indicated they were considering supplying criteria and documentation of medical necessity requested by the auditor. Subsequent correspondence by BCBSAL advises that the auditor was provided records and criteria while onsite.	The requested documentation was not provided and was re-requested by the auditor 8-16-13 prior to departing the onsite. The criteria for coverage of this elective procedure and medical records showing that the criteria were met are required for the finding to be removed.	**Remove** Prior authorization documentation supports long history of hearing loss with failed amplification from hearing aids; patient was 32 years. Meets BCBSAL policy for coverage.
50 **Feb 2012**	**$60.00 Overpaid-** No documentation was provided showing that the network discount adjustment had been credited to PEEHIP.	BCBSAL responded that the claim processed correctly based on the pricing in effect at the time services were rendered.	No documentation provided. No additional refunds or adjustments are applicable at this time. A PEEHIP override is required to remove the finding.	**Remove with Follow-Up** Paid based on rates available at processing; retroactive settlement of hospital's cost report was in progress but not completed at time of BCBSAL response. Follow-up on adjustment.
78 **Aug 2011**	**$25.00 Overpaid-** No documentation has been provided showing that the network discount adjustment has been credited to the client.	BCBSAL did not respond to this objection.	The auditor viewed a network pricing adjustment while onsite. A PEHIP override is required to remove the finding.	**Remove with Follow-Up** No evidence of related discount adjustment; requires review of change date vs. process date. Change in discount would not alter the $25.00 copayment. Follow-up on adjustment.

#/DOS	Sample Selection	BCBSAL Information	Required Action	Segal Comment
82 **Apr 2012**	**$5,225.24 Overpaid -** A duplicate claim was allowed for reimbursement.	BCBSAL did not respond to this objection.	A review of all claims considered for these dates of service are required for the finding to be removed.	**Remove** RAS notes do not clarify the cause for duplicate assessment. Mother's bill does not include nursery charge; newborn level III sick baby bill is correctly processed as a separate patient claim.
86 **Mar 2012**	**$5,782.94 Overpaid-** A duplicate claim was allowed for reimbursement	BCBSAL provided documentation showing that the primary diagnosis for the newborn claim is V30.00.	The RAS auditor is aware that this code is used exclusively for a well newborn. The baby's claim should not be reimbursed separately, but should be included in the per diem reimbursement allowed for the member's claim.	**Remove** RAS notes do not clarify the cause for duplicate assessment. Mother's bill for 4 days includes 2 day routine nursery; two days for nursery level II charges were correctly processed as a separate patient claim.

Disputed PEEHIP Physician Claims Details

#/DOS	Sample Selection	BCBSAL Response	Required Action	Segal Comment
5 **Dec 2011**	**$55.00 Overpaid -** BCBSAL did not provide documentation to support payment of the procedure that is often performed for cosmetic purposes.	BCBSAL did not respond to this objection.	The documentation used for the determination to allow the current surgical procedures is required for the finding to be removed.	**Remove with Follow-Up** BCBSAL policy at the time of processing did not review charges for cosmetic treatment of varicose veins. Follow-up with medical records to determine if cosmetic for patient age 73.

#/DOS	Sample Selection	BCBSAL Response	Required Action	Segal Comment
14 **Nov 2011**	**$4,906.00 Overpaid -** Documentation to show that the injury to the member was not the responsibility of another party was not provided. In addition, BCBSAL did not supply the documentation to support coverage of multiple procedures that were billed.	BCBSAL did not respond to this objection.	Documentation showing that the injury was not the responsibility of other party liability or worker's compensation needs to be provided for the finding to be removed.	**Remove** Charges were billed with appropriate modifiers to allow reimbursement per BCBSAL policy. Medical diagnosis (incisional hernia without mention of obstruction or gangrene) is not typically identified for subrogation investigation.
17 **Jan 2012**	**$2,378.00 Overpaid -** BCBSAL did not provide documentation to support payment of the procedure that is often performed for cosmetic purposes.	BCBSAL did not provide documentation for this claim.	Documentation showing that the procedure was not performed for cosmetic reason is required to remove the finding.	**Remove with Follow-Up** Operative report supports history of nasal trauma; procedure meets BCBSAL policy for coverage. Follow-up with subrogation inquiry may be appropriate for December 2010 fall and April 2011 injury. Does RAS have recommendations regarding BCBSAL subrogation policy and procedures?
19 **Jan 2012**	**$903.00 Overpaid-** The plan excludes coverage of services or expenses related to sexual dysfunctions, sexual inadequacies.	BCBSAL responds that the treatment was not provided for sexual dysfunction but for impotence of organic nature.	Documentation of the criteria and medical necessity or a PEEHIP override is required to remove the finding.	**Remove with Follow-Up** Diagnosis of organic impotence is supported by history of prostate cancer. Follow-up with subrogation inquiry may be appropriate for removal and replacement of a device. Does RAS have recommendations regarding BCBSAL subrogation policy and procedures?

#/DOS	Sample Selection	BCBSAL Response	Required Action	Segal Comment
32 **Mar 2012**	**$924.50 Overpaid-** The plan excludes coverage of services or expenses related to sexual dysfunctions, sexual inadequacies.	BCBSAL responds that the prosthesis was not provided for sexual dysfunction but for impotence of organic nature.	Documentation of the criteria and medical necessity or a PEEHIP override is required to remove the finding.	**Remove** Diagnosis of organic impotence is supported by history of Peyronie's disease. Procedure code suggests this is an initial insertion.
38 **Oct 2011**	**$3,336.50 Overpaid-** The documentation to show that this injury was not due to other party liability or possible product liability was not provided. In addition, the requested medical records and operative report were not provided to support	BCBSAL responds that this item was one of several for which the requested medical records and criteria were provided to the onsite auditors.	The requested medical records and criteria were not provided to the onsite auditor. The criteria and medical records showing that the mesh replacement was not subject to a product liability recall are required for the finding to be removed.	**Remove** Medical diagnosis reimbursed per BCBSAL policy. Mesh implant with no indication of Product Liability concern.
41 **Oct 2011**	**$6,139.00 Overpaid-** The documentation to show that this injury was not due to other party liability or possible product liability was not provided. In addition, the requested medical records and operative report were not provided to support	BCBSAL responded that the mentioned documentation would not have been requested or required.	The plan requires that the covered services be medically necessary. The supporting medical records, including the operative report, are required to remove the finding.	**Remove with Follow-up** Medical diagnosis reimbursed per BCBSAL policy. Mesh implant with no indication of Product Liability concern. Follow-up on subrogation questionnaire sent in December 2013 per RAS suggestion.

#/DOS	Sample Selection	BCBSAL Response	Required Action	Segal Comment
42 **Feb 2012**	**$4,310.00 Overpaid-** Documentation that injury was not due to other party liability or possible product liability was not provided. Requested medical records and operative report were not provided to support coverage for repetitive	BCBSAL responded that they provided documentation showing where procedure 49565 is being considered as the primary procedure for 49568, thus allowing codes to be reimbursed separately.	The objection was based on the auditor's knowledge that codes 44120 and 49565 cannot be billed together. Subrogation documentation and/or a PEEHIP override are required to remove the finding.	**Remove with Follow-up** Medical diagnosis reimbursed per BCBSAL policy. Mesh implant with no indication of Product Liability concern. Follow-up on subrogation questionnaire sent in December 2013 per RAS suggestion.
45 **Dec 2011**	**$3,947.50 Overpaid-** Per the BCBSAL, the member fell from their personal vehicle. BCBSAL did not provide documentation showing that the medical payment from the member's automobile coverage was exhausted.	BCBSAL stated that Subrogation was not involved.	Documentation showing that the claim was not reimbursed to the provider or the member by the auto carrier or a PEEHIP override is required for the finding to be removed.	**Remove and Follow-Up** Hopped off truck tailgate at home. Subrogation form was completed with no indication of other coverage. Follow-up on coverage available through personal automobile coverage. Was this a single event or standard policy for BCBSAL to discount the potential for personal auto coverage recoveries?
46 **Mar 2012**	**$1,295.50 Overpaid -** The documentation was not provided to support the medical necessity for the elective procedures performed.	BCBSAL responded that standard documentation was provided showing the claim was reviewed by Blue Cross' medical review department and the claim was deemed medically necessary.	The documentation was not provided to the onsite auditor. The criteria and documentation used to support medical necessity for the elective procedure or a PEEHIP override are required for the finding to be removed.	**Remove** RAS is questioning a cesarean section delivery with lysis of adhesions and grafts. BCBSAL subsequently requested and received the medical records to support the services were not elective.

#/DOS	Sample Selection	BCBSAL Response	Required Action	Segal Comment
47 **Jan 2012**	**$2,920.50** Overpaid - Documentation showing that the injury was not the responsibility of another party was not provided.	BCBSAL responded that according to their investigation by the Subrogation area, the diagnosis does not have criteria that would warrant subrogation investigation.	Complete medical records showing that the complete rupture of rotator cuff were not the responsibility of another party or a PEEHIP override are required for the finding to be removed.	**Remove** Medical records indicate the left shoulder has been symptomatic for the last three years. Follow-up with subrogation inquiry is not likely to obtain a specific injury or liable third party.
50 **Mar 2012**	**$169.50 Overpaid -** The same procedure code was billed and reimbursed two times for the same date of service. The operative report requested was not provided for review.	BCBSAL responded to Current Procedural Terminology (CPT) code 30420, which was not a disputed charge by the auditor. The requested operative report was not provided to support coverage for repetitive procedures. The provider billed code 30140-51 and 30140-50-51. The second procedure signifies a bilateral multiple surgery procedure. The first charge should have been disallowed as a duplication of service since the provider also billed as a bilateral procedure.	The requested operative report was not provided to support coverage for repetitive procedures.	**Remove** CMS guidelines allow for multiple surgery and bilateral reductions; meets medical criteria for coverage per BCBSAL review. Is RAS suggesting that all multiple and bilateral surgeries should be accompanied by an operative report prior to payment? This would appear to be a matter for BCBSAL medical policy.

#/DOS	Sample Selection	BCBSAL Response	Required Action	Segal Comment
52 **Dec 2011**	**$6,149.00 Overpaid -** The operative report requested was not provided for review. The member responded that the intestines were cut by the surgeon while performing a hysterectomy.	BCBSAL responded with claims payment and subrogation documentation stating that this particular CPT code (49002-78) does not require subrogation, however the accident code associated with the facility claim was subrogated and our investigation is now closed.	The member provided a statement indicating that the surgeon cut the intestine while performing a hysterectomy. This confirms that another party is liable for the claim and PEEHIP has the right to expect to be reimbursed for associated costs.	**<u>Remove</u> and Follow-Up** Same procedure was performed on multiple dates. Only one of three charges on 12/2/2011 was reimbursed. On 3/17/2012 patient stated "no plans for lawsuit at this time, will consult an attorney." Claim should be followed up to determine the status of any attorney discussion engaged. Follow-up is required to determine if the patient has since decided to file suit against the surgeon.
57 **Dec 2011**	**$2,770.50 Overpaid -** The same procedure code was billed and reimbursed three times for the same date of service. The operative report requested was not provided for review. In addition, the requested completed claim form and subrogation documentation were not provided.	BCBSAL responded that per processing guides there is no limit to the number of times this procedure can be performed on the same day. The modifiers indicate multiple procedures (50), distinct procedure (59) and repeat procedures (76). This procedure code is considered an add-on procedure and is payable at 100% of the allowance. This claim was submitted electronically and the operative notes and claim form are not available. This diagnosis does not warrant subrogation review as it is not accident related.	Per industry standard, the procedure is allowable once and supporting documentation is required when modifiers (59) and (76) are applied. The diagnosis may be related to another party liability. The operative report and documentation showing that another party was not liable for the claim are required for the finding to be removed.	**<u>Remove</u> and Discuss** Complex hernia repair with multiple surgical procedures billed with appropriate modifiers and paid per BCBSAL policy. Discuss if RAS is suggesting that all multiple and bilateral surgeries should be accompanied by an operative report prior to payment. This would appear to be a matter for BCBSAL medical policy, but would be worthy of discussion prior to the next RAS review to outline documentation expectations for the claims sample.

#/DOS	Sample Selection	BCBSAL Response	Required Action	Segal Comment
60 **Dec 2011**	**$2,722.00 Overpaid -** The requested claim form and subrogation documentation has not been provided for review.	BCBSAL responded that this selection was currently being subrogated.	Documentation showing that PEEHIP is reimbursed for the claim is required for the finding to be removed.	**Remove and Follow-Up** Still pursuing based on 8/28/13 response. Follow-up on current status. If not recovered, was the claim referred to the group per policy?
62 **Feb 2012**	**$1,449.50 Overpaid -** Reimbursement **was** provided for a global maternity delivery charge with the onset of care occurring prior to the member's effective date. The overpayment is estimated to be 50 percent of the billed charge.	BCBSAL responded that payments on global maternity codes are reduced by the paid amount of fragmented codes reported within the global period.	No fragmented codes were submitted for payment under this contract. The global delivery charge on 2-28-12 should have been denied and a breakdown of charges required from the provider. The charges incurred for the 6 months prior to the member's effective date of 10-1-11 should have been denied. **A PEEHIP** override is required for the finding to be removed	**Remove** BCBSAL states waiting period does not pertain to maternity expenses. Patient was eligible 10/1/2011; cesarean delivery was 2/28/2012 (coverage was in place for almost 5 months). BCBSAL further comments that this Host Plan claim did reduce the provider fee; the payment screen indicates a flat reimbursement rate. It is unclear how RAS arrived at a 50% overpayment. Any fee reduction first requires confirmation of the allowance for procedure 59515 (cesarean delivery including post-partum care) and for each office visit and lab expense for dates of service after the patient's effective date of coverage and before delivery; the individual allowances for a 5 month period of time are typically equal to or greater than the global fee for procedure 59510 which includes services prior to delivery.

#/DOS	Sample Selection	BCBSAL Response	Required Action	Segal Comment
76 **Jan 2012**	**$2,547.50 Overpaid - BCBSAL** did not provide documentation to support the payment of the procedure that is often done for cosmetic reasons.	**BCBSAL** provided the medical records and supporting documentation on 10-25-13 and again on 01-06-14 for auditor review. The documentation shows that the procedure is not performed for cosmetic reasons. It also shows that the procedure is performed due to repeated injuries to the 19 year old male's nose in 2007 & 2010.	Based on the new information provided to the auditor, completed claim form and subrogation documentation is required for the finding to be removed.	**Remove and Follow-Up** Repeated injuries to nose. Follow-up can be made with subrogation inquiry, however, most often the responses return no evidence of other recovery. RAS should comment on the BCBSAL subrogation procedures including identification and follow through to recovery or closure.
93 **Jun 2011**	**$2,504.35 Overpaid -** Documentation showing that the injury was not the responsibility of another party was not provided.	BCBSAL provided documentation showing that the injury to the member's teeth was due to a fall in a kitchen.	The subrogation documentation showing that this fall occurred in the member's kitchen and was not the responsibility of another party is required for the finding to be removed.	**Remove** Fell in kitchen at home. Homeowners policies do not provide coverage for residents of the property.

This Page Intentionally Blank

Exhibit 3

Advanced Pharmacy Concepts

Response Topics for Alabama Public Education Employees' Health Insurance Plan

October 1, 2014

EXECUTIVE SUMMARY

The Alabama Public Education Employees' Health Insurance Plan (PEEHP) asked Advanced Pharmacy Concepts (APC) to review and provide comment on the September 2014 report issued by Recovery Audit Specialists, LLC entitled "Alabama Public Employee Health Insurance Plans 2014 Recovery Audit Management Report". PEEHIP asked APC to review the report with regard to the conclusions related to PEEHIP's rate guarantees and the effect of the September 2009 AWP litigation and settlement.

The Recovery Audit Specialists (RAS) report states that poor contract negotiation has led to "unrealized savings lost" by PEEHIP of more than $17 million for the audit period[1]. APC has reviewed the information provided in the report and disagrees with the findings. We believe that RAS misunderstands the pharmacy benefit industry, especially with regard to industry standards and payment provisions for pharmaceuticals. With regard to discount guarantees, it is a business decision as to how the PBM contract is written. With regard to the AWP adjustment in 2009, the PBM that contracted with PEEHIP followed an adjustment method consistent with the industry.

BACKGROUND ON ADVANCED PHARMACY CONCEPTS

Advanced Pharmacy Concepts, Inc. (APC) has been providing consulting and audit services related to the pharmacy benefits industry since 1997. Our staff has experience in health plans and at pharmacy benefit management companies. APC's staff of twenty-five individuals averages ten years in managed care/pharmacy benefits management, and the two individuals who reviewed the RAS report each have over fifteen years of direct experience in pharmacy benefit management.

APC provides consulting and audit services for large health plans, self-insured employers, government benefit plans, and Taft-Hartley groups, and has performed audits of health plan on behalf of the Centers for Medicare and Medicaid. APC's sole focus is consulting and auditing in the pharmacy benefits sector of the health care industry.

DISCUSSION OF RAS FINDINGS

APC's report does not address the entire RAS report but – at the direction of PEEHIP – examines the sections related to the pharmacy benefit, which are pages 31-36 and pages 48-53.

Brand and Generic Rate Guarantees

On pages 48 and 49, the RAS report discusses prescription discount guarantees. The RAS report acknowledges that the contract provides for guarantees to be reconciled in aggregate, but recommends changes to contract language to require that no individual claim process at a

[1] Page 7 of the RAS report.

discount that is less than the guarantee for that category. The report also states that such language is common for health plan PBM contracts.

Although APC has seen contracts with per claim guarantees, we would categorize it as being rare for commercial benefit plans. Most contracts are written for aggregate reconciliation of guarantees within a given distribution channel. PBMs have varying rates they must pay to pharmacies based on each pharmacy's (or pharmacy chain's) specific contract. These variations are factored into the PBMs' rate guarantees. When a PBM is required to guarantee that no claim is adjudicated at a discount less favorable than the per claim guarantee, the PBM will present rates that are at or near their profit threshold for their most expensive pharmacy contract. The result is a set of guarantees in the contract that are less aggressive than those that would be offered with a more traditional aggregate reconciliation.

Whether or not to reconcile in aggregate by channel is a business decision that balances contract terms with performance. RAS's assertion that there is significant "Potential Unrealized Savings Lost" assumes that PEEHIP would have been able to negotiate the same pricing guarantees into their contract *and* be able to reconcile on an individual claims basis. If the pricing condition had been per claim reconciliation, the pricing guarantees would have been less aggressive.

We do believe that contracts with PBMs that allow the PBM to offset any guarantee with any other guarantee are not advantageous because it allows too much latitude. This type of contract would allow a PBM to offset a missed guarantee on Retail Brands, for example, to be offset with over-performance on rebates. A guarantee by channel is recommended, which means that Retail Brand, Retail Generic, Mail Brand, Mail Generic, Specialty drugs, and rebates would be reconciled within their own categories.

The report also discusses the effect of a low cost generic program at retail pharmacy chains. The example of pharmacies' $4 generic program is misleading. Pharmacies create a list of drugs costing less than $4 that they will dispense to patients without insurance for $4. In most cases the rates negotiated by the PBMs on behalf of their health plan clients are lower than $4 and are typically included in the calculation of the guaranteed rate. Language can be added to the contract if it does not already exist that requires the PBM to utilize lower-of logic in the calculation of patient copays and client paid amounts. APC also recommends language that requires the PBM to use the calculated ingredient cost (or patient paid amount in the case of a copay or partial copay that covers 100% of the drug cost) in calculating the guaranteed rate. The PBM should not use a drug cost of $0 for those claims even though the plan is not billed for an ingredient cost for those claims.

AWP Settlement of 2009

On pages 35-37 and 49-53, RAS discusses the AWP rollback of 2009 and contends that PEEHIP was disadvantaged due to their PBM's adjustment of rates. We believe that the RAS report conveys a misunderstanding of the AWP settlement and of PBMs' handling of the implications of that settlement.

Background on the 2009 Adjustment of Average Wholesale Price

Introduced in the late 1960's, Average Wholesale Price (AWP) evolved as a means of standardizing prescription drug reimbursements for the California Medicaid Program. Prior to the establishment of AWP, pharmacies billed according to what each one charged for drugs, creating a system that was labor intensive and plagued by inconsistent pricing. The California Medicaid program began paying pharmacies a standardized price for each drug. Ultimately insurers and employers embraced the concept and AWP became a benchmark for drug pricing and contracting. It was not long before publishing AWP and other drug pricing data evolved into a business in its own right.

One publisher was First DataBank (FDB). The firm, founded in 1977, surveyed pharmaceutical wholesaler companies to determine the list prices for drugs being sold to retail pharmacies. Using a proprietary process, FDB blended wholesaler list prices to create the "average wholesale price" or AWP associated with the package size of product, as identified by its national drug code (NDC). Quickly, AWP became the metric upon which third party payors based payments for drug products. In 1998, FDB acquired MediSpan, a competing drug pricing compendia. Pricing established by FDB applied to both references until the FTC forced the sale of MediSpan by FDB.

From its inception, FDB described the AWP as a value calculated from a survey of wholesaler prices. This was widely accepted to be the case until investigations for a class action suit revealed that since at least 2001[i] only the prices of one wholesaler, McKesson, were collected and reported. In late 2001 and early 2002, McKesson changed its methodology for drug pricing for approximately 1400 NDC codes. Historically, wholesalers varied their drug mark-ups, applying a 20% increase over wholesale acquisition cost (WAC) to some manufacturers' products while others were increased at 25%. McKesson adopted a 25% mark-up for many popular medications that were previously increased only 20%. Because McKesson was the sole source of wholesaler prices in FDB's surveys, the action by McKesson raised AWP drug prices immediately.

McKesson's pricing change had a negative impact on consumers, unions and other self-insured employers, health insurers and health and welfare plans including the government. As the situation was revealed, payers took action, ultimately leading to class action suits against FDB/MediSpan and McKesson. The plaintiffs in the suit contended that FDB sought to curry favor with McKesson, hoping, among other things, that McKesson would utilize FDB as a pricing source for contract purposes.[ii] Furthermore, because pharmacy reimbursement is directly tied to the AWP, it was anticipated pharmacies would become the direct beneficiaries of the new methodology.

While both parties denied any wrong-doing, FDB and MediSpan reached a settlement in this case and a Final Order and Judgment approving the settlement for FDB and MediSpan was entered in the United States District Court for the District of Massachusetts on March 30, 2009.

While the settlement dictated changes in AWP prices for only 1400 affected NDCs, FDB announced additional planned changes to its pricing database. In September 2009, FDB adjusted prices for all products that have a WAC to AWP ratio of more than 120%.

In 2009, Advanced Pharmacy Concepts reviewed the methods that various PBMs used to accommodate this pricing change. The objective of the adjustment methods was to keep the dollar amounts billed to the health plan the same before and after the AWP change. The drug cost billed to a health benefit plan is Ingredient Cost minus patient copayment. PBM contracts with health benefit plans are written such that the amount billed (the ingredient cost) is a discount off AWP[2].

One method to address the AWP change was to change the discounts charged to the plan in order to keep ingredient cost consistent with what was paid before the pricing change. As illustrated below, in order to maintain a consistent ingredient cost of $106.25 for a prescription, a discount of AWP-15% before the FDB AWP change would have had to become a discount of AWP-11.46% after the AWP adjustment. The discount percentage is being applied to a lower AWP number.

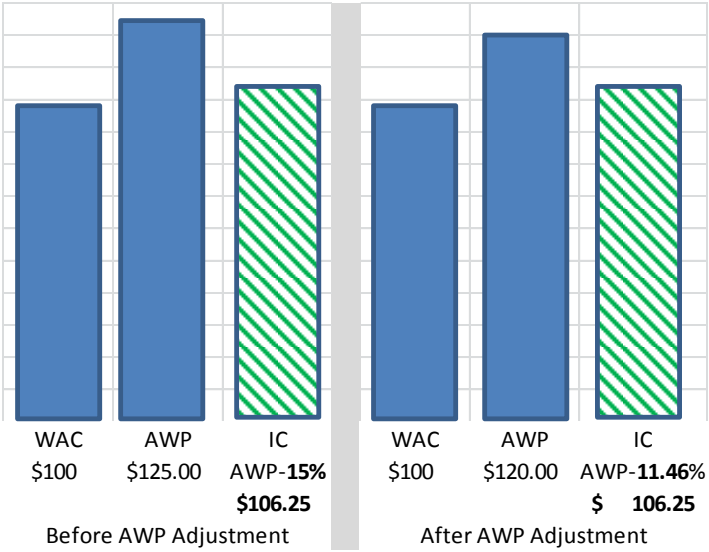


Figure 1 Illustration of AWP Change to maintin consistent IC Cost to the Plan remains the same

However, since not all NDCs had to be adjusted, there had to be a calculation to take into account the proportion of those NDCs adjusted and those that were not adjusted in order to determine the aggregate impact. The adjustments to the discount did not exactly correspond to the change from WAC*125% to WAC*120% because not all drugs were impacted by the AWP change, or were changed to a greater or lesser extent.

The second method used by some PBMs was to create their own "pre-rollback" AWP in their benefit adjudication systems. These PBMs kept their clients' discounts at the same rate before and after September 2009 but applied that rebate to an unpublished number that was higher than

[2] Pricing metrics other than AWP have been discussed but have not gained traction in any segment of the pharmacy benefit industry.

the newly published AWPs by the drug database companies. In other words, they inflated the real AWP so that the discounts would look as if they didn't change.

The subject of AWP as a pricing benchmark and methods that PBMs used to adjust to the 2009 AWP changes is also described in an article published by the Journal of Managed Care Pharmacy[iii], which provides additional background.

RAS Report

The RAS report to the State of Alabama presents two arguments related to the AWP adjustment: (1) that the PBM's adjustment was not fair, and (2) that PEEHIP is owed funds from the class action suit.

The RAS report to the State of Alabama states that wholesale drug costs decreased by 5% as a result of this settlement (page 35 of RAS report) and suggests that PEEHIP's cost should have decreased as well. This is a misconception. AWP can be compared to a sticker price on a car – no one actually pays that price. We have used an example below.

New Car Shopping Price Adjustment Compariosn			
	Before Adjustment	After Adjustment	*PBM Equivalent*
Published Dealer Invoice	$ 45,000	$ 45,000	*WAC*
MSRP	$ 56,250	$ 54,000	*AWP*
Negotiated Discount to Buyer	16.4%	13.0%	*PBM Discount*
Net Cost to Consumer	$ 47,000	$ 47,000	*Ingredient Cost*
Dealer Profit	$ 2,000	$ 2,000	*PBM Margin*

Figure 2 Car Shopping Analogy to Drug Pricing

The illustration presents the relationship of Manufacturer Suggested Retail Price (MSRP) or "Sticker Price" for a car as being similar to AWP for a drug. It is very rare that a consumer will pay full sticker price for a new car, just as it is not likely that a health plan is paying full AWP for drugs. Now consider that the MSRP is based on a percent over the invoice. If the sticker price is high, the percent discount offered can be larger than if the sticker price is reduced. If one changes that percent increase, it does not change the invoice price for the car and will not change the profit margin required by the dealership.

The manner in which PEEHIP's PBM handled the AWP adjustment was consistent with the practices in the industry.

With regard to the Class Action Suit, on pages 35, 36, and 53, the RAS report seems to infer that RAS believes the intent of the judgment was that damages would be paid not only to the parties to the suit but to the healthcare industry in general. The argument may be that since FDB

inflated AWP, and pricing was based on AWP (for all entities that used AWP as a metric, which includes drug wholesalers, retail pharmacies, PBMs, etc.), then all the middlemen entities needed to compensate for their profits during the time period between 2001 and 2009. This argument had been promoted by various parties in the latter part of 2009 but was abandoned because there was no reasonable or workable solution.

CONCLUSION

APC disagrees with the pharmacy benefit conclusions in the RAS report. The findings of "Potential Unrealized Savings Lost" fall into the realm of 'what might have been', however prescription drug pricing discounts do not exist in a vaccuum and the agreement between a benefit plan and a PBM is a multi-variate negotiation. It is not reasonable to assume that one important component of a contract can be changed without having an effect on other contract provisions.

In terms of the AWP adjustment of 2009 and the Class Action Suit that prompted it, APC believes that the rate adjustments equitably preserved the costs to benefit plans. Additionally, recoupment of funds from all parties that may have profited from the artificial inflation of AWP from 2001 to 2009 is an unreasonable expectation.

[i] United States District Court, District of Massachusetts Second Amended Class Action Complaint Leave to File Granted November 22, 2006. New England Carpenters Health Benefits fund et al. vs. First Databank, Inc and McKesson. Case 1:05-cv-11148-PBS Document 174 Filed 11/30/2006 Page 44 of 95. Item 124 "Beginning sometime in late 2001 or early 2002, First Data, by agreement with McKesson, limited its purported "surveys" to McKesson and did not "survey" other wholesalers. First Data agreed to utilize for markup purposes data received from McKesson. At the same time and as part of a common plan, McKesson implemented a 5%increase in the WAC to AWP markup for hundreds of brand name drugs that it distributed."

[ii] United States District Court, District of Massachusetts Second Amended Class Action Complaint Leave to File Granted November 22, 2006. New England Carpenters Health Benefits fund et al. vs. First Databank, Inc and McKesson. Case 1:05-cv-11148-PBS Document 174 Filed 11/30/2006 Page 8 of 95. Item 14 "First Data agreed to this Scheme to curry favor with McKesson so that McKesson would utilize First Data as the pricing source it has in some of it contracts with pharmaceutical companies and others in the distribution chain, as well as in the pricing database that it provides to its customers, thereby increasing First Data's business."

[iii] Curtiss, Frederick R., PhD, RPh, Lettrick, Phillip, RPh, and Fairman, Kathleen. What is the Price Benchmark to Replace Average Wholesale Price (AWP)? Journal of Managed Care Pharmacy, Setpember 2010, Vol. 16, No. 7, pp. 492-501.

Exhibit 4

BlueCross BlueShield of Alabama

October 31, 2014

Ms. Diane E. Scott, CPA, CGMA
Chief Financial Officer
Retirement Systems of Alabama
Public Education Employees' Health Insurance Board (PEEHIP)
201 South Union Street, Suite 200
Montgomery, AL 36104

Dear Ms. Scott:

Blue Cross and Blue Shield of Alabama (Blue Cross) has received the final report issued September 3, 2014 by Recovery Audit Specialists, LLC (RAS) regarding the recovery audit performed on PEEHIP claims. After reviewing the report, it has been determined that all documentation was provided to RAS at the time of the audit to validate the appropriateness of the claims, as well as, all information necessary for the performance of the audit. In addition, the requests made by RAS were responded to in a timely manner and the "23 undocumented claims outstanding" have been processed and documented in accordance with Blue Cross policies.

In an effort to show our transparency, we are providing a brief description of the audit timeline along with additional facts and potential costs for expanding the audit sample by RAS:

RAS Audit Timeline for PEEHIP

- June 2013 – Received health claims initial data request (population of all claims for 2 years).
    - Selected sample of 200 claims to be reviewed onsite.
- August 2013 – RAS began a one week onsite review.
- August to December 2013 – Received notification that RAS had not received requested information. Research determined information was made available while onsite and was accessible by the auditors.
- December 3, 2013 – Received draft report.
- January 6, 2014 – To assist in supporting and helping to close these two audits, Blue Cross sent all the information that had been available prior and during the onsite to your auditors from the period August 2013 – October 2013. The information supported the payment made for each claim. The packets included your auditors' questions along with our response and corresponding support. This information was sent to Ms. Mellinger at RAS via email.
- January 9, 2014 – Emailed Ms. Russell at RAS to schedule a conference call and requested to close the audit.
- January 15, 2014 – Received feedback from Ms. Russell at RAS "I will let you know when our team has finished review of the materials and we are ready for the group call."

- January 16, 2014 – September 23, 2014 (**250 Days**) – No communication from RAS concerning the status of audit or a request for discussion of anything pertaining to the audit.
- January 24, 2014 – Blue Cross sent final response letter to RAS, again summarizing all information that had been provided in past communication with auditors.
- July 29, 2014 – Based on an email forwarded from PEEHIP, Ms. Russell of RAS stated they had destroyed all documentation (electronic and paper) related to the audit. Email stated this was RAS's standard practice once an audit is complete.
    - *It is industry standard to never destroy work papers/documentation while the audit is still outstanding. In addition, you should always have work papers/documentation to support your findings and keep for a period of time.*
- September 24, 2014 – Received report from RAS citing a number of findings due to missing documentation. However, Blue Cross records show all information was provided.

Additional Information:

- RAS took 15 months to complete their audit and produce a final report
- Other Onsite Customer Audits that were conducted and completed in less time
    - 2011 – 13 audits started and completed
    - 2012 – 10 audits started and completed
    - 2013 – 14 audits started and completed
    - 2014 – 10 audits started and completed
- Of the confirmed errors
    - Three claims made $10,000 of the total error in the sample. All other errors noted were disputed and Blue Cross provided specific information to valid appropriate payment of these claims.
- Blue Cross facilitates both fee-for-service and recovery auditors. The scope of an audit outlined in the Administrative Services Agreement (ASA) is a contributing factor of our ability to pass on a low administrative cost. The ASA specifies the audit should be conducted on the basis of generally accepted auditing standards and a statistically valid sample would be utilized. Any review of claims conducted on any basis other than generally accepted auditing standards will require a mutually agreed upon fee to be paid by PEEHIP to cover the cost incurred by Blue Cross for such review. (see costs section below)

Potential Costs for additional Auditing by RAS

- As outlined in the Administrative Services Agreement, conducting a review of claims on any basis other than generally accepted auditing standards will require a mutually agreed upon fee to be paid by PEEHIP to cover the cost incurred by Blue Cross for such review. Blue Cross suggests a fee of $5,000 per 100 claims selected for review as part of any out of sample review. Claims affected by any systematic error identified during the audit of sample claims are <u>not</u> considered as out of sample items and thus <u>not</u> subject to any additional fees.
    - At $5,000 per 100 claims it would cost approximately **<u>$2.8 million</u>** to facilitate 56,000 (5%) claims.

We value our relationship with PEEHIP and are proud to have you as a customer. We are available to discuss our determinations and look forward to answering any questions you may have. For additional information, please contact me via email at kbmiller@bcbsal.org or 205-220-6123.

Sincerely,

Keith Miller
Director of Internal Audit and Corporate Compliance
Blue Cross and Blue Shield of Alabama

This Page Intentionally Blank

Exhibit 5

October 30, 2014

Via Email

Diane E. Scott, CPA, CGFM
Chief Financial Officer
Retirement Systems of Alabama

RE: MEDIMPACT RESPONSE TO PEEHIP, RAS AUDIT REPORT

Dear Ms. Scott:

It is standard in the PBM industry to have contracts with clients that include minimum guaranteed pharmacy network rates in the aggregate. This means that a PBM will guarantee their clients that they will pay no more than the minimum guaranteed discount off AWP plus dispensing fee for brand and generic prescriptions filled at the retail pharmacy network during a given contract year. This is done because it is not practical for a PBM to guarantee a client a single set of retail rates and apply those rates to every prescription filled at every retail pharmacy on a pass-through basis.

MedImpact's retail pharmacy network includes over 60,000 pharmacies made up of major chains, Pharmacy Services Administration Organizations (PSAO's) and independents. Due to the various reimbursement rates for retail pharmacies, PBMs must structure their contracts with clients to include aggregate minimum guaranteed pharmacy network rates vs. guaranteed rates at the claim level, as the latter is not realistic to secure, operationalize and administer. PEEHIP secured a contract with MedImpact that included pharmacy network rate guarantees in the aggregate that improved year over year for each year of their 3 year contract term.

Additionally, PEEHIP negotiated contract terms and language that ensured MedImpact billed PEEHIP the exact amount MedImpact reimbursed the pharmacies. MedImpact agreed to "meet or exceed" these aggregate guarantees and in fact exceeded the October 2009 to September 2010 pharmacy network guarantees. This resulted in PEEHIP achieving $15,699,124 in savings over the contracted guaranteed network rates. Each prescription was accurately priced, with proof of this being that the amount MedImpact collected from PEEHIP each year exactly equaled the amount MedImpact paid the pharmacies during these periods.

The date of the AWP First DataBank class action settlement was September 26, 2009. PEEHIP's contract with MedImpact, which was effective October 1, 2010, included language to account for the impact the settlement had on the AWP pricing for products identified in the lawsuit. All pharmacy network rate guarantees were included in the contract on a post-settlement AWP basis.

Sincerely,

Erin M. Kenny

Erin M. Kenny, PharmD, MBA
Account Executive
MedImpact Health Systems, Inc.
erin.kenny@medimpact.com

Proprietary and Confidential
The contents of this document are confidential and proprietary to MedImpact and may not be reproduced, transmitted, published, or disclosed to others without prior authorization.