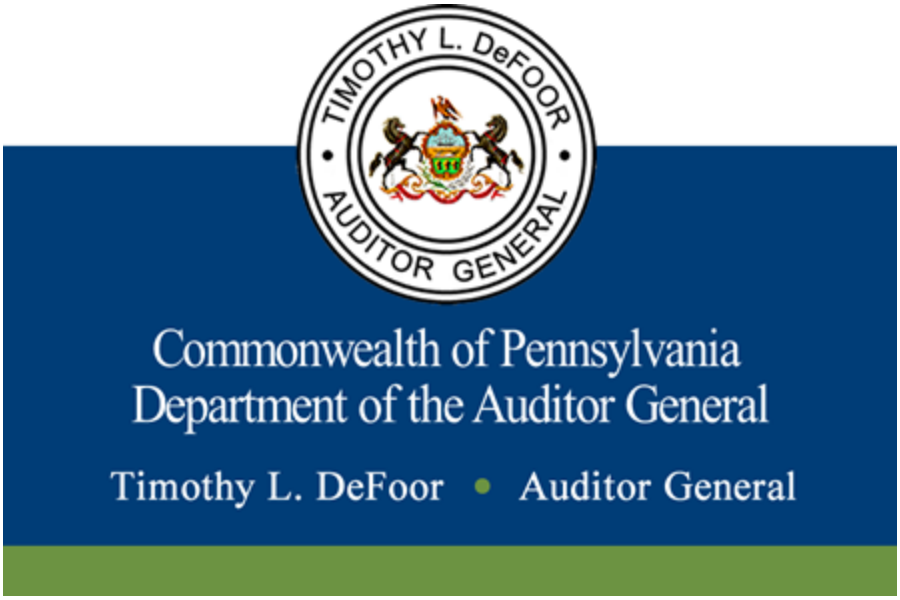
PERFORMANCE AUDIT REPORT

Pennsylvania Department of Human Services

PerformRx, LLC

An Audit of the Pharmacy Benefit Manager Services for
the Physical HealthChoices Medicaid Program
in Pennsylvania

August 2024



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TIMOTHY L. DEFOOR
AUDITOR GENERAL

August 21, 2024

The Honorable Valerie A. Arkoosh, MD, MPH
Secretary
Pennsylvania Department of Human Services
P.O. Box 2675
Harrisburg, PA 17110-2675

Mr. Jim Gartner, MBA, R.Ph.
President
PerformRx, LLC
200 Stevens Drive
Philadelphia, PA 19113-1570

Dear Secretary Arkoosh and Mr. Gartner:

This report contains the results of the Department of the Auditor General's performance audit of the Pennsylvania Department of Human Services (DHS) Physical HealthChoices (HealthChoices) Medicaid program and the pharmacy benefit manager (PBM) PerformRx, LLC (PerformRx). Our audit period was January 1, 2022, through December 31, 2022. This performance audit was conducted pursuant to Sections 402 and 403 of The Fiscal Code and Section 449.2 of the Human Services Code.[1]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.[2] We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our audit included the following three objectives:

Pertaining to DHS, the audit objectives were as follows:

- Determine whether DHS effectively monitored the PBMs' pharmacy claims, including, but not limited to, the accuracy of the pharmacy information used to prepare the capitation rates for the HealthChoices Medicaid program.

[1] *See* 72 P.S. §§ 402 and 403, 62 P.S. § 449.2, effective December 27, 2022 (Act 98 of 2022).
[2] U.S. Government Accountability Office. *Government Auditing Standards*. 2018 Revision. Technical Update April 2021.

- Determine whether DHS effectively monitored the PBMs' contracts to ensure compliance and transparency for the HealthChoices Medicaid program.

Pertaining to PerformRx, the audit objective was as follows:

- Determine if the PBM was compliant with 62 P.S. § 449(h)(3) and (4) of the Human Services Code (as amended by Act 120 of 2020) regarding charges and fees paid to the PBM by the pharmacies, or pharmacy service organizations, as compared to the corresponding amounts billed to the applicable HealthChoices managed care organizations (MCOs) to ensure transparency, compliance, and accountability for the HealthChoices Medicaid Program.

Our methodology to satisfy these audit objectives, along with our evaluation of management's internal controls significant to these audit objectives, is included in *Appendix A* of this report. This report presents three findings and 17 recommendations.

As discussed in *Finding 1,* we found that DHS failed to effectively monitor the HealthChoices program's pharmacy expenditures of $4.6 billion in calendar year 2022. This resulted in undisclosed spread pricing in which PBMs were not reporting transmission fees to the MCOs and DHS that are charged to the pharmacies. This lack of transparency resulted in overstated pharmacy data. DHS declined to provide MCO financial reports, which prevented the auditors from determining whether the transmission fees charged by PBMs were properly accounted for in the MCOs' Medical Loss Ratio (MLR) calculations or properly accounted for in setting future capitation rates for the HealthChoices program.

In *Finding 2*, we found DHS did not effectively monitor contracts between the Physical HealthChoices MCOs and PBMs. DHS did not have written policies and procedures for its contract monitoring efforts, and it did not verify that PBM contracts complied with the HealthChoices contract.

In *Finding 3*, we found PerformRx, LLC was transparent and accountable to the pharmacies for transmission fees charged during pharmacy drug claims but was not adequately transparent to the three HealthChoices MCOs or DHS.

In closing, we thank DHS and PerformRx for their cooperation and assistance during the audit. DHS is in general disagreement with *Finding 1* and general agreement with *Finding 2*. See *DHS' Response and Auditor's Conclusion* section of this audit report. PerformRx is in general agreement with *Finding 3.* For further detail, see the *PerformRx LLC's Response and Auditor's*

Conclusion section of this audit report. We reserve the right to follow up at an appropriate time to determine whether and to what extent our recommendations have been implemented.

Sincerely,

Timothy L. DeFoor
Auditor General

A Performance Audit

Pennsylvania Department of Human Services
PerformRx, LLC

Pharmacy Benefit Manager Services for the Physical HealthChoices Medicaid Program in Pennsylvania

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Executive Summary

This report presents the results of our performance audit of the Pennsylvania Department of Human Services (DHS) Physical HealthChoices (HealthChoices) Medicaid program regarding DHS's monitoring of pharmacy claims and pharmacy benefit manager (PBM) contracts, as well as one of the PBMs, PerformRx, LLC's (PerformRx) compliance with Act 120 of 2020. Our performance audit included the following three objectives.

Pertaining to DHS, the audit objectives were as follows:

- Determine whether DHS effectively monitored the PBMs' pharmacy claims, including, but not limited to, the accuracy of the pharmacy information used to prepare the capitation rates for the HealthChoices Medicaid program.

- Determine whether DHS effectively monitored the PBMs' contracts to ensure compliance and transparency for the HealthChoices Medicaid program.

Pertaining to PerformRx, the audit objective was as follows:

- Determine if the PBM was compliant with 62 P.S. § 449(h)(3) and (4) of the Human Services Code (as amended by Act 120 of 2020) regarding charges and fees paid to the PBM by the pharmacies, or pharmacy service organizations, as compared to the corresponding amounts billed to the applicable HealthChoices managed care organizations (MCOs) to ensure transparency, compliance, and accountability for the HealthChoices Medicaid Program.

The audit period was January 1, 2022, through December 31, 2022.

Our audit results are contained in three findings with 17 recommendations. DHS is in general disagreement with *Finding 1* and general agreement with *Finding 2*. See *DHS' Response and Auditor's Conclusion* section of this audit report. PerformRx is in general agreement with *Finding 3*'s facts but disagrees with the audit's interpretation of the transmission fees being spread pricing and the audit's implication that the transmission fees are not justifiable. For further detail, see *PerformRx LLC's Response and Auditor's Conclusion* section of this audit report.

Finding 1 – DHS did not effectively monitor pharmacy drug claims which resulted in undisclosed spread pricing, overstated pharmacy data, and a lack of transparency.

Our audit found that DHS had an inaccurate perception that it lacked authority to audit PBMs; ineffectively monitored MCOs' pharmacy data reports; and ineffectively monitored spread pricing due to not validating pharmacy data to source documents resulting in DHS' unawareness of the existence of spread pricing. DHS therefore failed to effectively monitor the HealthChoices program's pharmacy expenditures of $4.6 billion in calendar year 2022. Additionally, DHS declined to provide MCO financial reports preventing the auditors from determining whether the transmission fees charged by PBMs were properly accounted for in the MCOs' Medical Loss Ratio (MLR) calculations or properly accounted for in setting future capitation rates for the HealthChoices program.

The following deficiencies noted during the audit, if left unresolved, could put the program's federal funding at risk:

- DHS' lack of written policy and procedures for its monitoring of pharmacy encounter data to ensure encounter data submitted to the Centers for Medicare and Medicaid Services (CMS) is a complete and accurate representation of the services provided to the Medicaid members;
- DHS' lack of validation that encounter data provided to CMS is correct; and
- DHS' lack of oversight that the encounter records on PROMISe™ were actually reporting the amount the PBMs paid pharmacies.

We offer seven recommendations to DHS to assist in monitoring pharmacy claims and two recommendations to the General Assembly to amend Act 120 of 2020.

Finding 2 – DHS did not effectively monitor contracts between the Physical HealthChoices managed care organizations and pharmacy benefit managers.

DHS did not adequately monitor the contracts between MCOs and PBMs in the HealthChoices program. DHS does not have policies and procedures for its contract monitoring efforts, and it does not verify the current PBM contracts comply with the current HealthChoices contract.

DHS is the Pennsylvania's Medicaid oversight agency and has the responsibility to ensure compliance with the federal and state laws and its HealthChoices agreement. Reliance on the MCOs to monitor the program compliance is insufficient. For instance, although DHS banned spread pricing and implemented pass-through pricing effective January 1, 2020; by not

monitoring the PBMs, our audit found that seven of the eight PBMs charged pharmacies transmission fees which created a spread between what the MCO paid the PBM and what the PBM paid the pharmacy for the same drug claim. This spread pricing practice, although allowable by Act 120 of 2020, requires transparency and disclosure to the pharmacies during adjudication of a pharmacy claim.

DHS' lack of effective oversight of the MCOs' PBM contracts provided little to no assurance that PBMs' contracts or practices comply with the current HealthChoices agreements, Act 120 of 2020, or specific state and federal regulations, potentially putting the Medicaid program at risk for noncompliance.

We offer five recommendations to DHS to assist in monitoring PBM contracts.

Finding 3 – PerformRx, LLC was transparent and accountable to the pharmacies for transmission fees but was not transparent to the MCOs and DHS regarding the fees which resulted in undisclosed spread pricing.

During calendar year 2022, PerformRx was the PBM for three of the HealthChoices MCOs. Our performance audit determined that PerformRx was partially compliant with Act 120 of 2020 by providing transparency to the pharmacies regarding transmission fees during adjudication. However, PerformRx failed to disclose the transmission fees to the three MCOs and DHS which violated the transparency requirements set forth by Act 120 of 2020. To remedy the noncompliance found by our audit, PerformRx submitted the required information dated back to 2019.

We offer three recommendations to PerformRx for transparency and monitoring of its pharmacy adjustments, like reversals.

A Performance Audit

Pennsylvania Department of Human Services
PerformRx, LLC

Pharmacy Benefit Manager Services for the Physical HealthChoices Medicaid Program in Pennsylvania

Introduction and Background

The Department of the Auditor General (DAG) conducted this performance audit of the Pennsylvania Department of Human Services' (DHS) Physical HealthChoices (HealthChoices) Medicaid program and PerformRx, LLC (PerformRx), a pharmacy benefit manager (PBM) pursuant to Sections 402 and 403 of The Fiscal Code (Code) and Section 449.2 of the Human Services Code.[3,4,5]

In 2022, the Pennsylvania General Assembly and Governor enacted Act 98 of 2022, which authorizes DAG to conduct audits of PBMs. Act 98 states, in part, "The Department of the Auditor General may conduct an audit and review of a pharmacy benefits manager that provides pharmacy benefits management to a medical assistance managed care organization under contract with the department [DHS]."

Our performance audit had three audit objectives and covered the period January 1, 2022, through December 31, 2022. The first two audit objectives relate to DHS and the third to PerformRx:

1. Determine whether DHS effectively monitors the PBMs' pharmacy claims, including, but not limited to, the accuracy of the pharmacy information used to prepare the capitation rates for the HealthChoices Medicaid program.

2. Determine whether DHS effectively monitors the PBMs' contracts to ensure compliance and transparency for the HealthChoices Medicaid program.

3. Determine if PerformRx is compliant with 62 P.S. § 449(h)(3) and (4) of the Human Services Code (as amended by Act 120 of 2020[6]) regarding charges and fees paid to the PBM by the pharmacies, or pharmacy service organizations, as compared to the corresponding amounts billed to the applicable HealthChoices managed care

[3] PerformRx is a pharmacy benefit manager used by and contracted with three of the current seven HealthChoices' managed care organizations also referred to as MCOs.
[4] *See* 72 P.S. §§ 402 and 403.
[5] *See* 62 P.S. § 449.2, effective December 27, 2022 (Act 98 of 2022).
[6] Pursuant to Section 3 of Act 120, effective January 25, 2021, the amendment of Section 449 "shall apply to any agreement or contract relating to pharmacy services to medical assistance recipients in the managed care delivery system entered into or amended on or after the effective date [i.e., January 25, 2021] of this section."

organizations (MCOs) to ensure transparency, compliance, and accountability for the HealthChoices Medicaid Program.[7]

Appendix A of this audit report provides a detailed description of the audit objectives, scope, methodology, data reliability, and evaluation of management's internal controls related to the audit objectives. *Appendix B* provides definitions for terms used throughout this audit report.

In the sections that follow, we present relevant background information on DHS, HealthChoices' MCOs, PBMs, PerformRx, LLC, the pharmaceutical supply chain, and the pharmacy claims process.

Pennsylvania Department of Human Services (DHS)

DHS oversees the Medicaid program (also called Medical Assistance) in Pennsylvania, which pays for health care services for eligible individuals. Medicaid is operated in Pennsylvania primarily as three distinct programs: 1) Physical HealthChoices, 2) Community HealthChoices, and 3) Behavioral HealthChoices. This audit reviewed DHS' monitoring only within the Physical HealthChoices program, referred to as HealthChoices.[8]

DHS contracts with MCOs to administer health care for its Medicaid members. Each MCO participating in the HealthChoices program subcontracts with a PBM to administer some, if not all, of the prescription drug benefit. The MCO agreements with the PBMs are considered subcontracts of the MCOs and are, therefore, not directly contracted with or executed by DHS.

According to DHS records, the HealthChoices pharmacy expenditures were more than $4.6 billion of the $14.5 billion spent for the HealthChoices program in 2022.

HealthChoices MCOs January 1, 2022, through December 31, 2022

Between January 1, 2022, and December 31, 2022, the HealthChoices contract was re-procured with a start date of the new contract on September 1, 2022. Based on the new contract beginning

[7] Note that our audit procedures do not distinguish between pharmacies and pharmacy services organizations, and we refer to all of them as pharmacies.
[8] We also did not include the Adult Community Autism Program and the Children's Health Insurance Program (known as CHIP) in our audit.

September 1, 2022, some of the previous MCOs added regional zones, some MCOs exited regional zones, and one MCO contract was not continued.

The following eight MCOs were contracted for the period January 1, 2022, through August 31, 2022:

MCO[9]	Abbreviation
1. Health Partners Plans, Inc.	Health Partners
2. UnitedHealthcare of Pennsylvania, Inc.	UnitedHealthcare
3. Keystone First	Keystone First
4. Highmark Wholecare (formerly Gateway Health Plan)	Highmark
5. UPMC for You, Inc.	UPMC
6. AmeriHealth Caritas Pennsylvania	AmeriHealth
7. Geisinger Health Plan	Geisinger
8. Aetna Better Health, Inc.	Aetna

The contract with Aetna was not continued, while the other seven MCOs were contracted for the new HealthChoices contract effective September 1, 2022. Below is a list of the contracted MCOs, by regional zone, for the two contract periods during calendar year 2022:

[9] MCOs may use various legal entities with similar, but different, legal names for different services which is out of the scope for this audit.

January 1 – August 31, 2022	September 1 – December 31, 2022[10]
HC Southeast Zone	**HC Southeast Zone**
Aetna	Geisinger
Health Partners	Health Partners
UnitedHealthcare	Keystone First
Keystone First	UnitedHealthcare
	UPMC
HC Southwest Zone	**HC Southwest Zone**
Aetna	AmeriHealth
Highmark	Geisinger
UnitedHealthcare	Health Partners
UPMC	Highmark
	UPMC
HC Lehigh/Capital Zone	**HC Lehigh/Capital Zone**
Aetna	AmeriHealth
Highmark	Geisinger
UnitedHealthcare	Health Partners
UPMC	Highmark
AmeriHealth	UPMC
HC New West Zone	**HC Northwest Zone**
Aetna	AmeriHealth
Highmark	Geisinger
UPMC	Health Partners
AmeriHealth	UPMC
HC New East Zone	**HC Northeast Zone**
Aetna	AmeriHealth
Geisinger	Geisinger
AmeriHealth	Health Partners
	UPMC

[10] Source: PhysicalHealthChoices-Main (pa.gov), Statewide HealthChoices Physical Health Managed Care Map of MCOs by Zones effective September 1, 2022. See https://www.pa.gov/en/agencies/dhs/resources/medicaid/statewide-mco-map.html (last accessed July 1, 2024).

HealthChoices MCOs' PBMs January 1, 2022, through December 31, 2022

During the audit period, each HealthChoices MCO contracted with a PBM to provide various pharmacy benefits, including, but not limited to, the adjudication of pharmacy claims, as follows:

HealthChoices MCOs	PBM Vendor
1. Geisinger	PerformRx, LLC
2. AmeriHealth	PerformRx, LLC
3. Keystone First	PerformRx, LLC
4. Health Partners	CaremarkPCS Health, LLC
5. Highmark	CaremarkPCS Health, LLC
6. Aetna[A]	CaremarkPCS Health, LLC
7. UPMC	Express Scripts, Inc.
8. UnitedHealthcare	OptumRx, Inc.
[A] As noted in the preceding section, Aetna did not continue with the HealthChoices program for the new contract effective September 1, 2022.	

We selected a PBM as part of this audit to determine whether the selected PBM is compliant with Act 120 of 2020, which disallows the use of spread pricing in the Medicaid program unless there is adequate transparency and accountability related to a transmission fee charged by the PBM during the payment process to the pharmacy.[11] The PBM selected was PerformRx, LLC, since it serves as a PBM for three of the MCOs.

PerformRx, LLC (PerformRx)

Founded in 1999, PerformRx, a Pennsylvania limited liability company (LLC), serves as a PBM and provides a "boutique service model" for its clients which include MCOs.[12] It serves three MCOs in the HealthChoices program, as noted in the chart above: Geisinger, AmeriHealth, and Keystone First. AmeriHealth and Keystone First, jointly, contract with PerformRx for PBM

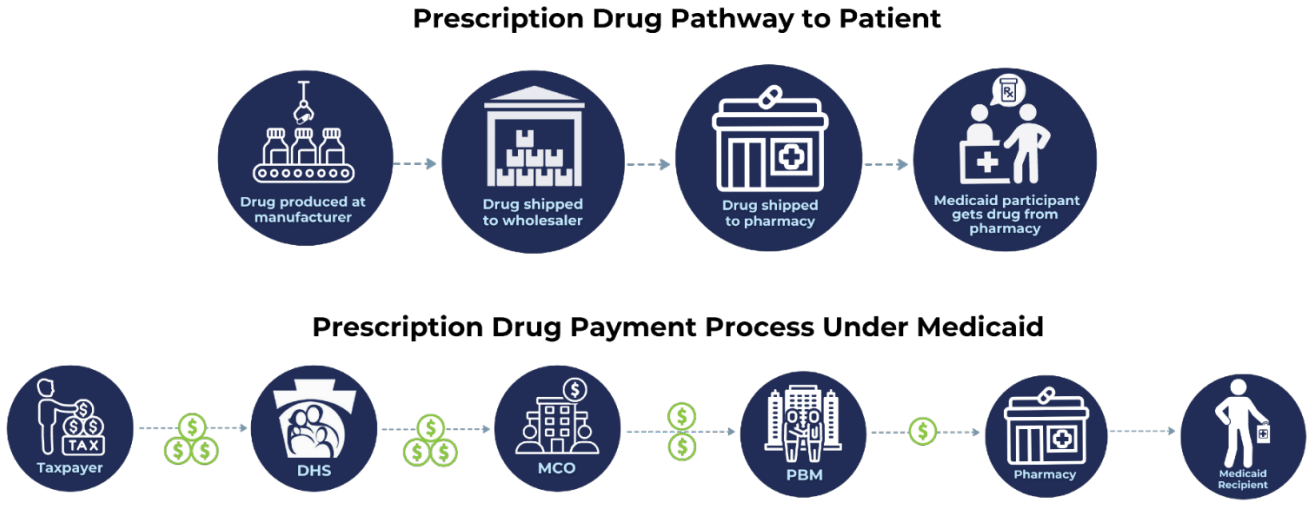
[11] Act 120 of 2020 prohibits a differential between the amount paid by the MCO to the PBM and the amount paid by the PBM to the pharmacy unless it is a transmission fee that is disclosed and part of the adjudication process. For purposes of this audit the differential is referred to as spread pricing. Therefore, we interpret the Act as prohibiting spread pricing unless it is for a disclosed transmission fee processed during payment to the pharmacy for the claim. A claim includes, but is not limited to, the drug cost, dispensing fee, and copay amount.

[12] PerformRx's website provides the information on the "boutique service model." Managed Care Organizations - PerformRx (last accessed June 5, 2024).

services. Additionally, Geisinger contracts with PerformRx for PBM services. *See PerformRx, LLC Finding 3* for the results of our audit of PerformRx.

Pharmaceutical Supply Chain

The following diagram illustrates the pharmaceutical supply chain and the flow of a drug from the manufacturer through the pharmaceutical supply chain to the Medicaid member. It also illustrates the flow of the monthly capitated payment from DHS to the MCO, the payment of the drugs and dispensing fees from the MCO to the PBM, and the payment from the PBM to the pharmacies for dispensed drugs.[13]



Source: Developed by DAG auditors based on information reviewed from several public sources, including the DHS website and The 2023 Economic Report on U.S. Pharmacies and Pharmacy Benefit Managers located at https://drugch.nl/pharmacy. Dollars are reduced as administrative costs are taken.

The PBMs develop and maintain a pharmacy provider network through contracts with pharmacies.[14] Through those contracts, the PBMs establish the rates paid to pharmacies for drugs and for costs associated with dispensing those drugs to Medicaid participants. Once the claims

[13] The explanation and diagram are simplified for the reader. A drug claim includes, but is not limited to, the cost of the drug, the dispensing fee paid for dispensing the fee, less applicable copay and third-party liability.
[14] Pharmacies may join Pharmacy Services Administration Organizations (PSAOs) and the PSAO then contracts with the PBMs. For purposes of this audit, we will just refer to pharmacies.

are paid by the PBM to the pharmacy, the PBM provides the encounter information to the MCOs for the MCOs to report the encounter information to DHS' Provider Reimbursement and Operations Management Information System, referred to as PROMISe™.

DHS' actuaries use the accumulation of the pharmacy encounter data, associated costs, and other relevant program information to calculate future capitation rates that DHS pays the MCOs to operate the HealthChoices program.[15] These capitation rates include the cost of the pharmacy benefits that are currently being subcontracted by the MCOs to the PBMs.

Pharmacy Claims Process

PerformRx and DHS described the pharmacy claims process as follows:

- A Medicaid member obtains a prescription from their physician and takes that prescription to the pharmacy.
- The pharmacy then begins the dispensing process by electronically submitting a claim through their adjudication claims processing system.
- The system processes the claims in real time.
- Once the pharmacy enters the claim, the system pulls in relevant information regarding the member and the prescription, including the benefit, the pricing, and member eligibility for that time period and transaction.

The automated validation of the claim is real-time and the claim either passes or fails the validation criteria.[16] If the claim passes the validation process, the claims processing system returns an approval. If the claim fails, the claim is rejected.

The claims processing system uses standard approval and rejection codes based on the National Council for Prescription Drug Programs (NCPDP). If rejected, the pharmacy is able to intervene and work with the member to determine if the claim can be corrected and reprocessed. If approved, the pharmacy fills the prescription, and the claim is then processed by the PBM.

[15] An encounter is defined in *Appendix B* of this audit report as any covered health care service provided to a member, regardless of whether the individual has an associated Claim. A pharmacy claim becomes an encounter when reported to the MCO in the National Council for Prescription Drug Program (NCPDP) format.

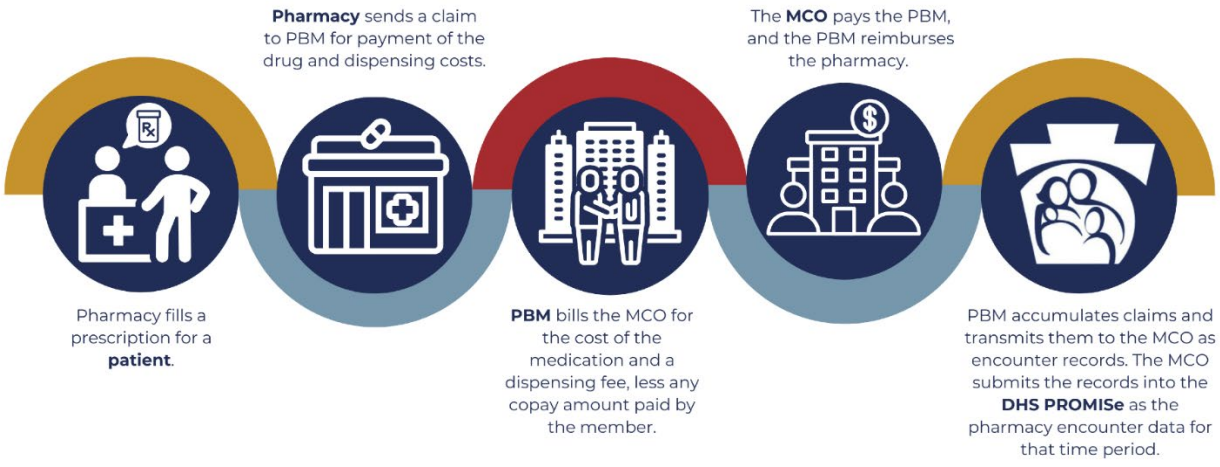
[16] We did not audit the validation criteria, such as eligibility, or the claims processing software which can be different between the PBMs.

PerformRx's claims processing system accumulates claims twice a month and creates invoices for each claim to send to the MCO for a payment request. The MCO approves the payment request and sends the payment to the PBM. This process of the claim between the pharmacy and the payment request to the MCO is automated without manual intervention.

Upon MCO approval and payment to the PBM, a remittance advice is sent to the pharmacy through the claims processing system. The remittance advice details the claim and includes, but is not limited to, the amounts being paid to the pharmacy for the drug, the dispensing fee paid to the pharmacy, member copays received by the pharmacy, and the transmission fees charged by the PBM to the pharmacy.

Each claim transmitted to the MCO is then considered an encounter for the member and transmitted to DHS as an encounter record into PROMISe™.[17] The accumulation of the encounter records then represents the encounter data used by DHS' actuaries to set future capitation rates. The capitation rates are used by DHS to pay the MCOs to run the HealthChoices program.

The following is an illustration of the above pharmacy claims process:



Source: Developed by DAG auditors based on information received from DHS and PerformRx.

[17] Since this audit is not of the MCOs, we did not review the MCO's process it does before sending the encounter records to DHS.

The billing practice used by PBMs called spread pricing has drawn scrutiny in Pennsylvania and other states.[18,19] Through spread pricing, a PBM pays the pharmacy less than the MCO paid the PBM for the same claim.[20] In this audit, we found spread pricing as a result of a transmission fee that the PBM charges the pharmacy per claim. The PBM keeps the fee or spread as another revenue source. Since January 1, 2020, DHS required the PBMs to pay the pharmacies the amount the MCO paid the PBM, which is called pass-through pricing. We conducted this audit to determine if DHS adequately monitors HealthChoices pharmacy claims and PBM contracts to ensure the PBMs are practicing pass-through pricing or alternatively, spread pricing, and whether it complied with Act 120 of 2020 requirements for transparency and accountability.

[18] *See* also, Act 77 of 2024, July 17, 2024.

[19] Other states include, but are not limited to, Ohio, Kentucky, Illinois, and Arkansas, listed in a letter dated March 1, 2023 from the Congress of the United States to the Centers for Medicare & Medicaid Services (CMS), *Letter-to-CMS.pdf (house.gov) (last accessed July 8, 2024).

[20] CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers | CMS. CMS defines spread pricing in this press release as: Spread pricing occurs when health plans contract with pharmacy benefit managers (PBMs) to manage their prescription drug benefits, and PBMs keep a portion of the amount paid to them by the health plans for prescription drugs instead of passing the full payments on to pharmacies. Thus, there is a spread between the amount that the health plan pays the PBM and the amount that the PBM reimburses the pharmacy for a beneficiary's prescription (last accessed July 16, 2024).

DHS Finding 1 – DHS did not effectively monitor pharmacy drug claims which resulted in undisclosed spread pricing, overstated pharmacy data, and a lack of transparency.

The Pennsylvania Department of Human Services (DHS) failed to effectively monitor the Physical HealthChoices (HealthChoices) program's pharmacy expenditures of $4.6 billion in calendar year 2022.[21] The following sections in this finding describe:

- DHS' inaccurate perception that it lacks authority to audit PBMs.
- DHS' ineffective monitoring of MCOs' reports on pharmacy data.
- DHS' ineffective monitoring and lack of validating pharmacy data to source documents resulted in DHS' lack of awareness of spread pricing.
- DHS declined to provide MCO financial reports to allow the auditors to determine whether the transmission fees were properly accounted for in the MCO Medical Loss Ratio (MLR) calculations and for future capitation rates.

Without effective monitoring of pharmacy data by DHS, PBMs can practice spread pricing without DHS' knowledge, and MLR and capitation rate calculations may be inaccurate. By not adequately monitoring PBMs, DHS could put Medicaid HealthChoices program funds at risk.

DHS' inaccurate perception that it lacks authority to audit PBMs

DHS management stated it has no authority to monitor or conduct audits or reviews of PBMs, and it has no process for auditing PBMs. DHS stated that the state regulations apply to Medicaid providers and a PBM is not a Medicaid provider of services to Medicaid members. We, however, disagree in that DHS has clear authority granted by the Code of Federal Regulations (CFR), Pennsylvania Act 120 of 2020,[22] and the HealthChoices contracts and subcontracts to audit PBMs as follows:

[21] References to HealthChoices throughout this audit is referring only to the Physical HealthChoices program.
[22] Amendment to the state Human Services Code (Code), effective January 25, 2021. Please note that pursuant to Section 3 of Act 120 of 2020, the amendment of Section 449 of the Code "shall apply to any agreement or contract relating to pharmacy services to medical assistance recipients in the managed care delivery system entered into or amended on or after the effective date [i.e., January 25, 2021] of this section." *See* 62 P.S. § 449.

- ✓ Title 42 of the CFR requires:
    - Subcontractors to agree that DHS has the right to audit and make their records available for audit.[23]
    - States to review and validate encounter data and that states have procedures and quality assurance protocols sufficient to ensure submitted encounter data is a complete and accurate representation of the services provided to the Medicaid members.[24]
    - States to ensure encounter data for Medicaid members is validated for accuracy and completeness before submitting the data to the Centers for Medicare & Medicaid Services (CMS).[25]

- ✓ Pennsylvania Act 120 of 2020 provides that DHS may conduct an audit or review of the PBMs to ensure compliance with the law and related contracts; that the PBMs shall maintain records of pharmacy services eligible for payment by Medicaid; and that the PBMs shall disclose the information to DHS upon request.[26]

- ✓ HealthChoices contracts between DHS and the MCOs, and each subcontract between the MCOs and the PBMs, contain the required provisions that allow DHS to audit records pertaining to HealthChoices Medicaid pharmacy expenditures.

Due to DHS' perceived lack of authority, it did not effectively monitor pharmacy encounter records in PROMISe™ to ensure the encounter information agrees with pharmacy claims, MCO payments for the claims, and the corresponding PBM payments to the pharmacies.

DHS' ineffective monitoring of MCOs' reports on pharmacy data

Although DHS did not provide written policy and procedures for its monitoring and did not validate individual pharmacy encounter records to ensure the MCOs and PBMs are reporting the amount actually paid to the pharmacies by reviewing source documentation, such as payment remittance advices, we found for calendar year 2022 DHS did monitor aggregate pharmacy encounter data in PROMISe™ and MCO reports, as follows:

[23] 42 CFR 438.230(c)(3)(i) and (ii).
[24] 42 CFR 438.242(d).
[25] 42 CFR 438.818(a)(2).
[26] 62 P.S. § 449(b)(1)-(2), (d).

- Annually, DHS staff reviewed MCO policies and procedures related to the HealthChoices pharmacy benefits and how the MCOs are to monitor the PBMs and pharmacies. This type of monitoring, however, does not ensure the actual practices of the PBMs are in accordance with the requirements in the HealthChoices agreement.

- Quarterly, DHS staff reviewed monthly MCO-prepared accuracy reports that demonstrate that at least 90% of the MCO's encounter records in total for the quarter were accepted into PROMISe™ by zone.[27] DHS takes no action if the MCO reports that the total encounters for the past quarter meet the benchmark of 90% or more. If the benchmark is not met, DHS contacts the MCO to discuss causes and remediation efforts. We reviewed the accuracy reports for calendar year 2022 and noted three MCOs reported less than 90% of the encounters were accepted by PROMISe™ for at least one quarter. For one of the three MCOs, the report had no comments of follow-up with the MCO. According to DHS, the MCO had an incorrect identification number resulting in rejected encounters, and that DHS typically applies corrective action when the MCO is not meeting the requirement for two consecutive quarters.

- Quarterly, DHS staff reviewed monthly MCO-prepared timeliness reports that demonstrate that at least 90% of the MCO's encounter records in total are within the timeliness requirements of the HealthChoices agreement.[28] If the MCO reports that the total encounters for the past quarter meet the benchmark of 90%, DHS takes no action. If the benchmark is not met, DHS contacts the MCO to discuss remediation efforts. We reviewed the timeliness reports for calendar year 2022 and noted four MCOs reported less than 90% of the encounters met the timeliness requirements in at least one quarter. Each MCOs' reports notated follow-up by DHS.

- Quarterly, DHS staff reviewed monthly MCO-prepared supplemental reports that compare the total number of supplemental records submitted by the MCO to the total number of encounter records in PROMISe™. These records must also meet a benchmark of 90% or more in total for the quarter. If the benchmark is not met, DHS contacts the MCO to discuss remediation efforts. We reviewed the supplemental reports for calendar

[27] Accepted into PROMISe™ means the encounter record met the requirements of the fields needed for the system to accept the encounter record from the MCO's system.

[28] Timeliness requirements in the HealthChoices agreement for processing drug claims includes processing 90% of clean claims within thirty days of receipt by the MCO or its subcontractor; 100% of clean claims within forty-five (45) days; and 100% of all claims within ninety (90) days. A "clean" claim is defined as a claim that can be processed without additional information needed from the provider or from a third party.

year 2022 and noted two MCOs fell below the 90% threshold for at least one quarter, and both MCOs' reports contained notations on DHS' follow-up.

- DHS staff reviewed MCO-prepared Lag Reports for Pharmacy Payments, referred to herein as Report 4C. This report is a quarterly report and is used, among other things, to indicate if there is a difference between the total amount the MCO paid the PBM and the total amount the PBMs paid the pharmacy. DHS stated that all the quarterly reports for the MCOs reported zero as the differential for calendar year 2022, indicating that each of the PBMs are practicing pass-through pricing. We confirmed that all the reports were reporting zero as a differential; however, our review of pharmacy claims and encounter records from PROMISe™ described in the next section of this finding found contradictory information for all but one MCO.

- DHS staff reviewed MCO-prepared Outpatient Drug Pricing Transparency (Part D) reports, referred to herein as Transparency Reports. DHS relies on this report prepared by the MCOs to determine whether the MCO's PBM is charging pharmacies fees by reporting the pharmacies fees (the spread) in total by month. However, DHS' lack of adequate review of the data reported by the MCOs is problematic in that we found the Transparency Reports for calendar year 2022 to be incomplete (missing information), inconsistent (MCOs did not complete the reports like other MCOs), inaccurate (MCOs reported pharmacy fees as PBM paid fees), and misleading (MCOs reports made it appear as though the PBMs were practicing pass-through pricing, when in fact, they were practicing spread pricing). DHS indicated that the Transparency Reports are for informational purposes only. DHS, however, should consider this report an important tool to monitor the MCOs and PBMs administrative fees for rate setting, MLR calculations, and Act 120 of 2020 compliance.

- DHS contracted with a vendor to conduct a mandatory triennial audit of pharmacy data; however, DHS opted out of having the vendor validate information to source documentation at the PBMs and pharmacies.[29]

- DHS contracted with an external quality review organization (EQRO) to conduct the mandated annual external quality review (EQR) statewide and for each MCO.[30]

[29] 42 CFR 438.602(e). At a minimum, a triennial audit of encounter and financial data must be performed. However, CMS does not require validation of the encounter records to source documentation; it is merely considered optional.
[30] 42 CFR 438.364.

However, DHS was unable to confirm whether the EQRO conducted validation of pharmacy claims to source documentation.

- DHS reviewed other various financial reports from the MCOs. DHS would not provide us with copies of the reports which would have allowed us to determine what data would be used by the actuaries for future capitation rate setting and MLR purposes. DHS stated the reports were considered proprietary in nature. See the last section in this finding.

Although DHS is conducting the above aggregate monitoring, DHS failed to ensure the pharmacy encounter records in PROMISE™ represent the actual amounts paid by the PBM to the pharmacy. This is evidenced by our test work of 60 claims selected from PerformRx, LLC's (PerformRx) claims processing system and 40 encounter records selected from PROMISe™ as described in the next section.[31]

DHS' ineffective monitoring and lack of validating pharmacy encounter data to source documents resulted in DHS' lack of awareness of spread pricing

Although DHS management stated that since January 2020, the PBMs were practicing pass-through pricing and the Transparency Reports and Report 4Cs reported PBMs are practicing pass-through pricing as we describe in the prior section, DHS did not actually verify this pass-through pricing through effective monitoring practices.

Since the Transparency report and Report 4C are the only reporting mechanisms for MCOs to report PBM fees required by Act 120 of 2020,[32] DHS should reevaluate the importance of the reports and its monitoring of the PBMs actual practices.

[31] The three MCOs tested for the claims were AmeriHealth, Keystone First, and Geisinger. The four MCOs tested for the 40 encounter records were UPMC, United Healthcare, Health Partners Plan, and Gateway. We did not test Aetna encounter records since there were no encounters for Aetna in October 2022 since it was no longer an MCO for HealthChoices effective September 1, 2022.

[32] Section 449(j) of the Code provides, in part: "(j) A managed care organization utilizing a pharmacy benefit manager shall report to the department [DHS] information related to each outpatient drug encounter, including the following: (1) The amount paid to the pharmacy benefit manager by the managed care organization. (2) The amount paid by the pharmacy benefit manager to the pharmacy. (3) Any differences between the amount paid in paragraph (1) and the amount paid in paragraph (2)." *See* 62 P.S. § 449(j)(1)-(3).

To confirm whether the MCOs' PBMs were or were not practicing pass-through pricing versus spread pricing, we selected 60 claims from PerformRx's claims processing system and 40 encounter records from PROMISe™.[33] The following provides a summary of our selection methodology:

1. PerformRx's drug claims processed in calendar year 2022 totaled 34,346,412 claims for its three MCOs, and a total of $1.8 billion was paid to the pharmacies for those claims.[34] We selected 20 claims per MCO for a total of 60 claims to review. Each group of 20 claims included haphazardly selecting a claim per month and judgmentally selecting eight claims based on other criteria such as a claim that appeared to be an adjustment. The 60 claims were from 18 different corporate pharmacies.

2. PROMISe™ encounter records processed in October 2022 for the four MCOs that did not use PerformRx as a PBM were 1.5 million pharmacy encounter records totaling nearly $208 million. We haphazardly selected 10 encounter records for each of these four MCOs for a total of 40 encounters. We selected these 40 encounter records based on the same 18 corporate pharmacies as selected for the 60 selected claims processed by PerformRx as noted above.

The selection above provided claims or encounters for the seven MCOs for each of the 18 corporate pharmacies to conduct confirmations with the pharmacies, as explained further below in this finding.

For the 60 claims and 40 encounters, we had DHS, the MCO, or PBM provide the following supporting documentation:

- Claim transaction detail from the PBM's claims processing system for the selected claim or encounter, and any prior or subsequent information associated with that encounter or claim;
- Pharmacy contract payment provisions;
- Documentation of MCO payments to the PBM for the claims;
- Remittance advices from the PBM to the pharmacies for the claims; and
- PROMISe™ encounter records and related supplemental files.

[33] Based on the HealthChoices contract effective September 1, 2022, we selected October 2022 encounter records which therefore, left Aetna out of the testing since it was no longer an MCO.
[34] See *Appendix A* for details regarding assessment of data reliability.

The following chart illustrates our testing results for attributes discussed below the chart:

	Number of Claims or Encounters Selected[A]	Encounter Record Agreed to Pharmacy Paid Amount[B]	Pass-Through Pricing[C]	Fees & Spread Pricing[D]	Transparent to Pharmacies[E]	Transparent to DHS Report 4C[F]	Transparent to DHS Report 6D[G]
MCO 1	20	3	No	Yes	Yes	No	No
MCO 2	20	0	No	Yes	Yes	No	No
MCO 3	20	1	No	Yes	Yes	No	No
MCO 4	10	0	No	Yes	No	No	No
MCO 5	10	0	No	Yes	No	No	No
MCO 6	10	0	No	Yes	No	No	Yes
MCO 7	10	10	Yes	No	N/A	N/A	N/A
Total	**100**	**14**	**1**	**6**	**3**	**0**	**1**

[A] We selected 60 claims and 40 encounter records to ensure we were tracing information from the front-end of the claims process to the encounter record, and vice versa. The claims process is explained in the *Introduction and Background* section of this report.
[B] The encounter record in PROMISe™ and the Pharmacy paid amount from the PBM remittance advice paid amount agreed.
[C] The MCO's PBM practiced pass-through pricing by paying the pharmacy the amount the MCO paid the PBM for the drug claim.
[D] The MCO's PBM charged a fee, creating a difference between the amount the MCO paid the PBM and the PBM paid the pharmacy.
[E] At least one pharmacy confirmed the amount it was paid was less than the amount on the PROMISe™ record due to a fee charged by the PBM, indicating transparency regarding the PBM's fee.
[F] The Report 4C listed transmission fees if the MCO's PBM was charging the pharmacies a fee.
[G] The Transparency Report accurately reflected the MCO's PBM was charging pharmacies a fee per drug claim.
N/A Not applicable since pass-through pricing was practiced.

Source: Developed by DAG auditors based on information received from DHS, MCOs, and PBMs. For data reliability, we traced the DHS PROMISe™ encounter records to claims data from pharmacies and payment remittances from the PBM to the pharmacies to determine if the PBM was charging a transmission fee and to determine whether the amount listed on the DHS PROMISe™ encounter record was reduced by the transmission fee. Other than the three MCOs that use PerformRx, we did not perform procedures to assess the completeness of the invoices and payment remittances; therefore, we considered the data from the other four MCOs and their PBMs of undetermined reliability as noted in Appendix A. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our findings and conclusions.

Our test work found that only one MCO's PBM actually practiced pass-through pricing, while the other six MCOs' PBMs were charging fees, and therefore, NOT practicing pass-through

pricing in calendar year 2022. Although a differential, known as spread pricing, is not permitted by Act 120 of 2020, if the PBM charges a fee creating a spread, it must be disclosed and assessed during adjudication of the claim.[35]

To determine if the PBMs charging fees were transparent with the pharmacies regarding the fees, we sent confirmations to the 18 corporate pharmacies for the 100 claims and encounters based on the amount listed as paid in PROMISe™. The confirmation letter for each pharmacy requested that the pharmacy verify whether the DHS encounter record amounts recorded in PROMISe™ were the amounts actually received by the pharmacy. Six of the 18 pharmacies confirmed that there were encounter record amounts that were incorrect due to a fee charged by three MCOs' PBM. This provided evidence that the PBM for those MCOs was transparent to the pharmacies since the pharmacies were aware of the fees.

Since none of the 18 pharmacies indicated any of the other four MCOs' PBMs were charging a fee, we reviewed these MCOs PBMs' payment remittances and noted that the fees, if assessed, were either listed line-by-line but not reduced on each line, reducing the payment total at the end; or were not listed until the end of the remittance in total and were offset at the end of the payment remittance. Since none of the 18 pharmacies acknowledged that a transmission fee reduced its payment amount paid by the other three MCOs' PBMs that charged fees, we concluded these three MCOs' PBMs were not adequately transparent to the pharmacies as required by Act 120 of 2020.

We also found that not only was the amount in PROMISe™ overstated for each encounter record by the amount of the fees charged by the PBMs to the pharmacies, but for one claim which was subsequently voided by the PBM, the claim still appeared paid in PROMISe™, overstating the encounter record. According to the PBM, the void was rejected by PROMISe™ and not resubmitted. This is problematic because: 1) the encounter record was not detected by the MCO or DHS, 2) the claim adjustment should have been resubmitted by the PBM and MCO to offset the amount listed in PROMISe™ but was not, and 3) it overstated the encounter data in calendar year 2022.

[35] Act 120 of 2020 does not define or call the differential between the MCO and PBM payments as spread pricing. We interpret that the prohibition of a differential is prohibiting spread pricing, unless the differential causing the spread pricing is a transmission fee that is disclosed and processed during adjudication.

DHS declined to provide MCO financial reports to allow the auditors to determine whether the transmission fees were properly accounted for in the MCO Medical Loss Ratio calculations and for future capitation rates

In 2019, CMS published new guidance on spread pricing in Medicaid to ensure the PBMs were not up-charging taxpayers by inflating encounter pharmacy data, which would lead to inflated capitation rates in future years.[36] CMS explicitly states that all PBM revenue needs to be accounted for to accurately calculate the MCO's MLR.[37] The importance of the MLR is that the MCOs are to spend at least 85% of its capitated payments on medical care, and no more than 15% on administrative costs and profits.[38] CMS states that:

> In calculating and reporting the MLR, **states** are responsible for ensuring that managed care plans are complying with these MLR requirements and **should be routinely auditing** reported data and MLR calculations to ensure that revenues, expenditures, and other amounts are appropriately identified and classified within each managed care plan's MLR; that is, **distinguishing** which amounts were actually paid for benefits, or activities that improve health care quality, and which amounts were actually paid for **administrative services**, taxes, or other activities.[39] (Emphasis added.)

Since we identified that MCOs were practicing spread pricing by charging transmission fees, we requested the financial reports that would be used by DHS actuaries to calculate future capitation rates and which were used by MCOs for MLR calculations. DHS declined to provide the auditors with these financial reports due to the proprietary nature of the information. We were therefore unable to conclude if the MLR calculations were accurate and we were unable to conclude if the data provided to the actuaries for future capitation rate setting were correct. We did however, meet with the actuary team who confirmed that it used encounter data and financial reports provided by DHS. Based on our audit results, it is likely that the MLR for the MCOs that did not report the transmission fees on the transparency reports and Report 4C were inaccurate and the encounter data used for the future capitation rates was overstated by the $7 million in administrative costs the pharmacies paid the PBMs.

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[36] CIB: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors (medicaid.gov) and CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers | CMS (last accessed June 28, 2024).
[37] *Id.*
[38] *See Appendix E* for an explanation of the MLR.
[39] CIB: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors (medicaid.gov) (last accessed June 28, 2024).

A Performance Audit

Pennsylvania Department of Human Services
PerformRx, LLC

Pharmacy Benefit Manager Services for the Physical HealthChoices Medicaid Program in Pennsylvania

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In summary, DHS failed to effectively monitor the HealthChoices program's pharmacy expenditures of $4.6 billion in calendar year 2022, which resulted in the following:

- DHS' lack of awareness that the PBMs assessed pharmacies transmission fees;
- PBMs practiced spread pricing rather than pass-through pricing;
- PBMs' non-compliance with Act 120 of 2020;
- Report 4Cs and Transparency Reports were inaccurate; and
- Pharmacy encounter data was overstated, which affects the pharmacy data used for the capitation rates and potentially the MCOs' Medical Loss Ratio.

Additionally, the following deficiencies noted during the audit, if left unresolved, could put the program's federal funding at risk:

- DHS' lack of written policy and procedures for its monitoring of pharmacy encounter data to ensure encounter data submitted to CMS is a complete and accurate representation of the services provided to the Medicaid members as required by CFR 438.242(d);
- DHS' lack of validation that encounter data provided to CMS is correct; and
- DHS' lack of assurance that the encounter records on PROMISe™ were actually reporting the amount the PBMs paid pharmacies.

If CMS would decide to penalize DHS for its ineffective monitoring, the financial consequences could be dire. The funds the federal government provides to the state are based on the state's Federal Medicaid Assistance Percentage (FMAP). The FMAP is a specified percentage of program expenditures paid by the federal government to partially fund a state's Medicaid program.[40] Since Pennsylvania receives an FMAP percentage of over 50%, by DHS not effectively monitoring, more than half of the $4.6 billion, or $2.3 billion, could be potentially at risk in Medicaid pharmacy outpatient drug expenditures as based upon calendar year 2022 numbers.

[40] Financial Management | Medicaid (last accessed June 11, 2024).

Recommendations for DHS Finding 1

We recommend that DHS:

1. Develop written policy and procedures for its monitoring of pharmacy encounter data to ensure encounter data submitted to CMS is a complete and accurate representation of the services provided to the Medicaid members.

2. Not only focus on the aggregate performance of accuracy and timeliness benchmarks, but also on whether individual claims processed by each MCO's PBM are accurate based on prescription, pharmacy remittance advices, and any related adjustment documentation.

3. Design a system of review to audit pharmacy encounter data, on a sample basis, by tracing the encounter data to pharmacy remittance advices for adjudicated claims. Additionally, DHS should audit, on a sample basis, claims from pharmacies and payment remittances to pharmacies, including any adjusted claims, to ensure the final disposition on PROMISe™ is accurate.

4. Add pharmacy encounter validation to supporting documentation in the scope of the triennial audit that is currently underway.

5. Reconsider the importance of the Transparency Reports for rate setting, MLR reporting, and Act 120 of 2020 compliance. If DHS believes the transmission fees are not an administrative cost that should be considered for rate setting and MLR reporting, then DHS should contact CMS for further guidance.

6. Re-evaluate the network of PBMs contracted with MCOs to determine if pharmacy claims processing and monitoring of PBM practices could be achieved more effectively, such as contracting with one PBM for use by all the MCOs.

7. Work with its actuary team to ensure that the transmission fees were adequately accounted for in the encounter data, MLR calculations, and capitation rates.

We recommend that the General Assembly:

1. Further amend the Code (i.e., Act 120 of 2020) by ensuring that there are clear distinctions between the terms "spread pricing", "pass-through pricing", and

"pharmacy transmission fees" by adding concise and understandable definitions of all three terms.

2. Further amend the Code (i.e., Act 120 of 2020) to make certain that DHS is fully aware of all of its obligations and powers pertaining to PBMs including its monitoring duties under the law and related contracts.

DHS Finding 2 – DHS did not effectively monitor contracts between the Physical HealthChoices managed care organizations and pharmacy benefit managers.

Our audit found that the Pennsylvania Department of Human Services (DHS) did not adequately monitor the contracts between managed care organizations (MCOs) and Pharmacy Benefit Managers (PBMs) in the Physical HealthChoices (HealthChoices) program. DHS does not have policies and procedures for its contract monitoring efforts, and it does not verify the current PBM contracts comply with the current HealthChoices contract.

According to federal regulations, the state must have a monitoring system in place to monitor the MCOs and PBMs and has the right to conduct audits of both the MCOs and PBMs.[41,42] Although DHS shifts some of its monitoring duties onto the MCOs, the state is still required to maintain an effective monitoring system of the HealthChoices program, otherwise, the federal regulations, as well as Pennsylvania Act 120 of 2020[43], would not have required the MCOs and subcontractor, like a PBM, to make their records available for audit. Additionally, due to the corporate structure of some of the MCOs using subsidiary companies as the PBM, there is an inherent incentive for the MCOs to not report non-compliance of the PBMs and ensure their profitability. Therefore, DHS has an obligation to evaluate full regulatory compliance through effective and up-to-date oversight of subcontractors, such as PBMs, to ensure the integrity of the program is not compromised.

As Pennsylvania's Medicaid oversight agency, DHS ultimately has the responsibility to ensure compliance with the HealthChoices agreement. Based on the numerous national issues that have been of concern in recent years, DHS recognized that there was spread pricing and then banned it effective January 1, 2020; however, by not monitoring the PBMs, seven of the eight PBMs continued with spread pricing practices.[44]

[41] 42 CFR 438.602(a).
[42] 42 CFR 438.230(c)(3)(i) and (ii).
[43] Amending the state Human Services Code (Code), effective January 25, 2021. *See* 62 P.S. § 449(b).
[44] Spread pricing is a differential between what the MCO paid the PBM and what the PBM paid the pharmacy for a drug claim according to CMS in its 2019 guidance at CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers | CMS (last accessed June 28, 2024). In this case, the PBM is charging the pharmacy a transmission fee that reduces the PBMs payment to the pharmacy for each drug claim.

Although DHS did not provide policies and procedures for its monitoring efforts of the MCO and PBM contracts, it did provide the following:

- DHS required the MCOs to submit policies and procedures for how the MCO will conduct business and how the MCO will monitor its subcontractors.[45] DHS management indicated that it relies on the MCOs to monitor their own subcontractors, like PBMs. DHS' reliance on the MCOs, however, is not a sufficient monitoring system to evaluate whether the practices are actually being conducted and that the PBMs are actually compliant with the HealthChoices agreement's requirements. DHS should be verifying the MCOs are actually monitoring the PBMs, and DHS should be doing its own monitoring of PBMs to ensure compliance with the HealthChoices agreement.

- DHS required the MCOs to complete an Annual Subcontractor Identification report. We obtained each MCOs' annual report for calendar year 2022. While MCOs list their respective PBM as an approved subcontractor, the list does not ensure the PBMs are actually compliant with applicable provisions of the HealthChoices agreement or transparent with regard to PBMs' practices of fee assessment and spread pricing.

- DHS required the MCOs to complete a DHS checklist to ensure the MCOs' subcontract with its PBM addresses specific requirements in the HealthChoices agreement.[46] To verify the checklist was completed, we requested the checklists for the requirements in the September 1, 2022, HealthChoices agreement. DHS provided a blank checklist it had created dated November 2023. The blank checklist did provide 28 provisions required by the September 1, 2022, HealthChoices agreement; however, DHS did not have the MCOs complete the updated checklists for the six PBM agreements in place for the September 1, 2022 agreement. Instead, DHS provided outdated checklists from the MCOs. DHS explained the reason the checklists were not completed for the September 1, 2022, agreement was that:

  > … Subcontractor checklists are completed when the subcontract is first entered into. If the subcontractor does not change, a new checklist is not completed, and the previous checklist remains valid. There is no subcontractor checklist available for UPMC's subcontract with its PBM, Express Scripts, because they have been contracted with that entity since 2006. In 2006, completion of subcontractor checklists was not a program

[45] DHS provided the Prior Authorization Review Panel (PARP) Resource Guide for evidence of the monitoring policies and procedures submitted by the MCOs.

[46] See *Appendix D* for the 28 requirements listed for MCO contracts with PBMs based on the September 1, 2022 HealthChoices agreement. However, none of the checklists provided by DHS were for the September 1, 2022 new HealthChoices agreement.

> requirement or process that was in place. For the same reason, there is no subcontractor checklist available for [the AmeriHealth and Keystone First] subcontract with PerformRx executed in 2011.
>
> Many of the amendments that DHS receives are due to extensions of the original contract with limited content change outside of the dates of coverage and same terms/conditions apply. In those instances, a Subcontractor Checklist is not necessary. A new subcontractor checklist is done on a case-by-case basis dependent upon the nature of the amendment. Staff with appropriate subject matter expertise review the contracts for compliance with HealthChoices Agreement requirements.

Further, our review of the outdated checklists found that the checklists had no markings to evidence review by DHS. The checklists had no dates within the document to ascertain which HealthChoices agreement was used by DHS to create the checklist or which HealthChoices agreement was used by the MCO to complete the checklist. We additionally found that the checklists were not applicable to the PBM contracts or HealthChoices agreements in place for calendar year 2022.[47] We attempted to confirm the checklists against the PBM contracts but found that provisions of both the HealthChoices agreement and the PBM contracts were not aligned. By DHS not requiring the MCOs to complete a new checklist for a new or updated HealthChoices agreements and for new or updated PBM contracts, DHS does not have assurance that current PBM contracts comply with the current HealthChoices agreement.

DHS' lack of effective oversight of the MCOs' PBM contracts and lack of documentation to support monitoring past an initial contract with a PBM provides little to no assurance that PBMs' contracts or practices comply with the current HealthChoices agreements, Act 120 of 2020, or specific regulations, potentially putting the Medicaid program at risk for noncompliance. For instance, had DHS ensured the PBM agreements were actually updated as of January 1, 2020 to ensure the PBMs are actually practicing pass-through pricing, there would be no spread pricing or if there was, DHS would have been aware of it. Additionally, the lack of verification that the PBMs are not including gag clauses in the pharmacy's contract does not ensure compliance with the federal prohibition on such clauses.

[47] For calendar year 2022, there were initially eight MCOs and seven PBM contracts; however, one MCO and PBM contract was not renewed for the September 1, 2022 HealthChoices contract.

Recommendations for DHS Finding 2

We recommend that DHS:

1. Utilize its statutory authority to monitor PBMs' practices to ensure compliance with the HealthChoices agreement.

2. Implement written policies and procedures for its monitoring of PBM contracts to ensure monitoring efforts are documented for the HealthChoices program.

3. Monitor the contract language between MCOs and PBMs, document the review; and put into place enforcement mechanisms to address any non-compliance.

4. Require MCOs to update the PBM contracts for compliance with the HealthChoices agreement and current laws, such as the Code, as amended by Act 120 of 2020.

5. Ensure the current HealthChoices provisions are within the subcontractors' contracts by requiring the MCOs to complete the DHS checklist (*Appendix D*) for each new or updated HealthChoices agreement, and for each new or updated PBM contract.

Pennsylvania Department of Human Services' Response and Auditor's Conclusion

We provided copies of our draft audit findings and related recommendations to the Pennsylvania Department of Human Services (DHS) for its review. On the pages that follow, we included DHS' response in its entirety. Following the agency's response is our auditor's conclusion.

A Performance Audit

Pennsylvania Department of Human Services
PerformRx, LLC

Pharmacy Benefit Manager Services for the Physical HealthChoices Medicaid Program in Pennsylvania

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Audit Response from the Pennsylvania Department of Human Services

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

August 13, 2024

The Honorable Timothy L. DeFoor
Auditor General
Department of the Auditor General
229 Finance Building
Harrisburg, Pennsylvania 17120

Dear Mr. DeFoor:

Thank you for providing the draft audit report titled Pennsylvania Department of Human Services, An Audit of the Pharmacy Benefits Manager Services for the Physical HealthChoices Medicaid Program in Pennsylvania.

The Department of Human Services (DHS) is responsible for ensuring Medical Assistance (MA) beneficiaries have access to all covered services, including pharmacy. Since the beginning of managed care in the MA Program, DHS has entered into agreements through the competitive bidding process with qualified managed care organizations (MCOs). DHS pays the MCOs fixed per member per month (PMPM) payments for assuming the financial risk of furnishing the full range of health services, including pharmacy services, covered under the MA Program. DHS holds the MCOs accountable for ensuring access to all MA covered services for MA beneficiaries. The MCOs may choose to subcontract with Pharmacy Benefits Managers (PBMs). The pharmacies participating in the MCOs' networks have entered into agreements with the MCOs' designated PBMs. The MCOs or their subcontractors must contract on an equal basis with any pharmacy qualified to participate in the MA Program that is willing to comply with the MCOs' payment rates and terms and to adhere to their quality standards.

Since 2018, DHS has met regularly with leaders from the Pennsylvania Pharmacist Association (PPA), Philadelphia Association of Retail Druggists, individual pharmacists, and pharmacy owners regarding pharmacy payment issues related to the MCOs and their subcontracted PBMs. DHS values the relationships we have developed with the associations and the pharmacy provider community. The information and perspective they have shared has assisted DHS in instituting new strategies to oversee the MCOs and their PBM subcontracts. Based on the pharmacy community's input, DHS has amended the HealthChoices agreements by requiring the MCOs and their subcontracted PBMs to:

Deputy Secretary for Administration
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- Have processes in place that ensure the amount paid to all network pharmacies reflects the pharmacy's acquisition cost, professional services, and cost to dispense the prescription to a Medicaid beneficiary. MCOs must also submit all changes to their payment methodologies to DHS for review and approval prior to implementation.
- Accurately report to DHS the actual paid amount by the MCO or subcontracted PBM to the dispensing provider on each drug encounter.
- Contract on an equal basis with any pharmacy qualified to participate in the MA Program that is willing to comply with the MCO's payment rates and terms and to adhere to quality standards established by the MCO, including agreements with pharmacies to provide specific drugs or services, such as specialty drugs, drugs delivered by mail, and 90-day supplies.
- Submit to DHS quarterly pharmacy transparency reports disclosing all payments and fees between the MCO and subcontracted PBM and between the PBMs and their contracted pharmacies.
- Establish first and second level drug pricing dispute processes.
- Preclude the use of effective rate payments to MA enrolled network pharmacies.
- Report all changes to the maximum allowable cost (MAC) rates in real time to network pharmacy providers.

Since implementing these changes, DHS has observed reductions in pharmacy complaints related to PBMs.

The findings and recommendations along with DHS' responses are listed below:

Finding 1: DHS did not effectively monitor pharmacy drug claims which resulted in undisclosed spread pricing, overstated pharmacy data, and a lack of transparency.

DHS' inaccurate perception that it lacks authority to audit PBMs.

DHS Response: DHS enters into agreements with MCOs to provide Medicaid covered services to eligible consumers. The MCOs subcontract with PBMs. The PBMs contract with pharmacies to establish the pharmacy provider network. The finding notes that DHS reported not having the authority to audit PBM subcontractors. While the DHS Bureau of Program Integrity does not have oversight authority over the PBMs, DHS is aware that the Office of Medical Assistance Programs (OMAP) has the authority to audit PBMs. However, DHS has historically held the MCOs responsible as the prime agreement holders for ensuring their subcontractors are compliant with all requirements. DHS requests the MCO take corrective actions when it becomes aware that a subcontractor is not compliant with requirements of the HealthChoices agreement.

DHS' ineffective monitoring of MCOs' report on pharmacy data.

DHS Response: DHS monitors and validates MCO submitted encounter data. The drug encounter is a copy of the PBM's electronic claim transaction exchanged with the

pharmacy. DHS also receives the amount paid by the MCO to the PBM for each claim through additional data reported by the MCO. DHS disagrees with the auditor's conclusion that transmission fees constitute spread pricing. On May 15, 2019, the Center for Medicare and Medicaid Services (CMS) in announcing its Informational Bulletin on Medical Loss Ratio Requirements Related to Third-Party Vendors described spread pricing as a differential between what the MCO paid the PBM and what the PBM paid the pharmacy for a drug claim.[1] PBMs contract directly with the pharmacy or the pharmacy's delegate, such as a Pharmacy Services Administration Organization (PSAO). The standardized, HIPAA compliant, National Council for Prescription Drug Programs (NCPDP) electronic pharmacy claim transaction does not include a field for the transmission fee. Therefore, the MCO drug encounters received by DHS do not include the transmission fee. PBMs report the pharmacy transmission fee per claim to their contracted pharmacy on the remittance advice, which is the record of claim adjudication.

DHS disagrees with the finding that the 4C and Transparency Reports were inaccurate. The Transparency Reports accurately report the amount paid by the MCO to the PBM and the amount paid by the PBM to the pharmacy. The 4C Reports reflect what was paid by the MCO for the MA covered service. This finding is based on the auditor's interpretation of spread pricing, with which as indicated above, DHS disagrees.

DHS' ineffective monitoring and lack of validating pharmacy data to source documents resulted in DHS' unawareness of spread pricing.

DHS Response: DHS disagrees with the auditor's interpretation that transmission fees constitute spread pricing. DHS considers the MCO submitted drug encounters and additional claim data to be the source documents for monitoring spread pricing between the MCO their subcontracted PBM and the PBM's contracted pharmacy. DHS monitors and validates all MCO encounters and additional claim data for accuracy and completeness. In addition, the DHS actuary conducts a triennial audit of MCO pharmacy encounters, as required by CMS. The terms and conditions of the PBM-pharmacy contract may include claim transmission fees. Transmission fees are known between the PBM and their contracted pharmacy or the pharmacy's delegate. Transmission fees are not unique to MA claims and the PBM-pharmacy contract may include fees applied to every claim, regardless of the payer. PBMs contracting with MCOs in the MA Program are not precluded from charging transmission fees if they are disclosed and applied at the time of claim adjudication. 62 P.S. § 449(h)(4)[2]

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[1] Centers for Medicaid & Medicare Services. (2019, May 15). CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers [Press release]. https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not

[2] DHS would like to understand how the auditor would characterize the PBM and pharmacy transmission fees if the pharmacies made a separate payment to the PBM as opposed to the remittance advice showing a payment withhold. DHS would also like to know if the auditor reviewed the PBM and pharmacy contract payment provisions to determine if transmission fees are disclosed and collected per the terms and conditions of that contract.

The report did not identify any evidence of spread pricing as described by CMS. DHS monitors spread pricing through reporting in the aggregate and has not identified spread pricing. The draft report states that monitoring should be done on an individual claim level. This recommendation is based on the auditor's inaccurate description of spread pricing. The audit report discloses no evidence that individual claim monitoring would yield different results than aggregate monitoring. If DHS identifies spread pricing, as described by CMS, and prohibited by the HealthChoices Agreement and Act 120 of 2020, the MCOs will be held accountable for the non-compliance of their subcontractors.

DHS investigated the one voided pharmacy claim identified in the report and concluded that the claim was paid to the pharmacy, and DHS received the paid MCO drug encounter. The discrepancy was related to encounter file load timing lag which was identified and resolved in late 2022 – early 2023. For perspective, during calendar year 2022, DHS processed more than 43 million paid MCO drug encounters. This audit was limited to 60 pharmacy claims and 40 MCO drug encounters from one PBM, which the auditor acknowledged were not randomly selected.

DHS declined to provide MCO financial reports to allow the auditors to determine whether the transmission fees were properly accounted for in the MCO Medical Loss Ratio (MLR) calculations and for future capitation rates.

DHS Response: DHS provided all reports requested by the auditors that were not considered confidential and proprietary information of the MCOs. DHS would have provided the additional reports if the Auditor General's Office entered into a non-disclosure agreement, which it declined to do. The audit report suggests that the reports that were not provided prevented the auditors from determining if the MLR calculations were accurate. As an initial matter, the auditors asked for documentation to support the $4.6 billion in drug expenditures, not the MLR calculations. In their 2019 bulletin on third-party vendors and PBM spread, CMS advises that all subcontractors that administer claims for the MCO must report the incurred claims, expenditures for activities that improve health care quality, and information about mandatory deductions or exclusions from incurred claims (overpayment recoveries, rebates, other non-claims costs, etc.) to the MCO. CMS provides guidance for identifying non-claim costs that should be excluded from the incurred claims section as follows:

> "Additionally, when the subcontractor is also performing an administrative function not attributable to its direct provision of Medicaid covered services, such as eligibility and coverage verification, claims processing, utilization review or network development, payment by the managed care plan to the subcontractor for such functions are non-claims administrative expense as described in 42 CFR 438.8 (e)(2)(v)(A),and should not be counted as an incurred claim for the purposes of MLR calculations" – CMS Informational Bulletin, Medical Loss Ratio (MLR) Requirements Related to Third Party Vendors, Issued May 15, 2019.

The transmission fees paid by the pharmacies to the PBM are a cost to the pharmacy, not an administrative cost to the MCO and are therefore not reported by the MCO on the MLR reports. Because the transmission fees are not an expense of the MCOs, they would not have been included in the MCO cost reports, which are the reports that would have supported the $4.6 billion in drug expenditures.

DHS disagrees with auditor's interpretation that transmission fees resulted in spread pricing. The fees owed by the pharmacy to the PBM are withheld from the pharmacy claim payment based on the PBM-pharmacy contract terms and conditions and reported on the remittance advice. The auditors' suggestion that CMS might disallow federal financial participation because of ineffective monitoring is based on what the auditors consider spread pricing, which as stated above, is not consistent with CMS' description of spread pricing. In any event, ineffective monitoring is not a basis for disallowing the entire $4.6 billion in drug expenditures. Moreover, the result of what the auditors believe was the ineffective monitoring was $7 million in transmission fees paid by the pharmacies to the PBMs which they believe should be subtracted from the MCO's incurred claims in the MLR calculations.

Recommendations for Finding 1:

We recommend that DHS:

1. Develop written policy and procedures for its monitoring of pharmacy encounter data to ensure encounter data submitted to CMS is a complete and accurate representation of the services provided to the Medicaid members.
2. Not only focus on the aggregate performance of accuracy and timeliness benchmarks, but also on whether individual claims processed by each MCO's PBM are accurate based on prescription, pharmacy remittance advices, and any related adjustment documentation.
3. Design a system of review to audit pharmacy encounter data, on a sample basis, by tracing the encounter data to pharmacy remittance advices for adjudicated claims. Additionally, DHS should audit, on a sample basis, claims from pharmacies and payment remittances to pharmacies, including any adjusted claims, to ensure the final disposition on PROMISe is accurate.
4. Add pharmacy encounter validation to supporting documentation in the scope of the Triennial audit that is currently underway.
5. Reconsider the importance of the Transparency Reports for rate setting, MLR reporting, and Act 120 of 2020 compliance. If DHS believes the transmission fees are not an administrative cost that should be considered for rate setting and MLR reporting, then DHS should contact CMS for further guidance.
6. Re-evaluate the network of PBMs contracted with MCOs to determine if pharmacy claims processing and monitoring of PBM practices could be achieved more effectively, such as contracting with one PBM for use by all the MCOs.
7. Work with its actuary team to ensure that the transmission fees were adequately accounted for in the encounter data, MLR calculations, and capitation rates.

DHS Response to Recommendation 1: DHS disagrees with this recommendation. We have written policies and procedures for monitoring pharmacy encounter data.

DHS Response to Recommendation 2: DHS disagrees with this recommendation. The audit disclosed no evidence that individual claim monitoring would yield different results than aggregate monitoring. While we don't think this is necessary, we will consider this recommendation.

DHS Response to Recommendation 3: DHS disagrees with this recommendation. The audit disclosed no evidence that individual claim monitoring would yield different results than aggregate monitoring. While we don't think this is necessary, we will consider this recommendation.

DHS Response to Recommendation 4: DHS disagrees with this recommendation. DHS already includes all pharmacy encounter information in the Triennial audit.

DHS Response to Recommendation 5: DHS will consider this recommendation.

DHS Response to Recommendation 6: DHS will consider this recommendation.

DHS Response to Recommendation 7: DHS disagrees with this recommendation. The transmission fees paid by the pharmacies to the PBM are a cost to the pharmacy, not an administrative cost to the MCO and are therefore not included in encounter data, MLR calculations, or capitation rates.

Finding 2: DHS did not effectively monitor contracts between the Physical HealthChoices managed care organizations and the pharmacy benefit managers.

DHS Response: DHS holds the MCO responsible as the prime contract holder for ensuring their subcontractors are compliant with all state and federal requirements. DHS holds the MCOs accountable when non-compliance is identified through a quality improvement plan and/or corrective action plan.

DHS ensures MCO compliance with the HealthChoices Agreement Exhibit BBB requirements through MCO policy and MCO-PBM subcontract review. All covered drug policies, programs, and drug utilization management programs, such as but not limited to prior authorization, step therapy, partial fills, specialty pharmacy, pill-splitting, mail order, 90-day supply programs, limited pharmacy networks, medication therapy and management programs must be submitted to DHS for review and written approval prior to implementation of any changes, and annually thereafter. DHS requires the MCOs to submit new PBM subcontracts for review and approval for compliance with the HealthChoices agreement requirements and current laws prior to making any changes.

Many of the recommendations in the report to DHS are dependent on the auditors' interpretation that transmission fees constitute spread pricing. This interpretation is not consistent with the CMS description of spread pricing. DHS requests that the auditors reconsider what constitutes spread pricing.

DHS will require the MCOs to audit the PBMs for compliance with the HealthChoices and MCO-PBM agreements. Additionally, DHS will consider the feasibility of contracting with a single PBM for use by all MA MCOs.

Recommendations for Finding 2:
We recommend that DHS:

1. Utilize its statutory authority to monitor PBMs' practices to ensure compliance with the HealthChoices agreement.
2. Implement written policies and procedures for its monitoring of PBM contracts to ensure monitoring efforts are documented for the HealthChoices program.
3. Monitor the contract language between MCOs and PBMs, document the review; and put into place enforcement mechanisms to address any non-compliance.
4. Require MCOs to update the PBM contracts for compliance with the HealthChoices agreement and current laws, such as the Code, as amended by Act 120 of 2020.
5. Ensure the current HealthChoices provisions are within the subcontractors' contracts by requiring the MCOs to complete the DHS checklist (Appendix D) for each new or updated HealthChoices agreement, and for each new or updated PBM contract.

DHS Response to Recommendation 1: DHS disagrees with this recommendation. DHS holds the MCOs responsible as the prime agreement holders for ensuring their subcontractors are compliant with all requirements. DHS requests the MCO take corrective actions when it becomes aware that a subcontractor is not compliant with requirements of the HealthChoices agreement.

DHS Response to Recommendation 2: DHS will consider this recommendation.

DHS Response to Recommendation 3: DHS will consider this recommendation.

DHS Response to Recommendation 4: DHS will consider this recommendation.

DHS Response to Recommendation 5: DHS will consider this recommendation.

The Honorable Timothy L. DeFoor 8

Thank you for the opportunity to respond to this draft audit report. Please contact Mr. David R. Bryan, Manager, Audit Resolution Section, Bureau of Financial Operations at (717) 783-7217, or via email at davbryan@pa.gov if you have any questions regarding this matter.

Sincerely,

Stephanie Shell
Deputy Secretary for Administration

c: Ms. Janet B. Ciccocioppo, Department of the Auditor General
Mr. Gordon R. Denlinger, Department of the Auditor General
Mr. Scott D. King, Department of the Auditor General
Ms. Peggy Morningstar, Department of the Auditor General
Mr. David R. Bryan, Bureau of Financial Operations, Audit Resolution Section

Auditor's Conclusion to the Pennsylvania Department of Human Services' Response

The Pennsylvania Department of Human Services (DHS) management generally disagreed with the overall context of the audit report, because the Department of the Auditor General (DAG) classified the act of the pharmacy benefit managers (PBMs) charging transmission fees as a type of spread pricing. Additionally, DHS disagrees that the transmission fee should be disclosed to DHS and accounted for when calculating the Managed Care Organizations' (MCOs') Medical Loss Ratios (MLRs). We note DHS' disagreements and assertions below along with DAG's conclusions as to each of DHS' statements.

As reported in our audit, the Centers for Medicare and Medicaid Services (CMS) stated in the 2019 Informational Bulletin that any difference between the amount the MCO paid the PBM and the PBM paid the pharmacy for drug claims in which the PBM retains an additional revenue source to cover the PBM's costs for services procured by the MCO, is spread pricing. It further stated that this is an administrative cost to the MCO that should be accounted for in the MLR and when setting future capitation rates.[48]

Finding 1 – DHS did not effectively monitor pharmacy drug claims which resulted in undisclosed spread pricing, overstated pharmacy data, and a lack of transparency.

DHS' inaccurate perception that it lacks authority to audit PBMs.

DHS Assertion – "While the DHS Bureau of Program Integrity [BPI] does not have oversight authority over the PBMs, DHS is aware that the Office of Medical Assistance Programs (OMAP) has the authority to audit PBMs. However, DHS has historically held the MCOs responsible as the prime agreement holders for ensuring their subcontractors are compliant with all requirements."

DAG Response – **DAG disagrees** that DHS' BPI does not have authority to audit the PBMs. If OMAP has the authority to audit PBMs, then so does BPI. There is a difference between an agency having the authority to audit PBMs and an Office or Bureau within the agency being assigned the duty to audit the PBM.

[48] CIB: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors (medicaid.gov) and CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers | CMS (last accessed June 28, 2024).

DHS' ineffective monitoring of MCOs' reports on pharmacy data.

DHS Assertion – "DHS disagrees with the auditor's conclusion that transmission fees constitute spread pricing."

DAG Response – **DAG disagrees**. The May 15, 2019 CMS Informational Bulletin is clear in stating that a PBM needs to classify and report its revenues and expenditures to the MCO for the MCO to accurately reflect medical costs and non-medical administrative costs for the MLR. The transmission fees, permitted under Act 120 of 2020, is an administrative fee charged by the PBM to the pharmacy and should be reported as an administrative cost for the MCO's MLR, in addition to the amount the MCO pays the PBM for processing claims.

The following chart is an illustration of the amounts the MCOs paid to the PBMs, the amounts the PBMs paid to the pharmacies, the difference of the two amounts paid which is the spread or retained differential caused from the transmission fees, and the amount the MCOs paid the PBMs to process the claims for calendar year 2022.

MCO	PBM	Amount MCO Paid to PBM	Amount PBM Paid to Pharmacies	Spread Amount kept by PBM	MCO Admin. Fees Paid to PBM
1	PBM 1	$460,162,581	$459,636,599	$526,001	$4,879,515
2	PBM 1	631,851,875	631,096,755	755,120	13,431,427
3	PBM 1	885,480,707	884,592,719	887,988	19,219,940
4	PBM 2	618,914,570	617,759,869	1,154,701	5,418,836
5	PBM 2	414,646,906	413,807,469	839,437	3,238,162
6	PBM 3	298,234,020	298,234,020	-	4,857,864
7	PBM 4	1,011,466,928	1,009,246,871	2,220,057	9,169,748
8[A]	PBM 2	236,484,329	236,070,755	413,574	2,878,787
	Totals	**$4,557,241,916**	**$4,550,445,057**	**$6,796,878**	**$63,094,279**

[A] MCO 8 was not included in our test work for ***Finding 1*** in the report since the population for the DHS PROMISe™ encounter data was selected for October 2022, and MCO 8 was no longer in the HealthChoices program as of August 31, 2022.

Source: Developed by DAG auditors based on information received from the Transparency Reports obtained from DHS. As noted in Appendix A, the data from the Transparency Reports obtained from DHS is of undetermined reliability; however, this is the best data available. Although this determination may affect the precision of the numbers we present, there is sufficient evidence in total to support our findings and conclusions.

As illustrated, the spread or retained differential for the transmission fees was nearly $7 million that the PBMs charged pharmacies over and above the $63 million the MCOs paid the PBMs for services. DHS' lack of knowledge of the transmission fees and its inaccurate classification of the

costs as pharmacy costs and not costs of the HealthChoices program should be addressed by DHS with CMS for further clarification.

DHS Assertion – "The standardized, HIPAA compliant, National Council for Prescription Drug Programs (NCPDP) electronic pharmacy claim transaction does not include a field for the transmission fee. Therefore, the MCO drug encounters received by DHS do not include the transmission fee."

DAG Response – DAG agrees that the encounter records do not report the transmission fees, and therefore, the encounter records are overstated because the amounts listed as the paid amounts are the amounts the MCO paid and not the amounts the PBM paid to the pharmacies which were reduced by the transmission fees. DHS should consult with CMS or the NCPDP to determine how to report transmission fees that are permitted by Act 120 of 2020 and not prohibited by the federal government.

DHS Assertion – "DHS disagrees with the finding that the 4C and Transparency Reports were inaccurate."

DAG response – **DAG disagrees**. DHS provided additional information or amended reports for the MCOs that failed to disclose the MCO administrative fees and/or the Pharmacy transmission fees based on the auditors' inquiries. Additionally, DHS management stated that none of the calendar year 2022 Report 4Cs contained adjustments for a spread pricing differential because all of the PBMs are practicing pass-through pricing. However, our audit found that there are differentials for the MCOs' PBMs that charge transmission fees, and therefore, DAG asserts both reports from the MCOs were misleading and inaccurate.

DHS' ineffective monitoring and lack of validating pharmacy encounter data to source documents resulted in DHS' unawareness of spread pricing.

DHS Assertion – "DHS considers the MCO submitted drug encounters and additional claim data to be the source documents for monitoring spread pricing between the MCO their subcontracted PBM and the PBMs contracted pharmacy."

DAG Response – **DAG disagrees**. According to the State Toolkit for Validating Medicaid Managed Care Encounter Data prepared by CMS, dated August 2019 and amended after our audit period, data sources include, but are not limited to, claims data and remittance advices from the plans or plans' subcontractors, like PBMs.

DHS Assertion – "DHS would like to understand how the auditor would characterize the PBM and pharmacy fees if the pharmacies made a separate payment to the PBM as opposed to the remittance advice showing a payment withhold. DHS would also like to know if the auditor reviewed the PBM and pharmacy contract payment provisions to determine if transmission fees are disclosed and collected per the terms and conditions of that contract."

DAG Response – DAG would characterize the PBM and pharmacy fees collected separately from the drug claim's remittance advice as spread pricing that is noncompliant with Act 120 of 2020 Section 449(h)(3) and (4)[49] because the fees in this scenario would be a differential that is prohibited under subsection (3) and would also be transmission fees that were not processed during adjudication in non-compliance with subsection (4). Additionally, DAG reviewed pharmacy contract payment provisions to determine if the drug and dispensing fees were collected per the terms and conditions of the contract. We did not request or review the pharmacy contract provisions regarding transmission fees since they were assessed at the same fee amount for the applicable pharmacies for that MCO unless it met other criteria, like a vaccine that had no fee. However, we found that the transmission fees were transparent to the pharmacies for PerformRx, LLC as noted in *Finding 3* of our audit report.

DHS Assertion Seven – "The report did not identify any evidence of spread pricing as described by CMS. DHS monitors spread pricing through reporting in the aggregate and has not identified spread pricing. The draft reports states that monitoring should be done on an individual claim level. This recommendation is based on the auditor's inaccurate description of spread pricing."

DAG Response – **DAG disagrees**. As previously noted, DAG did identify evidence of spread pricing by the PBMs that charge pharmacies transmission fees as described by CMS. See also the table above that indicates that seven of the eight PBMs were paying the pharmacies less than the MCOs were paying the PBMs for the same drug claim, totaling nearly $7 million in additional revenue to the PBMs for calendar year 2022.

DHS Assertion – "The audit report discloses no evidence that individual claim monitoring would yield different results than aggregate monitoring."

DAG Response – **DAG disagrees**. As detailed in the audit report, our audit procedures identified undisclosed transmission fees paid by pharmacies to PBMs and a voided prescription claim record that was not properly voided in PROMISe™ by the PBM. DHS' lack of awareness

[49] 62 P.S. § 449(h)(3)-(4).

was confirmed during meetings between the auditors and DHS management. Had DHS monitored pharmacy claims on an individual basis, at least for a sample of claims, DHS may have identified the overstated pharmacy drug encounter data and the potential weakness in the process for rejected voids that are not resubmitted.

DHS Assertion – "If DHS identifies spread pricing, as described by CMS, and prohibited by the HealthChoices agreement and Act 120 of 2020, the MCOs will be held accountable for the non-compliance of their subcontractors."

DAG Response – **DAG disagrees** with DHS' assertion that the HealthChoices agreement and Act 120 of 2020 prohibit spread pricing for the PBM transmission fees. The transmission fees are a legalized type of spread pricing based on CMS description and Act 120 of 2020. Additionally, the HealthChoices agreement has the following provision that does not indicate spread pricing is prohibited:

> Appendix BBB.
>
> 9. Drug Encounters b. …For all Drug Encounter data… the following data elements are required… iii. Actual paid amount by the PH-MCO, or the PH-MCO's PBM, to the provider for the drug dispensed.
> …
> 14. Pharmacy Benefit Manager (PBM) The PH-MCO must: … c. Report differences between the amount paid by the PH-MCO to the PBM and the amount paid by the PBM to the providers of covered drugs as administrative fees."

The agreement provisions are consistent with DAG's audit recommending that DHS, not just the MCOs, should be monitoring the PBMs for compliance.

DHS Assertion – "DHS investigated the one voided pharmacy claim identified in the report and concluded that the claim was paid to the pharmacy, and DHS received the paid MCO drug encounter. The discrepancy was related to encounter file load timing lag which was identified and resolved in late 2022 – early 2023."

DAG Response – **DAG agrees** that the voided pharmacy claim in question was initially paid to the pharmacy and DHS received the paid MCO drug encounter; however, we disagree that the voided transaction problem was due to a "file load timing lag" issue. The claim in question was subsequently reversed by the pharmacy, refunded to the PBM, and submitted to DHS for reversal. That reversal was rejected by the DHS PROMISe™ and not properly resubmitted by

the PBM, causing the DHS encounter record to be overstated by the amount of that claim as of June 6, 2024. DHS' lack of claim-specific monitoring of pharmacy claims and PBM practices is inadequate to ensure the HealthChoices program is compliant with federal and state laws. Had DHS performed claim-specific monitoring, it may have discovered system weaknesses like the overstated claim that was subsequently voided, rejected by PROMISe™, and not resubmitted by the PBMs or MCOs.

DHS Assertion – "The transmission fees paid by the pharmacies to the PBM are a cost to the pharmacy, not an administrative cost to the MCO and are therefore not reported by the MCO on the MLR reports. Because the transmission fees are not an expense of the MCOs, they would not have been included in the MCO cost reports, which are the reports that would have supported the $4.6 billion in drug expenditures."

DAG Response – **DAG disagrees**. Although the transmission fees are a cost to the pharmacy, they are revenue to the PBM, and therefore, should be reported to the MCOs for proper accounting in the MLR.

DHS Assertion – "The auditors' suggestion that CMS might disallow federal financial participation because of ineffective monitoring is based on what the auditors consider spread pricing. In any event, ineffective monitoring is not a basis for disallowing the entire $4.6 billion in drug expenditures. Moreover, the result of what the auditors believe was the ineffective monitoring was $7 million in transmission fees paid by the pharmacies to the PBMs which they believe should be subtracted from the MCO's incurred claims in the MLR calculations."

DAG Response – **DAG disagrees** that the audit indicated that the entire $4.6 billion in drug-related expenditures would be disallowed. DAG asserted that the totality of DHS' ineffective monitoring could put the Federal dollars at risk of CMS disallowance. A disallowance is where the State is required to pay back a percentage or portion of the Federal funds to CMS.

Recommendations for Finding 1

DHS Response to Recommendation 1 – "DHS disagrees with this recommendation. We have written policies and procedures for monitoring pharmacy encounter data."

DAG Response – **DAG disagrees.** DAG first requested DHS policies and procedures related to the audit objectives on November 13, 2023. In response DHS provided numerous MCO reports, MCO prepared monitoring reports, systems notices, MCO operations memorandums, participant denial notices, MCO policy and procedures manual, and reporting templates. Since subsequent

emails and conversations did not result in the receipt of DHS specific policies and procedures, DAG then requested on May 20, 2024, DHS policies and procedures specifically for encounter data validation. DHS responded with Code of Federal Regulations citations, agreement requirements, CMS requirements, and NCPDP formatting requirements. No internal DHS written policies and procedures detailing how and when DHS monitors PBM encounter data were ever produced by DHS.

DHS Response to Recommendation 2 and Recommendation 3 – "DHS disagrees with this recommendation. The audit disclosed no evidence that individual claim monitoring would yield different results than aggregate monitoring. While we don't think this is necessary, we will consider this recommendation."

DAG Response – **DAG disagrees.** As detailed in the audit report and above, our audit procedures identified undisclosed transmissions fees paid by pharmacies to PBMs and a voided prescription claim record that was not properly voided in PROMISe™ by the PBM. However, DAG is pleased that DHS will consider Recommendations 2 and 3.

DHS Response to Recommendation 4 – "DHS disagrees with this recommendation. DHS already includes all pharmacy encounter information in the Triennial audit."

DAG Response – DAG agrees that DHS likely provided the vendor with the pharmacy encounter data. DHS, however, stated the current triennial audit will be the same process used in 2021 for the completed triennial audit of 2019 HealthChoices data which did not include a validation of DHS encounter records against source systems, such as the PBM's claims processing system, and medical records, such as pharmacy claims.

DHS Response to Recommendations 5 and 6 – DHS will consider this recommendation.

DAG Response – DAG is pleased that DHS will consider Recommendations 5 and 6.

DHS Response to Recommendation 7 – "DHS disagrees with this recommendation. The transmission fees paid by the pharmacies to the PBM are a cost to the pharmacy, not an administrative cost to the MCO and are therefore not included in encounter data, MLR calculations, or capitation rates."

DAG Response – **DAG disagrees**. The transmission fees the PBM charges the pharmacies are a source of revenue to the PBM and therefore should be reported as a reduction to the drug claim as an administrative cost on the encounter record, should be reported to the MCOs for MLR

calculations, and should be reported to the actuaries for future capitated rates, consistent with the CMS 2019 guidance.[50]

Finding 2 – DHS did not effectively monitor contracts between the Physical HealthChoices managed care organizations and pharmacy benefit managers.

Recommendations for Finding 2

DHS Response to Recommendation 1 – "DHS disagrees with this recommendation. DHS holds the MCOs responsible as the prime agreement holders for ensuring their subcontractors are compliant with all requirements. DHS requests the MCO take corrective actions when it becomes aware that a subcontractor is not compliant with requirements of the HealthChoices agreement."

DAG Response – **DAG disagrees** that DHS should solely rely on the MCOs to do the monitoring of the PBMs since several of the MCOs and PBMs are part of the same network of companies. Due to conflicts of interest, it is imperative that DHS recognize the need for its independent monitoring of PBMs, especially those within the same MCOs' corporate network.

DHS Responses to Recommendations 2, 3, 4, and 5 – DHS will consider these recommendations.

DAG Response – DAG is pleased that DHS will consider Recommendations 2, 3, 4, and 5.

[50] Id.

PerformRx, LLC Finding 3 – PerformRx, LLC was transparent and accountable to the pharmacies for transmission fees but was not transparent to the MCOs and DHS regarding the fees which resulted in undisclosed spread pricing.

During calendar year 2022, PerformRx, LLC (PerformRx) was the pharmacy benefit manager (PBM) for three of the Physical HealthChoices (HealthChoices) managed care organizations (MCOs). The three MCOs were AmeriHealth, Keystone First, and Geisinger. Our performance audit determined that PerformRx was partially compliant with Act 120 of 2020 since the transmission fees it charged were disclosed to the pharmacies and processed during adjudication, but they failed to disclose and report the transmission fees to the three MCOs and the Pennsylvania Department of Human Services (DHS).

Act 120 of 2020 requires that PBMs charging a transmission or transaction fee to pharmacies must disclose the fee and process the fee at the time of adjudication.[51] To ensure the requirements set forth by Act 120 of 2020 were met, we reviewed PerformRx's procedures for processing drug claims for HealthChoices and examined the following:

1. Whether the contracts between PerformRx and MCOs disclosed that PerformRx will charge transmission fees to the pharmacies;

2. Whether PerformRx practices spread pricing based on the following:

    a. Whether the payments for claims from the MCO to PerformRx are the same amount that PerformRx paid the pharmacies;

    b. Whether transmission fees, if charged, were disclosed to the pharmacies on the remittance advices from PerformRx; and

    c. Whether the payment information in DHS' PROMISe™ agrees with the amount actually paid to the pharmacy;[52]

[51] Adjudication is when the PBM makes payment to reimburse the pharmacy for the drug claim being processed.
[52] DHS system notice #SYS-2019-031 states, in part, "All drug encounters must include the **actual total amount paid to the dispensing provider**, regardless if the MCO paid directly or the claim was paid by a subcontractor of the MCO." Emphasis added.

3. Whether pharmacies knew that PerformRx reduced its drug payments by a transmission fee per claim based on confirmations sent to selected pharmacies; and

4. Whether the MCOs reported PerformRx' transmission fees on the MCOs' Outpatient Drug Pricing Transparency (Part D) reports (Transparency Reports) completed quarterly and submitted to DHS.

PerformRx contracts with HealthChoices MCOs

We obtained the Geisinger contract with PerformRx and the joint contract between AmeriHealth and Keystone First with PerformRx. Our review of the two contracts found that each contained provisions that allowed PerformRx to charge a transmission fee to the pharmacies. This provides notice to the three MCOs that there may be spread pricing, and therefore, the MCOs were aware or should have been aware that PerformRx may charge pharmacies a transmission fee. According to PerformRx, the transmission fees are charged to the pharmacies as administrative fees to reduce the amount paid by the MCOs.

Testing for Spread Pricing

We tested pharmacy drug claims for all three MCOs. To do this, PerformRx provided its monthly claims data for calendar year 2022 for each of the three MCOs. According to that data, a total of 34,346,412 claims were processed by PerformRx in calendar year 2022 for the three MCOs, and a total of $1.8 billion was paid to the pharmacies for those claims.[53]

We selected 20 claims per MCO from the claims data provided by PerformRx, for a total selection of 60 claims. To select the 20 claims for each MCO, we haphazardly selected 12 claims, one per month, and judgmentally selected eight claims based on other criteria, such as claims that appeared to be an adjustment. Based on the total selection of 60 claims, we obtained the following supporting documentation from PerformRx:

- Claim transaction detail from PerformRx's claims processing system for the selected claim and any prior or subsequent information associated with that claim;
- Pharmacy contract payment provisions;

[53] *See Appendix A* for details regarding assessment of data reliability.

- Documentation of MCO payments to the PBM for the claims; and
- Remittance advices from PerformRx to the pharmacies for the claims.

To facilitate our review, PerformRx explained the claims process as described in the *Introduction and Background* section of this audit report. Additionally, PerformRx indicated that the pharmacies may reverse, or void claims, each month for several reasons, for instance, if the member does not pick up the prescription, the pharmacist will return the medication to inventory and submit a reversal transaction to negate the claim. If the reversal is entered within the same financial cycle as the original claim, it becomes an in-cycle reversal, and the two transactions cancel each other out. Therefore, for an in-cycle reversal, no encounter has taken place with a drug and a Medicaid member, so it is not a transaction submitted to the MCO or subsequently recorded in PROMISe™.

Alternatively, an out-of-cycle adjustment occurs when a reversal is processed after the financial cycle in which the original claim was created. Since the first transaction created a payment to the pharmacy and an encounter record in PROMISe™, another transaction is required to recoup the payment from the pharmacy and to reduce the amount paid by the PBM in the PROMISe™ record. The two transactions result in two remittance advices to the pharmacy, one for the original claim's payment and a second one for the reversing transaction to recoup the funds from the pharmacy.

Of the 60 claims tested, totaling $108,723.38 in transactions, we found four of the 60 claims did not include a transmission fee, and were therefore pass-through pricing, with no spread between the MCO payment and the PBM payment. Thirteen claims were reversed in-cycle with no remittance advices or PROMISe™ encounter records, and the remaining 43 claims had the following exceptions:

- 42 claims had an MCO payment to PerformRx that was higher than the amount PerformRx paid to the pharmacy due to a transmission fee, creating a spread in pricing. Additionally, the MCO payment amount was recorded in the PROMISe™ encounter record rather than the lower actual amount paid to the pharmacy. This type of spread pricing overstates the pharmacy encounter data in PROMISe™. (*See* E-1 and E-2 in the table in *Appendix F*.)

- One claim listed as an out-of-cycle reversal was not properly voided in PROMISe™ because the reversing transaction was rejected by PROMISe™ and was not resubmitted by PerformRx. (*See* E-3 in the table in *Appendix F*.) Again, resulting in an overstated PROMISe™ encounter record.

Although PerformRx disclosed transmission fees to the pharmacies on remittance advices at the time of payment, the encounter records submitted to the MCOs and to DHS did not report the transmission fees. Therefore, it was not transparent to the MCO or to DHS that the MCO payment to the PBM and the PBM payment to the pharmacies were different. Although DHS procedures and system notices indicate the amount to be recorded in the encounter record is to be the actual amount paid to the pharmacy, PerformRx did not offset the MCO amount paid by the transmission fees, resulting in undisclosed spread pricing.

We also noted during our audit procedures that the pharmacies do not pay transmission fees for in-cycle reversals since there are no payment remittances. The out-of-cycle reversals, however, do result in the pharmacies paying a transmission fee for the initial claim and another transmission fee for the reversal transaction. One fee is retained by the PBM, and one fee is used to pay back the MCO for the full amount the MCO initially paid the PBM.

Pharmacy Confirmation Results

To determine whether the pharmacies actually knew that they were charged a transmission fee per claim, we sent confirmations to the 18 corporate pharmacies associated with the 60 claims. Each of the 18 pharmacies responded and 6 confirmed the amount listed on the PROMISe™ encounter record was reduced by a fee. Although only 6 of the 18 pharmacies confirmed 17 of the 60 claims included transmission fees that reduced the reimbursement paid by PerformRx, we concluded that PerformRx adequately and transparently disclosed the transmission fees to the respective pharmacies on remittance advices.

DHS Transparency Reports

Since our testing revealed that the encounter records sent to DHS did not include the transmission fees that were charged to the pharmacies, we obtained the calendar year 2022 quarterly Transparency Reports from DHS that require the MCOs to report MCO administrative fees for the PBM services and PBM transmission fees charged to the pharmacies. Our review of the calendar year 2022 reports for these three MCOs found that no transmission fees were disclosed on the Transparency Reports, even though we found transmission fees were being charged to pharmacies.

After we raised this lack of disclosure with DHS, DHS provided revised Transparency Reports for the three MCOs, adding $2 million in transmission fees not previously reported to DHS on the Transparency Reports. According to PerformRx, it was unaware of the reporting requirement that resulted in the unintentional omission of the data; therefore, it recreated the past deficient reports for the MCOs and remedied the defect going forward.

In Summary

Although PerformRx adequately and accurately disclosed transmission fees to the pharmacies, PerformRx failed to disclose the transmission fees to the MCOs and DHS which violates the transparency requirements set forth by Act 120 of 2020. Therefore, PerformRx was not fully compliant with the statutory and regulatory standards. This undermines the transparency requirements required for spread pricing practices.

Recommendations for PerformRx, LLC Finding 3

We recommend that PerformRx:

1. Continue to be transparent with pharmacies regarding the transmission fees and determine if the transmission fee is justifiable since MCOs already pay PerformRx for the processing of the claims.

2. Implement procedures to ensure compliance with Act 120's transparency requirement, not only with the pharmacies, but also with the MCOs and DHS.

3. Monitor out-of-cycle reversals that are rejected by PROMISe™ in order to resubmit the reversing transaction within the time requirements allowed by the HealthChoices agreement to ensure the DHS PROMISe™ encounter data is not overstated.

PerformRx, LLC's Response and Auditor's Conclusion

We provided copies of our draft audit finding and related recommendations to PerformRx, LLC (PerformRx) for its review. On the pages that follow, we included PerformRx's response in its entirety. Following PerformRx's response is our auditor's conclusion.

A Performance Audit

Pennsylvania Department of Human Services
PerformRx, LLC

Pharmacy Benefit Manager Services for the Physical HealthChoices Medicaid Program in Pennsylvania

Audit Response from PerformRx, LLC

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07/29/2024

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Mr. King:

PerformRx, LLC ("PerformRx") appreciates this opportunity to respond to the draft audit findings set forth in the Pennsylvania Department of the Auditor General's ("DAG") July 2024 *Draft Audit Finding* report (the "Audit Report"). In this response, we address each of the DAG's recommendations in the Audit Report.

PerformRx acknowledges the difference between the amount paid by the managed care organizations ("MCO") for prescription drug claims and the net amount received by the pharmacies for claims. This difference is referred to in the Audit Report as the "transmission fee," and is charged by PerformRx to network pharmacies on a per-claim basis. The MCO payment amount reflects the network pharmacies' contracted reimbursement rates; payment to the pharmacies is reduced by the transmission fee (which is disclosed in network pharmacy contracts) during the payment process. While the pharmacies' reimbursement is also based on the contracted rate, pharmacies are also subject to the transmission fee charged by PerformRx, which is completely transparent to network pharmacies. Further, the transmission fee is reported to DHS separately by the MCO in Report #6D - PA Transparency Report ("Quarterly Transparency Reporting") and is reflected as "Provider fees paid to the PBM" following the amount shown as being paid to pharmacies as "PBM Payments to Dispensing Providers."

PerformRx disagrees with the first recommendation in the Audit Report to the extent it implies the transmission fee is not justifiable "since MCOs already pay PerformRx for the processing of the claims." (Audit Report, p. 11.) The transmission fee (or "spread," as characterized in the Audit Report) is used to reduce the administrative burden on the MCO by offsetting some of the cost of administering the network and processing claims on their behalf, and is separate from the administrative fees charged to the MCO. Both fees together are used to cover the cost of the PBM services required in administering the benefit. Transmission fees are in no way tied to, or calculated by, the reimbursement rates for drug cost and professional dispensing fees paid to network pharmacies. The transmission fees are akin to a credit card transaction fee charged by a retail merchant. PerformRx does not agree that this is spread pricing, which is normally applied through a differential in ingredient cost and/or professional dispensing fee; and as explained above, the amount paid by the MCOs is a complete reflection of the reimbursement rates for ingredient cost and dispensing fee set out in the network pharmacy contracts.

PerformRx agrees with the DAG's determination that PerformRx adequately and accurately disclosed administration fees to pharmacies. PerformRx will follow the DAG's recommendation to continue being transparent with pharmacies and determining that fees remain justifiable and valid.

PerformRx acknowledges the DAG's determination that PerformRx failed to disclose administration fees to the MCOs in sufficient detail. However, as noted by the auditors, the MCOs were aware transmission fees were being charged to the

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pharmacies.[1] Nonetheless, effective as of November 2023, PerformRx enhanced its client invoices by including a dedicated column showing transmission fees to ensure visibility and transparency. In addition, in partnership with DHS and the MCOs, PerformRx revised and resubmitted all of the Quarterly Transparency Reporting to include the transmission fees (i.e., provider fees paid to the PBM as indicated in the reporting), which revealed that the transmission fees amounted to less than 0.2% of the drug spend for the corresponding time period. The report coding has been corrected and all subsequent reporting will reflect transmission fees.

PerformRx also acknowledges the DAG's determination that it failed to disclose transmission fees in the encounter records sent to DHS. The encounter records are based on NCPDP coding, which does not include an available field for reporting transmission fees. As a result, the only mechanism for reporting the transmission fees is via the Quarterly Transparency Reporting referenced above. To modify the amounts reported in the encounter reporting, without a designated field for transmission fees, would inaccurately reflect the MCO paid amount and artificially reduce the reported drug spend.

Sincerely,

James A. Gartner
President

CC:
Matthew McGrath: Manager, Audit & Quality, PerformRx
Cheryl Monkman, CIA, CRMA: Vice President, Corporate Audit, AmeriHealth Caritas
William Canfield: Director, Bureau of Audits, Office of Comptroller Operations
Janet B. Ciccocioppo, CPA: Deputy Auditor General for Audits, Dept. of the Auditor General
Gordon R. Denlinger, CPA: Deputy Auditor General for Audits, Dept. of the Auditor General
F. Stephenson Matthes: Chief Counsel, Department of the Auditor General

[1] "Our review of the two contracts found that each contained provisions that allowed PerformRx to charge a transmission fee to the pharmacies." (Audit Report, p. 9.)

Auditor's Conclusion to PerformRx, LLC's Response

PerformRx, LLC management (PerformRx) is generally in agreement with *Finding 3* and acknowledges it charged managed care organizations (MCOs) for contracted services, charged pharmacies administrative transmission fees, recorded the encounter records at the higher MCO paid amount rather than the actual payment amount that was reduced by the transmission fee, and paid the pharmacies based on the pharmacy's contractual reimbursement rates.

PerformRx, however, compares charging the pharmacies a transmission fee on a per-claim basis as "akin to a credit card transaction fee charged by a retail merchant." **The Pennsylvania Department of the Auditor General (DAG) disagrees with this analogy** because a retail store pays a merchant a fee for processing the retail store's credit card transactions from its customers, akin to the MCO paying the PBM for processing drug claims for the MCO's pharmacy benefit for its Medicaid members. The PBM's transmission fee charged to the pharmacy would be comparable to the merchant charging a fee to the retail store and to the credit card bank.

PerformRx management also disagreed with DAG's Recommendation 1 to the extent that it implies transmission fees are not justifiable because the transmission fee is a pharmacy fee in addition to the MCO payments for PerformRx's services. PerformRx indicates the pharmacy transmission fees are to reduce the MCOs administrative burden by offsetting the cost of administering the network and processing claims on the MCO's behalf. **DAG disagrees** that the fee is justifiable because DHS pays the MCOs a capitated rate to administer the Physical HealthChoices Medicaid program which includes the cost of administering a pharmacy network and processing pharmacy claims. If the MCO chooses to use a PBM rather than do the services itself, the MCO contracts and pays the PBM for the services. This administrative expense, whether incurred by the MCO or the PBM, is already considered in the capitation rates paid to the MCO. Therefore, the PBM should not be supplementing its revenue by charging the pharmacies a fee for services it is already contracted to do for an MCO.

In addition, PerformRx does not agree that the differential created by the transmission fee is spread pricing because the transmission fee is not applied to the ingredient cost and/or professional dispensing fee. **DAG disagrees**, since the transmission fee offsets the total amount to be paid on the payment remittance on a per-claim basis. Act 120 of 2020 requires that if transmission fees are charged, that they are to be processed during adjudication. This provides more transparency to the pharmacy. Transmission fees directly reduce the pharmacies' ingredient cost and professional dispensing fee on a per-claim basis, like third-party liabilities and member co-payments.

Although PerformRx acknowledged that the transmission fee is an administrative fee to the pharmacies and is in addition to the MCO's administrative fees, PerformRx asserts that the fee is part of the drug cost recorded on the encounter record because the National Council for Prescription Drug Programs (NCPDP) format has no field available for reporting transmission fees. **DAG disagrees**, since according to DHS' system notice #SYS-2018-025, effective February 1, 2019, and a clarification notice, #SYS-2019-031, both state that the actual total amount paid on the encounter record **must** be the **actual** total amount paid to the dispensing provider, regardless of who paid the dispensing provider (the MCO or the PBM).[54,55]

PerformRx further stated that reducing the encounter record without a designated field for transmission fees would inaccurately reflect the MCO paid amount and artificially reduce the reported drug spend. **Again, DAG disagrees**, in that the Centers for Medicare and Medicaid Services (CMS) May 15, 2019, Informational Bulletin (CMS 2019 guidance) indicates that the amounts paid for benefits or activities that improve the Medicaid member's health care quality are to be distinguished from amounts paid for administrative services.[56] Therefore, since the transmission fee is not improving the Medicaid recipient's health, the transmission fee should be reflected on the encounter record as a reduction of payment, similar to the third-party liability payments and member's copay that reduce the amount paid to the pharmacy. Additionally, reporting the amount paid by the MCO rather than the actual amount paid to the pharmacy less the transmission fee overstates the following:

- The drug costs reported to the MCO;
- The MCO's Medical Loss Ratio (MLR) medical spend (See *Appendix C* of this report);
- The drug costs reported to DHS for its actuaries to properly account for drug costs for future capitation rate setting; and

[54] DHS system notice #SYS-2018-031, effective February 1, 2019, states, in part "The total paid amount field in each pharmacy encounter must accurately represent the actual amount paid by the [PBM] to the dispensing pharmacy provider."
[55] DHS system notice #SYS-2019-031, states in part, "All drug encounters must include the **actual total amount paid to the dispensing provider**, regardless if the MCO paid directly or the claim was paid by a subcontractor of the MCO." (Emphasis added). This clarifies that the encounter record's MCO Amount Paid and Total Amount Paid are to reflect the actual amount paid to the pharmacy, **regardless** of which entity, the MCO or the PBM, pays the dispensing provider.
[56] CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers | CMS (last accessed June 28, 2024).

- The drug costs reported to CMS for the amounts actually spent on drug costs for the HealthChoices program.

In summary, DAG still recommends PerformRx reconsider the need to charge the pharmacies a transmission fee and, if considered necessary, renegotiate the administration costs it charges the MCOs. Additionally, if the reporting format for the encounter record requires additional coding to improve the reportability of the transmission fee as a reduction to the amount paid, similar to how third party liabilities and member copays are accounted for, PerformRx should work with the responsible parties to add the field so the encounter record accurately reflects the actual amount paid to the dispensing provider as required by Act 120 of 2020, DHS, and CMS.

Appendix A Objectives, Scope, Methodology, and Data Reliability

The Department of the Auditor General (Department) conducted this performance audit pursuant to Sections 402 and 403 of The Fiscal Code[57] and Section 449.2 of the Human Services Code.[58]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives.[59] We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Refer to the *Introduction and Background* section of this audit report for how the Physical HealthChoices Medicaid Program (HealthChoices) and the Pharmacy Benefit Manager (PBM) included in our audit were selected.

Objectives

Our performance audit objectives were as follows:

Pertaining to the Pennsylvania Department of Human Services (DHS):

1. Determine whether DHS effectively monitors the PBMs' pharmacy claims, including, but not limited to, the accuracy of the pharmacy information used to prepare the capitation rates for the HealthChoices Medicaid program.

2. Determine whether DHS effectively monitors the PBMs' contracts to ensure compliance and transparency for the HealthChoices Medicaid program.

Pertaining to PerformRx, LLC (PerformRx):

3. Determine if the PBM is compliant with 62 P.S. § 449(h)(3) and (4) of the Human Services Code (as amended by Act 120 of 2020) regarding charges and fees paid to the

[57] *See* 72 P.S. §§ 402 and 403.
[58] *See* 62 P.S. § 449.2, effective December 27, 2022 (Act 98 of 2022).
[59] U.S. Government Accountability Office. *Government Auditing Standards*. 2018 Revision Technical Update April 2021.

PBM by the pharmacies, or pharmacy service organizations, as compared to the corresponding amounts billed to the applicable HealthChoices MCOs to ensure transparency, compliance, and accountability for the HealthChoices Medicaid Program.

Scope

This performance audit covered the period January 1, 2022, through December 31, 2022.

DHS and PerformRx management are responsible for establishing and maintaining effective internal controls to provide reasonable assurance of compliance with applicable laws, regulations, and administrative policies and procedures. In conducting our audit, we obtained an understanding of DHS' and PerformRx's internal controls, including information system controls.

Standards for Internal Control in the Federal Government (also known as and hereafter referred to as the Green Book), issued by the Comptroller General of the United States, provides a framework for management to establish and maintain an effective internal control system.[60] We used the framework included in the Green Book when assessing the DHS and PerformRx internal control systems.

The Green Book's standards are organized into five components of internal control. In an effective system of internal control, these five components work together in an integrated manner to help an entity achieve its objectives. The five components contain 17 related principles, listed in the table below, which are the requirements an entity should follow in establishing an effective system of internal control.

We determined that all of the internal control components are significant to the three audit objectives. The table below represents a summary of the level of the internal control assessment for effectiveness of design (D); implementation (I); or operating effectiveness (OE) that we performed for each principle with respect to both DHS and PerformRx, along with a conclusion regarding whether issues were found with the principles, and if those issues are included in a finding.[61]

[60] Even though the Green Book was written for the federal government, it explicitly states that it may also be adopted by state, local, and quasi-government entities, as well as not-for-profit organizations, as a framework for establishing and maintaining an effective internal control system.

[61] The Green Book, Sections OV3.05 and 3.06, states the following regarding the level of assessment of internal controls. Evaluating the design of internal control includes determining if controls individually and in combination

			DHS (Objectives 1 and 2)		PerformRx (Objective 3)	
Component		**Principle**	**Level of Assessment**	**Conclusion**	**Level of Assessment**	**Conclusion**
Control Environment	1	The oversight body and management should demonstrate a commitment to integrity and ethical values.	D	No issues	D	No issues
	2	The oversight body should oversee the entity's internal control system.	D	No issues	D	No issues
	3	Management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity's objectives.	D	No issues	D	No issues
	4	Management should demonstrate a commitment to recruit, develop, and retain competent individuals.	D	No issues	D	No issues
	5	Management should evaluate performance and hold individuals accountable for their internal control responsibilities.	D	No issues	D	No issues
Risk Assessment	6	Management should define objectives clearly to enable the identification of risks and define risk tolerances.	D	No issues	D	No issues

with other controls are capable of achieving an objective and addressing related risks. Evaluating implementation includes determining if the control exists and if the entity has placed the control into operation. Evaluating operating effectiveness includes determining if controls were applied at relevant times during the audit period, the consistency with which they were applied, and by whom or by what means they were applied.

			DHS (Objectives 1 and 2)		PerformRx (Objective 3)	
Component		**Principle**	**Level of Assessment**	**Conclusion**	**Level of Assessment**	**Conclusion**
	7	Management should identify, analyze, and respond to risks related to achieving the defined objectives.	D	No issues	D	No issues
	8	Management should consider the potential for fraud when identifying, analyzing, and responding to risks.	D, I	Finding 1 Finding 2	D	No issues
	9	Management should identify, analyze, and respond to significant changes that could impact the internal control system.	D	No issues	D	No issues
Control Activities	10	Management should design control activities to achieve objectives and respond to risks.	D, I, OE	Finding 1 Finding 2	D, I, OE	Finding 3
	11	Management should design the entity's information system and related control activities to achieve objectives and respond to risks.	D	No issues	D	No issues
	12	Management should implement control activities through policies.	D, I, OE	Finding 1 Finding 2	D, I	No issues
Information and Communication	13	Management should use quality information to achieve the entity's objectives.	D, I, OE	Finding 1 Finding 2	D, I, OE	No issues
	14	Management should internally communicate the necessary quality information to achieve the entity's objectives.	D, I, OE	Finding 1 Finding 2	D, I	No issues

			DHS (Objectives 1 and 2)		PerformRx (Objective 3)	
Component		**Principle**	**Level of Assessment**	**Conclusion**	**Level of Assessment**	**Conclusion**
	15	Management should externally communicate the necessary quality information to achieve the entity's objectives.	D, I, OE	Finding 1 Finding 2	D, I, OE	Finding 3
Monitoring	16	Management should establish and operate monitoring activities to monitor the internal control system and evaluate results.	D, I, OE	Finding 1 Finding 2	D, I, OE	Finding 3
	17	Management should remediate identified internal control deficiencies on a timely basis.	D, I, OE	Finding 1 Finding 2	D, I	No issues

Government Auditing Standards require that we consider information system controls "…to obtain sufficient, appropriate evidence to support the audit findings and conclusions."[62] This process further involves determining whether the data that supports the audit objectives is reliable. In addition, Publication GAO-20-283G, *Assessing Data Reliability*, provides guidance for evaluating data using various tests of sufficiency and appropriateness when the data are integral to the audit objectives.[63] See our assessment in the *Data Reliability* section that follows.

Our procedures to assess the design, implementation, and/or operating effectiveness accordingly are discussed in the *Methodology* section that follows. Deficiencies in internal controls we identified during the conduct of our audit and determined to be significant within the context of our audit objectives are summarized in the conclusion section below and described in detail within the respective audit findings in this audit report. See the table above for descriptions of each of the principle numbers included in the conclusions below.

[62] U.S. Government Accountability Office. *Government Auditing Standards*. 2018 Revision. Technical Update April 2021. Paragraph 8.59 through 8.67.
[63] U.S. Government Accountability Office. *Assessing Data Reliability*. December 2019.

Conclusion for Objectives 1 and 2:

Our assessment of DHS management's internal controls did not find any issues associated with Principles 1 through 7, 9, and 11. We found, however, issues with management's internal controls regarding Principles 8, 10, and 12 through 17. These areas include issues with 1) DHS' lack of effectively monitoring pharmacy drug claims and 2) DHS' lack of effectively monitoring PBM contracts. These issues are described in detail in *Finding 1* and *Finding 2*.

Conclusion for Objective 3:

Our assessment of PerformRx's management's internal controls did not find issues associated with Principle 1 through 9, 11 through 14, and 17. We found, however, issues with management's internal controls regarding Principles 10, 15 and 16. These areas include issues with PerformRx' lack of sufficient transparency and disclosure of transmission fees to the respective MCOs and DHS. These issues are described in detail in *Finding 3*.

Methodology

The following planning procedures were performed to address all three of our audit objectives:

- Identified those charged with governance and communicated an overview of the objectives, scope, methodology, and timing of the performance audit.

- Obtained an understanding of DHS' organizational structure, information published on its website, Enterprise Risk Management (ERM) Reports for FY 21/22 and FY 22/23, DHS' responses to our fraud questionnaires, responses to Information Systems Controls Assessment and Understanding of IT Environment forms, and from interviews with DHS management. [DHS – All Principles]

- Obtained an understanding of PerformRx's organizational structure, information published on its website, responses to our internal control and fraud questionnaires, responses to Information Systems Controls Assessment and Understanding of IT Environment forms, and from interviews with PerformRx management. [PerformRx – All Principles]

- Interviewed stakeholders of the pharmaceutical industry and distribution chain applicable to the Medicaid program.

- Retained a consultant of external specialists with subject-matter expertise including knowledge of the pharmaceutical supply chain and pharmacy benefit manager activities. The consultant assisted with information as needed during audit planning, audit execution, and audit report writing.[64] See an informational memo written by the specialists in *Appendix C* of this audit report.

- Reviewed the independence and qualifications of the specialists on the consultant's team.

- Reviewed the following laws and regulations applicable to the HealthChoices Medicaid Program: [Principle 12]

    - Act 120 of 2020 Human Services Code – Medical Assistance Pharmacy Services and Prescription Drub Pricing Study, 62 P.S. § 449
    - Act 98 of 2022 Human Services Code – Pharmacy Benefits Manager Audit and Obligations and Abrogating Regulations, 62 P.S. § 449.2
    - Act 77 of 2024, July 17, 2024
    - Code of Federal Regulations (CFR) Title 42. Public Health Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services:
        - 438.8 Medical loss ratio (MLR) standards.
        - 438.66 State monitoring requirements.
        - 438.230 Subcontractual relationships and delegation.
        - 438.242 Health information systems.
        - 438.364 External quality review results.
        - 438.602 State responsibilities.
        - 438.604 Data, information, and documentation that must be submitted.
        - 438.818 Enrollee encounter data.
    - 55 Pa. Code: Human Services, Part III Medical Assistance Manual
        - Chapter 1101. General Provisions
            - Section 1101.73 Provider misutilization and abuse.

[64] GAGAS 1.27 p. defines Specialist as: "An individual or organization possessing special skill or knowledge in a particular field other than accounting or auditing that assists auditors in conducting engagements. A specialist may be either an internal specialist or an external specialist."

- Chapter 1121. Pharmaceutical Services
  - Section 1121.42(1) Ongoing responsibilities of providers.
  - Section 1121.51 General payment policy.
  - Section 1121.71 Scope of claims review procedures.
- Chapter 1229. Health Maintenance Organization Services
  - Section 1229.71 Scope of claims review procedures.

- Designed audit procedures to provide reasonable assurance of detecting significant violations of law, regulations, policies, etc. in the context of our audit objectives. [Principle 12]

- Obtained an understanding of DHS and PerformRx's internal controls and assessed the design, implementation, and/or operating effectiveness of such internal controls to the extent necessary to address the audit objectives. [All Principles]

- Evaluated the significance of identified internal control deficiencies within the context of our audit objectives. [All Principles]

- Considered illegal acts, fraud, and abuse throughout the audit process. [All Principles]

- Conducted fraud/abuse, audit risk, and control risk brainstorming meetings to highlight high risk areas and to be aware of situations in which fraud and control weaknesses may exist. [Principle 8]

- Assessed significance and audit risk within the context of the audit objectives and applied these assessments to establish the scope and methodology for addressing the audit objectives. [All Principles]

- Designed the audit procedures to obtain sufficient, appropriate evidence that provided a reasonable basis for findings and conclusions based on the audit objectives and to reduce audit risk to an acceptably low level.

- Planned audit procedures and test work based on ongoing risk assessments to obtain sufficient and appropriate evidence to adequately support our audit objectives.

- We obtained information for the background of this audit report regarding Medicaid, the HealthChoices program, and PBMs.

The following procedures were performed to address Objective 1:

Items selected for review for this objective were based on auditor's professional judgment and not through statistical selection. The results of our review, therefore, cannot be projected to, and are not representative of, the corresponding populations.

- Interviewed and corresponded with DHS management to gain an understanding of the program, bureaus and individuals involved in the program, internal control procedures, monitoring, and key reports that are significant to the audit objective. [Principles 8, 10, and 12 through 17]

- Reviewed laws, regulations, DHS HealthChoices agreements with the MCOs, MCO contracts and amendments with PBMs, and the Prior Authorization Review Panel (PARP) to identify potential criteria needed to evaluate the audit objective.[65]

- Centers for Medicare and Medicaid Services (CMS), Center for Medicaid & CHIP Services (CMCS) Informational Bulletin regarding Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors, dated May 15, 2019.

- Reviewed CMS' State Toolkits for Validating Medicaid Managed Care Encounter Data, dated August 2019 and the revision dated September 2023.

- Reviewed DHS' instructions, data, and results for the following reports:

  - Report 4C Electronic Lag Report, Pharmacy Rebates (Report 4C)
  - Report 6B Pharmaceutical Price and Utilization Statistics
  - Report 6D Outpatient Drug Pricing Transparency Part D Report (Transparency Report)
  - NCPDP Timeliness and Accuracy reports, and
  - Drug Supplemental Files.

- Reviewed the HealthChoices Data Books prepared by DHS' actuaries for the calendar year 2022, 2023, 2024, and 2025 capitation rates to determine if the claims data used by the DHS actuaries to set the capitation rates included adjustments for PBM transmission fees. [Principle 15]

[65] We requested DHS' policies and procedures for monitoring pharmacy encounter data; however, they only provided the PARP.

- Reviewed the Pennsylvania PROMISe™ Provider Handbook, Pennsylvania Department of Human Services, NCPDP D.0 Pharmacy Billing, which includes an overview of PROMISe™ for Pennsylvania's claims processing for the Medicaid program, including HealthChoices. [Principles 12 and 13]

- Documented an understanding of information technology general controls and data entry controls over PROMISe™, which included reviewing the PROMISe™ System and Organization Control (SOC) report and the most recent Peer Review Acceptance Letter for the company that conducted the review and provided the opinion. [Principle 11]

- Performed the following procedures to determine if DHS verified whether PBMs complied with Act 120 of 2020, during calendar year 2022:

  - Obtained the October 2022 PROMISe™ HealthChoices pharmacy encounter data.[66] For our audit procedures, we included in the audit population the four MCOs that did not use PerformRx as a PBM. This population included 1.5 million pharmacy encounter records in PROMISe™ for HealthChoices, totaling $208 million. The three MCOs that used PerformRx are included in our audit procedures noted under Objective 3.
  - We haphazardly selected 10 encounter records for each of the four MCOs not tested for Objective 3, for a total of 40 encounters. We selected these 40 encounter records based on the same 18 corporate pharmacies as selected for the 60 selected claims processed by PerformRx as noted below.
  - Traced the encounter record information to the applicable pharmacy invoice and payment remittances to determine if the PBMs reported the amount the PBM paid the pharmacy and/or the amount the MCO paid the PBM in the encounter record.
  - Determined if the pharmacy was paid for the drug in accordance with the PBM and pharmacy contract provision.
  - Reviewed PROMISe™ supplemental files and adjustments to review subsequent adjustments.
  - Determined if the PBMs charged transmission fees and whether the transmission fees were reported on the encounter record.
    [Principles 8, 10, and 12 through 17]

[66] See the Data Reliability section of this Appendix for details regarding assessment of data reliability.

- Reviewed the applicable provisions of the January 1, 2022 and September 1, 2022, DHS and MCOs HealthChoices agreement related to pharmacy claims and encounter data. [Principle 15]

- Reviewed MCO audit report opinions and DHS letters to the MCOs regarding any deficiencies noted. MCO audit report opinions included opinions for the MCO's annual financial statement audit and the MCO's annual opinion for compliance with the DHS HealthChoices Guide. [Principles 16 and 17]

- Reviewed CMS Medical Loss Ratio (MLR) requirements, guidance, related news articles to determine whether PBM transmission fees should be categorized as administrative costs or medical costs for the calculation of the annual MLR and for rate setting purposes.

- Interviewed DHS outside actuarial vendor to determine if they considered the transmission fees charged by MCOs PBMs as administrative costs or medical costs for rate setting purposes.

The following procedures were performed to address Objective 2:

- Interviewed agency personnel to gain an understanding of the program, bureaus and individuals involved in the program, internal control procedures, and key reports that are significant to the audit objective. [Principles 8, 10, and 12 through 17]

- Reviewed laws, regulations, DHS HealthChoices agreements with the MCOs, MCO contracts and amendments with PBMs, to identify potential criteria needed to evaluate the audit objective.[67]

- Reviewed contracts for CY 2022's HealthChoices program, including the contracts between DHS and the MCOs, and the contracts between the MCOs and the PBMs to determine if the contract addresses Act 120 of 2020 requirements. [Principle 15]

- Obtained the Statewide Preferred Drug List (PDL) and MCO PDL Compliance reports for the CY 2022 to determine if DHS monitors the adherence to and use of these lists. [Principle 16]

[67] We requested DHS' policies and procedures for monitoring pharmacy encounter data; however, they only provided the PARP.

- Interviewed DHS management to obtain an understanding of its monitoring procedures for the HealthChoices MCOs' PBM contracts because DHS provided no written monitoring procedures. [Principles 10 and 12 through 17]

- Determine if the MCOs completed the annual required Subcontractor Identification list (list) which listed the MCO's subcontractors for the fiscal year. Initially, DHS provided the correct fiscal year annual lists for six out of eight MCOs for calendar year 2022. Upon receiving the eight correct lists we were able to ascertain that DHS gave us the incorrect PBM contracts for three MCOs. [Principle 16]

- Determined if DHS completed a Subcontractor Checklist to ensure each of the eight MCOs' PBM contracts complied with terms that are required to be in the HealthChoices agreement. DHS only provided checklists for five MCOs' PBM contracts and indicated a checklist is not required for each HealthChoices agreement or each PBM contract unless the PBM is new to the program. Therefore, none of the MCOs completed the checklist in *Appendix D* of this report with the September 1, 2022 HealthChoices agreement to ensure the PBM contract still complies with the new HealthChoices agreement. [Principles 10, 12, and 16]

- Determine whether DHS monitors the System and Organization Controls (SOC) reports for MCOs and their subcontractors. DHS indicated it did not require or monitor MCO SOC reports until calendar year 2023 and they do not require or monitor the PBM SOC reports. [Principles 11 and 16]

- Determine if DHS ensured the HealthChoices MCO contracts and PBM subcontracts have the required audit provision allowing DHS to audit the MCOs' and PBMs' Medicaid activities. [Principle 16]

The following procedures were performed to address Objective 3:

Items selected for review for this objective were based on auditor's professional judgment and not through statistical selection. The results of our review, therefore, cannot be projected to, and are not representative of, the corresponding populations.

- Interviewed PerformRx management to gain an understanding of the PBM role in the pharmacy claims process. [Principles 8, 10, and 12 through 17]

- Inquired of PerformRx about internal control procedures and key documents and reports that are significant to the audit objective. [Principle 10]

- Obtained and reviewed various PerformRx policies and procedures pertaining to contracting and networking with pharmacies. [Principles 12 and 14]

- Determined if PerformRx is following Act 120 of 2020 Section 449(h)(3) and (4) of the Human Services Code to determine whether each of the three MCOs' contracts with PerformRx complied with provision (h)(3) and therefore does not charge or retain a differential at the time of claim adjudication, or if the contracts comply with provision (h)(4) and therefore do charge a transmission fee at the time of adjudication, that the fee is disclosed and transparent in the contract.

- Obtained Medicaid drug claims data from PerformRx's claims processing system for the three HealthChoices MCOs for which it provides pharmacy services.[68] The total population of pharmacy claims we received from PerformRx's claims processing system for the three MCOs for calendar year 2022 was 34 million pharmacy transactions, including claims, reversals and adjustments (claims) totaling $1.8 billion for the calendar year 2022.

- Verified the claims data for calendar year 2022 reconciled to the outside vendor's invoices that issues payments to the pharmacies. [Principle 13]

- Performed the following procedures to determine if DHS verified whether PerformRx complied with Act 120 of 2020, during calendar year 2022:

    - Selected a test selection of claims from the CY 2022 claims data for the three MCOs that used PerformRx as a PBM. Since audit risk was assessed high, we judgmentally selected 60 claims to test. We selected 20 claims per MCO for a total of 60 claims to review. Each group of 20 claims included haphazardly selecting a claim per month and judgmentally selecting eight claims based on other criteria such as a claim that appeared to be an adjustment. The 60 claims were from 18 different corporate pharmacies.
    - Determined if the PBM charged a transmission fee causing spread pricing and whether the amount on the DHS encounter record is the amount the PBM paid the pharmacy less the transmission fee or the amount the MCO paid the PBM by

[68] See the Data Reliability section of this Appendix for details regarding assessment of data reliability.

tracing the claim's record information to the applicable pharmacy invoice and payment remittance. [Principles 10, 15, and 16]
- Determined if the pharmacy was paid for the drug in accordance with the PBM and pharmacy contract provision. [Principle 14]
- Reviewed PROMISe™ supplemental files and adjustments. [Principles 10, 15, and 16]
- Confirmed the actual amounts paid with the applicable pharmacy. [Principles 10 and 15]

- Determine whether any transmission fees charged by PerformRx were reported to the three MCOs and DHS via the Transparency Reports. [Principles 15 and 17]

- Reviewed the National Average Drug Acquisition Cost (NADAC) data compared to the testing items to ensure the PBM payments for drugs were reasonable.

- Reviewed whether PerformRx's administrative function of paying pharmacies for drugs distributed to Medicaid recipients is permitted to be outsourced to an entity in a non-contiguous US state, such as Abarca, which is in Puerto Rico, a non-contiguous US state

Data Reliability

Government Auditing Standards requires us to assess the sufficiency and appropriateness of computer-processed information that we used to support our findings, conclusions, and recommendations. The assessment of the sufficiency and appropriateness of computer-processed information includes considerations regarding the completeness and accuracy of the data for the intended purposes.[69]

For audit Objective 1 regarding DHS monitoring of HealthChoices pharmacy encounter data, DHS provided October 2022 PROMISe™ encounter records for the 7 HealthChoices MCOs.[70] In order to confirm the completeness and accuracy of the data, we performed the following:

- Interviewed DHS management to document the PROMISe™ information received from the MCOs for pharmacy claims.

[69] U.S. Government Accountability Office. Government Auditing Standards. 2018 Revisions. Technical Update April 2021. Paragraph 8.98.
[70] The eighth MCO, Aetna, was no longer in the HealthChoices program in October 2022.

- Documented an understanding of information system controls.

- Compared each of the MCOs October 2022 total encounter records in PROMISe™ to applicable MCO-prepared reports. The reports utilized included NCPDP Timeliness and Accuracy reports.

- Traced a selection of 40 DHS PROMISe™ encounter records (as described in Methodology for Objective 1) to the PBM's claims processing transaction detail for the amount paid by the MCO to the PBM and the amount paid to the pharmacy on the PBM payment remittance less a transmission fee if charged by the PBM.

In addition to the above procedures, as part of our overall process in obtaining assurance of the reliability of computer-processed information and data files, we obtained a management representation letter from DHS. This letter, signed by DHS management, included a confirmation statement indicating that the information provided to us had not been altered and was a complete and accurate duplication of the information from its original source.

Based on the above procedures, we found no limitations with using the DHS PROMISe™ pharmacy encounter data for our intended purposes. In accordance with *Government Auditing Standards*, we concluded the DHS pharmacy encounter data for the period January 1, 2022, through December 31, 2022, to be sufficiently reliable regarding completeness and accuracy for the purposes of this engagement.

As part of our audit procedures for Objective 1, we used PBM claims information obtained from the applicable four MCOs that did not contract with PerformRx as their PBM for HealthChoices. The information obtained included pharmacy claims detail from the PBM's claims processing system and payment remittances to pharmacies to determine if the PBMs were charging the pharmacies transmission fees, and if so, were the fees transparent to DHS based on the Transparency Reports and the pharmacies based on the payment remittances and confirmations, including whether the fees were recorded on the DHS PROMISe™ encounter record used for MCOs' MLR calculations and future capitation rate setting. While we performed a comparison of the information in the PBM's claims detail to the PBM's payment remittance and to the PROMISe™ encounter record, we did not assess the PBMs' claims processing systems or payment remittances for completeness. Therefore, we consider the information to be data of undetermined reliability, as noted in *Finding 1* of this audit report. This data was the best data available. Although this determination may affect the precision of the numbers presented in *Finding 1*, there is sufficient evidence to support our findings and conclusions.

Additionally, the Transparency Reports for calendar year 2022 provided by DHS were found to be incomplete (missing information), inconsistent (MCOs did not complete the reports like other MCOs), inaccurate (MCOs reported pharmacy fees as PBM paid fees), and misleading (MCOs reports made it appear as though the PBMs were practicing pass-through pricing, when in fact, they were practicing spread pricing.) Based on our discussion with DHS regarding the Transparency Reports not accurately reflecting the PBM transmission fees, DHS provided 15 amended reports and additional information. We also found that the Report 4Cs indicate the PBMs were practicing pass-through pricing, when in fact, the seven of the eight MCOs' PBMs were practicing spread pricing. We determined both of the reports to be of undetermined reliability. However, the reports were the best data provided by DHS. Although this determination may affect the precision of numbers we present, there is sufficient evidence in total to support our findings and conclusions.

For Objective 3, we used pharmacy drug claims data provided by PerformRx which are maintained in PerformRx's claim processing system for the three applicable HealthChoices MCOs for calendar year 2022. In order to confirm the completeness and accuracy of the data, we performed the following:

- Interviewed PerformRx management to document the pharmacy claims processing procedures.

- Obtained an understanding of PerformRx's claim processing system including information technology general controls.

- Compared the data files total amounts for each MCOs' financial cycle for the calendar year 2022 to the applicable invoices sent to PerformRx's vendor for payment processing.

In addition to the above procedures described below, as part of our overall process in obtaining assurance of the reliability of computer-processed information and data files, we obtained a management representation letter from PerformRx. This letter, signed by PerformRx's management, included a confirmation statement indicating that the information provided to us had not been altered and was a complete and accurate duplication of the information from its original source.

Based on the above procedures, we found no limitations with using the PerformRx claims processing data for our intended purposes. In accordance with *Government Auditing Standards*, we concluded the PerformRx claims data, for the period January 1, 2022, through December 31,

2022, to be sufficiently reliable regarding completeness and accuracy for the purposes of this engagement.

Appendix B Definitions

The following definitions are summarized as they relate to the pharmacy industry for the benefit of the reader of this audit report and are either based on definitions listed in the September 1, 2022, Pennsylvania Department of Human Services (DHS) Physical HealthChoices (HealthChoices) Contract or other sources as noted.

Actuarially Sound Capitation Rate – Projected rates determined by the Actuary and paid by DHS to the managed care organization (MCO) to provide reasonable, appropriate and attainable physical health services required under the terms of the HealthChoices contract.

Actuary – An individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In relation to this audit, Actuary refers to an individual or entity who is acting on behalf of the State when used in reference to the development and certification of the capitation rates.

Adjudicated Claim – A claim that has been processed to payment or denial.

Capitation – A payment DHS makes periodically to a MCO on behalf of each member enrolled under the HealthChoices contract and based on the actuarially sound rates for the provision of services in the program. DHS makes the payment regardless of whether an individual member receives services during the period covered by the payment.

Centers for Medicare & Medicaid Services (CMS) – The federal agency within the U.S. Department of Health and Human Services responsible for oversight of Medicaid programs.

Claim – A bill from a Provider of a pharmacy service or product that is assigned a unique identifier (i.e., claim reference number).

Covered Outpatient Drug – A brand name drug, a generic drug, or an over-the-counter drug which:

1. Is approved by the U.S. Food and Drug Administration.
2. Is distributed by a manufacturer that entered into a Federal Drug Rebate Program agreement with CMS.
3. May be dispensed only upon prescription in the Medicaid program.

4. Has been prescribed or ordered by a licensed prescriber within the scope of the prescriber's practice.
5. Is dispensed or administered in an outpatient setting.

Data Book – A document provided by the Actuary that describes the methodology of setting the capitation rates for the MCOs to provide physical health services for the HealthChoices program.

Denied Claim – An Adjudicated Claim that does not result in a payment obligation to a Provider.

DHS – The Pennsylvania Department of Human Services.

Encounter – Any covered health care service provided to a member, regardless of whether the individual has an associated Claim. A pharmacy claim becomes an encounter when reported to the MCO in the National Council for Prescription Drug Program (NCPDP) format.

Formulary – A DHS-approved list of outpatient drugs determined by the MCO's Pharmacy and Therapeutics (P&T) Committee to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, and cost for the MCO's members.

HealthChoices Program – The name of Pennsylvania's Medicaid Managed Care program that provides mandatory managed health care to Recipients.

HealthChoices Zone (Zone) – A multiple-county area in which the HealthChoices Program has been implemented to provide physical health services through mandatory managed care to Medicaid recipients in Pennsylvania.

Internal Control Number – The unique number assigned by DHS to identify an individual Claim or Encounter.

Managed Care Organization – An entity that contracts with the Commonwealth of Pennsylvania through DHS to provide managed care services for the Medicaid program.

Medical Assistance – The Medical Assistance Program authorized by Title XIX of the federal Social Security Act, 42 U.S.C. §§1396 et seq., and regulations promulgated thereunder, and 62 P.S. §§441.1 et seq. and regulations at 55 Pa. Code Chapters 1101 et seq. Medicaid is also referred to as Medical Assistance (MA) in Pennsylvania that pays for health care services for eligible individuals.

National Council for Prescription Drug Programs (NCPDP) – A not-for-profit organization that develops healthcare and pharmaceutical industry standards.

Network – All contracted or employed Providers for the MCO who are providing covered services to Medicaid HealthChoices' members. For purposes of this audit, a pharmacy network is the group of pharmacies a MCO allows its Medicaid members to use to fill prescriptions.

Pass-Through Payment – A practice in which the PBM pays the pharmacy the same amount that the MCO paid the PBM for the same claim. The MCO pays the PBM for the services on a separate invoice.

Physical Health Managed Care Organization – A risk-bearing entity which has an agreement with DHS to provide the physical health services under the HealthChoices program.

Preferred Drug List – A list of DHS-approved outpatient drugs designated as preferred products because they were determined to have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness and cost for the MCO members by the MCO's P&T Committee.

PROMISe™ – The Provider Reimbursement and Operations Management Information System is a web-based application for registered providers and is a HIPAA-compliant claims processing and management information system.[71]

[71] http://dhs.pa.gov/about/Pages/Online-Services.aspx (last accessed April 9, 2024).

Appendix C Consultant Memo

The Department of the Auditor General (DAG) contracted with an independent consultant, Three Axis Advisors, to prepare an informational memo on the dynamics of the Pharmacy Benefit Manager (PBM) industry and their impact on public programs.

A Performance Audit

Pennsylvania Department of Human Services
PerformRx, LLC

Pharmacy Benefit Manager Services for the Physical HealthChoices Medicaid Program in Pennsylvania

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THREE AXIS ADVISORS

Memo

To: Peggy Morningstar – Pennsylvania Department of the Auditor General

From: Benjamin Link, Antonio Ciaccia – 3 Axis Advisors, LLC

Date: May 29, 2024

Re: The dynamics of the PBM industry and their impact on public programs

Prescription drug costs stand as a critical pillar in health policy, consistently capturing public interest and concern. Surveys of public sentiment have consistently found that the vast majority of individuals believe that the cost of prescription drugs is unreasonable; however, the majority of individuals say that affording prescriptions drugs is easy.[i] The reality is that what on its surface seems like a relatively simple transaction between a patient and pharmacy is an endeavor subject to many potential complications and competing incentives.

Patients generally rely upon health insurance to assist in purchasing their medications. However, the landscape of insurance acquisition is fragmented, lacking a universal standard for benefit design or cost-sharing. While a significant portion of individuals secure prescription drug coverage through employer-sponsored health plans, government-run programs like Medicare and Medicaid increasingly shoulder the responsibility of providing coverage for a growing number of individuals.

As a result of the various manners in which people obtain prescription drug coverage, patients can experience varying levels of financial support as they purchase prescription medications. The more financial support offered to the patient at the point-of-sale with the pharmacy, the more that the costs of the financing the benefit fall on the health plan sponsor. Unquestionably, one of the largest purchasers of prescription medications are the various Medicaid programs across the country.

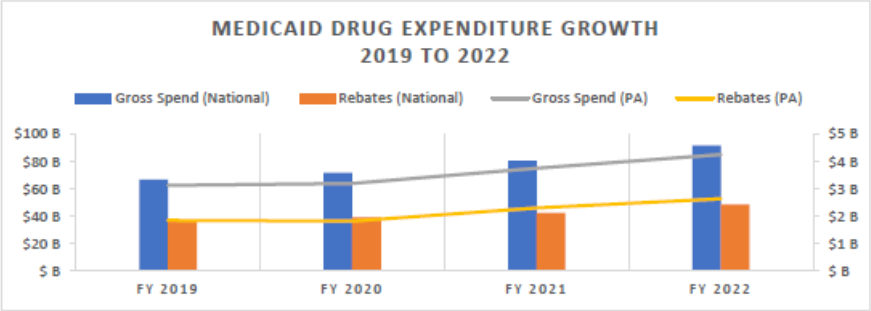
Medicaid holds a distinctive position among payers, catering to the healthcare needs of the nation's most economically vulnerable demographics, including low-income children, families, seniors, and individuals with disabilities. These groups exhibit health needs that are exacerbated by the effects of poverty, unemployment, and other socioeconomic factors, often requiring substantial assistance to access healthcare services. The scale of the Medicaid program reflects both its enrollment figures and its characteristic of minimal cost-sharing, primarily burdening health plans (and by extension, taxpayers) with drug-related costs rather than individual patients. While the inclusion of pharmacy benefits is at the discretion of states, all states incorporate prescription drug programs into their Medicaid State plans, albeit with variations in administration within federal pricing and rebate guidelines.

Following a notable surge in 2014 driven by specialty drugs and the Affordable Care Act's expansion, growth in Medicaid drug spending has mirrored the broader trend in the United States, albeit at a slower pace. Nonetheless, state policymakers harbor concerns regarding future spending trajectories. Medicaid's pivotal role in financing coverage for populations with elevated healthcare needs translates into covering a disproportionate share of high-

cost specialty drugs, compounded by the obligation to accommodate emerging "blockbuster" medications within its pharmacy benefit structure. Policymakers and program administrators recognize that drug development is increasingly specialized, with drug prices growing rapidly alongside the sophistication of drug therapy, creating potentially new challenges for those tasked with financing a prescription drug benefit. This is true even despite the fact that federal law requires that Medicaid programs receive the biggest discounts possible from drug manufacturers relative to other market segments.[ii]

As already identified, prescription drug prices are composed of several component costs. The first is the underlying cost of the drug product, the second is the amount of money given to the provider for their services and business operations. Additional costs may be borne depending upon prescription drug benefit design, such as administrative costs to pharmacy benefit managers (PBMs), incentive fees, and others.

Net spending on prescription medications in Medicaid nationally has grown significantly over the last four years (where data is available).[1] Nationally, net expenditures have grown 46% whereas Pennsylvania Medicaid net expenditures have grown 26% (see graph below).



Unsurprisingly given the level of public investment into Medicaid drug programs, the manner in which costs are recognized has grown in scrutiny as the costs have grown. Currently the majority of individuals both nationally (74.3%) and within Pennsylvania (93.9%) receive their Medicaid benefits through Managed Care Organizations (MCOs).[iii] As a result, managed care is the primary Medicaid delivery system and the primary manner in which states recognize costs related to the operation of their Medicaid programs.

States commonly compensate MCOs for risk-based managed care services via predetermined, fixed payments for a specified set of benefits. These payments, known as capitation payments, are typically disbursed on a per member per month (PMPM) basis. MCOs then engage in negotiations with healthcare providers to furnish services to their enrollees. These services may be provided either on a fee-for-service basis or through arrangements where providers receive a predetermined periodic sum for delivering services. The Omnibus Budget Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35) requires that capitation payments to risk-based managed

[1] Net Spending = Gross Spending – Rebates; data gathered from MACSTATS Exhibit 28

care plans be made on an actuarially sound basis (§1903(m)(2)(A)(iii) of the Social Security Act). The regulations require that state Medicaid managed care rates be developed in accordance with generally accepted actuarial principles and practices, appropriate for the population and services, and certified by qualified actuaries.

Regulations stipulate that states must adhere to the procedures outlined in 42 CFR 438.5(b) or provide justification for why these requirements are inapplicable when setting actuarially sound rates. A crucial aspect of determining payment rates for MCOs involves acquiring base utilization and price data. This data serves as the foundation for projecting expenditure trends, enabling states to develop payment rates that align with targeted spending objectives for each fiscal year.

In recent years, challenges have emerged in obtaining accurate base utilization and price data, particularly highlighted by Medicaid audits revealing discrepancies between the pricing activity reported by MCOs and the actual costs paid to providers for services, a phenomenon commonly known as "spread pricing." This phenomenon occurs when health plans contract with Pharmacy Benefit Managers (PBMs) to oversee prescription drug benefits when PBMs retain a portion of the payments from health plans instead of passing on the full amount to pharmacies. Consequently, a disparity arises between the payment made by the health plan to the PBM and the reimbursement provided by the PBM to the pharmacy for a beneficiary's prescription. Failure to effectively monitor and address spread pricing can lead to PBMs profiting from overcharging health plans, such as MCOs, ultimately driving up Medicaid costs borne by taxpayers. Note that since February 2019, the Pennsylvania Medicaid program has disallowed the use of spread pricing by MCO PBMs, and the state formally outlawed the practice in 2020.[iv]

Medicaid and Children's Health Insurance Program (CHIP) managed care plans are currently mandated to exclude prescription drug rebates from the actual claims costs used to calculate Medical Loss Ratios (MLRs). The MLR is a key metric in the health insurance industry, used to measure the percentage of premium revenues spent on clinical services and quality improvement, as opposed to administrative costs and profits. For example, an MLR of 85% means that 85 cents of every premium dollar are spent on providing health care services and quality improvement, while the remaining 15 cents cover administrative costs and profits. According to the Centers for Medicare & Medicaid Services (CMS) "prescription drug rebates" encompass **any price concessions or discounts received by managed care plans or their PBMs**, irrespective of the rebate source.[v] This includes payments from pharmaceutical manufacturers, wholesalers, and retail pharmacies. Consequently, any amount retained by a PBM through spread pricing must be excluded from the claims costs used in calculating the managed care plan's MLR. States undertake program integrity initiatives to ensure that base pricing data obtained from MCOs is accurate, appropriate, and in keeping with CMS' guidance for appropriate recognition of claim costs.

Program integrity activities are meant to ensure that taxpayer dollars are spent appropriately on delivering accessible, quality, necessary care and preventing fraud, waste, and abuse. Both the federal and state agencies that oversee Medicaid are statutorily responsible for ensuring program integrity. In 2018, Ohio reported finding around $225 million in PBM spread in one year (and an additional $20 million in spread from other insurer/PBM subsidiaries), $208 million of which came from generic drugs (31.4% of gross generic cost).[vi] Kentucky reported similar findings in their audit with an overall spread of $124 million (13% gross drug cost) in one year despite

only 57.6% of all claims being transacted in a spread model.[vii] Maryland's audit found $72 million in spread, amounting to a sizable $6.96 per prescription.[viii] Lastly, Florida's analysis found $113 million in spread pricing.[ix]

These findings underscore growing concerns within Medicaid programs regarding the increasing difficulty in identifying spread pricing. This challenge is exacerbated by the prevalence of retrospective reconciliations across pharmacy payments, where the amount paid at the point of sale potentially differs from the net amount paid after reconciliation.[x] [xi]

States are keenly interested and remain committed to ensuring that payments within their programs accurately reflect payments to providers, aligning with their program integrity obligations. This commitment extends to the development of payment rates for MCOs, aiming to ensure prudent use of state funds and equitable reimbursement for healthcare services rendered, which is why transparent accounting of PBM business practices and right-sizing of compensation within public programs hold significant importance to state regulators.

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[i] Kirzinger, A., Montero, A., Sparks, G. et al. Public Opinion on Prescription Drugs and Their Prices. August 21, 2023. KFF. https://www.kff.org/health-costs/poll-finding/public-opinion-on-prescription-drugs-and-their-prices/
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[iv] Act No. 120; HB 941 https://legiscan.com/PA/text/HB941/id/2216330
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Appendix D MCO Subcontractor Checklist

The Pennsylvania Department of Human Services (DHS) created the following checklist that the managed care organizations (MCOs) are required to complete for new PBM contracts to ensure the MCO's contract with the new PBM complies with the Physical HealthChoices agreement for the Physical HealthChoices Medicaid Program.

MCOs are required to submit these reports upon contracting with a pharmacy benefit manager (PBM). At the time the original contract is submitted to DHS for approval, the full subcontract checklist in place at that time is completed, and a new checklist is not completed again unless the MCO contracts with a different PBM. See *Finding 2* regarding DHS' inadequate monitoring of PBM contracts.

Subcontractor Checklist

MCO shall complete the checklist indicating the location that the requirement is included or met.

Number	HealthChoices Agreement Reference	Requirement	Requirement Met?
All subcontracts			
1	Exhibit II, Section XIII Confidentiality	The specific activities and report responsibilities delegated to the subcontractor.	
2	Exhibit II, Section XIII Confidentiality	A provision for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	
3	Exhibit II, Section XIII Confidentiality	All subcontractors shall comply with all applicable requirements of the Agreement between the PH-MCO and the Department concerning the HealthChoices Program.	
4	Exhibit II, Section XIII Confidentiality	Meet the applicable requirements of 42 CFR Subsection 434.6.	
5	Exhibit II, Section XIII Confidentiality	Include nondiscrimination provisions.	
6	Exhibit II, Section XIII Confidentiality	Include the provisions of the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq).	

Number	HealthChoices Agreement Reference	Requirement	Requirement Met?
7	Exhibit II, Section XIII Confidentiality	Contain a provision in all subcontracts with any individual firm, corporation, or any other entity which provides medical services and receives reimbursement from the PH-MCO either directly or indirectly through capitation, that data for all services provided will be reported timely to the PH-MCO. Penalties and sanctions will be imposed for failure to comply. The data is to be included in the utilization and encounter data provided to the Department in the format.	
8	Exhibit II, Section XIII Confidentiality	Contain a provision in all subcontracts with any individual, firm, corporation, or any other entity which provides medical services to HealthChoices members, that the subcontractor will report all new third party resources to the PH-MCO identified through the provision of medical services, which previously did not appear on the Department's recipient information files provided to the PH-MCO.	
9	Exhibit II, Section XIII Confidentiality	Contain a hold harmless clause that stipulates that the PH-MCO subcontractor agrees to hold harmless the Commonwealth, all Commonwealth officers and employees, and all PH-MCO members in the event of nonpayment by the PH-MCO to the subcontractor. The subcontractor shall further indemnify and hold harmless the Commonwealth and their agents, officers and employees against all injuries, death, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against the Commonwealth or their agents, officers or employees, through the intentional conduct, negligence or omission of the subcontractor, its agents, officers, employees or the PH-MCO.	
10	Exhibit II, Section XIII Confidentiality	Contain a provision in all subcontracts that the subcontractor agrees to comply with all applicable Medicaid, federal and state laws and regulations; including sub-regulatory guidance.	
11	Exhibit II, Section XIII Confidentiality	Contain provisions in all subcontracts with any individual firm, corporation or any other entity which provides medical services to HealthChoices members, that prohibits gag clauses which limit the subcontractor from disclosure of medical necessary or appropriate health care information or alternate therapies to members, other health care professionals or the Department.	

Number	HealthChoices Agreement Reference	Requirement	Requirement Met?
12	Exhibit II, Section XIII Confidentiality	Contain provisions in all employee contracts prohibiting gag clauses which limit said employees from the disclosure of information pertaining to the HealthChoices Program.	
13	Exhibit II, Section XIII Confidentiality	Contain provisions in all subcontracts with any individual, firm, corporation or any other entity which provides medical services to HealthChoices members, that limits incentives to those permissible under the applicable Federal regulation.	
14	Exhibit II, Section XIII Confidentiality	Contain a provision in all subcontracts that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to Medical Assistance consumers.	
15	Exhibit II, Section XIII Confidentiality	Contain a provision that the PH-MCO and its subcontractor(s) must agree to maintain books and records relating to the HealthChoices Program services and expenditures, including reports to the Department and source information used in preparation of these reports. These records include but are not limited to financial statements, records relating to quality of care, medical records and prescription files.	
16	Exhibit II, Section XIII Confidentiality	Contain a provision that the PH-MCO and its subcontractor(s) must agree to comply with all standards for practice and medical records keeping specified by the Commonwealth.	

Number	HealthChoices Agreement Reference	Requirement	Requirement Met?
17	Exhibit II, Section XIII Confidentiality	Contain a provision that the PH-MCO and its subcontractor(s) and the subcontractor's contractor(s) shall, at their own expense, make all books, records, contracts, computers, or other electronic systems available for audit, review, evaluation or inspection by the Commonwealth, its designated representatives, CMS, the HHS Inspector General, the Comptroller General or their designees. Access must be granted either on-site, electronically or through the mail at the discretion of the reviewing entity. The right to audit exists for ten (10) years from the final date of the contract period; or from the date of completion of any audit, whichever is longer. The PH-MCO must fully cooperate with any and all reviews and/or audits by state or federal agencies or their agents, such as the Independent Assessment Contractor, by assuring that appropriate employees and involved parties are available for interviews relating to reviews or audits. All records to be sent by mail shall be sent to the requesting entity in the form of accurate, legible paper copies, unless otherwise indicated, within fifteen (15) calendar days of such request and at no expense to the requesting entity. Such requests made by the Commonwealth shall not be unreasonable	
18	Exhibit II, Section XIII Confidentiality	Requirement for subcontractor(s) must agree to retain the source records for its data reports for a minimum of seven years and must have written policies and procedures for storing this information.	
19	Exhibit II, Section XIII Confidentiality	A provision that subcontractor recognize that payments made to the subcontractor are derived from federal and state funds. Additionally, the PH-MCO shall require, as a written provision in all contracts for services rendered to Recipient, that the subcontractor shall be held civilly and/or criminally liable to both the PH-MCO and the Department, in the event of nonperformance, misrepresentation, fraud, or abuse. A clause notifying subcontractors of the prohibition and sanctions for the submission of false claims and statements.	
20	Exhibit II, Section XIII Confidentiality	A provision that subcontractor cooperate with Quality Management/Utilization Management Program requirements.	

Number	HealthChoices Agreement Reference	Requirement	Requirement Met?
Medical Services Subcontracts			
21	Section XII Subcontractual Relationships	A requirement for the submission of all Encounter Data for services provided within the time frames required in Section VIII, Reporting Requirements, no matter whether reimbursement for these services is made by the PH-MCO either directly or indirectly through capitation.	
22	Section XII Subcontractual Relationships	Language which ensures compliance with all applicable federal and state laws.	
23	Section XII Subcontractual Relationships	Language which prohibits gag clauses which would limit the subcontractor from disclosure of Medically Necessary or appropriate health care information or alternative therapies to Members, other Health Care Providers, or to the Department.	
24	Section XII Subcontractual Relationships	A requirement that ensures that the Department has ready access to any and all documents and records of transactions pertaining to the provision of services to Recipients.	
25	Section XII Subcontractual Relationships	The definition of Medically Necessary as outlined in Section II of this Agreement, Definitions. (Not included in above “All Subcontracts” checklist.)	
26	Section XII Subcontractual Relationships	The PH-MCO must ensure, when applicable, that its Subcontracts adhere to the standards for Network composition and adequacy. (Not included in above “All Subcontracts” checklist.)	
27	Section XII Subcontractual Relationships	The PH-MCO must ensure, when applicable, compliance with the requirements of Section V.B.1, General Prior Authorization Requirements for Subcontracts for utilization review services. (Not included in above “All Subcontracts” checklist.)	

Number	HealthChoices Agreement Reference	Requirement	Requirement Met?
28	Section XII Subcontractual Relationships	Contain a provision for a transition plan for Subcontracts with an entity to provide any information systems. This transition plan must include information on how the data, including all historical Claims and service data shall be converted and made available to a new Subcontractor. The PH-MCO must make all necessary revisions to its Subcontracts to be in compliance with the requirements set forth in Section XIII.A, Compliance with Program Standards. The PH-MCO must make revisions as contracts and Subcontracts become due for renewal provided that all contracts and Subcontracts are amended within one (1) year of execution of this Agreement with the exception of the Encounter Data requirements, which must be amended immediately, if necessary, to comply with Encounter Data to the PH-MCO within the time frames specified in Section VIII.B, Systems Reports. (Not included in above “All Subcontracts” checklist.)	

Appendix E Medical Loss Ratio

The Centers for Medicare and Medicaid Services (CMS) provides guidance on calculation and reporting standards for the Medical Loss Ratio (MLR).[72] The MLR is a key metric used in Medicaid managed care to calculate the amount of funding that was used for medical costs versus administrative costs spent by a managed care organization (MCO) or the MCO's third party vendors, like a PBM.[73]

The Pennsylvania Department of Human Services contracted with the MCOs effective January 1, 2022 and effective September 1, 2022 and required a MLR at or above 88 percent or the subsequent year's capitation rates are adjusted based on the following as outlined in the Appendix 3b of the MCO agreement titled: Medical Loss Ratio Reporting and Remittance Requirements:

D. Medical Loss Ratio (MLR) Reduction

> A reduction to revenue will be applied to Base Capitation Rates for [physical health] MCOs that have reported a total, inclusive of [sic] both the Newly Eligible and all other populations MLRs, MLR below 88 percent (88.00%) on the most recently submitted MLR Report, as required in Appendix 3h. The reduction applied will be based on the following schedule:
>
> - MLR below 85.00% will result in a 1.50% reduction
> - MLR greater than or equal to 85.00% but less than 86.00% will result in a 0.50% reduction
> - MLR greater than or equal to 86.00% but less than 87.00% will result in a 0.25% reduction
> - MLR greater than or equal to 87.00% but less than 88.00% will result in a 0.125% reduction

[72] See 42 CFR 438.8 for information regarding the MLR calculations.
[73] A transmission fee paid by a pharmacy to a PBM and retained by the PBM as another source of profit on its claims processing, is an administrative cost, and not a medical cost for purposes of calculating the MCO's MLR. Additionally, "states are responsible for ensuring that managed care plans are complying with these MLR requirements and should be routinely auditing reported data and MLR calculations to ensure that revenues, expenditures, and other amounts are appropriately identified…" according to CMS in its 2019 guidance at CIB: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors (medicaid.gov) (last accessed June 28, 2024).

The Department will apply the MLR Reduction, per the schedule above, based on the following calculation to determine the MLR Reduction Amount:

	Base Capitation Rate
MINUS	MCO Assessment Amount
MINUS	Provider Pay for Performance Amount
EQUALS	Amount Subject to MLR Reduction
MULTIPLIED BY	MLR Reduction Percentage
EQUALS	MLR Reduction Amount

The MLR Reduction Percentage, on the schedule above, is limited to a percentage that would result in Base Capitation Rates that are not lower than the lower bound Base Capitation Rates before Risk Adjustment as provided to the [physical health] MCOs in Section II.B above. If this limitation is necessary, [DHS] will notify the [physical health] MCO of the MLR Reduction Percentage that was used to determine the applicable Reduction Amount above.

Appendix F — PerformRx Test Results for a Selection of 60 Claims From its Claims Processing System

The following table illustrates our 60 drug claims tested for Objective 3 as stated in the *Introduction and Background* section to determine if PerformRx, LLC complied with 62 P.S. §449(h)(3) and (4) of the Human Services Code (as amended by Act 120 of 2020) regarding fees imposed on the pharmacies compared to the corresponding amounts billed to the applicable Physical HealthChoices managed care organizations and recorded on the Pennsylvania Department of Human Services' Provider Reimbursement and Operations Management Information System. (*See* PerformRx, LLC *Finding 3* for more information on this objective, our selection of claims, and test results.)

Item #	MCO	Plan Paid Amount	Payment Verified with Contract Terms	Paid, In-cycle, or Out-of-cycle Transaction	MCO Payment Agreed to PBM Payment to Pharmacy	Pharmacy Payment Agreed to PROMISe™
1	MCO1	$411.85	√	P	E-1	E-2
2	MCO1	$12,457.72	√	P	E-1	E-2
3	MCO1	$6,441.26	√	P	E-1	E-2
4	MCO1	$6.68	√	P	E-1	E-2
5	MCO1	$11,118.71	√	P	E-1	E-2
6	MCO1	$32.01	√	I	N/A	N/A
7	MCO1	$27.88	√	P	E-1	E-2
8	MCO1	$11,460.03	√	P	√	√
9	MCO1	$27.37	√	I	N/A	N/A
10	MCO1	$12,352.20	√	P	E-1	E-2
11	MCO1	$222.50	√	P	E-1	E-2
12	MCO1	$34.08	√	P	E-1	E-2
13	MCO1	$(73.44)	√	I	N/A	N/A
14	MCO1	$14.22	√	P	E-1	E-2
15	MCO1	$(1,279.50)	√	O	√	√
16	MCO1	$40.47	√	P	E-1	E-2
17	MCO1	$(6,024.15)	√	O	E-1	E-2

Item #	MCO	Plan Paid Amount	Payment Verified with Contract Terms	Paid, In-cycle, or Out-of-cycle Transaction	MCO Payment Agreed to PBM Payment to Pharmacy	Pharmacy Payment Agreed to PROMISe™
18	MCO1	$(15.41)	√	I	N/A	N/A
19	MCO1	$166.75	√	P	E-1	E-2
20	MCO1	$(40.00)	√	O	√	√
21	MCO2	$8.88	√	P	E-1	E-2
22	MCO2	$8.07	√	P	E-1	E-2
23	MCO2	$3.58	√	P	E-1	E-2
24	MCO2	$6.47	√	P	E-1	E-2
25	MCO2	$7.24	√	P	E-1	E-2
26	MCO2	$81.24	√	P	E-1	E-2
27	MCO2	$11.30	√	P	E-1	E-2
28	MCO2	$879.04	√	P	E-1	E-2
29	MCO2	$10.42	√	O	E-1	E-2
30	MCO2	$1,474.21	√	I	N/A	N/A
31	MCO2	$9.76	√	P	E-1	E-2
32	MCO2	$433.94	√	P	E-1	E-2
33	MCO2	$73.89	√	P	E-1	E-2
34	MCO2	$21.76	√	P	E-1	E-2
35	MCO2	$(553.43)	√	I	N/A	N/A
36	MCO2	$(996.00)	√	I	N/A	N/A
37	MCO2	$(760.30)	√	O	E-1	E-3
38	MCO2	$(12.68)	√	O	E-1	E-2
39	MCO2	$5,949.76	√	P	E-1	E-2
40	MCO2	$58.50	√	P	E-1	E-2
41	MCO3	$11.76	√	P	E-1	E-2
42	MCO3	$6.55	√	P	E-1	E-2
43	MCO3	$41.35	√	I	N/A	N/A
44	MCO3	$6.38	√	P	E-1	E-2
45	MCO3	$9.33	√	I	N/A	N/A

Item #	MCO	Plan Paid Amount	Payment Verified with Contract Terms	Paid, In-cycle, or Out-of-cycle Transaction	MCO Payment Agreed to PBM Payment to Pharmacy	Pharmacy Payment Agreed to PROMISe™
46	MCO3	$48.53	√	P	E-1	E-2
47	MCO3	$7.00	√	O	E-1	E-2
48	MCO3	$347.10	√	P	E-1	E-2
49	MCO3	$15.05	√	P	E-1	E-2
50	MCO3	$10,679.77	√	O	E-1	E-2
51	MCO3	$254.49	√	P	E-1	E-2
52	MCO3	$2,038.91	√	P	E-1	E-2
53	MCO3	$313.32	√	P	E-1	E-2
54	MCO3	$459.87	√	I	N/A	N/A
55	MCO3	$(76.72)	√	I	N/A	N/A
56	MCO3	$(7,573.59)	√	I	N/A	N/A
57	MCO3	$(398.09)	√	O	E-1	E-2
58	MCO3	$(12,457.72)	√	I	N/A	N/A
59	MCO3	$12.15	√	P	E-1	E-2
60	MCO3	$359.00	√	P	√	√

P Claim is a paid claim with no adjustments at the time the data was pulled from PerformRx's claims processing system.
O Out-of-cycle adjusted claim is a claim with an original claim paid and processed in one financial cycle with a subsequent claim in a different financial cycle to void the first transaction in the claims processing system and PROMISe™.
I In-cycle adjusted claim is a claim adjusted within the claims processing system in the same financial cycle, and therefore, there is no remittance advices or PROMISe™ encounter record. For these in-cycle adjusted claims, we confirmed there were no PROMISe™ encounter records and marked the procedures for payments N/A.
√ Audit step completed with no exceptions.
E-1 The claims detail from the claims processing system listed the MCO paid amount as more than the PBM paid amount on the remittance advice to the pharmacy due to a transmission fee charged.
E-2 The PBM remittance advice of amount paid to the pharmacy was less than the amount recorded on PROMISe™.
E-3 PROMISe™ did not show the reversing transaction as processed to net the original claim amount to zero. According to PerformRx, the claim was rejected by PROMISe™, and therefore, the reversal was not processed through in PROMISe™ which in turn overstated the encounter data.

Source: This table was created by the Pennsylvania Department of Auditor General staff using documentation provided by PerformRx and DHS.

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Pennsylvania House of Representatives

A Performance Audit

Pennsylvania Department of Human Services
PerformRx, LLC

Pharmacy Benefit Manager Services for the Physical HealthChoices Medicaid Program in Pennsylvania

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A Performance Audit

Pennsylvania Department of Human Services
PerformRx, LLC

Pharmacy Benefit Manager Services for the Physical HealthChoices Medicaid Program in Pennsylvania

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