

JOINT COMMITTEE ON GOVERNMENT AND FINANCE  
WEST VIRGINIA OFFICE OF THE LEGISLATIVE AUDITOR

# POST AUDIT DIVISION

LEGISLATIVE AUDIT REPORT

## PEIA Internal Controls Over Pharmacy Benefits Manager Contract

Legislative Auditor: Aaron Allred  
Post Audit Division Director: Justin Robinson





GENERALLY ACCEPTED GOVERNMENT  
AUDITING STANDARDS STATEMENT

We conducted this performance audit in accordance with Generally Accepted Government Auditing Standards (**GAGAS**). Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

POST AUDIT DIVISION  
Justin Robinson, Director



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## PEIA Internal Controls Over Pharmacy Benefits Manager Contract

October 10, 2021

### LEGISLATIVE AUDITOR'S STAFF CONTRIBUTORS

Aaron Allred.....Legislative Auditor  
  
Justin Robinson.....Director  
Mike Jones, CFE, CRMA.....Audit Manager  
Randolph Mays II.....Senior Auditor  
Brianna Walker, CFE.....Auditor  
Christian Baumgarner.....Auditor  
Nathan Hamilton.....Referencer

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Improvements to PEIA's Third-Party Risk Management and Internal Controls Over the Pharmacy Benefits Manager Services for Which It Contracts Could Assist in Timelier Detection of Potential Fraud. The Use of Additional Fraud Detection Techniques May Have Allowed PEIA to Detect and Respond to the Fraud It Identified in 2015 More Quickly, Which Began in 2009 and Encompasses Approximately \$5 Million in Fraudulent Claims.

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## EXECUTIVE SUMMARY

The Legislative Auditor conducted this audit of the West Virginia Public Employees Insurance Agency (PEIA) in accordance with W.Va. Code §4-2-5. The objective of this review was to determine the cause(s) of the pharmacy benefit management fraud disclosed by PEIA, to determine if PEIA's internal controls over the pharmacy benefits for fraud prevention and detection are sufficient to deter and detect potential recurrences, and to determine if PEIA has a fraud response plan for the pharmacy benefits and if the plan ensures the effective and timely action in the event of a fraud event.

### Frequently Used Acronyms in This Report

ACFE: Association of Certified Fraud Examiners

CVS: CVS Caremark

ESI: Express Scripts

NDC: National Drug Code

PBM: Pharmacy Benefit Manager

PEIA: Public Employees Insurance Agency

PHI: Protected Health Information

### Report Highlights

#### **Issue 1: Improvements to PEIA's Third-Party Risk Management and Internal Controls Over the Pharmacy Benefits Management Services for Which It Contracts Could Assist in Timelier Detection of Potential Fraud. The Use of Additional Fraud Detection Techniques May Have Allowed PEIA to Detect and Respond to the Fraud It Identified in 2015 More Quickly, Which Began in 2009 and Encompasses Approximately \$5 Million in Fraudulent Claims.**

As a result of a fraud scheme which was perpetuated over eight years, PEIA paid approximately \$5million in fraudulent claims. While PEIA was able to detect this fraud through direct member complaints, its procedures for responding to such complaints, and it has continued to work with law enforcement to pursue recoveries; several factors may have contributed to PEIA's ability to detect and respond to this fraud more quickly and reduce the impact of the fraud.

- PEIA's internal controls for third-party risk management could be improved to detect and respond to potential fraud more quickly. Such controls should be designed to monitor the performance of the pharmacy benefits manager (PBM) in fulfilling its contractual obligation to prevent and detect fraud and communicate noted deficiencies in those processes. Additionally, PEIA should implement internal fraud detection procedures capable of detecting potential fraud in the PBM claim data which may have gone undetected by the PBM as an additional layer of fraud risk management.
- While the contract grants PEIA the authority to have audits conducted of the PBM and the claims data, PEIA states these audits to be cost prohibitive in comparison with actual recoveries and relies on its internal audit reviews as they are more cost effective and impactful in monitoring the pharmacy benefit. Based on analyses conducted by the Legislative Auditor, PEIA's internal audit reviews could have encompassed additional fraud detection techniques that could have identified potentially fraudulent claims



involved in this fraud more quickly and reduced the impact of the fraud.

- A “fraud risk management framework” is an essential tool for an organization to properly plan for the risk of fraud and its impact on the organization. It was determined PEIA did not have an established fraud management framework in place until it was created by PEIA during the audit.

## Recommendations

1. The Legislative Auditor recommends PEIA develop, implement, and consistently employ third-party risk management processes to assess the adequacy of third-party internal controls in carrying out contracted services and to address risks, monitor performance, and communicate noted deficiencies in those processes to the third-party during the life of the contract. For the PBM contract, these processes should also include a type of data analysis that would allow PEIA to detect patterns of potentially fraudulent transactions that may have gone undetected by the PBM such as the Benford or Z-Score analyses discussed in this report.
2. The Legislative Auditor recommends PEIA continue to develop its fraud risk management framework and employ processes and procedures designed to reduce the risks associated with its utilization of third parties to provide services that may be impacted by fraud.
3. The Legislative Auditor recommends PEIA define specific fraud prevention and internal control activities within the PBM contract that it expects its PBM or other contracted parties to perform in carrying out its contracted services.
4. The Legislative Auditor recommends PEIA consider adding language to the PBM contract that would cause the PBM to share the financial impact of fraud occurring in the event the PBM’s processing of fraudulent claims have a direct financial impact on PEIA due to a failure on the part of the PBM to properly prevent or detect such fraud under the terms of the contract.
5. The Legislative Auditor recommends the Legislature, in conjunction with PEIA, consider amending WV Code to allow PEIA to file complaints with the entities charged with oversight of the various healthcare professions, as well as the WV Attorney General’s Office, in the event of identified fraud, waste, and abuse.

## **Issue 1: Improvements to PEIA’s Third-Party Risk Management and Internal Controls Over the Pharmacy Benefits Management Services for Which It Contracts Could Assist in Timelier Detection of Potential Fraud. The Use of Additional Fraud Detection Techniques May Have Allowed PEIA to Detect and Respond to the Fraud It Identified in 2015 More Quickly, Which Began in 2009 and Encompasses Approximately \$5 Million in Fraudulent Claims.**

### **Background**

The West Virginia Public Employees Insurance Agency (PEIA), was created by an Act of the West Virginia Legislature effective July 1, 1990, replacing the West Virginia Public Employees Insurance Board. PEIA is the state agency responsible for administering a health and life benefit plan among other benefit offerings to eligible employees and retirees of the state, county boards of education, local governmental entities, as well as other persons as specifically authorized to participate by statute. PEIA’s mission is to administer affordable insurance programs and quality services that protect, promote, and benefit the health and well-being of its members.

PEIA sets out to fulfill its mission to provide members prescription drug benefits via a contract with a third-party vendor for the prescription drug component of its Preferred Provider Benefit Plan (PPB). This third-party provider is known as a Pharmacy Benefits Manager (PBM). The PBM contract provides for services including pharmacy network contracting, pharmacy claims processing, mail and specialty drugs, and formulary and rebate administration. In addition to these services, the PBM contract provides for the administrator, currently CVS Caremark (CVS), to have “established procedures and system edits to aggressively monitor and proactively search for cases and potential cases of fraud and abuse.” This specific requirement was not included in the previous contract with Express Scripts (ESI), who was the third-party administrator from July 1, 2012, through June 30, 2016. CVS is the current PMB and has been the third-party administrator since July 1, 2016.

PEIA informed the Legislative Auditor that in July 2015, PEIA received multiple complaints from members related to diabetic supplies. For example, a member contacted PEIA informing them that she had been trying to get a pharmacy to stop sending her diabetic supplies. This member was meant to be testing two times per day. However, she was receiving enough supplies to test six times per day. In another instance, PEIA was provided samples of blood glucose meters being received by a member that seemed suspicious for further inspection. PEIA found that the National Drug Code (NDC) had been altered to reflect another brand of meter and PEIA had been charged six times the actual meter’s value. Due to these complaints, PEIA found that the ESI, the PBM at the time, was processing claims for prescriptions that members had no knowledge of existing, were unrelated to a member’s medical diagnosis, or were for a larger count than what they were prescribed. Members also noted in their complaints that their prescriptions were being changed from local pharmacies to out-of-state pharmacies without their knowledge or consent. The physicians (prescribers) who had written these prescriptions had never treated, met, or spoke with the members. In addition to members receiving supplies with a manipulated National Drug Code or mislabeled product, some products members received were not even approved for sale in the United States.

After PEIA was alerted to these issues, it contacted the PBM at the time, ESI, and attempted to gather information as to why the PBM had not identified these patterns. According to PEIA,

*ESI stated that it was “aware” of this type of activity, they did not provide any specific detail nor were they readily forthcoming with any information on their*



*knowledge of these operations.*

In reviewing the contract between PEIA and ESI, there were no noted stipulations within the contract requiring ESI to monitor or proactively search for instances of fraud or to notify PEIA in the event fraud was detected. As previously mentioned, the current contract with CVS has specific language addressing the reporting and detection of fraud by the PBM. However, neither the current CVS contract nor the prior ESI contract contain language that would share in any of the financial risk of fraud or incentive in the recovery of fraud that occurs, potentially reducing the significance the PBM may place on its efforts to prevent or detect fraud.

In response to these member complaints, PEIA conducted internal claims reviews to identify specific patterns. PEIA found that many of the fraudulent transactions involved members who lived in West Virginia while the prescribers were located or licensed in another state, with the pharmacy filling the order in a third separate state. For many of these transactions, PEIA was never billed for the physician visit, but the prescriptions were issued anyway. Many of the pharmacies were located by PEIA, using simple internet map searches such as Google Earth, identified the physical addresses as being residential buildings or mail drop off sites. PEIA's efforts in its investigation revealed that the pharmacies involved in the fraud scheme were not legitimate pharmacies. Instead, these pharmacies exploited lax oversight laws in various states to obtain provisional licenses that would allow them to operate for up to four years without a physical site inspection by regulators. PEIA discovered as many as 20 pharmacies involved in the scheme used the same address in Utah, multiple pharmacies were using the same abandoned house address in Texas, several were operating out of a mailbox drawer in Alabama, and in Michigan a pharmacy was licensed to a vacant lot. These pharmacies were incorporated in various states to operate across multiple jurisdictions solely to commit fraud. PEIA further asserts that pharmacies involved in these fraudulent schemes were also identified in Ohio, New York, Missouri, and Florida, indicating that this fraud was a nationwide issue not just limited to WV or PEIA, and its reporting actions after identifying this fraud has led to state and federal enforcement actions in these other jurisdictions. When PEIA contacted ESI about blocking individual pharmacies due to the fraudulent activity, ESI initially resisted, stating that it would require a lot of programming or expense; however, ESI did block the pharmacies. Soon after, CVS Caremark became the new PBM on July 1, 2016.

PEIA shared its information with investigators at the WV Office of the Insurance Commission Fraud Unit and the Consumer Protection Division of the WV Attorney General's Office. Subsequently, PEIA and the WV Attorney General's Office met with the WV Department of Health and Human Resources' Medicaid Fraud Unit to advise them of the patterns and information that had been discovered. The investigation ultimately grew to encompass over a half-dozen federal agencies. During the investigation conducted by PEIA, there were several structural roadblocks to investigating the fraudulent activity and stopping the perpetrators. PEIA stated that this fraud involved collusion, making it difficult to detect and investigate through traditional measures. Also, PEIA was precluded from filing a formal complaint with the Attorney General's Office since it is not considered a "consumer" under WV law. Additionally, PEIA was unable to file complaints with the WV Board of Medicine since it was not a "patient". These roadblocks ultimately make it more difficult for PEIA to respond to fraud and mitigate further risk associated with it.

PEIA informed the Legislative Auditor that the Protected Health Information (PHI) needed to carry out this fraud scheme was obtained through several different means. The Health Insurance Portability Accountability Act (HIPAA) defines PHI as, "individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral". Individually identifiable health information is information that allows an

individual's identity to be ascertained because it is not de-identified. This includes demographic data that relates to:

- The individual's past, present, or future physical or mental health or condition,
- The provision of health care to the individual, or
- The past, present, or future payment for the provision of health care to the individual,

Individually identifiable health information includes many common identifiers such as name, address, date of birth, and social security number.

According to PEIA, the investigation into the fraudulent activity revealed that the member's PHI was obtained through various social engineering schemes on social media platforms, or via phishing emails. These types of schemes would have led to members providing enough PHI information to allow the fraud to be committed. Specific examples of the types of schemes where members PHI was obtained include:

- Members filling out an innocuous online questionnaire.
- Members requesting a "free diabetic cookbook" online.
- Infomercial ads that were designed to get people to call for "free" products.

Once the call center received a member's information it would then send the information to a prescriber, sometimes a doctor or nurse practitioner, who would write a prescription for the member for whatever supplies they were directed to by a call center. Often these were for amounts greater than what the member needed. The prescriber would then sign a prescription and return it to a pharmacy. Often the supplies were prescribed for PEIA members who were not diabetic. According to PEIA, "when investigated, the pharmacy would say that they 'acted on a valid prescription from a licensed practitioner and the physician said that they were only 'helping a patient get their needed supplies' and when the prescribers were contacted, they used the defense, 'diabetic supplies are technically over-the-counter supplies and don't require a prescription.'" Essentially, each party involved in the scheme had the defense that they were acting on a "valid" request to fulfill the medical needs of a patient for supplies that are viewed as low risk.

PEIA informed the Legislative Auditor that because of some of the methods used to gather PHI, it has worked with the Consumer Protections Division of the West Virginia Attorney General's Office to alert the public about these types of scams via consumer alerts. PEIA has also included information on its website regarding fraud on the active members and non-Medicare retiree's webpages, as well as any notices about fraud and prevention in newsletters to members. PEIA has also developed networks with other states through the State and Local Governments Benefits Association to monitor prescriber and pharmacy patterns for other signs and indicators of potential fraud, waste, and abuse. According to PEIA, the data analytics profiles developed by PEIA as a result of this fraud have been shared with other states for use in their fraud detection methods. Additionally, as of February 24, 2021, 75 pharmacies PEIA identified as participants in the fraudulent activity have been placed on a blocked pharmacy list. PEIA informed the Legislative Auditor that the fraud remains under investigation within multiple agencies and jurisdictions, including with the WV Attorney General, and it continues to pursue recoveries. According to PEIA, it identified 65,733 potentially fraudulent transactions from claims processed from 2009 through 2017 totaling approximately \$5 million<sup>1</sup>.

<sup>1</sup> This total amount is unaudited, as determining the total loss was outside the audit scope.

## PEIA Reliance Upon PBM Internal Controls

PEIA contracts with the PBM for the services of its prescription drug benefits program including processing claims as well as monitoring for fraud and employing internal controls to prevent and detect potential fraud within its claims processes. While it is an acceptable practice to utilize a third party to perform functions that are beyond an entity's capacity due to a lack of staff or expertise, monitoring of these activities must still occur. Monitoring the third party to ensure that it is functioning as expected within the contract terms and communicating noted deficiencies within the PBM's processes for corrective actions is a critical part of an entities third-party risk management process. Further, if PEIA intends to rely upon the control activities of the third party in the prevention and detection of fraud within the claims process, the contractual arrangement must provide a clear expectation of the activities to be performed, and how instances of noted fraud or potential fraud are communicated to PEIA.

In the ESI contract there was not a clear delineation of the functional control activities related to fraud PEIA expected ESI to utilize when processing pharmacy claims. The contract with ESI did not have a requirement for ESI to notify PEIA in the event fraudulent transactions were discovered. ESI acknowledged in its response to PEIA it knew the fraud was occurring, however there was no adverse impact on ESI for not reporting the fraud or allowing the fraud to perpetuate. ESI was compliant with the terms of the contract as there was no requirement in the contract for it to notify PEIA of the fraud. Additionally, the ESI contract did not provide for any shared financial risk or incentive for the prevention or detection of fraudulent claims and therefore its actions did not negatively impact ESI's bottom line.

The current PBM contract with CVS attempts to address the shortcomings of the previous contract. First, the contract with CVS requires the PBM to have established procedures and system edits to aggressively monitor and proactively search for potential cases of fraud and abuse. Second, the contract contains a notification requirement for suspected fraudulent or abusive activity of no later than 30 days after discovery. While these contract terms are an improvement over the terms of the previous contract with ESI, there still lacks any shared risk, financial or otherwise, should fraud occur and go undetected until after the fraudulent claims are processed as the financial impact of such fraud is solely the responsibility of PEIA<sup>2</sup>. Further, the performance of the PBM in meeting its contractual obligations must be consistently monitored by PEIA to determine if deficiencies within the PBM's processes or internal controls exist that require corrective action so those deficiencies can be communicated to the PBM.

Both the previous ESI and current CVS contracts contain clauses enabling PEIA the right to audit financial aspects of the agreement including claims, rebates, performance guarantees; and the ability to request various data reports including, but not limited to, claims data. The Legislative Auditor requested all PBM related audits performed by PEIA from 2012 through 2021. In response, PEIA stated that, "although these audits are permitted annually, given prior experiences with minimal findings, are not warranted". PEIA informed the Legislative Auditor that two independent audits by outside firms in the past have not been cost effective in relation to the recoveries and PEIA relies on its internal audit reviews stating they are more cost effective and impactful in monitoring the pharmacy benefit. PEIA also states it conducts regular audits of the pharmaceutical rebates and weekly and monthly reviews of claims. In relation to the fraud cited in this report, PEIA asserts it

<sup>2</sup> The Legislative Auditor notes that including contract provisions for sharing of financial risk associated with fraud may increase the cost of the contract as a result of the need for additional insurance or bonding to cover the associated liability.

was the result of its processes and response to reported complaints that led to it uncovering the fraud and the resulting enforcement actions taken across various jurisdictions. While these efforts did lead to uncovering this fraud, it is the opinion of the Legislative Auditor that additional fraud detection measures utilizing PEIA's internal audit function and the PBM claims data could have detected this fraud sooner, potentially reducing its impact on PEIA and its members.

### **Need for PBM Monitoring and Improved Fraud Detection Procedures**

The current third-party risk management activities, specifically monitoring activities, performed by PEIA over the PBM meant to establish an effective internal control system<sup>3</sup> could be improved to detect, prevent, and respond to fraud more effectively. With regard to third-party risk management, when an entity contracts with a third-party for services, it essentially removes its internal controls for those services and relies on the internal controls of the third-party in its performance of those services. As a result, to manage its third-party risk and to assess the adequacy of the internal controls of the third-party in performing those services, the contracting entity, PEIA, must consistently monitor the performance of the third-party to ensure that it is meeting its contractual obligations with regard to its processes and internal controls. Monitoring activities involve ongoing evaluations to determine if internal controls are both present and functional.

PEIA informed the Legislative Auditor it requires the PBM to provide annually the SOC-1 Reports<sup>4</sup> meant to verify that the PBM's controls are effective and functional. However, additional independent verification that the PBM claim processing controls and fraud detection procedures are functioning as intended is still necessary. Without independently verifying controls are present and functional in relation to fraud, specific to the services the PBM provides to PEIA, PEIA cannot be assured the PBM is detecting fraud properly or if there are further issues with the services PEIA relies upon. As the contracts with the PBMs lack any shared financial risk or incentive in the prevention or detection of fraud, this may reduce the PBM's emphasis on these activities in its execution of its services. This furthers the need for PEIA to monitor the PBM's claim data to ensure fraud prevention and detection is occurring as expected as PEIA assumes all associated financial risk.

According to the Association of Certified Fraud Examiners (ACFE), quick detection of fraud is vital in protecting an organization from potential damage as the longer fraud goes undetected the greater the financial impact on the organization. While PEIA noted collusion was involved and many fraudulent claims were made under risk tolerance levels making the fraud difficult to detect through traditional methods, other fraud detection methods may have been able to identify the fraud sooner. PEIA stated, "an annual audit of the PBM would not have detected the patterns of behavior previously noted in the larger scheme...", "... [as the audit] would not get down to such a granular level as to detect the behaviors at issue."

To determine if there were other tools available to PEIA that would have assisted it in proactively monitoring, within a reasonable amount of time, the relied upon activities of the PBM, the Legislative Auditor conducted data analysis on the PBM data for two different fiscal years. The Legislative Auditor selected two methods known to be practical and capable of detecting potential fraud, a Benford analysis and a Z-Score analysis, as both can be performed in Microsoft Excel without specialized software. Once the spreadsheet templates were created for each method, the results

<sup>3</sup> As defined by the Committee of Sponsoring Organizations (COSO) of the Treadway Commission, a joint initiative between the American Institute of Certified Public Accountants, American Accounting Association, Financial Executives International, Institute of Internal Auditors, and the Institute of Management Accountants to develop a standard framework for internal control.

<sup>4</sup> SOC-1 Report is a report on controls at a Service Organization relevant to user entities' internal control over financial reporting. These reports are specifically intended to meet the needs of entities that use service organizations (user entities) and the CPAs that audit the user entities' financial statements (user auditors), in evaluating the effect of the controls at the service organization on the user entities' financial statements. Source: aicpa.org

of each analysis were immediate upon entering the PBM data into the spreadsheet.

The first analysis that the Legislative Auditor performed on the PBM data was a Benford analysis using Benford’s Law<sup>5</sup>. Benford’s Law relates to the frequency distribution of digits in a numerical data set. Fraud examiners use Benford’s Law on natural numbers such as payment amounts. The idea is that if a fraudster submits enough fake invoices, it upsets the natural order numbers should occur. The Benford analysis alone does not indicate a transaction is fraudulent, rather it is a potential indicator of fraud and an alert that a transaction is anomalous and should be investigated further.

The second analysis that the Legislative Auditor performed on the PBM data was a Z-Score analysis. A Z-Score analysis is less precise than a Benford analysis as the Z-Score merely indicates a statistical measurement of a number in relationship to the mean of the population. The Z-Score analysis tells the analyzer how far a transaction exceeds the norm. Like the Benford analysis, the Z-Score analysis alone does not indicate a transaction is fraudulent, rather it is a potential indicator of fraud and an indicator the transaction should be investigated further.

The Legislative Auditor obtained approximately 5.7 million claim transactions processed by ESI in 2010 and in 2015 correlating to two different years PEIA identified as when the fraud occurred. To determine if the Benford or Z-Score analysis would have flagged transactions from the now known fictitious and fraudulent pharmacies, both fraud analysis techniques were applied to the 5.7 million claims transactions for 2010 and 2015. The flagged transactions were further analyzed, and the pharmacies associated with the flagged transaction compared to the list of fictitious pharmacies that PEIA identified as being involved in the fraudulent activity. Since PEIA has identified through its investigations that these pharmacies were established under fraudulent means for the purpose of committing fraud through false pharmacy claims, any flagged claim transactions from these pharmacies would therefore be fraudulent.

These two techniques flagged approximately 11,000 transactions originating from the fictitious pharmacies that PEIA had placed on the blocked pharmacy list in those two years of claims transactions alone, flagging approximately 7,000 in FY 2010 and roughly 4,000 in FY 2015. Additionally, the Legislative Auditor was able to identify transactions processed from 31 pharmacies in a single year known to have been involved in the fraud scheme. Table 1 shows the breakdown of these transactions detected by each analysis technique. Both techniques analyzed the same data set but due to different methodologies they return different results.

<b>Table 1: Benford and Z-Score Analysis Results</b>				
	<b>FY 2010</b>		<b>FY2015</b>	
	<b>Benford</b>	<b>Z-Score</b>	<b>Benford</b>	<b>Z-Score</b>
<b>Number of Known Fraudulent Pharmacies Flagged</b>	<b>8</b>	<b>4</b>	<b>31</b>	<b>8</b>
<b>Number of Transactions Flagged from Known Fraudulent Pharmacies</b>	<b>1,271</b>	<b>5,758</b>	<b>2,231</b>	<b>1,803</b>
Source: Legislative Auditor's Analysis				

Previously, PEIA indicated to the Legislative Auditor that an audit even done at a granular level, “would have given the fraud perpetrators up to a year to run their various schemes without

<sup>5</sup> See Appendix B, Objective, Scope, and Methodology, on page 13 of this report.

detection,” and would require key medical records and receipts for an auditor to uncover. However, the patterns the Benford and Z-Score analyses identified included significant concentrations of transactions within certain pharmacies, states, and drug codes, indicating these could be additional tools to identify potentially fraudulent activity and test the effectiveness of the PBM’s fraud detection and prevention processes. Applied on a quarterly basis, these types of analyses could detect potential fraud sooner, reducing the financial impact of fraud, while at the same time being less cumbersome to perform than on an annual set of claims data.

### **PEIA Fraud Risk Management Framework**

COSO and the ACFE released a joint Fraud Risk Management Guide. The Fraud Risk Management Guide has five fraud risk management principles that are necessary for the effective management of an organization’s fraud risk. These five principles include establishing a Fraud Risk Management Program, performing comprehensive fraud risk assessments, utilizing preventive and detective fraud controls, establishing a communication process, and ongoing monitoring of fraud controls.

In a May 20, 2020, letter the Legislative Auditor asked PEIA if it had a fraud risk management framework in place during the effective dates of the ESI contract. PEIA did not provide the Legislative Auditor with a specific framework, but rather an informal list of techniques that PEIA may use in their fraud prevention, detection, mitigation, and elimination. Documentation of a fraud management framework was not provided to the Legislative Auditor until January 15, 2021. Inspection of the document determined the fraud management framework was created, approved, and effective July 15, 2020, indicating that this was created and implemented after the inquiry by the Legislative Auditor. Prior to the current framework, which went into effect July 15, 2020, PEIA primarily relied upon contract language to address the vendor’s responsibilities in monitoring for fraud, waste, and abuse. While the overall impact of PEIA not having a documented fraud management framework in place during the time the fraud discussed in this report occurred is unclear, it is the opinion of the Legislative Auditor that the absence of this framework may have contributed to PEIA’s ability to detect and respond to the fraud timelier.

### **Conclusion**

The Legislative Auditor believes there are several areas of PEIA’s third-party risk management and fraud detection procedures that could be improved to better detect and respond to fraud timelier and to minimize its financial impact. The issues noted in the report are summarized as follows:

- PEIA could improve its third-party risk management procedures for monitoring the PBM;
- PEIA has a reliance on the PBM’s controls to detect fraud without employing independent procedures designed to detect fraud and determine the effectiveness of the PBM’s controls;
- The PBM contract does not delineate the specific fraud risk management activities the PBM is expected to perform in detecting, preventing, or responding to fraud, nor does the contract provide for any shared financial risk of fraud with the PBM or incentive for detecting fraud and pursuing recovery when detected; and
- PEIA did not have an established fraud risk management framework in place until it was created during the audit, which may have contributed to its timeliness to detect this fraud.

Improvements in these areas would assist in detecting similar fraud schemes sooner and



reducing their impacts. While there is an obvious financial risk associated with fraudulent healthcare claims, there is also the health risk to the members that should not be understated. In this instance, PEIA indicated it expended approximately \$5 million from July 1, 2009, to January 31, 2017, on 65,733 fraudulent claims. Additionally, PEIA stated, “The actions taken by PEIA, the WV AG’s office and others have the potential to save PEIA and/or the State \$21 million to \$26 million over the next five years by implementing audit controls to stop these practices<sup>6</sup>.” The unfortunate truth is the cost of fraud is a cost that should not have to be incurred in the first place, and efforts made in its prevention and quick detection are paramount at reducing this cost. The significance of the potential financial savings cited highlights the need for PEIA to have a strong internal control structure that monitors the controls of third-party PBM and assesses the potential fraud risks facing the entity. By employing additional procedures to detect potential fraud that may have gone undetected by the PBM, PEIA can further reduce the risk and associated cost this type of fraud causes.

The National Health Care Anti-Fraud Association (NHCAA) estimates that the financial losses caused by health care fraud in the United States are in the tens of billions of dollars each year. NHCAA conservatively estimates that 3% of total health care expenditures could be fraudulent. As noted by PEIA, the fraud discussed in this report accounts for 0.3% (three-tenths of one percent)<sup>7</sup> of PEIA’s total pharmacy spend during the scope of the audit. The United States has one of the highest costs of healthcare in the world. In 2018, the United States spent approximately \$3.6 trillion on healthcare. Healthcare costs in the United States have increased over the past decades, from 5% of gross domestic product (GDP) in 1960 to 18% in 2018. One of the reasons healthcare costs are rising is because healthcare is becoming more complex. Due to the ever-increasing complexities in operations and regulations, healthcare organizations of all sizes and types are facing unique challenges related to the design of their operations and internal control systems. In many instances this requires the outsourcing of certain healthcare functions organizations may not be able to perform on their own or with the resources available to them, which in turn results in increased risks. Many of the risks associated with healthcare can be mitigated with strong internal control systems. However, not even the strongest internal control systems can prevent an individual determined to commit fraud. Organizations faced with a high likelihood of becoming victims of fraud should employ a proactive approach to fraud management which can be assisted by developing a fraud management framework.

As a result of the issues noted in this report, the Legislative Auditor makes the following recommendations:

## **Recommendations**

1. The Legislative Auditor recommends PEIA develop, implement, and consistently employ third-party risk management processes to assess the adequacy of third-party internal controls in carrying out contracted services and to address risks, monitor performance, and communicate noted deficiencies in those processes to the third-party during the life of the contract. For the PBM contract, these processes should also include a type of data analysis that would allow PEIA to detect patterns of potentially fraudulent transactions that may have gone undetected by the PBM such as the Benford or Z-Score analyses discussed in this report.

<sup>6</sup> Potential savings claim is an unaudited amount.

<sup>7</sup> 0.3% of total pharmacy spend over the audit scope is an estimate provided by PEIA that is unaudited. The Legislative Auditor notes that it is unclear, based on the NHCAA estimate that 3% of total healthcare expenditures could be fraudulent, if this 0.3% of identified fraud over the audit scope means this was the only fraud that affected PEIA during the scope of the audit or if other fraud potentially remains undiscovered, as that determination was not an objective of this audit engagement.

2. The Legislative Auditor recommends PEIA continue to develop its fraud risk management framework and employ processes and procedures designed to reduce the risks associated with its utilization of third parties to provide services that may be impacted by fraud.
3. The Legislative Auditor recommends PEIA define specific fraud prevention and internal control activities within the PBM contract that it expects its PBM or other contracted parties to perform in carrying out its contracted services.
4. The Legislative Auditor recommends PEIA consider adding language to the PBM contract that would cause the PBM to share the financial impact of fraud occurring in the event the PBM's processing of fraudulent claims have a direct financial impact on PEIA due to a failure on the part of the PBM to properly prevent or detect such fraud under the terms of the contract.
5. The Legislative Auditor recommends the Legislature, in conjunction with PEIA, consider amending WV Code to allow PEIA to file complaints with the entities charged with oversight of the various healthcare professions, as well as the WV Attorney General's Office, in the event of identified fraud, waste, and abuse.

# WEST VIRGINIA LEGISLATIVE AUDITOR'S OFFICE

*Post Audit Division*

1900 Kanawha Blvd. East, Room W-329  
Charleston, WV 25305-0610  
(304) 347-4880

**Justin Robinson**  
Director



September 28, 2021

Ted Cheatham, Director  
WV Public Employees Insurance Agency  
601 57th St., SE, Suite 2  
Charleston, WV 25304

Director Cheatham:

This is to transmit a draft copy of the Post Audit Division's report on the WV Public Employees Insurance Agency's (PEIA) Pharmacy Benefit Manager contract. This report is scheduled to be presented during the October interim meetings of the Post Audits Subcommittee. The exact time and date of the meeting has not been set however the October interim meetings will occur October 10-12, 2021. We will inform you of the exact time and location once the information becomes available. It is recommended that a representative of the agency be present at the meeting to respond to the report and answer any questions committee members may have during or after the meeting.

We would also like to schedule an exit conference with PEIA to discuss the draft report and address any concerns you may have. Please contact Terri Stowers, Executive Assistant, at 304-347-4880 by close of business Friday, October 1, 2021, to arrange this meeting. In addition, if you would like to provide a written response to be included in the report, please provide this response by 12:00 pm on Thursday, October 7, 2021, in order for it to be included in the final report. Thank you for your cooperation.

Sincerely,

A handwritten signature in blue ink that reads "Justin Robinson".

Justin Robinson

Enclosure

## **Objectives, Scope, and Methodology**

The Post Audit Division of the Office of the Legislative Auditor conducted this post audit as authorized by Chapter 4, Article 2, Section 5 of the West Virginia Code, as amended. The post audit was conducted in accordance with the standards applicable to performance audits contained in the 2018 generally accepted government auditing standards (GAGAS) issued by the Government Accountability Office. Those standards require the audit to be planned and performed to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. The Legislative Auditor believes that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

### **Objectives**

The objectives of this audit were to determine the cause of the fraud disclosed by PEIA. Based on the fraud determine if PEIA's internal controls over the pharmacy benefits are sufficient to deter and detect potential recurrences and determine if PEIA has a fraud response plan for the pharmacy benefits and if that fraud response plan ensures the effective and timely action in the event of a fraud.

### **Scope**

The scope of this audit consisted of a review of PEIA's internal controls regarding PBM provider from 2010 – 2020. It also included PEIA's claims data for years 2010, 2015, and 2020.

### **Methodology**

Audit staff obtained and analyzed several different sources of evidence. Documentary evidence was obtained in the form of the Express Scripts Contract, the CVS Contract, and PEIA Health Insurance Fraud Policy. Analytical evidence was obtained in the form of the PBM Rx data for fiscal years 2010, 2015, and 2020. Testimonial evidence was obtained in the form of several letter responses from PEIA to Post Audit.

The PBM contracts were reviewed to determine if they contained contract language regarding fraud. PEIA's Health Insurance Fraud Policy was reviewed to determine if PEIA had proper internal controls in place during the fraud. All PBM Rx data for fiscal years 2010, 2015, and 2020 was reviewed using two different types of data analysis to determine if there was a way that PEIA could have detected the fraudulent behavior sooner.

The first type of analysis was a Benford analysis based on Benford's Law. Benford's Law quantifies the surprising fact that in many datasets the numbers are much more likely to start with small digits like one or two rather than with large digits like eight or nine. The law provides a specific probability distribution on the significant digits, telling exactly how likely each sequence of digits is. Fraud examiners use Benford's Law on natural numbers, like payment amounts. The theory is that if a fraudster submits an invoice for a fake payment, they won't submit invoices for lower numbers they will want to submit invoices for large numbers. If a fraudster submits enough invoices, it upsets the natural order of the way numbers should occur, according to Benford.

When using Benford's Law there are three different categories of tests, primary, advanced, and associated. The general rule when testing is to use primary tests first, followed by advanced, and then associated. The primary tests are the main Benford's Law tests which include test of the: first digits, second digits, and first two digits. The first and the second digit tests are high-level tests that are usually of too high a level to be of too much use except in certain situations. The first-two-digits test is a more focused test. The first-two-digit test is used to detect abnormal duplications of digits and possible biases in the data. Because of this the first two digits test is the test that the audit staff focused on when looking at outliers in the PBM claims data. When performing the Benford analysis the audit staff analyzed the first two digits of claim amounts in a graphical manner, where the normal rate of occurrence is represented by a logarithmic curve and anything above that curve is an outlier. The claims amount with the first two digits deemed outliers were then pulled out of the data and further analyzed to see if the pharmacies that the claims related to were part of the group of pharmacies that PEIA had blocked, and to determine how many potentially fraudulent charges PEIA would have been able to find and investigate further if they would have been performing a Benford analysis on PBM claims data.

The second analysis the audit team used was the Z-Score statistical calculation standardizes the data and its distribution regardless of the amounts and variance within the data set. While indexing or sorting the data will provide the same order as the Z-Score, the Z-Score tells the analyzer how far the data exceeds the norm. Any z-score greater than positive three or less than negative three is considered to be an outlier. The audit staff ran the Z-Score analysis on PBM claims data for years 2010, 2015, and 2020 to determine which claims were outliers by being between positive three and negative three. The claims that were deemed outliers were then pulled out of the data and further analyzed to see if the pharmacies that the outlier claims were related to were part of the group of pharmacies that PEIA blocked and to determine how many potentially fraudulent charges PEIA would have been able to find and investigate further if they would have been performing a Z-Score analysis on PBM claims data.



# Public Employees Insurance Agency

**WV Toll-free:** 1 (888) 680-7342  
**Phone:** 1 (304) 558-7850  
**Fax:** 1 (304) 558-2470  
**Website:** [www.wvpeia.com](http://www.wvpeia.com)

October 7, 2021

Justin Robinson, Director  
WV Legislative Auditor's Office  
Post Audit Division  
1900 Kanawha Boulevard,  
East, Room W-329  
Charleston, WV 25305-0610

**Re: Correspondence to PEIA Director, Ted Cheatham, dated September 28, 2021**

Director Robinson,

Thank you for the opportunity to respond to your report. This letter serves as formal response to correspondence from the West Virginia Legislative Auditor's Office Post Audit Division, dated September 28, 2021. In addition to the correspondence was a draft report from the Post Audit Division on the West Virginia Public Employees Insurance Agency's (PEIA) Pharmacy Benefit Manager (PBM) contract scheduled to be presented during the Post Audits Subcommittee interim meeting on October 10, 2021.

## **Issue 1:**

**Improvements to PEIA's Third-Party Risk Management and Internal Controls Over the Pharmacy Benefits Management Services for Which It Contracts Could Assist in Timelier Detection of Potential Fraud. The Use of Additional Fraud Detection Techniques May Have Allowed PEIA to Detect and Respond to the Fraud It Identified in 2015 More Quickly, Which Began in 2009 and Encompasses Approximately \$5 Million in Fraudulent Claims.**

PEIA response to Issue 1:

PEIA has reviewed the West Virginia Legislative Auditor's Office Post Audit Division (Post Audit) Issue 1 and believes it to be a reasonable representation and explanation of the Issue PEIA presented to Post Audit.

## **Report Recommendations:**

1. The Legislative Auditor recommends PEIA develop, implement, and consistently employ third-party risk management processes to assess the adequacy of third-party internal controls in carrying out contracted services and to address risks, monitor performance, and communicate noted deficiencies in those processes to the third-party during the life of the contract. For the PBM contract, these processes should also include a type of data analysis that would allow PEIA to detect patterns of potentially fraudulent transactions that may have gone undetected by the PBM such as the Benford or Z-Score analyses discussed in this report.



PEIA Response to Recommendation 1:

PEIA has reviewed this recommendation and will comply by exploring all options available in enhancing its ability to improve controls at the PBM level for detection of healthcare fraud risk. PEIA, would like further assistance on the referenced detection tools as it has not been successful mimicking Post Audits' results. PEIA's initial results have been discussed with Post Audit and PEIA will continue working with Post Audit to realize the benefits of this recommendation.

2. The Legislative Auditor recommends PEIA continue to develop its fraud risk management framework and employ processes and procedures designed to reduce the risks associated with its utilization of third parties to provide services that may be impacted by fraud.

PEIA Response to Recommendation 2:

PEIA has reviewed this recommendation and will comply by continuing to develop and enhance its fraud risk management framework for detection of healthcare fraud risk.

3. The Legislative Auditor recommends PEIA define specific fraud prevention and internal control activities within the PBM contract that it expects its PBM or other contracted parties to perform in carrying out its contracted services.

PEIA Response to Recommendation 3:

PEIA has reviewed this recommendation and will comply by requiring additional healthcare provider fraud prevention and internal control activities within the PBM and other contracted party's contracts.

4. The Legislative Auditor recommends PEIA consider adding language to the PBM contract that would share the financial impact of fraud occurring with the PBM in the event the PBM's processing of fraudulent claims have a direct financial impact on PEIA due to a failure on the part of the PBM to properly prevent or detect such fraud under the terms of the contract.

PEIA Response to Recommendation 4:

PEIA has reviewed this recommendation and will attempt to comply by requiring the PBM accept the risk of any loss PEIA may encounter in the event the PBM fails to prevent or detect suspected healthcare provider fraud.

5. The Legislative Auditor recommends the Legislature in conjunction with PEIA consider amending WV Code to allow PEIA to file complaints with the entities charged with oversight of the various healthcare professions, as well as the WV Attorney General's Office, in the event of identified fraud, waste, and abuse.

PEIA Response to Recommendation 5:

PEIA has reviewed this recommendation and will comply by submitting proposed legislation to amend W. Va. Code §5-16-12A (attached as an Enclosure to this response) which would allow PEIA to file complaints with the entities charged with oversight of the various healthcare professions, as well as the West Virginia Attorney General's Office, in the event of identification of suspected fraud, waste, and abuse.

Sincerely,

A handwritten signature in blue ink, appearing to read "William B. Hicks".

William B. Hicks, Esq.  
General Counsel

cc: Ted Cheatham, Director  
Jason Haught, Chief Financial Officer  
Felice Joseph, Pharmacy Director

Enclosure: Attachment 1, Proposed Legislation to amend W. Va. Code §5-16-12A.

Attachment 1  
Proposed Legislation to amend  
W. Va. Code §5-16-12A.

**§5-16-12a. Inspections; violations and penalties.**

(a) Employers and employees participating in any of the Public Employees Insurance Agency plans ~~shall provide, or providers billing the Public Employees Insurance Agency plans,~~ shall provide to the director, upon request, all documentation reasonably required for the director to discharge the responsibilities under this article. This documentation includes, but is not limited to, employment or eligibility records sufficient to verify actual full-time employment and eligibility of employees who participate in the Public Employees Insurance Agency plans, or claims utilization review information.

(b) Upon a determination of the director or his or her designated representative that there is probable cause to believe that fraud, abuse or other illegal activities involving transactions with the agency has occurred, the director or his or her designated representative is authorized to refer the alleged violations to the Insurance Commissioner, or other appropriate law enforcement agency for investigation and, if appropriate, prosecution, pursuant to article forty-one, chapter thirty-three of this code or applicable federal law. For purposes of this section, “transactions with the agency” includes, but is not limited to, application by any insured or dependent, any employer or any type of health care provider for payment to be made to that person or any third party by the agency.

(c) Upon a determination of the director or his or her designated representative that there is probable cause to believe that suspected fraud, abuse or other illegal activities involving provider transactions with the agency has occurred, the director or his or her designated representative is authorized to refer the alleged violations to the appropriate licensing board(s) under Chapter 31 of the Code of this State, State certification boards, or the same or similar boards of any other state, or the Office of the Attorney General as a consumer. The Public Employees Insurance Agency is further authorized to suspend payments to any provider or exclude them from the networks pending the investigation into suspected fraud, abuse or other illegal activities involving provider transactions with the agency.

~~(e)~~ (d) The Public Employees Insurance Agency is authorized through administrative proceeding to recover any benefits or claims paid to or for any provider, employee, or their dependents, who obtained or received payment or benefits through fraud. The Public Employees Insurance Agency is also authorized through administrative proceeding to recover any funds due from an employer or provider that knowingly allowed or provided benefits or claims to be fraudulently paid to an employee or dependents.

~~(d)~~ (e) For the purpose of any investigation or proceeding under this article, the director or any officer designated by him or her may administer oaths and affirmations, issue administrative subpoenas, take evidence, and require the production of any books, papers, correspondences, memoranda, agreements or other documents or records which may be relevant or material to the inquiry.

(1) Administrative subpoenas shall be served by personal service by a person over the age of eighteen, or by registered or certified mail addressed to the entity or person to be served at his or her residence, principal office or place of business. Proof of service, when necessary, shall be made by a return completed by the person making service, or in the case of registered or certified mail, such return shall be accompanied by the post office receipt of delivery of the subpoena. A party requesting the administrative subpoena is responsible for service and payment of any fees for service. Any person who serves the administrative

subpoena pursuant to this section is entitled to the same fee as sheriffs who serve witness subpoenas for the circuit courts of this state.

(2) Fees for the attendance and travel of witnesses subpoenaed shall be the same as for witnesses before the circuit courts of this state. All such fees related to any administrative subpoena issued at the request of a party to an administrative proceeding shall be paid by the requesting party. All requests by parties for administrative subpoenas shall be in writing and shall contain a statement acknowledging that the requesting party agrees to pay such fees.

(3) In case of disobedience or neglect of any administrative subpoena served, or the refusal of any witness to testify to any matter for which he or she may be lawfully interrogated, or to produce documents subpoenaed, the circuit court of the county in which the hearing is being held, or the judge thereof in vacation, upon application by the director, may compel obedience by attachment proceedings for contempt as in the case of disobedience of the requirements of a subpoena or subpoena duces tecum issued from such circuit court or a refusal to testify therein. Witnesses at such hearings shall testify under oath or affirmation.

(e) Only authorized employees, policyholder members or agents shall have access to confidential data or systems and applications containing confidential data within the Public Employees Insurance Agency.







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WEST VIRGINIA OFFICE OF THE LEGISLATIVE AUDITOR  
- POST AUDIT DIVISION -

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Room 329 W, Building 1  
1900 Kanawha Boulevard East  
Charleston, West Virginia 25305  
Phone: (304) 347-4880