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Performance Audit of the

Administration of Pharmacy Benefit Managers

May 17, 2023

Frank J. Mautino
Auditor General

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the performance audit of the Department of Healthcare and Family Services' administration of pharmacy benefit managers.

The audit was conducted pursuant to Senate Resolution Number 792. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Sections 3-14 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

Springfield, Illinois
May 2023

OFFICE OF THE AUDITOR GENERAL

May 17, 2023
Performance Audit
Report Highlights

Frank J. Mautino *Auditor General*
www.auditor.illinois.gov

Performance Audit of the

Administration of Pharmacy Benefit Managers

Background:

On April 9, 2022, the Illinois Senate adopted Senate Resolution Number 792, which directed the Office of the Auditor General to conduct a performance audit of the Department of Healthcare and Family Services' (HFS) administration of pharmacy benefit managers (PBMs) (See Appendix A). PBMs are contracted by Managed Care Organizations (MCOs) to be responsible for the purchasing and distribution of drugs under the plan. Subsequently, PBMs enter into contracts with individual pharmacies to provide prescription drugs and related products and services. Claims are generally filed at the point of sale at the pharmacy when the beneficiary fills the prescription, unlike the claims process for MCOs where claims are filed after the service occurs. PBMs are paid through the capitation rates given to MCOs, which are actuarially calculated; these payments cover pharmaceuticals as well as dispensing and administration fees. According to HFS, PBMs are under the dual oversight of the contracting MCO and HFS.

Key Findings:

- In calendar year 2021, HFS paid MCOs $16.2 billion in capitation payments, of which $2.64 billion was paid to PBMs. Of that, $2.55 billion went to individual pharmacies for covered drugs. HFS received $1.47 billion in drug rebates from pharmaceutical manufacturers.
- There is little monitoring being done of the PBMs by HFS. HFS did not have complete copies of contracts between the MCOs and the PBMs necessary to conduct monitoring of the contract provisions. HFS also does not monitor contracts between the PBMs and the pharmacies and, as such, is unaware of the rates paid to the pharmacies by the PBMs. There is no verification being conducted to ensure that the reimbursements to PBMs by MCOs are accurate and reflect the actual payments paid to the pharmacies. In addition, HFS does not monitor actual reimbursement rates or rebates. The entire monitoring function of the rates paid to pharmacies by PBMs is limited and based on self-reported, unaudited encounter data. As a result, HFS was unable to provide support for adequate monitoring of the PBMs.
- Illinois MCOs paid PBMs over $2.2 billion in calendar year 2020 for pharmacy services, and over $2.6 billion in calendar year 2021. The PBMs paid pharmacies $2.1 billion during calendar year 2020 and $2.5 billion during calendar year 2021. HFS's contracted actuary, Milliman, reviews encounter data and reimbursements; however, it does not audit or test self-reported data.
- MCOs were not in full compliance with all statutory requirements for their contracts with PBMs, and HFS does little to no monitoring to ensure that all requirements are met. Contracts between PBMs and pharmacies generally meet statutory requirements, but were missing many of the same provisions that were not in the MCO contracts.
- HFS was not engaging in monitoring practices of PBMs as mandated by the Illinois Public Aid Code (305 ILCS 5/5-36(c) through (j)) which establishes several provisions for monitoring PBMs under MCOs.
- Auditors also determined that HFS did not define "conflicts of interest" in administrative rule as required by 305 ILCS 5/5-36(d).
- Contractually negotiated reimbursement rates and administrative fees between MCOs and PBMs differ for each contract, which resulted in varying reimbursement rates that were difficult to review. Because of the varying reimbursement rates and administrative fees, auditors could not verify the amounts reported by HFS for claims paid or administrative expenses for each MCO or adequately review reimbursement practices.
- Auditors identified multiple affiliations between the MCOs, PBMs, and pharmacies that may impact the cost of the program and access to care for beneficiaries.

Key Recommendations:

The audit report contains five recommendations:

- HFS should ensure that contracts between MCOs and PBMs include the contractual requirements outlined in 215 ILCS 5/513b1 and 305 ILCS 5/5-30(h).
- HFS should provide more detailed monitoring of managed care organizations and their pharmacy benefit managers. Specifically, it should:
  - Report to the General Assembly on an annual basis as required by 305 ILCS 5/5-36(c);
  - Request and monitor PBM information as allowed and required by 305 ILCS 5/5-36(e),(g), and (h); and
  - Review and approve dispute resolution processes provided by PBMs as required by 305 ILCS 5/5-36(j).
- HFS should define "conflict of interest" in administrative rules as required by 305 ILCS 5/5-36(d).
- HFS should monitor reimbursement rates between managed care organizations and their pharmacy benefit managers, as required by the Illinois Public Aid Code.
- HFS should address affiliations between MCOs, PBMs, and pharmacies when it defines conflict of interest in the Administrative Code as required by 305 ILCS 5/5-36(d).

This performance audit was conducted by the staff of the Office of the Auditor General.

Report Digest

On April 9, 2022, the Illinois Senate adopted Senate Resolution Number 792 (see Appendix A), which directed the Office of the Auditor General to conduct a performance audit of the Department of Healthcare and Family Services' (HFS) administration of pharmacy benefit managers (PBMs). Our assessment of the audit determinations is shown in **Digest Exhibit 1**. (pages 1-2)

Digest Exhibit 1
ASSESSMENT OF AUDIT DETERMINATIONS

Determination from Audit Resolution	Auditor Assessment
The amount of State and federal funds used by managed care organizations to reimburse pharmacy benefit managers and, in time, the amount paid by pharmacy benefit managers to reimburse pharmacies for fiscal years 2020 and 2021. (HFS officials requested that the audit period be changed to calendar years, which was granted.)	• Illinois MCOs paid PBMs over $2.2 billion in calendar year 2020 for pharmacy services, and over $2.6 billion in calendar year 2021. The PBMs paid pharmacies over $2 billion during calendar year 2020 and $2.5 billion during calendar year 2021. The Department of Healthcare and Family Services' contracted actuary, Milliman, reviews encounter data and reimbursements; however, it does not audit or test self-reported data. (pages 13-15)
An examination of contracts between managed care organizations and pharmacy benefit managers and between pharmacy benefit managers and pharmacies receiving reimbursement.	• MCOs were not in full compliance with all statutory requirements for their contracts with PBMs, and HFS does little to no monitoring to ensure that all requirements are met. Contracts between PBMs and pharmacies generally meet statutory requirements, but were missing many of the same provisions that were not in the MCO contracts. (pages 16-21)
The level of oversight the Department of Healthcare and Family Services provides over the contracts and over the pharmacy benefit managers to ensure compliance with contract requirements.	• There was little monitoring being done of the PBMs by HFS. HFS did not have complete copies of contracts between the MCOs and the PBMs necessary to conduct monitoring of the contract provisions. HFS also does not monitor contracts between the PBMs and the pharmacies and, as such, is unaware of the rates paid to the pharmacies by the PBMs. There is no verification being conducted to ensure that the reimbursements to PBMs by MCOs are accurate and reflect the actual payments paid to the pharmacies. HFS did not provide the required annual report to the General Assembly, did not define "conflicts of interest" in administrative rule, and did not monitor various provisions found in 305 ILCS 5/5-36. (pages 22-27)
An overview of the distribution of and payments for pharmaceuticals in the medical assistance managed care program.	• In calendar year 2021, HFS paid MCOs $16.2 billion in capitation payments, of which $2.64 billion was paid to PBMs. Of that, $2.55 billion went to individual pharmacies for covered drugs. HFS received $1.47 billion in drug rebates from pharmaceutical manufacturers. (pages 10-12)

A review of the reimbursement practices and reimbursement rates of managed care organizations to pharmacy benefit managers.	• Contractually, each MCO sets maximum amounts it will reimburse its PBM for drugs and dispensing fees the PBM pays pharmacies; in most cases this is a percentage of the Average Wholesale Price of drugs. The contracts require the amounts paid to the PBMs to be "pass-through" funding, meaning that an MCO will only reimburse for the amount that the PBM actually paid the pharmacy. Administrative fees also differ by PBM contract. Some PBMs were paid per claim or on a per member per month basis; one was paid a combination of per claim and per member per month. Another was paid on a simple dollar amount basis. The reimbursement and administrative fee methodologies and actual amounts that were paid are considered proprietary and confidential information, so they are not listed in the audit. Because of the varying reimbursement rates and administrative fees, auditors could not verify the amounts reported by HFS for claims paid or administrative expenses for each MCO or adequately review reimbursement practices. (pages 41-47)
A *review of the reimbursement practices and reimbursement rates of pharmacy benefit managers to pharmacies, including out-of-state pharmacies and pharmacies affiliated with pharmacy benefit managers.*	• Reimbursements between the PBMs and pharmacies are contractually negotiated and may differ between individual pharmacies. None of the rate descriptions examined specifically discussed different payment structures for affiliated or out-of-state pharmacies. Auditors identified multiple affiliations between the MCOs, PBMs, and pharmacies that may impact the cost of the program and access to care for beneficiaries. Auditors discussed mail-order pharmacies with the PBMs and all PBMs noted that reimbursements for mail-order pharmacies tend to be less than the reimbursements for retail pharmacies. (pages 41-47)

Source: OAG assessment of the audit determinations contained in Senate Resolution Number 792.

Background

The Department of Healthcare and Family Services administers the medical assistance program most commonly known as Medicaid. This program is paid for by both State and federal government funds and provides health care coverage to Illinois' vulnerable populations.

Medicaid utilizes managed care programs to provide medical benefits for eligible individuals. The objective of these programs is to provide enhanced health care coordination and quality services at a sustainable cost. These programs are administered by managed care organizations (MCOs), who are contracted by HFS.

MCOs are responsible, under contract with HFS, for maintaining networks of providers which are sufficient to cover the individuals assigned to them and in

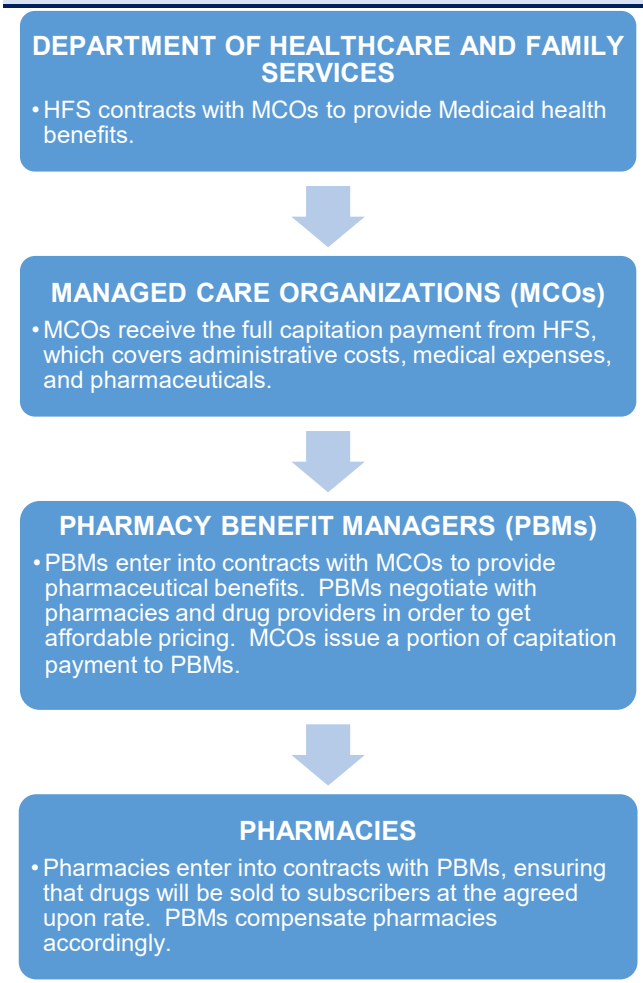
compliance with State and federal Medicaid regulations. HFS requires MCOs to offer at least the same set of services available to the fee-for-service population.

HFS is responsible for providing oversight of MCOs as well as other entities within managed care programs. PBMs are responsible for the purchasing and distribution of pharmaceutical drugs covered under the managed care plans and are the focus of Senate Resolution Number792. (page 2)

Pharmacy Benefit Managers

PBMs are companies that manage prescription drug benefits on behalf of Illinois' managed care programs, which includes providing claims processing services and other prescription drug services. PBMs are not exclusive to MCOs, but Senate Resolution Number 792 requires the Auditor General to look at PBMs that are contracting specifically with MCOs.

Digest Exhibit 2
PBM FUNDING PROCESS



Source: Documentation provided by the Department of Healthcare and Family Services.

According to HFS, PBMs are contracted by MCOs to be responsible for the purchasing and distribution of drugs under the plan. Subsequently, PBMs enter into contracts with individual pharmacies to provide prescription drugs and related products and services. Claims are generally filed at the point of sale at the pharmacy when the beneficiary fills the prescription, unlike the claims process for MCOs where claims are filed after the service occurs. The pharmacy requires each person to verify eligibility. PBMs are paid through the capitation rates given to MCOs, which are actuarially calculated; these payments cover pharmaceuticals as well as dispensing and administration fees. According to HFS, PBMs are under the dual oversight of the contracting MCO and HFS.

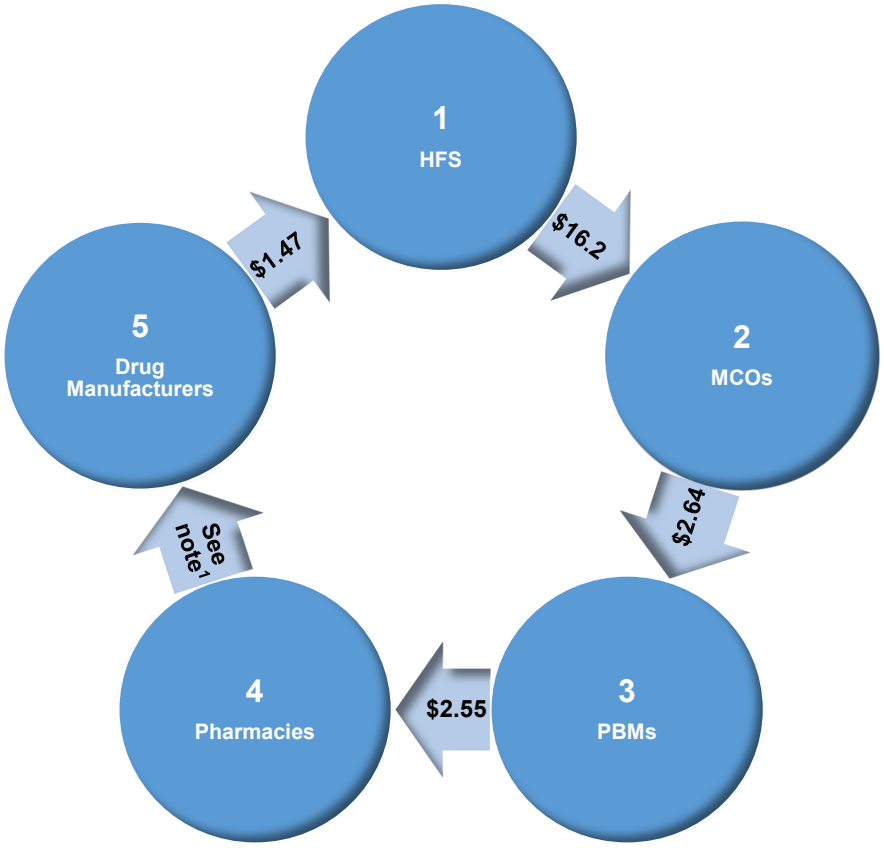
Digest Exhibit 2 flowcharts the PBM funding process. All MCOs in the State subcontract with at least one PBM. For instance, Aetna subcontracts with CVS Caremark as its PBM. Other PBMs may be subcontracted for long-term care or specialty drugs. Furthermore, MCOs might also own the PBM or pharmacy with which they contract; for instance, in the case of Aetna, it was acquired by CVS, which owns CVS Caremark. (page 9)

Pharmaceutical Distribution and Payments

Senate Resolution Number 792 asked auditors to provide an overview of the distribution of and payments for pharmaceuticals in the medical assistance managed care program. In calendar year 2021, HFS paid MCOs $16.2 billion in capitation payments, of which $2.64 billion was paid to PBMs. Of that, $2.55 billion went to individual pharmacies for covered drugs. HFS received $1.47 billion in drug rebates from pharmaceutical manufacturers.

These payments are shown in **Digest Exhibit 3**. According to HFS, it has no way to track its payments from pharmacies to manufacturers. HFS noted that it is "an arrangement between a private business (the pharmacy) and the manufacturer." Therefore, HFS did not know or monitor how much pharmacies paid drug manufacturers. (pages 10-12)

Digest Exhibit 3
DISTRIBUTION OF PAYMENTS FROM HFS FOR PHARMACEUTICALS UNDER MANAGED CARE FOR CALENDAR YEAR 2021
Payments in Billions



Note: [1] According to HFS, it has no way to track its payments from pharmacies to manufacturers. HFS noted that it is "an arrangement between a private business (the pharmacy) and the manufacturer." Therefore, HFS did not know or monitor how much pharmacies paid drug manufacturers.

Source: Documentation provided by the Department of Healthcare and Family Services.

State and Federal Funds and Reimbursements

Senate Resolution Number 792 asked auditors to review the amount of State and federal funds used by MCOs to reimburse PBMs and, in time, the amount paid by PBMs to reimburse pharmacies for fiscal years 2020 and 2021. HFS officials requested that the audit period be changed to calendar years, which was granted. In order to review these payments, auditors requested and reviewed payment information and monitoring documents.

Illinois MCOs paid PBMs over $2.2 billion in calendar year 2020 for pharmacy services, and over $2.6 billion in calendar year 2021. The PBMs paid pharmacies $2.1 billion during calendar year 2020 and $2.5 billion during calendar year 2021. HFS's contracted actuary, Milliman, reviews encounter data and reimbursements; however, it does not audit or test self-reported data.

Digest Exhibit 4 shows all MCO contractors for calendar years 2020 through 2021, their respective PBM subcontractors, and the total amount paid to each. MeridianRX and Prime Therapeutics, the PBM subcontractors for Meridian Health and Blue Cross Blue Shield, were paid the most over these two years. In total for calendar years 2020 and 2021, HFS through MCOs paid a total of over $4.8 billion to all PBM subcontractors. (pages 13-15)

Digest Exhibit 4
PAYMENTS TO PHARMACY BENEFIT MANAGERS
Calendar Year 2020 and Calendar Year 2021

CALENDAR YEAR 2020			
MCO Name	**PBM Name**	**Paid to PBM**	**Paid to Pharmacies**
Aetna	Envolve Pharmacy Solutions	$358,000,000	$335,700,000
Aetna	CVS Caremark	27,700,000	26,400,000
Blue Cross Blue Shield	Prime Therapeutics, LLC	500,300,000	484,900,000
CountyCare	MedImpact	378,500,000	362,900,000
Meridian Health	MeridianRX	705,100,000	640,000,000
Meridian YouthCare	Envolve Pharmacy Solutions	18,300,000	15,900,000
Molina	CVS Caremark	200,500,000	199,700,000
NextLevel	Envolve Pharmacy Solutions	13,500,000	13,500,000
CY20 Totals		**$2,201,900,000**	**$2,079,000,000**
CALENDAR YEAR 2021			
MCO Name	**PBM Name**	**Paid to PBM**	**Paid to Pharmacies**
Aetna	CVS Caremark	$434,900,000	$418,100,000
Blue Cross Blue Shield	Prime Therapeutics, LLC	625,800,000	606,500,000
CountyCare	MedImpact	457,800,000	445,200,000
Meridian Health	MeridianRX	789,900,000	757,700,000
Meridian YouthCare	Envolve Pharmacy Solutions	30,600,000	28,400,000
Molina	CVS Caremark	296,600,000	291,400,000
CY21 Totals		**$2,635,600,000**	**$2,547,300,000**

Note: Limitations noted by Milliman: "*Milliman has developed certain models to estimate the values included in this correspondence. The purpose of the models is to evaluate the health plan reported financial data. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose. The models rely on data and information as input to the models. We have relied upon certain data and information provided by HFS for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this correspondence may likewise be inaccurate or incomplete. Milliman's data and information reliance includes MCO-reported eligibility and financial experience, as well as information related to HFS' eligibility system and assignment of enrollees to rate cells. The models, including all input, calculations, and output may not be appropriate for any other purpose.*"

Source: Evaluated by Milliman, and provided by the Department of Healthcare and Family Services.

Contracts

Senate Resolution Number 792 asked auditors to examine contracts between MCOs and PBMs. Auditors received these contracts and their amendments between all five MCOs and their PBMs, and reviewed them for compliance with statutory requirements.

MCOs were not in full compliance with all statutory requirements for their contracts with PBMs, and HFS does little to no monitoring to ensure that all requirements are met. Contracts between PBMs and pharmacies generally meet statutory requirements, but were missing many of the same provisions that were not in the MCO contracts.

Auditors reviewed the contracts between MCOs and PBMs for requirements found in the Illinois Insurance Code. Our review found that the Aetna and Molina

contracts, whose PBM is CVS Caremark, were in compliance with all 13 statutory requirements reviewed. The other four contracts were missing six or more of the required contractual provisions. For example, the Meridian contracts, whose PBMs are MeridianRX and Envolve, were missing 12 of the 13 required contractual provisions.

Auditors recommended HFS should ensure that contracts between MCOs and PBMs include the contractual requirements outlined in 215 ILCS 5/513b1 and 305 ILCS 5/5-30(h). (pages 16-21)

HFS Oversight of Contracts and PBMs

Senate Resolution Number 792 asked auditors to review the level of oversight HFS provides over the contracts and over PBMs to ensure compliance with contract requirements.

Based on information provided to auditors, there is little monitoring being done of the PBMs by HFS. HFS did not have complete copies of contracts between the MCOS and the PBMs necessary to conduct monitoring of the contract provisions. HFS also does not monitor contracts between the PBMs and the pharmacies and, as such, is unaware of the rates paid to the pharmacies by the PBMs. There is no verification being conducted to ensure that the reimbursements to PBMs by MCOs are accurate and reflect the actual payments paid to the pharmacies. In addition, HFS does not monitor actual reimbursement rates or rebates. The entire monitoring function of the rates paid to pharmacies by PBMs is limited and based on self-reported, unaudited encounter data. As a result, HFS was unable to provide support for adequate monitoring of the PBMs.

Also, auditors found that HFS was not engaging in monitoring practices of PBMs as mandated by the Illinois Public Aid Code (305 ILCS 5/5-36(c) through (j)) which establishes several provisions for monitoring PBMs under MCOs.

Auditors recommended HFS should provide more detailed monitoring of managed care organizations and their pharmacy benefit managers. Specifically, it should:

- Report to the General Assembly on an annual basis as required by 305 ILCS 5/5-36(c);
- Request and monitor PBM information as allowed and required by 305 ILCS 5/5-36(e),(g), and (h); and
- Review and approve dispute resolution processes provided by PBMs as required by 305 ILCS 5/5-36(j).

Auditors also determined that HFS did not define "conflicts of interest" in administrative rule as required by 305 ILCS 5/5-36(d).

Auditors recommended HFS should define "conflict of interest" in administrative rules as required by 305 ILCS 5/5-36(d). (pages 22-27)

Federal Trade Commission Investigation Comments and Audits/Investigations of PBMs by Other States

HFS was not aware of a Federal Trade Commission (FTC) investigation into PBMs. Auditors reviewed complaints made to the FTC and audits conducted in other states to determine issues identified related to the monitoring of PBMs. Auditors questioned HFS regarding these complaints and findings and determined that in many instances, HFS was either unaware of the issue or was not conducting any monitoring related to the issue. (pages 28-40)

Reimbursement Practices and Rates

Senate Resolution Number 792 asked auditors to review the reimbursement practices and reimbursement rates of MCOs to PBMs. It also asked auditors to review the same between PBMs and pharmacies, including out-of-state pharmacies and pharmacies affiliated with PBMs.

Contractually negotiated reimbursement rates and administrative fees between MCOs and PBMs differ for each contract, which resulted in varying reimbursement rates that were difficult to review. Contractually, each MCO sets maximum amounts it will reimburse its PBM for drugs and dispensing fees the PBM pays pharmacies; in most cases this is a percentage of the Average Wholesale Price of drugs. However, this percentage is usually based on a period of time, such as a year, not based on individual drugs or prescriptions dispensed. The contracts require the amounts paid to the PBMs to be "pass-through" funding, meaning that an MCO will only reimburse for the amount that the PBM actually paid the pharmacy. Administrative fees also differ by PBM contract. Some PBMs were paid per claim or on a per member per month basis; one was paid a combination of per claim and per member per month. Another was paid on a simple dollar amount basis. The reimbursement and administrative fee methodologies and actual amounts that were paid are considered proprietary and confidential information, so they are not listed in the audit. Because of the varying reimbursement rates and administrative fees, auditors could not verify the amounts reported by HFS for claims paid or administrative expenses for each MCO or adequately review reimbursement practices.

Reimbursement Price Example

The average cost for a 30 day supply of Fluticasone SPR 50 MCG for all pharmacies ranged between $1.23 per day to $0.23 per day depending on the PBM. The overall average cost was $0.45. The average costs also differed between individual pharmacies. The highest was $1.36 per day and the lowest was $0.06 per day.

In order to further review these rates, auditors analyzed encounter data from October 1 through 7, 2021. During the review of encounter data, auditors determined that the reimbursements were so complicated that the data could not be used to review reimbursement practices. Auditors determined that reimbursements for drugs varied by PBM, by pharmacy, and for each drug. Encounter data showed that pharmacies were paid different prices for the same drug depending on the PBM. The data also showed each PBM paid its contracted pharmacies differently for the same drug. Officials from the PBMs gave

several reasons why reimbursements might vary, and HFS does not monitor either reimbursement rates or administrative fees.

Senate Resolution Number 792 asked auditors to review reimbursement practices and rates for out-of-state pharmacies and pharmacies affiliated with PBMs. HFS officials speculated that "out-of-state" pharmacies referred to mail-order or online prescriptions from out-of-state affiliated pharmacies, not beneficiaries in border towns receiving medicine in another state. When auditors asked HFS officials about out-of-state pharmacies, officials noted that it was not an area HFS examined. HFS officials also noted that out-of-state pharmacies would have to be licensed. According to the contracts between the MCOs and the PBMs, rates paid for mail-order or online pharmacies are less than for retail pharmacies. Auditors discussed mail-order pharmacies with the PBMs and all PBMs noted that reimbursements for mail-order pharmacies tend to be less than the reimbursements for retail pharmacies.

The Illinois Public Aid Code requires HFS to monitor and enforce compliance by MCOs with agreements they have entered into with providers on issues that include, among other things, payments and payment rates (305 ILCS 5/5-30(h-5)). Since HFS does not monitor reimbursement rates, it cannot determine if contracts are cost-efficient to the State.

Auditors recommended HFS should monitor reimbursement rates between managed care organizations and their pharmacy benefit managers, as required by the Illinois Public Aid Code. (pages 41-44)

Affiliations

Auditors identified multiple affiliations between the MCOs, PBMs, and pharmacies that may impact the cost of the program and access to care for beneficiaries. Auditors found the following affiliations:

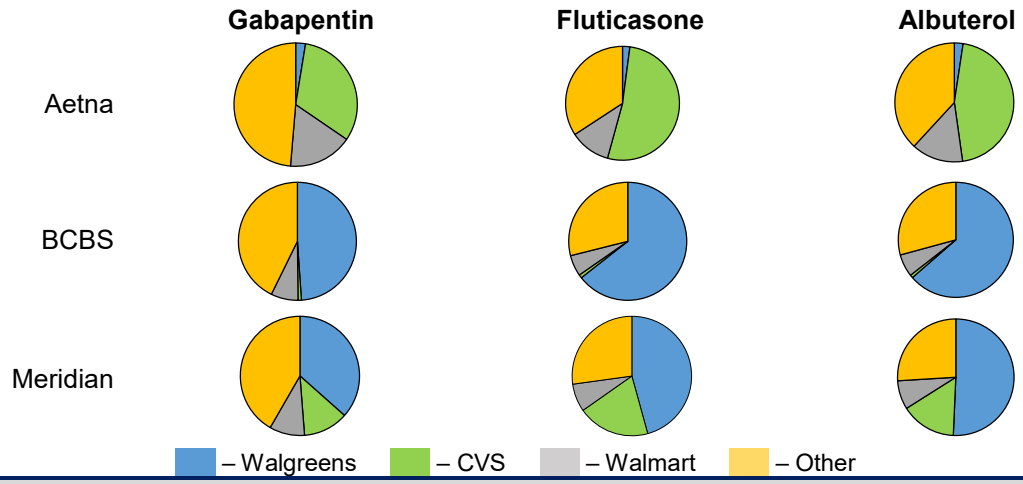
- **Aetna** - In November 2018, CVS acquired Aetna. CVS Caremark serves as the PBM for Aetna. As disclosed by Aetna, it is affiliated with the PBM (Caremark) and CVS network pharmacies.
- **Blue Cross Blue Shield** - Prime Therapeutics serves as the PBM for Blue Cross Blue Shield, which the MCO partially owned. AllianceRx Walgreens Prime served as a partnership between the PBM and Walgreens, but has ceased as of 2022. Although there is no longer an ownership affiliation, Prime has a contractual affiliation with Walgreens.
- **CountyCare** - The MCO is contracted with MedImpact as its PBM, with MedImpact Direct as "a non-dispensing mail order pharmacy." MedImpact does not own any of the network pharmacies, but some pharmacies are owned by Cook County Health, which also owns CountyCare.
- **Meridian** - The MCO, as well as its PBM (MeridianRx), are both owned by Centene. Meridian also provides services for YouthCare, with Envolve serving as its PBM. Envolve is also owned by Centene.

- **Molina** - CVS Caremark serves as the PBM for Molina. As stated previously, CVS Caremark has its own network of affiliated pharmacies.

In FTC comments reviewed by auditors, complainants allege that affiliations can lead to patient steering, in which PBMs steer beneficiaries to their own pharmacies. This is done by either requiring drugs to be dispensed through their own pharmacies or making drugs cheaper at their own pharmacies. Complainants further allege that PBMs may require drugs to be dispensed through a mail-order pharmacy which cuts off beneficiaries from preferred pharmacists that can advise them on their drug regimen and can create barriers to medications.

Auditors reviewed the encounter data to check for evidence of affiliations. Auditors took three drugs from the top ten drugs prescribed for the week ending October 7, 2021, and reviewed how many of these prescriptions were filled by MCO and pharmacy. The results are shown in **Digest Exhibit 5**.

Digest Exhibit 5
PRESCRIPTIONS FILLED BY PHARMACY THROUGH AETNA, BCBS, AND MERIDIAN
October 1 through 7, 2021



Source: Department of Healthcare and Family Services encounter data.

Aetna had very few prescriptions filled at Walgreens, while its affiliated pharmacy, CVS, distributed most of the prescriptions filled by Aetna customers. The opposite was true for Blue Cross Blue Shield, which filled most of its prescriptions through Walgreens, and very few through CVS. When auditors looked into why this occurred, it was determined that Walgreens had a contractual relationship with Prime (PBM for Blue Cross) while Caremark (PBM for Aetna) is owned by CVS. Caremark dropped Walgreens from its provider network in December 2020, which was likely due to its affiliation.

Auditors recommended HFS should address affiliations between MCOs, PBMs, and pharmacies when it defines conflict of interest in the Administrative Code as required by 305 ILCS 5/5-36(d). (pages 44-47)

Audit Recommendations

The audit report contains five recommendations directed to the Department of Healthcare and Family Services. The Department generally agreed with the recommendations. The complete response from the Department is included in this report as Appendix C.

This performance audit was conducted by staff of the Office of the Auditor General.

SIGNED ORIGINAL ON FILE

JOE BUTCHER
Division Director

This report is transmitted in accordance with Sections 3-14 and 3-15 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

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Contents

Recommendations

Introduction

On April 9, 2022, the Illinois Senate adopted Senate Resolution Number 792 (see Appendix A), which directed the Office of the Auditor General to conduct a performance audit of the Department of Healthcare and Family Services' (HFS) administration of pharmacy benefit managers (PBMs). The audit was to specifically include, but not be limited to, the following determinations:

1. The amount of State and federal funds used by managed care organizations to reimburse pharmacy benefit managers and, in time, the amount paid by pharmacy benefit managers to reimburse pharmacies for fiscal years 2020 and 2021;
2. An examination of contracts between managed care organizations and pharmacy benefit managers and between pharmacy benefit managers and pharmacies receiving reimbursement;
3. The level of oversight the Department of Healthcare and Family Services provides over the contracts and over the pharmacy benefit managers to ensure compliance with contract requirements;
4. An overview of the distribution of and payments for pharmaceuticals in the medical assistance managed care program;
5. A review of the reimbursement practices and reimbursement rates of managed care organizations to pharmacy benefit managers; and
6. A review of the reimbursement practices and reimbursement rates of pharmacy benefit managers to pharmacies, including out-of-state pharmacies and pharmacies affiliated with pharmacy benefit managers.

Background

According to the Department of Healthcare and Family Services, it administers the medical assistance programs most commonly known as Medicaid and the State Children's Health Insurance Program. These programs are paid for by both State and federal government funds and provide health care coverage to Illinois' vulnerable populations.

The Division of Medical Programs within HFS provides healthcare plans that offer a broad array of services as well as plans designated to a specific demographic. The majority of eligible persons are enrolled in either:

- **Medical Assistance**, as authorized under the Illinois Public Aid Code (305 ILCS 5/5 et seq.) and Title XIX of the Social Security Act, Medicaid; or
- **Children's Health Insurance**, as authorized under the Illinois Insurance Code (215 ILCS 106/1 et seq.) and Title XXI of the Social Security Act, the State Children's Health Insurance Program.

Medical Assistance, or Medicaid, utilizes managed care programs to provide medical benefits for eligible individuals. The objective of these programs is to provide enhanced health care coordination and quality services at a sustainable cost. These programs are administered by managed care organizations (MCOs), who are contracted by HFS.

MCOs are responsible, under contract with HFS, for maintaining networks of providers which are sufficient to cover the individuals assigned to them and in compliance with State and federal Medicaid regulations. HFS requires MCOs to offer at least the same set of services available to the fee-for-service population.

HFS is responsible for providing oversight of MCO contracts and the Illinois Department of Insurance regulates MCOs overall. PBMs are responsible for the purchasing of pharmaceutical drugs covered under the managed care plans and are the focus of Senate Resolution Number 792.

Pharmacy Services

Under the guidance of the federal Medicaid law, HFS and contracted MCOs offer coverage of prescription and certain over-the-counter drugs produced by companies holding rebate agreements with the federal Centers for Medicare and Medicaid Services. HFS develops and maintains a Preferred Drug List (PDL) that contains covered prescription medications based on clinical efficacy, safety, and cost effectiveness. According to HFS, the PDL also helps implement supplemental rebates at the State level that drive deeper discounts/revenues for the program. HFS requires MCOs to cover drugs manufactured by companies who participate in the federal Medicaid drug rebate program and to follow a universal PDL program. The Department also negotiates and contracts for supplemental drug rebates directly with drug manufacturers through the Preferred Drug List process; these rebates are above and beyond rebates provided under the federal drug rebate program.

Increase in Medical Coverage for Individuals in Illinois

In fiscal year 2021, more than 3.4 million individuals were enrolled in health care programs provided by HFS. This is an increase from approximately 2.9 million in fiscal year 2019 and 3.1 million in fiscal year 2020. According to HFS, it now provides medical coverage to approximately 25 percent of the State's population. Exhibit 1 shows the changes in Medical Program enrollment for fiscal years 2019 through 2021.

Exhibit 1
ENROLLMENT IN ILLINOIS' HEALTH CARE PROGRAMS PROVIDED BY HFS

	Fiscal Year 2019	Fiscal Year 2020	Fiscal Year 2021
Children	1,338,234	1,406,402	1,465,904
Adults with Disabilities	254,741	253,204	252,650
ACA Newly Eligible Adults[1]	570,551	641,711	774,007
Other Adults	498,238	523,468	640,548
Seniors	217,220	230,270	260,929
Partial Benefit Enrollees	43,213	46,984	46,467
Totals	**2,922,197**	**3,102,039**	**3,440,505**

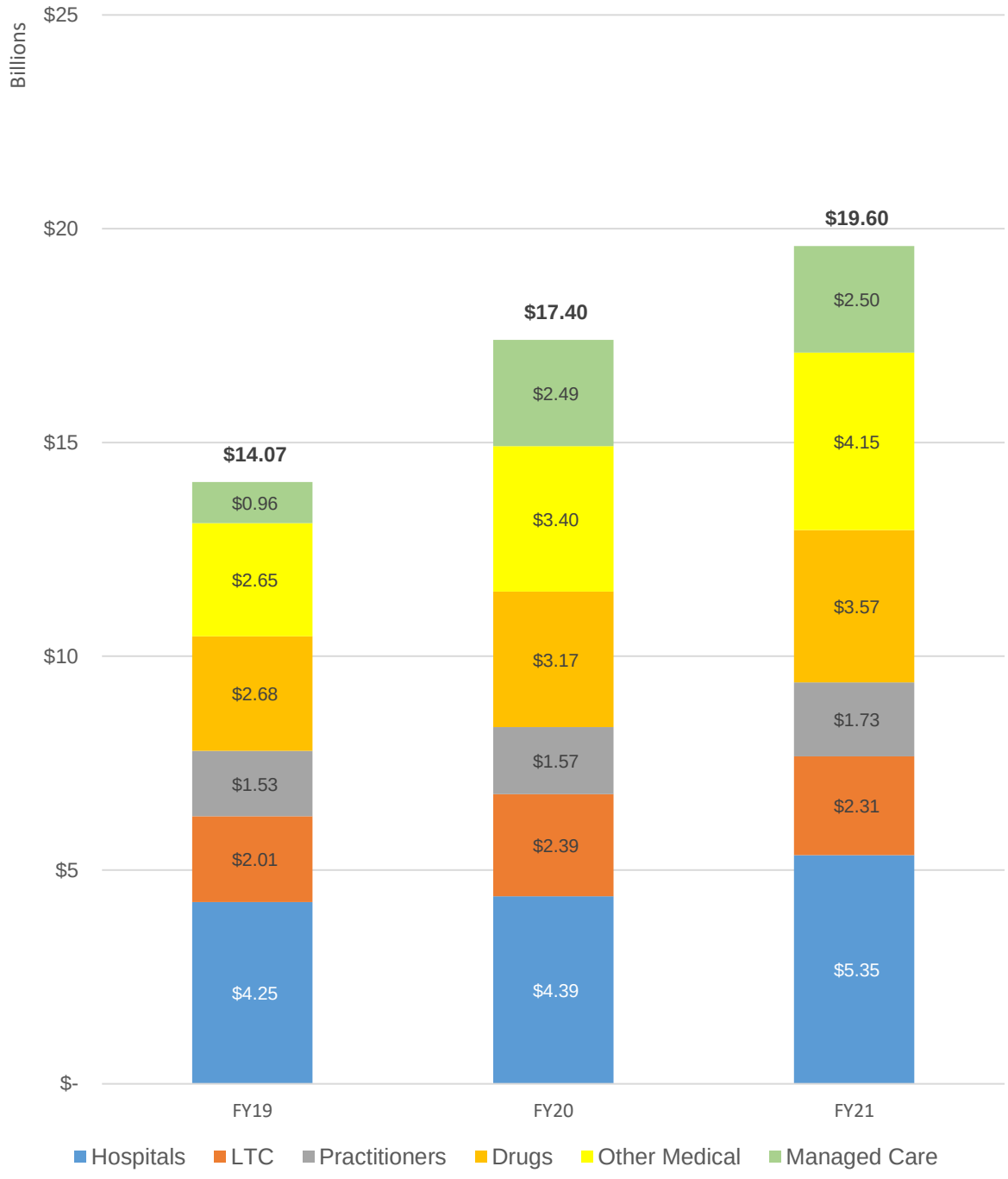
Note: [1] Adults added per the Affordable Care Act.

Source: Illinois Department of Healthcare and Family Services' 2021 Annual Report.

Cost of Medical Programs in Illinois

According to HFS, it spent almost $19.6 billion in General Revenue Fund related funds on health benefits and related services in fiscal year 2021. In total, HFS spent approximately $26.3 billion from all funds. The payments to managed care organizations increased from approximately $960 million in fiscal year 2019 to $2.8 billion in fiscal year 2021. Exhibit 2 shows the General Revenue Fund expenditures related to medical programs for fiscal years 2019, 2020, and 2021.

Exhibit 2
GENERAL REVENUE FUND EXPENDITURES RELATED TO MEDICAL PROGRAMS IN ILLINOIS
In Billions for Fiscal Years 2019, 2020, and 2021



Source: Department of Healthcare and Family Services data and its 2022 Annual Report.

Managed Care vs Fee-for-Service

HFS reimburses Medicaid providers using two methods: fee-for-service and managed care. Under fee-for-service, a fee is charged by medical providers directly to HFS for each encounter or service rendered. In 2011, the State began shifting its method of providing for medical services from fee-for-service arrangements to managed care as required by 305 ILCS 5/5-30. Under managed care, HFS makes fixed payments called capitation payments to MCOs for the cost of care for recipients enrolled in the program and for administrative costs for the MCO. According to HFS, the MCOs are at risk for the total cost of care. Exhibit 3 shows how much HFS has paid for managed care and fee-for-service programs for fiscal years 2019, 2020, and 2021.

Exhibit 3
MEDICAL ASSISTANCE PROGRAM EXPENDITURES
For Fiscal Year 2019 through Fiscal Year 2021

Medical Assistance Program	FY19 Expenditures		FY20 Expenditures		FY21 Expenditures	
	$	%	$	%	$	%
Managed Care	9,603,826,500	68.2	12,961,999,500	74.5	15,521,031,500	79.2
Fee-for-Service	4,469,292,500	31.8	4,441,053,300	25.5	4,075,728,200	20.8
Totals	**14,073,119,000**		**17,403,052,800**		**19,596,759,700**	

Source: Illinois Department of Healthcare and Family Services' 2021 Annual Report.

Managed Care Organizations and Pharmacy Benefit Managers

The Department of Healthcare and Family Services' Division of Medical Programs is responsible for providing healthcare coverage for adults and children who qualify for Medicaid. The mission of HFS is to work together to help Illinoisans access high quality health care and fulfill child support obligations to advance their physical, mental, and financial well-being. HFS accomplishes this primarily through the use of MCOs and PBMs, which are described in greater detail below.

Managed Care Organizations

The delivery of Medicaid health benefits is primarily provided through contractual agreements between HFS and MCOs, which are paid through capitation payments. An MCO is defined as an entity that has, or is seeking to qualify for, a comprehensive risk contract with HFS to provide covered services under the HFS Medical Program.

In 2018, HFS expanded the managed care program to cover every county in the State. There are two programs that cover the State: HealthChoice Illinois and Medicare-Medicaid Alignment Initiative. Under these two programs, MCOs are contracted to deliver Medicaid benefits.

MCO Programs

HealthChoice Illinois – Statewide program that includes children and their parents, Affordable Care Act (ACA) adults, seniors and persons with disabilities, special needs children, Youth in Care, former Youth in Care, and dual eligible adults age 21 and over, who receive long-term services and supports (LTSS) and have opted out of the Medicare-Medicaid Alignment Initiative.

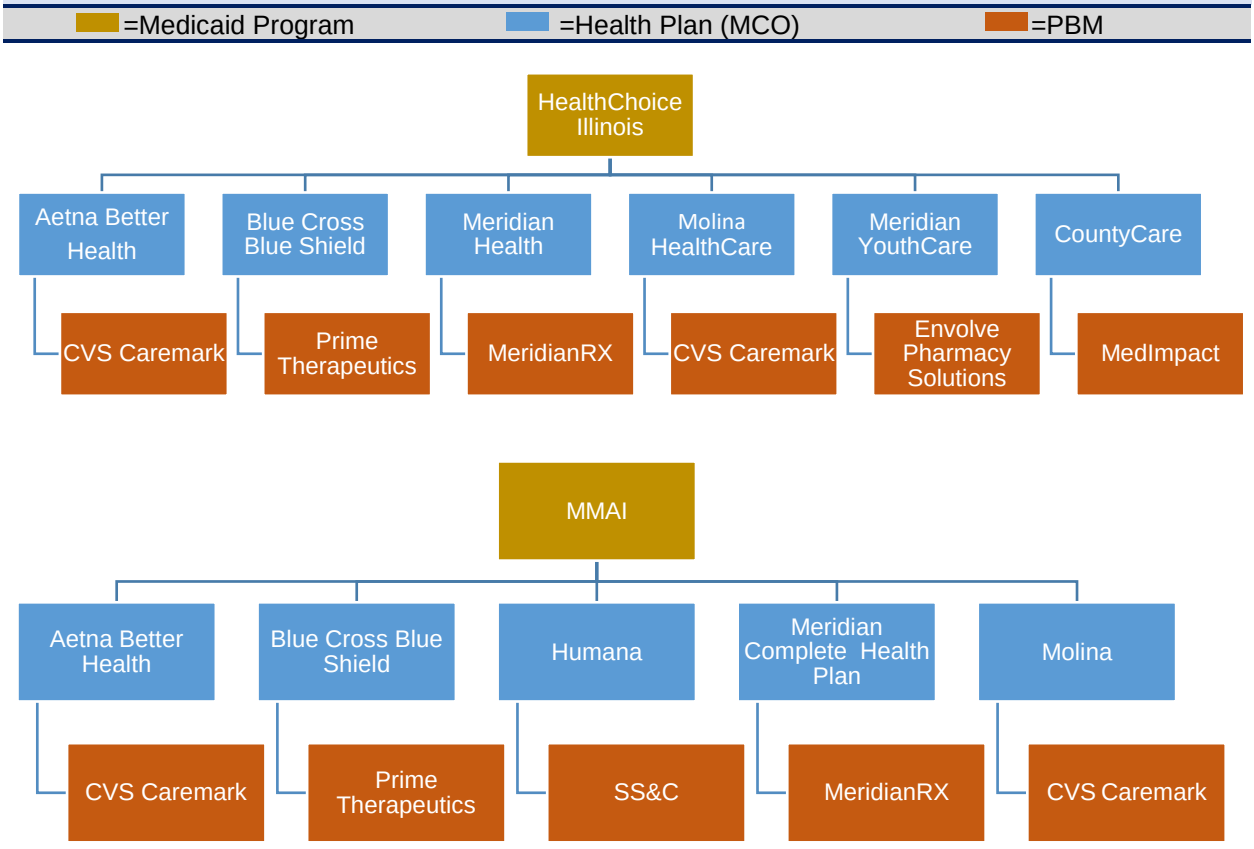
Medicare-Medicaid Alignment Initiative (MMAI) – MMAI became operational under HFS in July of 2021. HFS describes the program as an "on-going three-way partnership between HFS, the federal Centers for Medicare and Medicaid Services (CMS), and health plans." Like HealthChoice Illinois, MMAI has contracted MCOs that deliver services to eligible recipients, and are responsible for covering all Medicare and Medicaid services. This includes long-term services. According to HFS, those enrolled in MMAI "receive the full range of covered services under the Medicare and Medicaid programs." If either Medicare or Medicaid offers more expanded services than the other program, the contracted MCO must provide the more expansive of these services.

Both federal CMS and HFS provide capitation payments to MCOs under the MMAI program. Federal CMS sends two monthly payments to the MCOs for coverage under the Medicare Parts A/B and D programs, while HFS provides capitation payments for coverage related to Medicaid services. Federal CMS capitation payments are "risk adjusted using the prevailing federal CMS risk adjustment models." For the Medicaid rate, HFS calculates its payments "based on an enrollee's age, geographic service area, and care setting (nursing facility, waiver, or community)." This is also based on a "Long Term Services and

Supports (LTSS) blended rate based on the nursing facility and waiver enrollment mix in each MCO at the beginning of the calendar year." The nursing facility portion of this rate is risk adjusted.

Exhibit 4 shows the MCOs (Health Plans) and PBMs for each Medicaid program for calendar year 2021. According to HFS officials, MMAI doesn't cover pharmacy, which is covered by Medicare Part D and is directly paid through Medicare.

Exhibit 4
MEDICAID PROGRAMS, MCOs (HEALTH PLANS), AND PBM SUBCONTRACTORS
Calendar Year 2021



Source: Department of Healthcare and Family Services data.

As of June 2021, MCO enrollment was 2,727,103. This was an increase of 15 percent from the 2,308,766 enrollees in June 2020. Exhibit 5 shows MCOs by program as of June 2021.

Exhibit 5
ILLINOIS MANAGED CARE ORGANIZATION ENROLLMENT
June 2021

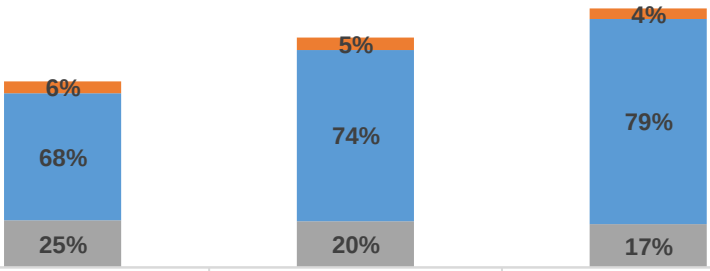
HealthChoice Illinois		MMAI	
Aetna Better Health of Illinois	410,547	Aetna Better Health Inc.	8,919
Blue Cross Blue Shield	641,401	Blue Cross and Blue Shield	18,834
CountyCare Health Plan (Cook Co.)	402,593	Humana	9,134
Meridian Health[1]	900,608	Meridian Complete Health Plan Inc.	13,000
Molina HealthCare	313,242	Molina	8,825
Totals	**2,668,391**		**58,712**

Note: [1] Includes Meridian YouthCare.

Source: Illinois Department of Healthcare and Family Services' 2021 Annual Report.

According to HFS, as of January 1, 2022, almost 80 percent of Illinois Medicaid beneficiaries were enrolled in an MCO plan. Exhibit 6 shows how much HFS has paid into managed care as a percentage of total medical assistance for fiscal years 2019 through 2021. It shows that managed care costs have increased, and outweigh all other medical assistance costs combined.

Exhibit 6
HFS MEDICAL ASSISTANCE EXPENDITURES
For Fiscal Years 2019, 2020, and 2021



	FY 2019	FY 2020	FY 2021
Pharmacy Expenditures	$894,689.10	$942,045.00	$800,495.00
Managed Care Expenditures	$9,603,826.50	$12,961,999.50	$15,521,031.50
Other Expenditures	$3,574,603.40	$3,499,008.30	$3,275,233.20
Totals	$14,073,119.00	$17,403,052.80	$19,596,759.70

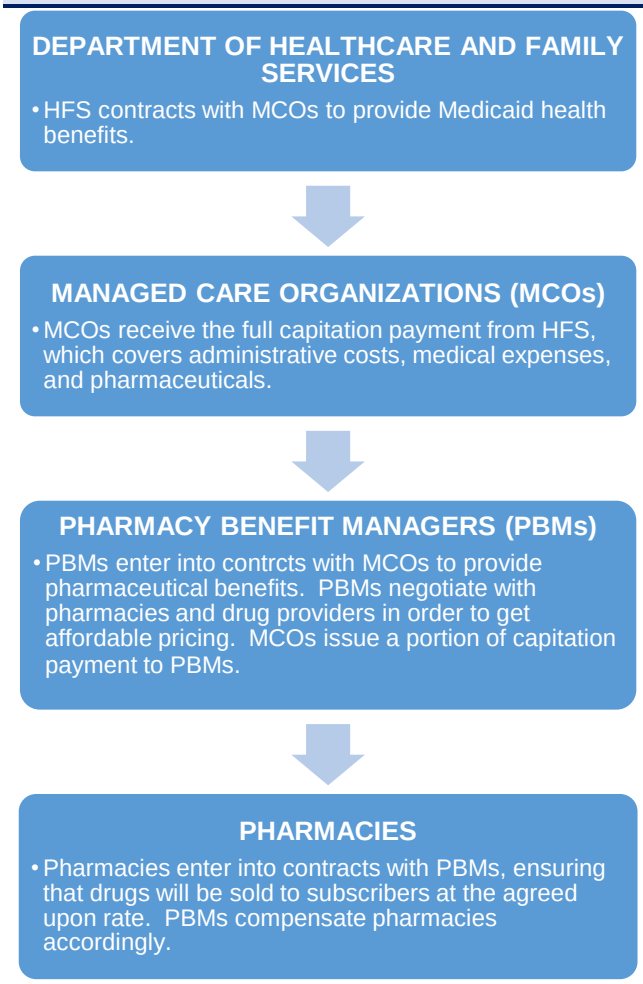
Note: "Other" includes expenditures for hospitals, long-term care, practitioners, other medical costs (such as laboratory work, transportation, and appliances), and the Children's Health rebate. It does not include expenditures from the Cook County Provider Trust, University of Illinois Hospital Services, Non-entitlements, Hospital Provider Fund, Trauma Center, Special Education Medicaid Matching, Money Follows the Person Budget Transfer, Electronic Health Record Incentive, Medicaid Buy-In, Medical Special Purposes Trust, Medical Interagency Program, and Juvenile Rehabilitation Services Funds.

Source: Department of Healthcare and Family Services data.

Pharmacy Benefit Managers

PBMs are companies that manage prescription drug benefits on behalf of Illinois' managed care programs, which includes providing claims processing services and other prescription drug services. PBMs are not exclusive to MCOs, but Senate Resolution Number 792 requires the Auditor General to look at PBMs that are contracting specifically with MCOs.

Exhibit 7
PBM FUNDING PROCESS



Source: Documentation provided by the Department of Healthcare and Family Services.

According to HFS, PBMs are contracted by MCOs to be responsible for the purchasing and distribution of drugs under the plan. Subsequently, PBMs enter into contracts with individual pharmacies to provide prescription drugs and related products and services. Claims are generally filed at the point of sale at the pharmacy when the beneficiary fills the prescription, unlike the claims process for MCOs where claims are filed after the service occurs. The pharmacy requires each person to verify eligibility. PBMs are paid through the capitation rates given to MCOs, which are actuarially calculated; these payments cover pharmaceuticals as well as dispensing and administration fees. According to HFS, PBMs are under the dual oversight of the contracting MCO and HFS.

Exhibit 7 flowcharts the PBM funding process.

All MCOs in the State subcontract with at least one PBM. For instance, Aetna subcontracts with CVS Caremark as its PBM. Other PBMs may be subcontracted for long-term care or specialty drugs. Furthermore, MCOs might also own the PBM or pharmacy with which they contract; for instance, in the case of Aetna, it was acquired by CVS, which owns CVS Caremark. This is further discussed in a later section.

Pharmaceutical Distribution and Payments

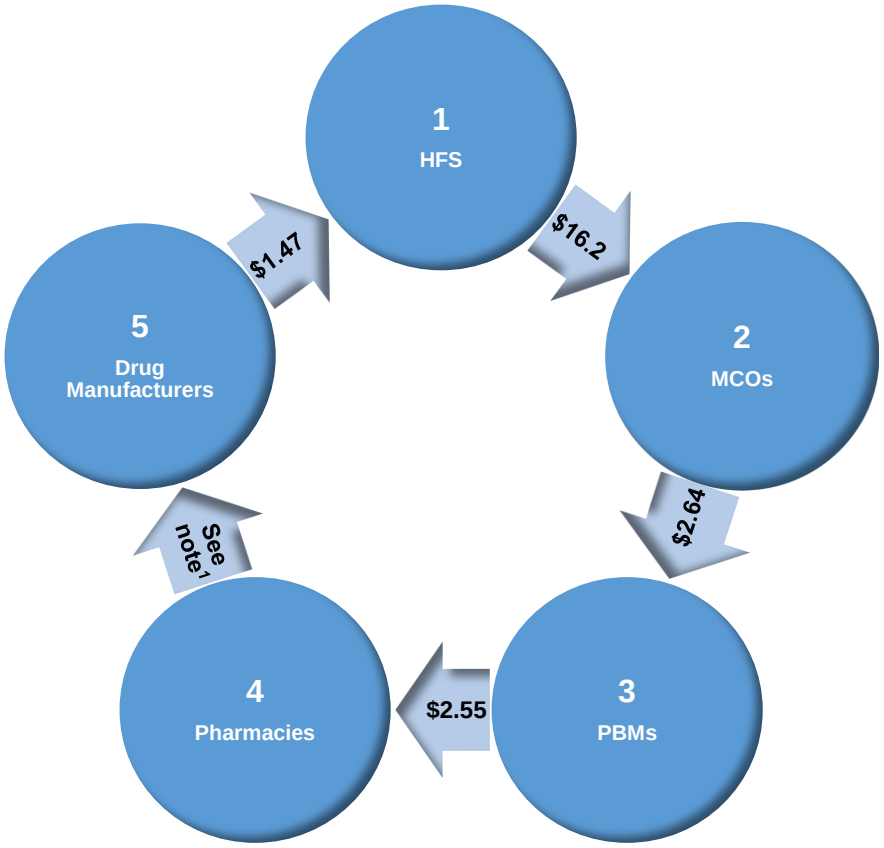
In calendar year 2021, HFS paid MCOs $16.2 billion in capitation payments, of which $2.64 billion was paid to PBMs. Of that, $2.55 billion went to individual pharmacies for covered drugs. HFS received $1.47 billion in drug rebates from pharmaceutical manufacturers.

Senate Resolution Number 792 asked auditors to provide an overview of the distribution of and payments for pharmaceuticals in the medical assistance managed care program. HFS contracts with MCOs to administer its medical assistance programs, which are paid through capitation payments. MCOs then contract with PBMs, which are responsible for the purchasing and distribution of drugs under the health plan. Subsequently, PBMs enter into contracts with individual pharmacies to provide prescription drugs and related products and services. Therefore, the payments for pharmaceuticals are paid from HFS' capitation payments to MCOs.

In addition to these payments, HFS receives drug rebates from pharmaceutical manufacturers. The federal government requires these manufacturers to enter into rebate agreements with state Medicaid agencies to sell covered drugs. Manufacturers may also enter into separate supplemental agreements with agencies for various reasons, such as placement upon the Preferred Drug List (PDL) or removal of drug restrictions. According to the State Finance Act, the rebates go into the Drug Rebate Fund, which can be used to pay for prescription drugs or payments to MCOs. The federally mandated rebates are set amounts that must be paid by the manufacturer; the supplemental rebates are negotiated between the manufacturers and state agencies.

Auditors requested documentation showing payments and rebate amounts, which are shown in Exhibit 8. In calendar year 2021, HFS paid MCOs $16.2 billion in capitation payments, of which $2.64 billion was paid to PBMs. Additionally, PBMs paid pharmacies $2.55 billion for cost of the drugs. According to HFS, it has no way to track its payments from pharmacies to manufacturers. HFS noted that it is "an arrangement between a private business (the pharmacy) and the manufacturer." Therefore, HFS did not know or monitor how much pharmacies paid drug manufacturers. Finally, in calendar year 2021, drug manufacturers paid HFS $1.47 billion in drug rebates.

Exhibit 8
DISTRIBUTION OF PAYMENTS FROM HFS FOR PHARMACEUTICALS UNDER MANAGED CARE FOR CALENDAR YEAR 2021
Payments in Billions



Note: [1] According to HFS, it has no way to track its payments from pharmacies to manufacturers. HFS noted that it is "an arrangement between a private business (the pharmacy) and the manufacturer." Therefore, HFS did not know or monitor how much pharmacies paid drug manufacturers.

Source: Documentation provided by the Department of Healthcare and Family Services.

Auditors asked HFS officials why the $1.47 billion in drug rebates was so high for calendar year 2021, when the payments to pharmacies was only $2.55 billion. Officials responded that the amount paid to pharmacies is not related to the rebate amount HFS receives, since the latter is based on drug costs, not what was paid. HFS officials reported that rebates are often referred to as "Federal or Mandatory Rebates." These rebates are paid by drug manufacturers on a quarterly basis to states and are shared between the states and the federal government based upon the federal match rate to offset the overall cost of prescription drugs under the Medicaid Program.

HFS separately negotiates and contracts for supplemental rebates on these drugs directly with the drug manufacturers. HFS further explained that the federal rebates are based on a percentage amount off of the drug costs, while supplemental rebates are based on the guaranteed net unit price or a percentage of

the wholesale acquisition cost. Because of the different methodologies in which rebates are claimed versus the pricing methodology HFS uses to pay for drugs, the price paid for drugs cannot be correlated to the rebate amount claimed.

State and Federal Funds and Reimbursements

Illinois MCOs paid PBMs over $2.2 billion in calendar year 2020 for pharmacy services, and over $2.6 billion in calendar year 2021. The PBMs paid pharmacies $2.1 billion during calendar year 2020 and $2.5 billion during calendar year 2021. The Department of Healthcare and Family Services' contracted actuary, Milliman, reviews encounter data and reimbursements; however, it does not audit or test self-reported data.

Senate Resolution Number 792 asked auditors to review the amount of State and federal funds used by MCOs to reimburse PBMs and, in time, the amount paid by PBMs to reimburse pharmacies for fiscal years 2020 and 2021. HFS officials requested that the audit period be changed to calendar years, which was granted. In order to review these payments, auditors requested and reviewed payment information and monitoring documents.

Payments

HFS contracts with an actuary, Milliman, to set capitation rates to the MCOs. In addition to this, Milliman also monitors encounter data and analyzes reimbursements. Milliman provided auditors with funds paid to and from the MCOs.

Exhibit 9 shows all MCO contractors for calendar years 2020 through 2021, their respective PBM subcontractors, and the total amount paid to each. MeridianRX and Prime Therapeutics, the PBM subcontractors for Meridian Health and Blue Cross Blue Shield, were paid the most over these two years. In total for calendar years 2020 and 2021, HFS through MCOs paid a total of over $4.8 billion to all PBM subcontractors.

Exhibit 9
PAYMENTS TO PHARMACY BENEFIT MANAGERS
Calendar Year 2020 and Calendar Year 2021

CALENDAR YEAR 2020			
MCO Name	**PBM Name**	**Paid to PBM**	**Paid to Pharmacies**
Aetna	Envolve Pharmacy Solutions	$358,000,000	$335,700,000
Aetna	CVS Caremark	27,700,000	26,400,000
Blue Cross Blue Shield	Prime Therapeutics, LLC	500,300,000	484,900,000
CountyCare	MedImpact	378,500,000	362,900,000
Meridian Health	MeridianRX	705,100,000	640,000,000
Meridian YouthCare	Envolve Pharmacy Solutions	18,300,000	15,900,000
Molina	CVS Caremark	200,500,000	199,700,000
NextLevel	Envolve Pharmacy Solutions	13,500,000	13,500,000
CY20 Totals		**$2,201,900,000**	**$2,079,000,000**
CALENDAR YEAR 2021			
MCO Name	**PBM Name**	**Paid to PBM**	**Paid to Pharmacies**
Aetna	CVS Caremark	$434,900,000	$418,100,000
Blue Cross Blue Shield	Prime Therapeutics, LLC	625,800,000	606,500,000
CountyCare	MedImpact	457,800,000	445,200,000
Meridian Health	MeridianRX	789,900,000	757,700,000
Meridian YouthCare	Envolve Pharmacy Solutions	30,600,000	28,400,000
Molina	CVS Caremark	296,600,000	291,400,000
CY21 Totals		**$2,635,600,000**	**$2,547,300,000**

Note: Limitations noted by Milliman: "*Milliman has developed certain models to estimate the values included in this correspondence. The purpose of the models is to evaluate the health plan reported financial data. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose. The models rely on data and information as input to the models. We have relied upon certain data and information provided by HFS for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this correspondence may likewise be inaccurate or incomplete. Milliman's data and information reliance includes MCO-reported eligibility and financial experience, as well as information related to HFS' eligibility system and assignment of enrollees to rate cells. The models, including all input, calculations, and output may not be appropriate for any other purpose.*"

Source: Evaluated by Milliman, and provided by the Department of Healthcare and Family Services.

Milliman Reviews

As part of the MCO contracts, the MCOs are required to participate in the quarterly Encounter Utilization Monitoring process. Milliman assists HFS with this process. The MCOs complete a standard data collection template, created by Milliman; each submission is required to have a signed attestation by an officer of the MCO stating that the data is accurate and complete. Milliman then reviews the MCO submissions for consistency with prior reporting, accuracy compared to other sources of data, and completeness of the encounter submissions to the encounter data warehouse. On an annual basis, Milliman reconciles the data to each MCO's National Association of Insurance Commissioners (NAIC) regulatory financial statement filings or audited financial statements; these NAIC filings are audited by an independent auditor hired by each MCO. MCOs are

required to submit a minimum of 98 percent of all encounters to the encounter data warehouse; according to Milliman, they have consistently scored above this minimum for retail and mail-order pharmacy services.

Milliman also reviews drug prices by comparing the retail pharmacy reimbursement levels for each MCO to the MCO yearly average. These reviews compare each MCO's experience to the costs at National Average Drug Acquisition Cost by drug and therapeutic class, and shows the 100 drugs where reimbursement levels were furthest above the MCO average. This is completed on an aggregate basis and does not look at prices paid to individual pharmacies. The 2021 review showed that Aetna had the highest reimbursement levels, and CountyCare had the lowest. Milliman found that if Aetna was able to achieve reimbursement levels consistent with the MCO average, it could reduce its retail pharmacy expenditures by approximately $10 million annually.

Milliman does not audit or test the encounter data that is submitted from the MCOs. Additionally, it relies on the MCOs to reconcile information between their Encounter Utilization Monitoring submissions and their NAIC annual statements. Milliman reviews the reconciliations for reasonableness. Milliman also does not audit data submitted by HFS for its retail pharmacy reimbursement reviews.

Contracts

MCOs were not in full compliance with all statutory requirements for their contracts with PBMs, and HFS does little to no monitoring to ensure that all requirements are met. Contracts between PBMs and pharmacies generally meet statutory requirements, but were missing many of the same provisions that were not in the MCO contracts.

Contracts between MCOs and PBMs

Senate Resolution Number 792 asked auditors to examine contracts between MCOs and PBMs. Auditors received these contracts and their amendments between all five MCOs and their PBMs, and reviewed them for compliance with statutory requirements. This review is summarized below.

Illinois Insurance Code

The Illinois Insurance Code outlines the requirements that PBMs must follow when contracting with a health insurer (215 ILCS 5/513b1). A contract must require a PBM to:

- Update the maximum allowable cost (MAC) pricing information at least every seven calendar days;
- Maintain a process that will, in a timely manner, eliminate drugs from MAC lists or modify drug prices to remain consistent with changes in pricing data;
- Provide access to the PBMs' MAC list to each pharmacy or pharmacy services administrative organization subject to the MAC list;
- Provide a process by which a contracted pharmacy can appeal the provider's reimbursement for a drug subject to MAC pricing. The appeals process must, at a minimum, include the following:
  - a requirement that a contracted pharmacy has 14 calendar days after the applicable fill date to appeal a MAC if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug;
  - a requirement that a PBM must respond to a challenge within 14 calendar days of the contracted pharmacy making the claim for which the appeal has been submitted;
  - a telephone number and email address or website to network providers, at which the provider can contact the PBM to process and submit an appeal;
  - a requirement that, if an appeal is denied, the PBM must provide the reason for the denial and the name and the national drug code number from national or regional wholesalers;
  - a requirement that, if an appeal is sustained, the PBM must make an adjustment in the drug price effective the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the MCO or PBM;

- Allow a plan sponsor an annual right to audit compliance with the terms of the contract set by the PBM;
- Allow a plan sponsor to request that the PBM disclose the actual amounts paid by the PBM to the pharmacy; and
- Provide notice to the contracting party of any consideration that the PBM receives from the manufacturer for "dispense as written" prescriptions once a generic or biologically similar product becomes available.

In addition, the Illinois Insurance Code prohibits a PBM from limiting a pharmacist's ability to disclose whether the cost-sharing obligation exceeds the retail price for a covered prescription drug and the availability of a more affordable alternative. These requirements became effective on January 1, 2020, for managed care plans that were amended or renewed on July 1, 2020, or afterwards.

Auditors reviewed the contracts between MCOs and PBMs for these requirements. Our review found that the Aetna and Molina contracts, whose PBM is CVS Caremark, were in compliance with all 13 statutory requirements. The other four contracts were missing six or more of the required contractual provisions. For example, the Meridian contracts, whose PBMs are MeridianRX and Envolve, were missing 12 of the 13 required contractual provisions. The only statutory requirement with full compliance across all MCO contracts was the requirement to allow a pharmacy to inform a patient of a less costly alternative to a prescribed medication. Our review did not include broad contract provisions that required contractors to abide by all State laws, which were present in every contract. Exhibit 10 shows a summary of the specific requirements missing per the Illinois Insurance Code.

Exhibit 10
MANAGED CARE ORGANIZATION CONTRACT REQUIREMENTS
Per the Illinois Insurance Code (215 ILCS 5/513b1)

Do the contracts require the PBM to…	**Yes**	**No**
Update maximum allowable cost (MAC) pricing information at least every seven calendar days?	4	2
Maintain a process that will, in a timely manner, eliminate drugs from MAC lists or modify drug prices to remain consistent with changes in pricing used in formulating MAC prices and product availability?	2	4
Provide access to its MAC list to each pharmacy?	4	2
Provide a process by which a pharmacy can appeal the provider's reimbursement for a drug subject to MAC pricing?	3	3
Allow a plan sponsor contracting with a PBM an annual right to audit compliance with the terms of the contract?	4	2
Allow a plan sponsor contracting with a PBM to request that the PBM disclose the actual amounts paid by the PBM to the pharmacy?	2	4
Provide notice to the party contracting with the PBM of any consideration that the PBM receives from the manufacturer for dispense as written prescriptions once a generic or biologically similar product becomes available?	2	4
Allow a pharmacy to inform a patient of a less costly alternative to a prescribed medication?	6	0
Does the MAC pricing appeal process include…	**Yes**	**No**
A requirement that a contracted pharmacy has 14 calendar days after the applicable fill date to appeal a MAC if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug?	3	3
A requirement that a PBM must respond to a challenge within 14 calendar days of the pharmacy making the claim for which the appeal has been submitted?	3	3
A telephone number and email address or website to network providers, at which the provider can contact the PBM to process and submit an appeal?	2	4
A requirement that, if an appeal is denied, the PBM must provide the reason for the denial and the name and the national drug code number from national or regional wholesalers?	2	4
A requirement that, if an appeal is sustained, the PBM must make an adjustment in the drug price effective the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers?	2	4

Source: OAG analysis of MCO-PBM contracts.

Auditors asked officials from the PBMs about these missing statutory requirements. PBM officials gave two reasons why auditors may have not seen these requirements in the contracts. First, auditors may have been looking at old contracts that were in place before the statute became effective as these requirements may be in the newer contracts, which were effective after the audit period. The contracts reviewed for this audit were the contracts which covered the audit period. Auditors did not review contracts entered into after the audit period. Second, the requirements may have been included in separate provider

manuals, pharmacy network agreements, or policy instead of the contracts. PBM officials said they were aware of these requirements and would add them into the contracts going forward.

Illinois Public Aid Code

The Illinois Public Aid Code requires that contracts between HFS and MCOs require the entity to establish an appeals and grievances process for consumers and providers (305 ILCS 5/5-30(h). Five out of six contracts contained such a provision.

Since numerous contracts were not in full compliance with the State law, HFS should review these contracts to ensure that these statutory requirements are added to the MCO contracts with the PBMs when these contracts are amended or renewed. Exhibit 11 shows a summary of the missing requirements from both the Insurance Code and the Public Aid Code by MCO. If these provisions are not met, pharmacies may not be able to appeal MAC prices, which are set by the PBMs. Also, MCOs may not be able to annually audit contracts, and there may be a lack of grievance procedures for consumers and providers. Additionally, any higher costs associated with these practices may ultimately result in higher capitation payments made by the State. A lack of monitoring by HFS is further discussed in the next section.

Exhibit 11
MANAGED CARE ORGANIZATION COMPLIANCE WITH 14 STATUTORY CONTRACT REQUIREMENTS
Per the Illinois Insurance Code and Illinois Public Aid Code

MCO	Met	Compliance
Aetna	13	93%
BCBS	5	36%
CountyCare	8	57%
Meridian	2	14%
Meridian (YouthCare)	2	14%
Molina	14	100%

Source: OAG analysis of MCO-PBM contracts.

Contract Compliance

RECOMMENDATION NUMBER 1

The Illinois Department of Healthcare and Family Services should ensure that contracts between MCOs and PBMs include the contractual requirements outlined in 215 ILCS 5/513b1 and 305 ILCS 5/5-30(h).

HFS Response: The Department accepts the recommendation. The Department believes the current contracts include the requirements as those contracts state the MCOs are responsible for its subcontractors and requires the MCOs and its subcontractors to comply with all laws and rules; however, HFS will ensure compliance with the contract requirements between the MCOs and PBMs.

Other Provisions

In addition to statutory requirements, auditors reviewed other contractual provisions. Exhibit 12 shows a summary of our review. The Exhibit shows that all PBMs were allowed to contract with drug manufacturers for rebates (although all PBMs stated to auditors that PBMs did not collect such rebates), required or allowed audits of pharmacies by PBMs, and contained provisions regarding prior

authorization and/or step therapy. A majority of the PBMs also had provisions requiring pass-through reimbursements.

Exhibit 12
MCO COMPLIANCE WITH NON-STATUTORY PROVISIONS

Do the PBM contracts…	Yes	No
Allow the PBM to contract with drug manufacturers for rebates?[1]	6	0
Require or allow audits of pharmacies?	6	0
Contain a provision for pass-through reimbursements?[2]	4	2
Contain provisions regarding prior authorization and/or step therapy?[3]	6	0

Notes:

[1] In meetings with the PBMs, officials told auditors that they do not collect such rebates.

[2] Pass-through reimbursements refer to reimbursements under a pass-through pricing model, which requires a PBM to charge a managed care plan the exact amount the PBM pays for prescriptions and dispensing fees. It is meant to prevent spread pricing, which occurs when there is a difference between payments made by a PBM to the pharmacy for a prescription and the charge to the payer for the same claim.

[3] Prior authorization refers to the act of seeking approval for certain medical and prescription drug plans from the health insurance carrier before they are paid for. Step therapy is a related practice that requires a patient to try a preferred drug to ascertain whether it is effective before other alternatives will be covered.

Source: OAG analysis of MCO-PBM contracts.

Contracts between PBMs and Pharmacies

Senate Resolution Number 792 asked auditors to examine contracts between PBMs and pharmacies. Auditors were provided with boilerplate contracts and their amendments that were issued between each PBM and the respective pharmacy. Some of these PBMs had different contracts for pharmacies depending on whether they were independent/chain or retail/specialty pharmacies, but the bulk of the contract language stayed the same. Auditors reviewed the contracts for compliance with statutory requirements. This review is summarized below.

Illinois Public Aid Code

The Illinois Public Aid Code outlines requirements for pharmacy benefits under the managed care program (305 ILCS 5/5-36). The law states that a PBM must not include the following in a contract with a pharmacy provider:

- A provision prohibiting the provider from informing a patient of a less costly alternative to a prescribed medication; and
- A provision that prohibits the provider from dispensing a particular amount of a prescribed medication, if the PBM allows that amount to be dispensed through a pharmacy owned or controlled by the PBM.

Auditors reviewed the contracts between PBMs and pharmacies for these requirements and all PBMs were in compliance.

In addition, the Illinois Public Aid Code stipulates that any material change to a contract provision that affects the terms of reimbursement, eligibility process,

dispute resolution, the drug verification process for the formulary, and contract termination, must be provided to the pharmacy at least 30 days prior to the change either in writing or through a website. It also states that PBMs must create a dispute resolution process for pharmacies, which requires HFS approval. Although these requirements do not have to be included in the contracts, auditors reviewed the contracts between PBMs and pharmacies for them. Two of the six (33 percent) contracts did not contain a provision about providing material changes at least 30 days prior to the change. All contracts included an outlined dispute resolution process.

Illinois Insurance Code

Although the mandates in the Illinois Insurance Code described above are only required for MCO contracts, auditors reviewed the PBM contracts for the mandates since some of them were missing in the MCO contracts. The PBM contracts that did not meet the statutory requirements were those that were missing the mandated provisions in both the MCO and PBM contracts.

Exhibit 13 shows the results of this review. All of the provisions were missing in both MCO and PBM contracts for at least two PBMs; most of the provisions were missing in both contracts for three or more PBMs. These latter provisions dealt with the MAC pricing appeal process for pharmacies. Although they are not required within these contracts, it shows further lack of monitoring of contracts by HFS.

Exhibit 13
PBM COMPLIANCE WITH ILLINOIS INSURANCE CODE CONTRACT REQUIREMENTS

Does the contract require the PBM to…	Yes	No
Provide access to its MAC list to each pharmacy?	4	2
Provide a process by which a pharmacy can appeal the provider's reimbursement for a drug subject to MAC pricing?	3	3
Does the MAC appeal process include…		
A requirement that a contracted pharmacy has 14 calendar days after the applicable fill date to appeal a MAC if the reimbursement for the drug is less than the net amount that the network provider paid to the supplier of the drug?	3	3
A requirement that a PBM must respond to a challenge within 14 calendar days of the pharmacy making the claim for which the appeal has been submitted?	3	3
A telephone number and email address or website to network providers, at which the provider can contact the PBM to process and submit an appeal?	2	4
A requirement that, if an appeal is denied, the PBM must provide the reason for the denial and the name and the national drug code number from national or regional wholesalers?	2	4
A requirement that, if an appeal is sustained, the PBM must make an adjustment in the drug price effective the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers?	2	4

Source: OAG analysis of PBM contracts.

HFS Oversight of Contracts and PBMs

Based on information provided to auditors, there is little monitoring being done of the PBMs by HFS. HFS did not have complete copies of contracts between the MCOs and the PBMs necessary to conduct monitoring of the contract provisions. HFS also does not monitor contracts between the PBMs and the pharmacies and, as such, is unaware of the rates paid to the pharmacies by the PBMs. There is no verification being conducted to ensure that the reimbursements to PBMs by MCOs are accurate and reflect the actual payments paid to the pharmacies. In addition, HFS does not monitor actual reimbursement rates or rebates. The entire monitoring function of the rates paid to pharmacies by PBMs is limited and based on self-reported, unaudited encounter data. As a result, HFS was unable to provide support for adequate monitoring of the PBMs.

Also, auditors found that HFS was not engaging in monitoring practices of PBMs as mandated by Illinois law. Auditors determined that HFS did not provide the required annual report to the General Assembly, did not define "conflicts of interest" in administrative rule, and did not monitor various provisions found in 305 ILCS 5/5-36. Based on HFS responses to data requests, contract requests, and statutory requirements, it is clear that HFS did little to no monitoring of PBMs.

Senate Resolution Number 792 asked auditors to review the level of oversight HFS provides over the contracts and over PBMs to ensure compliance with contract requirements. According to HFS, it administers the medical assistance programs most commonly known as Medicaid and the State Children's Health Insurance Program. These programs are jointly financed by State and federal government funds and provide critical health care coverage to Illinois' most vulnerable populations. Additionally, HFS must monitor and enforce compliance by MCOs with agreements they have entered into with providers on issues that include timeliness of payments, payment rates, and processes for obtaining prior approval (305 ILCS 5/5-30(h-5). Auditors reviewed HFS oversight of contracts, statutory requirements, claims data, and other documentation.

Contracts, Audits, and Data

HFS did not have complete copies of contracts necessary to conduct monitoring of the contract provisions. Originally, HFS only was able to provide redacted contracts between the MCOs and the PBMs. However, upon further requests by auditors, HFS requested the unredacted contracts from the MCOs in order to provide them to auditors. As described in the previous section, the MCO contracts were missing statutorily required contract provisions. Not having complete, unredacted contracts likely contributed to those omissions.

Additionally, when auditors asked HFS about its monitoring over the PBMs, HFS officials noted they do not have a "direct line of sight" over the contracts between PBMs and the pharmacies. As such, they were not aware of the rates that are paid to the pharmacies by the PBMs. Officials indicated that these rates were based on contracts between the PBMs and the pharmacies and "HFS is not a party to those contracts." In addition, Milliman stated it did not review the amounts each individual pharmacy was paid; however, it did review contracting efficiencies and

reimbursement rates "in composite." Furthermore, auditors asked HFS about contracts that pharmacies had with the PBMs; HFS responded that neither it nor Milliman monitored the contracts for fairness.

HFS did not provide any documentation to support actual reimbursements paid to PBMs by MCOs. In an attempt to determine whether the PBMs were being reimbursed the correct amount by the MCOs, auditors requested copies of financial statement audits for the PBMs from HFS. HFS officials questioned the need for these audits and ultimately responded that they did not have them. In addition, HFS and Milliman do not monitor actual reimbursement rates or rebates. Reimbursements made by the PBM to the pharmacy are evaluated, but only on an aggregate basis. HFS also has not done any analysis on how reimbursement rates for affiliated pharmacies compare to non-affiliated pharmacies. After the audit report draft was provided to HFS, HFS officials did provide an analysis showing the top drugs prescribed in State fiscal years 2021-2022 and part of 2023 for both managed care and fee-for-service. It shows the top 20 drugs prescribed for each by number of prescriptions as well as by dollar amounts paid, in aggregate.

According to HFS officials, "Encounters are submitted to HFS by the MCOs, and reflect what the MCO paid to the provider. In the case of a PBM, the MCOs are instructed to submit to HFS what the PBM paid to the pharmacy." HFS assesses penalties on MCOs that fail to submit the required amount of encounter data, which it reports on its website. However, the encounter data itself is not reviewed, verified, or audited. According to Milliman, the encounter data has "limitations." It was noted that the data was accepted from HFS without audit. This encounter data is also self-reported. As a result, **the entire monitoring function of the rates paid to pharmacies by PBMs is limited and based on self-reported, unaudited encounter data**.

Auditors discussed audits of PBMs with the HFS Office of the Inspector General (OIG). OIG officials stated that the office was "grappling with the notion" of auditing PBMs at all, due to the restrictiveness of contracts, as well as possible jurisdictional overlap with the Bureau of Managed Care. As the contracts currently stand, the OIG believes there is no way for them to recover funds from PBMs. OIG officials added that the OIG's focus was on issues of a criminal nature, or ones that could yield financial reclamation for the State, which does not include MCO contracted providers such as PBMs.

Without monitoring by HFS, it is unclear how HFS is in compliance with the Illinois Public Aid Code. Specifically, HFS must monitor and enforce compliance by MCOs with agreements they have entered into with providers on issues that include timeliness of payments, payment rates, and processes for obtaining prior approval.

External Quality Reviews and Corrective Action Plans

The Code of Federal Regulations requires that states contract with an external quality review organization to conduct an annual evaluation of health plans that serve Medicaid beneficiaries to determine each health plan's compliance with federal quality assessment and performance improvement standards. HFS has

contracted with Health Services Advisory Group since June 2002 for this purpose. They provide an annual, independent technical report that, among other things, provides conclusions as to the quality, timeliness, and access to the care furnished by the Medicaid managed care health plans. In addition to this annual report, Health Services Advisory Group will conduct analyses at the request of HFS.

Aetna Termination of Walgreens Contracts

HFS requested an access to pharmacies analysis at the end of calendar year 2020, when the IlliniCare Health Plan merged with Aetna, which resulted in the termination of contracts with Walgreens pharmacies. HFS requested an impact analysis and a time and distance analysis to verify compliance with the adequacy of the Aetna pharmacy network standards as outlined in HFS' Medicaid model contract. The contract requires the following:

- Pharmacy services must provide 100 percent coverage to enrollees;
- If enrollees live in a rural area, they must have access to at least one pharmacy within a 60-mile radius or 60-minute drive from their residence; and
- Enrollees who live in a non-rural area must have access to at least one pharmacy within a 15-mile radius or 15-minute drive from their residence.

On September 18, 2020, Aetna provided an updated provider data file to Health Services Advisory Group that included all pharmacies under the new contract, excluding Walgreens. This was compared to a quarterly IlliniCare provider data file provided in August 2020. This impact analysis found that 607 pharmacies (28 percent) were eliminated from the network due to the merger, with Regions 4 (Cook County) and 5 (Collar counties) losing more than 30 percent of available pharmacies. Decreases in Regions 1, 2, and 3 were between 16 to 23 percent.

The time and distance analysis, which was submitted to Aetna and HFS on November 30, 2020, found that Regions 1 (DeKalb County) and 2 (Champaign, McLean, and Vermilion Counties) did not have access to pharmacies within the time/distance standard for 202 beneficiaries. As a result, Aetna was required to respond to pharmacy network deficiencies identified in these regions. Aetna submitted a Corrective Action Plan on December 4, 2020, that included a list of additional pharmacies in those regions, and explained that all but two pharmacies either "did not allow open access or had a limited scope." Because of this, the MCO requested an exemption from the "100% compliance requirement" for DeKalb, McLean, and Vermilion counties. HFS responded to Aetna's Corrective Action Plan by requiring Aetna to verify the provider type of two of the pharmacies and analyze why it was not able to identify some providers as active in HFS' provider database. In addition, HFS directed Aetna to reach out to available pharmacy providers that HFS identified in the four non-compliant counties for contracting and registration in HFS' provider database. In its November 2020 draft copy of the time/distance analysis, Health Services Advisory Group agreed that Aetna should continue contracting efforts in those regions; it also recommended that HFS should consider: focusing future time/distance analyses on specific locations; conducting saturation analyses for each county in which IlliniCare was not in compliance, which may help determine

"the extent to which deficiencies in the pharmacy network resulted from the health plan's failure to contract with available pharmacies…versus a lack of available pharmacies for the region"; and continue monitoring the IlliniCare pharmacy network after the merger with Aetna.

Ultimately, as of December 1, 2020, the Aetna Better Health Plan merged with the IlliniCare Health Plan, which resulted in the termination of contracts with Walgreens pharmacies. When auditors asked HFS about this, officials responded that the Department did not "approve" of Aetna's decision; Aetna made HFS aware of the decision, and after reviewing the remaining pharmacy network, HFS determined that Aetna continued to be in compliance with its contractual obligations. It does not appear that a full review was conducted before Aetna proceeded with the decision that as of December 1, 2020, Walgreens would no longer be accepted under the health plan. HFS officials added that, "Wherever possible, the Department attempts to avoid requiring plans to contract with specific providers, nor do we attempt to influence providers to contract with specific plans. These are business decisions that both parties need to determine what is in their best interests."

Compliance with State Laws

Auditors found that HFS was not engaging in monitoring practices of PBMs as mandated by Illinois law. The Illinois Public Aid Code (305 ILCS 5/5-36(c) through (j)) establishes several provisions for monitoring PBMs under MCOs. Auditors provided HFS officials with several questions regarding this particular statute. Officials answered the following:

- 305 ILCS 5/5-36(c) -a report must be delivered to the General Assembly at least on an annual basis detailing any updates to "any contract, contract issues, formulary, dispensing fees, and maximum allowable cost concerns regarding a third-party administrator and managed care." **HFS officials stated that "no report has been prepared or submitted."**
- 305 ILCS 5/5-36(e) -gives HFS the ability to request information from a PBM regarding exclusive dispensary agreements, the percentage of claims paid to affiliated pharmacies, the aggregate amount of fees imposed on pharmacies, and the average annualized percentage of revenue collected by the PBM as a result of a Department contract which is not paid to pharmacies/manufacturers or used for administrative fees. **HFS officials stated that the Department had not requested this information but did request it after auditors raised the question.**
- 305 ILCS 5/5-36(g) -requires PBMs to disclose in writing to pharmacies any changes to contract provisions that affect reimbursement terms, the verification of benefits and eligibility, dispute resolution, formulary drug verification, or contract termination at least 30 days prior to the date of the contract change. **HFS officials indicated that they do not monitor this provision.**

- 305 ILCS 5/5-36(h) -PBM contracts with pharmacies are not allowed to include provisions prohibiting the provider from informing patients of a less costly alternative to a prescribed medication, as well as including a provision prohibiting a pharmacy to prescribe a particular amount of a prescribed drug if the PBM allows its own affiliated pharmacies to prescribe the same amount. **HFS officials stated they do not monitor this section of the statute.**
- 305 ILCS 5/5-36(j) -PBMs are required to establish a dispute resolution process arising from issues set forth in the law, subject to HFS approval. **HFS officials said they have "not reviewed or approved any dispute resolution processes specific to PBMs."** Officials pointed to a provider resolution portal online, but this is not specific to dispute resolutions in regards to PBMs.

Based on HFS responses to data requests, contract requests, and statutory requirements, it is clear that HFS did little to no monitoring of PBMs. Without sufficient monitoring, HFS cannot determine if PBMs are in compliance with contract requirements. As a result, HFS cannot determine what rates PBMs are paying to pharmacies, or if PBMs are engaging in unfair business practices. Monitoring these areas could result in better stewardship of Medicaid funds.

Oversight and Monitoring

RECOMMENDATION NUMBER	
2	***The Illinois Department of Healthcare and Family Services should provide more detailed monitoring of managed care organizations and their pharmacy benefit managers. Specifically, it should:*** • ***Report to the General Assembly on an annual basis as required by 305 ILCS 5/5-36(c);*** • ***Request and monitor PBM information as allowed and required by 305 ILCS 5/5-36(e),(g), and (h); and*** • ***Review and approve dispute resolution processes provided by PBMs as required by 305 ILCS 5/5-36(j).***

HFS Response: The Department accepts the recommendation. The Department will prepare and issue a report to the General Assembly on an annual basis as required by 305 ILCS 5/5-36(c). In addition, HFS will implement a process to request PBM information as allowed and required by 305 ILCS 5/5-36(e), (g), and (h). Furthermore, we will implement a process to review and approve dispute resolution processes provided by PBMs as required by 305 ILCS 5/5-36(j).

Additionally, 305 ILCS 5/5-36(d) requires HFS to define conflicts of interest in administrative rule, which HFS has not done. According to HFS officials, "…there is no administrative rule currently in place pursuant to this statutory provision and [General Counsel] does not have any record of an administrative rulemaking being initiated…" HFS officials speculated that, since the statute became effective right before the COVID-19 pandemic (on January 1, 2020), "it is likely that the appropriate program area that would have been tasked with defining 'conflict of interest' for purposes of this legislation had its attention drawn elsewhere." Based on information provided by HFS about affiliations between the MCOs, PBMs, and network pharmacies, it appears that a conflict of interest could currently exist; see the last section of this report for further

discussion on affiliations. HFS officials stated that they have not "received notice of any conflict of interests by the MCOs PBMs."

Furthermore, Section 9.2.30 of the Managed Care contracts provided by HFS stipulates that entities must notify the agency of any conflicts of interest, with HFS having sole discretion in determining whether a conflict exists and authority to initiate inquiries as to the existence of a conflict of interest. Without a clear definition of conflict of interest, it is difficult for HFS to determine whether a true conflict of interest exists. Additionally, it makes it easier for MCOs, PBMs, and pharmacies that have conflicts of interest to operate within the managed care program, which may result in higher rates or diminished access to care.

Conflict of Interest	
RECOMMENDATION NUMBER **3**	***The Illinois Department of Healthcare and Family Services should define "conflict of interest" in administrative rules as required by 305 ILCS 5/5-36(d).***

HFS Response: The Department accepts the recommendation. Section 9.2 of the HCI Contract, Certifications, defines conflicts of interest, and the MCOs attest to compliance with Section 9.2 on an annual basis per Attachment XIII and Attachment IX: Disclosures of Conflicts of Interest; however, the Department will define conflict of interest in administrative rules as required.

Federal Trade Commission Investigation Comments and Audits/Investigations of PBMs by Other States

HFS was not aware of a Federal Trade Commission (FTC) investigation into PBMs. Auditors reviewed complaints made to the FTC and audits conducted in other states to determine issues identified related to the monitoring of PBMs. Auditors questioned HFS regarding these complaints and findings and determined that in many instances, HFS was either unaware of the issue or was not conducting any monitoring related to the issue.

Comments to the Federal Trade Commission (FTC)

The FTC launched an investigation into the pharmacy benefit manager industry in June 2022. Specifically, the FTC is investigating:

- fees and clawbacks PBMs charge unaffiliated pharmacies (clawbacks are charges from a PBM to a pharmacy for a prescription claim after the point of sale);
- methods to steer patients toward PBM-owned pharmacies;
- the prevalence of administrative restrictions like prior authorizations;
- the impact of rebates and fees from drug manufacturers on formulary design; and
- the costs of prescription drugs to payers and patients, among other areas.

Prior to the launch of this investigation, the FTC issued a request for information about PBMs and received over 24,000 public comments. Auditors reviewed comments that related specifically to Illinois.

Auditors contacted HFS regarding the FTC investigation and HFS officials were unaware of the investigation. Auditors then sent a questionnaire to HFS asking if HFS or Milliman monitors PBM activities based on complaints to the FTC related to Illinois. Below is a summary of the unaudited FTC complaints and HFS' responses.

Restrictive, Burdensome Contracts - pharmacies complained of being tied by restrictive, non-negotiable contracts. They describe them as "take it or leave it" contracts that often pay lower than the drug acquisition costs. These contracts can also have overly burdensome requirements, such as accreditation requirements, confusing reimbursement methodologies, and prohibiting mailing drugs to beneficiaries. Additionally, pharmacies complained that PBMs provide little or no time to request information regarding contracts, and nearly all revision proposals submitted by the pharmacies are rejected. Independent pharmacies are often provided less than 30 days to review and enter contracts, established industry standards and definitions are routinely left out of contracts, and pharmacies are usually referred to provider manuals that can be changed at the sole discretion of the PBM. PBMs almost always have the right to change contracts and provider manuals with limited notice and can terminate contracts without cause.

Questions to HFS	Response
Is HFS or Milliman aware of complaints by Illinois pharmacists about "take or leave it" contracts, as described above, with PBMs? **HFS Response:** Yes, we have heard some complaints, primarily from lobbyists and not from providers themselves. We have also heard of independent pharmacies offering "take it or leave it contracts" with the PBMs, and when the PBMs have refused that pharmacy has introduced legislation that would in effect require that all PBMs contract with them. We require the plans to meet specific network adequacy requirements that also incorporate specific time and distance standards. If the PBMs are not able to meet those goals because pharmacies are not willing to accept those rates, the MCOs are subject to the enforcement provisions of the contract. Those are the standards that we hold the plans to, but the actual dispensing fees paid to the pharmacies are ultimately determined through negotiations between two private parties.	*Yes*
Does HFS or Milliman monitor PBM contracts with pharmacies to ensure that they are fair to pharmacists? **HFS Response:** We are in very little position to determine what is fair for either pharmacies or their employed pharmacists. What is most important to the State is that the millions of Illinois residents enrolled in our programs have adequate access to pharmacy services. Those standards are outlined in our contracts with the plans. If the plans are not able to meet the network adequacy standards, it is their responsibility to make the necessary adjustments to come into compliance, which could include offering higher rates for pharmacy services.	*No*

Reimbursements - complainants allege that PBMs take advantage of higher copays to profit off pharmacies on the back end. Ultimately, pharmacies complain that reimbursement rates are set by their competitors. As one complainant put it, "We do not have the opportunity to raise prices to offset costs of keeping our business up to date because our competition (PBMs) set our prices." Other pharmacies made similar remarks.

Questions to HFS	Response
Does HFS or Milliman monitor the reimbursements that PBMs give to pharmacies? **HFS Response:** The reimbursement made by the PBM to the pharmacy is reported to HFS and used in the development of capitation rates. As such, the reimbursements are evaluated on an aggregate basis and compared to benchmark reimbursement rates. Also, there are no copays in our program, so this complaint does not appear to apply in this circumstance. **Auditor Note:** Neither HFS nor Milliman monitors the individual rates paid to individual pharmacies for specific drugs.	*Yes*

Has HFS or Milliman done any studies or analysis on how the reimbursement rates for affiliated pharmacies compare to non-affiliated pharmacies?	*No*

Formularies - complainants allege that PBMs are incentivized to place expensive, brand-name drugs on their formularies to increase rebates. Additionally, they can change the formulary at any time during a beneficiary's plan. This results in barriers to preferred medications. Relatedly, complainants criticized the use of "step therapy," which is when formularies require beneficiaries to use a preferred drug first to ascertain if it is effective before other alternatives are covered. This requirement is not always known to physicians in advance.

Questions to HFS	**Response**
Is HFS or Milliman aware of "step therapy" practices being used by PBMs?	*Yes*
Does HFS or Milliman monitor PBM formularies? **HFS Response:** Step therapy is a very common clinical practice. HFS does monitor the MCO criteria unless there is stipulated language in the supplemental rebate agreement. HFS requires the MCOs to use a universal formulary, or Preferred Drug List, which HFS is responsible for developing and maintaining. Under the Medicaid program, the PBMs are not permitted to use their own formulary, nor are they collecting rebates and all rebates from drug sales as part of the Medicaid program are now collected by the State. **Auditor Note:** "Step therapy" is allowed in some of the contracts.	*Yes*

Patient Steering - many of the Illinois-based complainants claimed that PBMs steered beneficiaries to their own pharmacies. They do this by either requiring drugs to be dispensed through their own pharmacies or making drugs cheaper at their own pharmacies. Many times, the PBM requires drugs to be dispensed through a mail-order pharmacy. Not only does this cut off beneficiaries from preferred pharmacies, but it also cuts off beneficiaries from preferred pharmacists that can advise them on their drug regimen and can create barriers to medications. Patient steering can be especially harmful to beneficiaries who are low-income, elderly, or suffering from chronic conditions that require special medications, such as cancer patients or those with HIV/AIDS. These beneficiaries often need special attention, and their medications can require special storage, which mail-order pharmacies often do not provide. Mail-order pharmacies also often struggle maintaining patient confidentiality.

Questions to HFS	Response
Is HFS or Milliman aware of pharmacy complaints of patient steering?	*No*
Does HFS or Milliman monitor the PBMs for patient steering? **HFS Response:** HFS monitors customer complaints related to the MCO contracts and Managed Care Programs. At this time BMC (Bureau of Managed Care) has no record of complaints regarding patient steering by PBMs. We have heard complaints from lobbyists about patient steering, but have not been provided evidence nor received complaints from Medicaid customers about the practice. Also, in no circumstances would a PBM contracted with an MCO be offering cheaper drugs to Medicaid customers since the Medicaid customer has access to the pharmacy benefit free of charge. **Auditor Note:** HFS' website hosts a complaint portal to report issues with a MCO; however, it is only for managed care providers, not beneficiaries, and it has a strict timeline for when complaints must be filed. Furthermore, it is only for issues that cannot be resolved internally within the MCO's own dispute resolution process. In addition, auditors analyzed encounter data provided for the first week of October 2021, and found evidence of possible patient steering. When auditors asked about this, HFS officials responded that shutting out other non-affiliated pharmacies is competitive and profitable. HFS was only concerned with the MCOs being in compliance with federal regulations, and that the PBMs were under the authority of the MCOs, not HFS. Auditors questioned how this practice could be competitive, but HFS officials responded that other PBMs do the same.	*Yes*

Audits - complainants allege that PBMs are authorized to conduct audits of the pharmacies with which they contract, but complainants allege that these audits often come with little or no notice, are overly burdensome on pharmacy staff, and are abused by PBMs. They allege that PBMs will charge excessive fees even for small clerical errors, and that they select high-dollar prescriptions in order to claw back as much money as possible. One complainant stated that his pharmacy's audits increased dramatically after he started testifying against PBMs to the State legislature, even though there were zero discrepancies.

Questions to HFS	Response
Is HFS or Milliman aware of any pharmacy complaints of PBM audits?	*No*
Does HFS or Milliman monitor PBM audit documentation, or audits conducted by the MCOs?	*No*

Drug Dispensing - complainants allege that PBMs restrict what and how much pharmacists can dispense through formularies and fines. PBMs will fine a pharmacy for filling too many prescriptions that are on the "aberrant product" list, and pharmacists are prohibited from buying more than a 30-day supply. Quantity and dosing limits are placed on some formulary drugs, sometimes in the middle of

treatment, which requires staff time to appeal the decision. Illinois law does not allow PBMs to prohibit pharmacies from dispensing a particular amount of a prescribed medication if the amount is allowed to be dispensed through an affiliated pharmacy (305 ILCS 5/5-36(h)(2)).

Question to HFS	Response
Does HFS or Milliman monitor the contracts between PBMs and pharmacies to check for these types of provisions?	*No*
HFS Response: Again, the Department establishes the formulary that all Medicaid PBMs must use. Some PBMs have practices in place that will allow for a larger supply that what is permitted under FFS, but as far as we know the PBMs are not requiring shorter supplies than what is permitted under fee for service.	

Pickpocketing - a complainant described this process as PBMs intentionally reimbursing 340B pharmacies, or pharmacies under the 340B Drug Pricing Program, at lower rates than non-340B pharmacies because health centers receive a discount for them. The 340B Drug Pricing Program is a federal program that offers discounts for certain drugs to eligible health care organizations.

Question to HFS	Response
Does HFS or Milliman monitor PBM reimbursements to ensure 340B pharmacies are not intentionally reimbursed at lower rates?	*No*
HFS Response: There is absolutely no provision under federal law that guarantees that 340B providers are intended to be reimbursed at anything above actual acquisition cost for 340B drugs. Contract pharmacies are frequently engaged in spread pricing, in which they will charge the Medicaid PBMs far greater that what they actually spent to purchase the drugs, a practice that is strictly prohibited under the fee for service program but which is allowed under managed care. However, we do not require the PBMs to pay the 340B prices, and we know they frequently pay far more than that to the benefit of certain pharmacies and safety net providers.	

Transparency - several complainants stated that there is little transparency about fee arrangements with drug manufacturers, how much drugs will cost consumers, additional barriers, and why certain drugs are on the most expensive formularies. Additionally, rebates collected by rebate aggregators are not reported in PBM quarterly Securities and Exchange Commission (SEC) filings. This can lead to delays in treatment, unaffordability, and difficulty in prescribing medications.

Questions to HFS	Response
Does HFS or Milliman monitor fee arrangements between PBMs and drug manufacturers?	*No*
HFS Response: The state establishes the formulary, the state collects all of the rebate revenue, and there are no cost sharing requirements for Medicaid customers, so we do not believe these complaints are relevant to our program.	

Does HFS or Milliman monitor contracts to ensure transparency?	*No*
HFS Response: We do not monitor the contracts for transparency, but the formulary that all PBMs are required to utilize is made publicly available by the Department, and customers have zero cost sharing obligations.	

Data Sharing - According to a complainant, PBMs may be sharing beneficiary data to their own pharmacies in order to steer patients.

Questions to HFS	**Response**
Does HFS or Milliman monitor PBMs to ensure they are not sharing beneficiary data with affiliated pharmacies?	*No*
HFS Response: Each contract includes language to address the handling of Confidential Information, and Use and Ownership of data/materials by Vendors and their subcontractors. For example, please review see Sections 9.1.6 and 9.1.7 of the HealthChoice Illinois Model Contract that states: Section 9.1.6 - Contractor shall presume that all information received from the State or to which it gains access pursuant to this Contract is confidential. Contractor's information (excluding information regarding rates paid by Contractor to its Providers and Subcontractors), unless clearly marked as confidential and exempt from disclosure under the Illinois Freedom of Information Act, shall be considered public. No confidential data collected, maintained, or used in the course of performance of the Contract shall be disseminated except as authorized by law and with the written consent of the disclosing Party, either during the term of the Contract or thereafter, or as otherwise set forth in this Contract.	
Are PBMs explicitly prohibited from selling or sharing beneficiary data to any third party vendor?	*Yes*
HFS Response: Each contract includes language to address the handling of Confidential Information, and Use and Ownership of data/materials by Vendors and their subcontractors.	
Does HFS or Milliman have a process to prevent third party sales?	*No*
HFS Response: Each contract includes language to address the handling of Confidential Information, and Use and Ownership of data/materials by Vendors and their subcontractors. For example, please review see Sections 9.1.6 and 9.1.7 of the HealthChoice Illinois Model Contract that states: Section 9.1.6 - Contractor shall presume that all information received from the State or to which it gains access pursuant to this Contract is confidential. Contractor's information (excluding information regarding rates paid by Contractor to its Providers and Subcontractors), unless clearly marked as confidential and exempt from disclosure under the Illinois Freedom of Information Act, shall be considered public. No confidential data collected, maintained, or used in the course of performance of the Contract shall be disseminated except as authorized by law and with the written consent of the disclosing Party, either during the term of the Contract or thereafter, or as otherwise set forth in this Contract.	

Direct and Indirect Remuneration (DIR) Fees - a few complaints discussed these, which are types of clawback fees. The federal government has tried to prohibit them, but PBMs are finding loopholes, such as disguising administrative fees as network fees.

Questions to HFS	Response
Does HFS or Milliman monitor money that is clawed back by the PBM after reimbursements are processed?	*No*
Does HFS or Milliman monitor the collection of recoupments by PBMs?	*No*
Does HFS or Milliman have a process in place to ensure that recoupments are returned to the Department when warranted?	*No*
Does HFS or Milliman have a process in place to determine that recoupments or clawbacks collected by PBMs are accurate?	*No*

"White/Brown Bagging" - two complainants described these practices. "White bagging" refers to a practice in which medications that are administered within a clinic are required by the PBM to be obtained from a designated specialty pharmacy, usually one that is an affiliate of the PBM. "Brown bagging" refers to the practice of requiring a beneficiary to order drugs from a designated specialty pharmacy and bring it to the clinic for administration. These practices can lead to delayed care, safety/storage issues, drug waste (since clinics usually cannot use the drug for other patients), and liability issues if the patient has not stored the drug properly.

Questions to HFS	Response
Is HFS or Milliman aware of "white/brown bagging" practices among PBMs?	*No*
Does HFS or Milliman monitor PBMs for "white/brown bagging" practices? **HFS Response:** This is not a practice that we are familiar with in the Medicaid business for the PBMs, though we could not say whether or not it is occurring.	*No*

"**Prescription Trolling", "Patient Slamming", and "Claim Hijacking**" - a complainant described these PBM practices. "Prescription trolling" refers to when a PBM takes claims data and directly contacts the patient's prescriber to switch the prescription to an affiliated pharmacy. "Patient slamming" is a related practice in which a PBM takes claims data and shares it with an affiliated pharmacy in order to solicit a patient to use its own mail-order pharmacy. "Claim hijacking" is when a PBM fills a prescription at an affiliated pharmacy while the original pharmacy provider obtains prior authorization.

Questions to HFS	Response
Is HFS or Milliman aware of "prescription trolling" practices among PBMs?	*No*
Does HFS or Milliman monitor PBMs for "prescription trolling" practices? **HFS Response:** We have not heard from prescribers that this practice is occurring in the Medicaid space.	*No*
Is HFS or Milliman aware of "patient slamming" practices among PBMs?	*No*
Does HFS or Milliman monitor PBMs for "patient slamming" practices? **HFS Response:** This is not something that is monitored by the Department, however, if individuals enrolled with our medical programs would find it more convenient to have their prescriptions filled through the mail instead of having to arrive at a brick and mortar store, we would like those customers to be aware of their options for improved access.	*No*
Is HFS or Milliman aware of "claim hijacking" practices among PBMs?	*No*
Does HFS or Milliman monitor PBMs for "claim hijacking" practices?	*No*

Copay Accumulator Programs - a complainant criticized PBMs' use of these programs, which prohibit the use of assistance or coupon cards from being used towards a beneficiary's deductible for prescription drugs.

Question to HFS	Response
Does HFS or Milliman monitor the use of these programs (copay accumulator) among PBMs? **HFS Response:** We do not have deductibles for prescription drugs.	*No*

Other State Audits and Studies

Auditors examined audits and studies conducted in other states regarding PBMs contracting with Medicaid managed care programs. In many of the studies or audits reviewed, states found a lack of transparency in the contracting process between PBMs and pharmacies, as well as pricing discrepancies in the reimbursements between PBM-affiliated pharmacies and independent pharmacies.

The questionnaire that auditors sent to HFS included questions based on these findings as well. Below is a summary of those findings and HFS' responses.

Oversight and Monitoring

- In a 2020 audit in Utah, officials found inadequate oversight by the state over how drug prices are selected. Rate-setting was contracted to Milliman. This is the same contractor Illinois uses to set rates for its managed care organizations. Utah auditors found that, "While the rate-setting process involves analysis to certify capitated rates are actuarially sound, it is not sufficient oversight over the [MCO] pharmacy

programs…Without tracking the trend changes that may contribute to capitated rate increases, [the Department of Health] is unable to provide additional oversight steps to ensure costs are being managed." Additionally, auditors found that Milliman did not reduce capitation rates when MCOs engaged in practices that increased costs. The audit recommended the Department provide better oversight of the MCOs, review cost trends and contract changes, and oversight of contract compliance between MCOs and their PBMs.

- A 2020 New York audit found that the state's Department of Health did not establish sufficient controls and oversight to ensure the most cost-effective delivery of pharmacy services under managed care. Rather, the Department relied on MCOs and the PBMs to achieve the goal of effectively and efficiently managing drug costs for the Medicaid program. Because the Department did not require MCOs to use the most cost-effective drugs, provide them with information to determine the most cost-effective drugs, or review the MCO formularies to determine if they result in the use of the most cost-effective drugs, managed care costs were high; the Department ultimately decided to transition all managed care pharmacy benefits to the fee-for-service model.

Questions to HFS	**Response**
Is Milliman solely responsible for the rate setting process?	*No*
Is Milliman solely responsible for monitoring the MCOs and PBMs?	*No*
Is there additional oversight or monitoring provided by HFS during the rate setting process? **HFS Response:** Milliman is responsible for the majority of the rate setting process. In doing so, they regularly consult with HFS regarding program and policy changes and objectives, contract provisions, reimbursement structures and other issues that are incorporated into the rate development process.	*Yes*

Data and Contracts Issues

- A 2018 audit in Ohio noted that it was difficult for the State and health plans to oversee compliance because the exact terms of the financial agreements are hidden by the sheer number of entities involved in every transaction, as well as confidential contract provisions.
- A 2019 audit in Maryland noted that contracts between PBMs and pharmacies were difficult to examine by officials due to PBMs only allowing them to be reviewed "via a remote viewing webinar session."
- In a 2019 report, auditors in Minnesota found that the PBM contracted for managed care in the state was not reporting pharmacist payment data. Instead, it was simply reporting either what the MCO paid PBMs or the "per-claim" amounts.

Questions to HFS	Response
Does HFS or Milliman have the ability to examine all contracts between PBMs and pharmacies?	*Yes*
If so, does HFS or Milliman examine these contracts and monitor their provisions for transparency?	*No*

Pharmacy Types, Costs, Profits, and Closures

- A 2018 audit in Ohio found that 74 percent of pharmacies in the state were large chain pharmacies, with the remaining 26 percent being a combination of small chain and independent community pharmacies. Furthermore, when auditors took out the number of large chain pharmacies that closed due to a merger between CVS and Target pharmacy locations, the majority of closures were independent or small chain pharmacies. The audit also found that most pharmacy closures happened in specific regions, thus impacting access to care.
- In the same audit from Ohio, pharmacy costs were found to have gone up during the audit period by 14.1 percent. The report also questioned whether MCOs contracting with their own affiliated PBMs was a conflict of interest that could conceivably raise the rates the state pays for reimbursements as well as the cost of drugs at the point of sale.
- Additionally, the same Ohio audit found discrepancies between affiliated and independent pharmacies, as well as a lack of payment transparency between PBMs and pharmacies. Auditors also found that pharmacies and MCOs were paying additional fees to PBMs that did not include spread pricing. Auditors also noted that contracts with PBMs did not include provisions prohibiting the sale of de-identified beneficiary information to third party vendors. Affiliated pharmacies such as CVS received larger payments on average per prescription than independent pharmacies for specialty drugs ($55.09 compared to $35.19).
- In a 2019 study in New York, PBMs were found to have cut pharmacy profits by 83 percent. In the last quarter of 2017, 99 percent of all generic oral solid drug claims generated a profit of less than $10 for the pharmacy.
- A report released in 2020 found that CVS Caremark affiliated pharmacies in Florida reported much higher prices on specialty drugs compared to independent pharmacies. The reported 2018 cost for Aripiprazole was $11.18 for CVS, compared to a range of $0.24 to $0.53 for other pharmacies. Similar differences in prices were found for other drugs, such as Nexium. The report also found that PBMs engaged in differential drug pricing, setting different prices for different pharmacies that sometimes benefitted affiliated dispensers. CVS also accounted for a significant portion of claims.

- In a report commissioned by the Illinois Pharmacists Association, it was found that average pharmacy margins fell from an average of $6 per claim in 2017 to under $2 in July 2018.
- An audit conducted by the Maryland Department of Health in 2019 found that small pharmacies overwhelmingly believed that the managed care program was costly compared to the fee-for-service program, leading to fears of closure. In an analysis of all pharmacies in the state, auditors found that 93 percent of small pharmacies were located in urban or suburban areas, with the remainder in rural areas. The prospect of closures in these areas (especially rural) due to the pricing model was seen as a threat to patient access.

Question to HFS	**Response**
Does HFS or Milliman monitor pharmacy closures or network access issues in areas of the State?	*Yes*
HFS Response: Periodically throughout the term of a contract the Department, in coordination with its External Quality Review Organization, will conduct network adequacy reviews of each MCO to determine network adequacy and also time and distance standards compliance, which would include looking at access to and availability to pharmacies across a specific region or across the state. In addition, each quarter the health plans analyze the geographic distribution of the Provider Network and provide the results of this analysis to the Department for review.	

Drug Lists

- A report commissioned in 2019 to examine PBMs under managed care in the state of New York found that PBMs were changing to different drugs on their lists that might not qualify for rebates or federal funding that would offset costs for the state. An example cited was the switching of two HIV-1 drugs from brand name to generic, which disqualified some of the rebates the state was receiving.

Questions to HFS	**Response**
Do PBMs have control over what is placed on HFS' Preferred Drug List?	*No*
Does HFS or Milliman engage in monitoring or oversight to determine the cost efficiency of drugs on the Preferred Drug List?	*Yes*
HFS Response: HFS monitors cost through the PDL process.	

Rebates

- An audit conducted in Ohio noted concerns that PBMs were inappropriately withholding rebates and negotiating for additional discounts that were unknown to the health plans.

Questions to HFS	Response
Does HFS have timeliness requirements for when drug rebates must be forwarded to the Department? **HFS Response:** With the adoption of the universal PDL, the State collects rebates directly from the drug manufacturers for drugs purchased under the State's managed care program.	*No*
Does HFS or Milliman have a process in place to ensure delivery of full rebate amounts to the Department? **HFS Response:** Again, the Department collects rebates directly from the manufacturers, as opposed to collecting rebates from the PBMs.	*No*

Managed Care vs Fee-For-Service

- The Illinois Pharmacists Association report found that managed care does not appear to bring down drug costs compared to fee-for-service. Managed care results in less rebates for the State (51 percent) than fee-for-service (63 percent). According to HFS, since implementation of the universal PDL on January 1, 2020, HFS negotiates and collects rebates for both fee-for-service and managed care drugs, making the amount collected in rebate uniform throughout the agency. In the 2020 Utah audit, the fee-for-service payment model was found to provide pharmacy benefits at a lower cost because it has access to the unit rebate amount of federal rebates, prioritizing the lowest-cost prescription drugs. It also determines its own reimbursement rate to pharmacies based on "lesser of" indices, which are lower than PBM rates. Ultimately, the audit found that "…[MCOs] do not know the true net costs of drugs and are incentivized to reduce their costs at the pharmacy, not net costs to the state."
- The 2018 Ohio audit recommended that the state engage an independent third party to analyze the impact of moving to a fee-for-service model.

Questions to HFS	Response
Has HFS or Milliman conducted comparisons between the managed care and fee-for-service programs to determine cost effectiveness or program efficiency? **HFS Response:** Yes and no. Doing a detailed comparison of the managed care program and FFS is extremely complicated. We do look at total expenses in the aggregate, but certain policies adopted by the plans, such as allowing for 90 day refills of prescriptions when FFS would only allow for a 30 day refill does not allow for an apples to apples comparison. Known spread pricing occurring from pharmacies for 340B drugs in the MCO markets is an additional complicating factor. We know that the state's dispensing fee is far greater in managed care than it is from the PBMs because of federal requirements of what FFS is required to pay that does not apply to managed care. We knew that there were issues related to spread pricing by the PBMs which we have addressed by ensuring that those dollars are not accounted for in the benefit expenses paid by the plans. We also knew that it was possible that	*Yes/No*

additional revenues for the program could be generated through the adoption of the universal PDL, and the collection of rebate revenues has been a frequent item that has been pointed to in states' decisions to carve out the pharmacy benefit, which we believe Illinois has already address. In addition to that, the State has a significant tax on the Medicaid MCOs that is taxed on total premiums and is capped under federal law. Taking billions of dollars out of our managed care rates to carve out the pharmacy benefit would be a direct loss of hundreds of millions of dollars of revenue to the State. We also find it extremely suspicious that the pharmacies would want to carve out the pharmacy benefit from managed care if it meant that the Medicaid program in its entirety would pay pharmacies less money if all pharmacy payments were made under the fee for service program.	
Has HFS or Milliman conducted analyses determining whether managed care or fee-for-service is more cost effective for providers? **HFS Response:** We do not know what is meant by "cost effective for providers." Our primary goal and responsibility is to ensure that the millions of Illinois residents that rely on our medical programs have access to the medications that they need in a manner in which it is most efficient for the taxpayer.	*No*
Has HFS or Milliman conducted analyses to determine if the Managed Care program gives greater ease of access to beneficiaries?	*No*
Auditor Note: Three states (West Virginia, California, and North Dakota) have carved out their pharmacy benefits from their MCOs due to excessive costs, several others have required different payment models due to spread pricing and overcharging, and 10 states, including Illinois, have received over $490 million in Medicaid fraud allegation legal settlements.	

Based on these responses, HFS was unaware of many of these complaints. Additionally, according to an HFS official, HFS "was not aware of [the FTC] investigation." HFS' website hosts a complaint portal to report issues with a MCO; however, it is only for managed care providers, not beneficiaries, and it has a strict timeline for when complaints must be filed.

Reimbursement Practices and Rates

Contractually negotiated reimbursement rates and administrative fees between MCOs and PBMs differ for each contract, which resulted in varying reimbursement rates that were difficult to review. In order to further review these rates, auditors analyzed encounter data from October 1 through 7, 2021. During the review of encounter data, auditors determined that the reimbursements were so complicated that the data could not be used to review reimbursement practices. Officials from the PBMs gave several reasons why reimbursements might vary, and HFS does not monitor either reimbursement rates or administrative fees.

Auditors identified multiple affiliations between the MCOs, PBMs, and pharmacies that may impact the cost of the program and access to care for beneficiaries. Affiliations can also lead to patient steering, in which PBMs steer beneficiaries to their own pharmacies.

Senate Resolution Number 792 asked auditors to review the reimbursement practices and reimbursement rates of MCOs to PBMs. It also asked auditors to review the same between PBMs and pharmacies, including out-of-state pharmacies and pharmacies affiliated with PBMs. To do this, auditors reviewed contracts, met with all the PBMs, discussed the process with HFS and Milliman, and reviewed encounter data from October 1 through 7, 2021.

MCO Reimbursement Process Overview

HFS contracts with the MCOs using actuarially calculated capitation rates developed by Milliman. The capitation rates that HFS pays the managed care plans include the pharmaceutical costs. The MCOs contract with PBMs who perform claims processing services for products dispensed by participating pharmacies and verify compliance at the pharmacies. The MCOs reimburse the PBMs for the pharmaceuticals and dispensing fees and pay the PBMs an administration fee for processing claims. The PBMs contract with participating pharmacies, which are independent contractors, to provide prescription drugs and related products and services. The pharmacies require each person requesting pharmacy services to verify they are eligible and the pharmacies collect the patient pay amount from the eligible person. The PBMs pay the participating pharmacy for covered items dispensed to eligible persons pursuant to the contractual agreement between the PBM and pharmacy.

Reimbursement Rates between MCOs and PBMs

As part of the examination of contracts between MCOs and PBMs, auditors reviewed reimbursement schedules and administrative fees. Contractually, each MCO sets maximum amounts it will reimburse its PBM for drugs and dispensing fees the PBM pays pharmacies; in most cases this is a percentage of the Average Wholesale Price of drugs. However, this percentage is usually based on a period of time, such as a year, not based on individual drugs or prescriptions dispensed. The contracts require the amounts paid to the PBMs to be "pass-through" funding, meaning that an MCO will only reimburse for the amount that the PBM actually paid the pharmacy. Administrative fees also differ by PBM contract. Some

PBMs were paid per claim or on a per member per month basis; one was paid a combination of per claim and per member per month. Another was paid on a simple dollar amount basis. The reimbursement and administrative fee methodologies and actual amounts that were paid are considered proprietary and confidential information, so they are not listed in the audit. Because of the varying reimbursement rates and administrative fees, auditors could not verify the amounts reported by HFS for claims paid or administrative expenses for each MCO or adequately review reimbursement practices.

Reimbursement Rates between PBMs and Pharmacies

Auditors also reviewed reimbursement schedules as part of the examination of contracts between PBMs and pharmacies. Similar to the reimbursement rates between the MCOs and PBMs, reimbursements between the PBMs and pharmacies are contractually negotiated and may differ between individual pharmacies. The contracts provided to auditors were sample contracts and did not contain actual negotiated rates, but stated that rates can be based on a number of factors, including Average Wholesale Price, maximum allowable cost, dispensing fees, ingredient costs, and usual and customary prices. None of the rate descriptions examined specifically discussed different payment structures for affiliated or out-of-state pharmacies and independent pharmacies.

In order to further review the reimbursement rates and practices, auditors examined encounter data from HFS for the period October 1 through 7, 2021. During the review of the encounter data, auditors determined that the reimbursements were complicated due to the contractual methodologies. Auditors determined that reimbursements for drugs varied by PBM, by pharmacy, and for each drug. Encounter data showed that pharmacies were paid different prices for the same drug depending on the PBM. The data also showed each PBM paid its contracted pharmacies differently for the same drug. Auditors determined that these prices differed greatly.

Reimbursement Price Example

The average cost for a 30 day supply of Fluticasone SPR 50 MCG for all pharmacies ranged between $1.23 per day to $0.23 per day depending on the PBM. The overall average cost was $0.45. The average costs also differed between individual pharmacies. The highest was $1.36 per day and the lowest was $0.06 per day.

Auditors asked PBM officials why such varying payments occurred. Officials reiterated that prices depended on their individual pharmacy agreements, and that large chain pharmacies could negotiate better prices than smaller pharmacies. Officials from one of the PBMs noted that pricing is typically not drug-specific; rather, the goal of the pricing is to get adjustments into a range for a pharmacy that was in aggregate of a yearly average of Average Wholesale Price minus the percentage negotiated in its contract. For example, a pharmacy could lose $75 on a bottle of pills but gain $100 on an inhaler. Further, a pharmacy could be reimbursed based on its usual and customary prices or on a drug's maximum allowable cost. Therefore, although contractual agreements between the MCOs and PBMs outline a similar Average Wholesale Price based reimbursement method, and although many of the contracts require pass-through reimbursements, ultimately pharmacies may not be reimbursed the same way or at the same rate.

Auditors also asked HFS officials about how they monitor the reimbursement process. HFS officials stated that they conduct a meeting with MCOs and PBMs to detail processes and other areas, and the subcontracts of MCOs must be provided to HFS upon request. **According to HFS officials, HFS just pays the capitation rates without monitoring the MCO reimbursements. HFS officials also noted HFS has no relationship to the PBMs and does not regularly monitor their contracts.** At the end of the audit, HFS officials noted that HFS monitors reimbursements globally since those are used to develop the capitation rates and it reviews volume in order to collect proper rebate amounts. Auditors noted to HFS OIG officials that HFS did not know how much the pharmacies and PBMs were paid. In response, OIG officials said that when they had brought up the issue in the past, the general view seemed to be that once the capitation rates were paid, the risk was taken on entirely by the MCO. They agreed that administrative costs are extremely convoluted.

Senate Resolution Number 792 asked auditors to review reimbursement practices and rates for out-of-state pharmacies and pharmacies affiliated with PBMs. HFS officials speculated that "out-of-state" pharmacies referred to mail-order or online prescriptions from out-of-state affiliated pharmacies, not beneficiaries in border towns receiving medicine in another state. When auditors asked HFS officials about out-of-state pharmacies, officials noted that it was not an area HFS examined. HFS officials also noted that out-of-state pharmacies would have to be licensed. According to the contracts between the MCOs and the PBMs, rates paid for mail-order or online pharmacies are less than for retail pharmacies. Auditors discussed mail-order pharmacies with the PBMs and all PBMs noted that reimbursements for mail-order pharmacies tend to be less than the reimbursements for retail pharmacies.

As mentioned in an earlier section, the Illinois Public Aid Code requires HFS to monitor and enforce compliance by MCOs with agreements they have entered into with providers on issues that include, among other things, payments and payment rates (305 ILCS 5/5-30(h-5)). Since HFS does not monitor reimbursement rates, it cannot determine if contracts are cost-efficient to the State.

Reimbursement Rates	
RECOMMENDATION NUMBER **4**	***The Illinois Department of Healthcare and Family Services should monitor reimbursement rates between managed care organizations and their pharmacy benefit managers, as required by the Illinois Public Aid Code.***

HFS Response: The Department monitors reimbursements from the MCOs to the PBMs for the purpose of ensuring that administrative payments to the PBMs are not counted as medical benefits paid by the MCOs.

Auditor Comment:

During the audit, HFS officials noted HFS just pays the capitation rates without monitoring the MCO reimbursements. HFS also noted it did not regularly monitor the PBM contracts. After numerous requests, HFS did not provide documentation of any detailed monitoring of PBMs.

Affiliations

Auditors requested and received information from HFS on affiliations between MCOs, PBMs, and pharmacies. Auditors found the following affiliations:

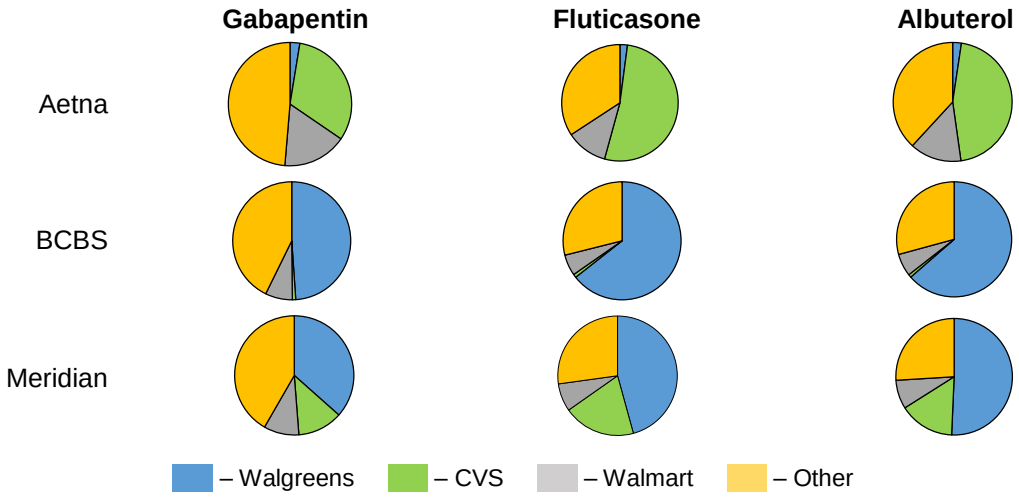
- **Aetna** - In November 2018, CVS acquired Aetna. CVS Caremark serves as the PBM for Aetna. As disclosed by Aetna, it is affiliated with the PBM (Caremark) and CVS network pharmacies.
- **Blue Cross Blue Shield** - Prime Therapeutics serves as the PBM for Blue Cross Blue Shield, which the MCO partially owned. AllianceRx Walgreens Prime served as a partnership between the PBM and Walgreens, but has ceased as of 2022. Although there is no longer an ownership affiliation, Prime has a contractual affiliation with Walgreens.
- **CountyCare** - The MCO is contracted with MedImpact as its PBM, with MedImpact Direct as "a non-dispensing mail order pharmacy." MedImpact does not own any of the network pharmacies, but some pharmacies are owned by Cook County Health, which also owns CountyCare.
- **Meridian** - The MCO, as well as its PBM (MeridianRx), are both owned by Centene. Meridian also provides services for YouthCare, with Envolve serving as its PBM. Envolve is also owned by Centene.
- **Molina** - CVS Caremark serves as the PBM for Molina. As stated previously, CVS Caremark has its own network of affiliated pharmacies.

As described previously related to the FTC comments, complainants allege that affiliations can lead to patient steering, in which PBMs steer beneficiaries to their own pharmacies. This is done by either requiring drugs to be dispensed through their own pharmacies or making drugs cheaper at their own pharmacies. Complainants further allege that PBMs may require drugs to be dispensed through

a mail-order pharmacy which cuts off beneficiaries from preferred pharmacists that can advise them on their drug regimen and can create barriers to medications.

Auditors reviewed the encounter data to check for evidence of affiliations. Auditors took three drugs from the top ten drugs prescribed for the week ending October 7, 2021, and reviewed how many of these prescriptions were filled by MCO and pharmacy. The results are shown in Exhibit 14. Aetna had very few prescriptions filled at Walgreens, while its affiliated pharmacy, CVS, distributed most of the prescriptions filled by Aetna customers. The opposite was true for Blue Cross Blue Shield, which filled most of its prescriptions through Walgreens, and very few through CVS. When auditors looked into why this occurred, it was determined that Walgreens had a contractual relationship with Prime (PBM for Blue Cross) while Caremark (PBM for Aetna) is owned by CVS. Caremark dropped Walgreens from its provider network in December 2020, which was likely due to its affiliation.

Exhibit 14
PRESCRIPTIONS FILLED BY PHARMACY THROUGH AETNA, BCBS, AND MERIDIAN
October 1 through 7, 2021



Source: Department of Healthcare and Family Services encounter data.

When auditors asked about the differences identified in the exhibit, HFS officials responded that shutting out other non-affiliated pharmacies is competitive and profitable, that HFS was only concerned with the MCOs being in compliance with federal regulations, and that the PBMs were under the administration of the MCOs, not HFS. Auditors questioned how this practice could be competitive, but HFS officials responded that other PBMs do the same. When auditors met with the HFS OIG, OIG officials agreed there were network access concerns with regards to affiliated pharmacies and the removal of competitor pharmacies from networks.

There are other issues related to these affiliations that HFS should monitor. One mentioned by some pharmacies was that reimbursement rates are set by their competitors. Additionally, based on MCO contract reviews of complaints, due to affiliations (mainly with Caremark which is owned by CVS), Caremark performs pharmacy audits on its competitors. This appears to possibly be an unfair business practice and may need to be addressed by HFS when adopting its administrative rule on conflict of interest.

HFS should address MCO, PBM, and pharmacy affiliations when it defines conflict of interest in the Illinois Administrative Code as required by 305 ILCS 5/5-36(d). To ensure that pharmacy reimbursements are competitive and that the State receives the best prices, HFS should monitor the affiliations between the MCOs, PBMs, and pharmacies. Additionally, HFS should monitor these affiliations to ensure access to care for Medicaid recipients is not affected.

Affiliations

RECOMMENDATION NUMBER	
5	***The Illinois Department of Healthcare and Family Services should address affiliations between MCOs, PBMs, and pharmacies when it defines conflict of interest in the Administrative Code as required by 305 ILCS 5/5-36(d).***

HFS Response: The Department accepts the recommendation. Department management stated, Section 9.2 of the contracts defines "affiliations" for conflicts of interest; however, the Department can include affiliations when it develops the conflict of interest rules.

Contract language

9.2.30 Conflict of interest. In addition to any other provision in this Contract governing conflicts of interest, Contractor certifies that neither Contractor nor any party directly or indirectly affiliated with Contractor, including Contractor's officers, directors, employees, and subcontractors, and the officers, directors, and employees of Contractor's subcontractors, shall have or acquire any conflict of interest in performance of this Contract.

9.2.30.1 For purposes of this section 9.2.30, "conflict of interest" shall mean an interest of Contractor, or any entity described above, that may be direct or indirect, professional, personal, financial, or beneficial in nature; that, at the sole discretion of the Department, compromises, appears to compromise, or gives the appearance of impropriety with regard to Contractor's duties and responsibilities under this Contract. This term shall include potential conflicts of interest. A conflict of interest may exist even if no unethical or improper act results from it, or may arise where Contractor becomes a party to any litigation, investigation, or transaction that materially affects Contractor's ability to perform under this Contract. Any situation in which Contractor's role under the Contract competes with Contractor's professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable individual, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur, or that gives the appearance of the existence of bias or improper conduct, is a conflict of interest.

9.2.30.2 Contractor shall disclose in writing any conflicts of interest to the Department no later than seven (7) days after learning of the conflict of interest. The Department may initiate any inquiry as to the existence of a conflict of interest. Contractor shall cooperate with all inquiries initiated pursuant to this section 9.2.30. Contractor shall have an opportunity to discuss the conflict of interest with the Department and suggest a remedy under this section 9.2.30.

9.2.30.3 Notwithstanding any other provisions in this Contract, the Department shall, at its sole discretion, determine whether a conflict of interest exists or whether Contractor failed to make any required disclosure. This determination shall not be subject to appeal by Contractor. If the Department concludes that a conflict of interest exists, or that Contractor failed to disclose any conflict of interest, the Department may impose one or more remedies, as set forth below.

9.2.30.4 The appropriate remedy for a conflict of interest shall be determined at the sole discretion of the Department and shall not be subject to appeal by Contractor. Available remedies shall include the elimination of the conflict of interest or the nonrenewal or termination of the Contract.

Auditor Comment:

We agree that the Department should include affiliations when it develops the conflict of interest rules. The contract language cited by the Department only appears in 3 of the 6 contracts and does not define affiliations. The contract language states any interest that compromises, appears to compromise, or gives the appearance of impropriety with regard to duties under the contract is a conflict of interest. The affiliations mentioned in our report may fall under this definition, which is why the Department needs to define conflict of interest by rule and specifically define affiliations.

Appendix A
Senate Resolution Number 792

SR0792

SENATE RESOLUTION

WHEREAS, The Medicaid program in Illinois has an immense and growing impact, both in terms of taxpayer dollars and in the effect it has on citizens across the State; and

WHEREAS, State resources for healthcare services are scarce, and many healthcare providers, including pharmacists, are discontinuing services or ceasing operation, leading to a profoundly detrimental impact on our communities and the expansion of pharmacy deserts; and

WHEREAS, Enrollment under the Illinois Department of Healthcare and Family Services' Medical Assistance Programs (Medicaid) exceeds three million; and

WHEREAS, A sizable portion of the Medicaid population is currently enrolled, often mandatorily, in Managed Care Organizations (MCOs), making outlays to MCOS, measured in billions of dollars, one of the largest disbursements in the State; and

WHEREAS, 12,500 licensed pharmacists in Illinois provide medications and patient care services to assure the rational and safe use of all medications; and

WHEREAS, Pharmacists, as front-line healthcare providers, answered the call to aid during the ongoing COVID-19 pandemic and have assumed additional responsibilities of care and practice in order to best serve the public health needs of the citizens of the State of Illinois; and

WHEREAS, A significant number of pharmacists respond to the charge of their community to establish a pharmacy to provide access to care for their patients; and

WHEREAS, Pharmacies generate additional taxable revenue for the State and yet are continuously reimbursed below their cost on medications dispensed to meet their patient's needs; and

WHEREAS, Pharmacy benefit managers are companies that manage prescription drug benefits on behalf of Illinois' Managed Care Programs, which includes providing claims processing services or other prescription drug services; and

WHEREAS, Public Act 101-452, which was signed into law August 23, 2019 and went into effect on January 1, 2020, provides oversight of pharmacy benefit managers; and

WHEREAS, A number of other states have performed audits evaluating the role and benefit of pharmacy benefit managers;

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and

WHEREAS, It is paramount that the General Assembly stay engaged in Medicaid funding and corresponding healthcare outcome issues and be prepared to make legislative and administrative recommendations; therefore, be it

RESOLVED, BY THE SENATE OF THE ONE HUNDRED SECOND GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that the Auditor General is directed to conduct a performance audit of the Department of Healthcare and Family Services' administration of pharmacy benefit managers; and be it further

RESOLVED, That the performance audit include, but not be limited to, the following determinations:

(1) The amount of State and federal funds used by managed care organizations to reimburse pharmacy benefit managers and, in time, the amount paid by pharmacy benefit managers to reimburse pharmacies for fiscal years 2020 and 2021;

(2) An examination of contracts between managed care organizations and pharmacy benefit managers and between pharmacy benefit managers and pharmacies receiving reimbursement;

(3) The level of oversight the Department of Healthcare and Family Services provides over the contracts

and over the pharmacy benefit managers to ensure compliance with contract requirements;

(4) An overview of the distribution of and payments for pharmaceuticals in the medical assistance managed care program;

(5) A review of the reimbursement practices and reimbursement rates of managed care organizations to pharmacy benefit managers; and

(6) A review of the reimbursement practices and reimbursement rates of pharmacy benefit managers to pharmacies, including out-of-state pharmacies and pharmacies affiliated with pharmacy benefit managers; and be it further

RESOLVED, That the Illinois Department of Healthcare and Family Services, as well as any other entity that may have information pertaining to this audit, cooperate fully and promptly with the Auditor General's Office in the conduct of this audit; and be it further

RESOLVED, That the Auditor General commence this audit as soon as possible and report his findings and recommendations upon completion in accordance with the provisions of Section 3-14 of the Illinois State Auditing Act; and be it further

RESOLVED, That a copy of this resolution be delivered to

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the Auditor General and the Illinois Department of Healthcare and Family Services.

Appendix B
Audit Scope and Methodology

This performance audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

Audit standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives found in Senate Resolution Number 792.

The audit objectives were delineated in Senate Resolution Number 792, which directed the Auditor General to conduct a performance audit of the Department of Healthcare and Family Services (HFS). The Resolution contained six determinations (see Appendix A).

A large amount of the information related to MCOs is confidential and proprietary per 305 ILCS 5/5-36(f). As a result, auditors aggregated and summarize information in the report instead of reporting specific numbers and contract information.

In conducting this audit, auditors reviewed applicable State statutes and rules. Auditors also reviewed management controls and assessed risk related to the audit's objectives. Auditors examined the five components of internal control – control environment, risk assessment, control activities, information and communication, and monitoring – along with the underlying principles. We considered all five components to be significant to the audit objectives. Any deficiencies in internal controls and monitoring that were significant within the context of the audit objectives are discussed in the body of the report.

During the audit, auditors conducted interviews and phone conferences with officials from HFS, the Illinois Pharmacists Association, and all pharmacy benefit managers (PBMs). Auditors also requested and reviewed specific documents and other information related to the audit, including annual reports, PBM affiliations, complaints made to the Federal Trade Commission, other state audits and studies, capitation payments made to MCOs, rebate payments made to HFS, and monitoring documents from HFS' contracted actuary, Milliman.

Encounter Data

In order to review reimbursement rates paid to pharmacies, auditors requested and received encounter data from October 1 through October 7, 2021. The data included pharmacy names, product descriptions, quantity and supply numbers, and payments made under both the managed care and fee-for-service programs. The encounter data itself is not reviewed, verified, or audited. According to Milliman, the encounter data has "limitations." It was noted that the data was accepted from HFS without audit. This encounter data is also self-reported. As a result, the entire monitoring function of the rates paid to pharmacies by PBMs is

limited and based on self-reported, unaudited encounter data. Auditors analyzed this data to find the top prescribed drugs, their total cost by MCO, and how many were distributed per MCO. Auditors also used this data to analyze the distribution of the top three prescribed drugs by MCO and pharmacy for any evidence of patient steering.

During this review, auditors determined that the reimbursements were complicated due to different contractual methodologies. Auditors determined that reimbursements for drugs varied by PBM, by pharmacy, and for each drug. The encounter data showed that pharmacies were paid different prices for the same drug depending on the PBM. The data also showed each PBM paid its contracted pharmacies differently for the same drug. Because this results in different reimbursement rates between drugs and pharmacies, auditors determined that the data was too complicated to analyze for overall trends.

Contracts

Auditors requested unredacted contracts and their amendments between all five MCOs and their PBMs, in order to review them for compliance with statutory requirements. Auditors reviewed these contracts for compliance with requirements found in the Illinois Insurance Code (215 ILCS 5/513b1) and the Illinois Public Aid Code (305 ILCS 5/5-30 and 5-36), as well as other criteria.

Auditors also requested unredacted contracts and their amendments between each PBM and their network pharmacies. Because each PBM has hundreds of pharmacies, auditors were provided with boilerplate contracts. Some of these PBMs had different contracts for pharmacies depending on whether they were independent/chain or retail/specialty pharmacies, but the bulk of the contract language stayed the same. Auditors reviewed these contracts for compliance with the Illinois Public Aid Code (305 ILCS 5/5-36) as well as other criteria.

The date of the Exit Conference, along with the principal attendees, are noted below:

Exit Conference	April 6, 2023
Agency	**Name and Title**
Illinois Department of Healthcare and Family Services	• Ben Winick, Chief of Staff • Amy Roberts, Bureau of Managed Care • Justin Sinner, Bureau Chief, Budget and Cash Management • Christopher Gange, Deputy General Counsel, Litigation and Eligibility • Heather Freeman, Manager, Pharmacy Billing/Professional & Ancillary Services • Jose Jimenez, Bureau Chief, Professional & Ancillary Services • Steffanie Garrett, General Counsel • Mike Casey, Administrator, Division of Finance • Amy Lyons, External Audit Liaison • Jamie Nardulli, Chief Internal Auditor • Robert Mendonsa, Deputy Administrator of Care Coordination Rate and Finance Administration • Laura Ray, Bureau Chief of Managed Care
Illinois Office of the Auditor General	• Scott Wahlbrink, Senior Audit Manager • Bill Helton, Audit Manager • Megan Chrisler, Audit Supervisor • Josh Kuhl, Audit Staff

Appendix C
Agency Response

HFS
Illinois Department of
Healthcare and Family Services

JB Pritzker, Governor
Theresa A. Eagleson, Director

201 South Grand Avenue East, Springfield, Illinois 62763
Telephone: +1 217-782-1200, TTY: +1 800-526-5812

April 13, 2023

Honorable Frank J. Mautino
Auditor General
740 East Ash
Springfield, IL 62703

Dear Auditor General Mautino:

The Department of Healthcare and Family Services (HFS) appreciates the work performed by your office in conducting the audit of the "Pharmacy Benefit Managers".

Enclosed with this letter are detailed responses that address each of the recommendations.

If you have any questions or comments about our responses to the recommendations, please contact Amy Lyons, External Audit Liaison, at (217) 558-4347 or through email at amy.lyons@illinois.gov.

Sincerely,

SIGNED ORIGINAL ON FILE

Theresa Eagleson
Director
Illinois Department of Healthcare and Family Services

Finding Statement: *#1 Contractual requirements missing*

Recommendation: *The Illinois Department of Healthcare and Family Services should ensure that contracts between MCOs and PBMs include the contractual requirements outlined in 215 ILCS 513b1 and 305 ILCS 5/5-30(h).*

Response: The Department accepts the recommendation. The Department believes the current contracts include the requirements as those contracts state the MCOs are responsible for its subcontractors and requires the MCOs and its subcontractors to comply with all laws and rules; however, HFS will ensure compliance with the contract requirements between the MCOs and PBMs.

Finding Statement: *#2 More detailed monitoring of MCOs and PBMs is needed*

Recommendation: *The Illinois Department of Healthcare and Family Services should provide more detailed monitoring of managed care organizations and their pharmacy benefit managers. Specifically, it should:*

- *Report to the General Assembly on an annual basis as required by 305 ILCS 5/5-36(c);*
- *Request and monitor PBM information as allowed and required by 305 ILCS 5/5-36(e), (g), and (h); and*
- *Review and approve dispute resolution processes provided by PBMs as required by 305 ILCS 5/5-36(j).*

Response: The Department accepts the recommendation. The Department will prepare and issue a report to the General Assembly on an annual basis as required by 305 ILCS 5/5-36(c). In addition, HFS will implement a process to request PBM information as allowed and required by 305 ILCS 5/5-36(e), (g), and (h). Furthermore, we will implement a process to review and approve dispute resolution processes provided by PBMs as required by 305 ILCS 5/5-36(j).

Finding Statement: *#3 Conflict of Interest is not defined as required*

Recommendation: *The Illinois Department of Healthcare and Family Services should define "conflict of interest" in administrative rules as required by 305 ILCS 5/5-36(d).*

Response: The Department accepts the recommendation. Section 9.2 of the HCI Contract, Certifications, defines conflicts of interest, and the MCOs attest to compliance with Section 9.2 on an annual basis per Attachment XIII and Attachment IX: Disclosures of Conflicts of Interest; however, the Department will define conflict of interest in administrative rules as required.

Finding Statement: *#4 Monitor rates between MCOs and PBMs as required*

Recommendation: *The Illinois Department of Healthcare and Family Services should monitor reimbursement rates between managed care organizations and their pharmacy benefit managers, as required by the Illinois Public Aid Code.*

Response: The Department monitors reimbursements from the MCOs to the PBMs for the purpose of ensuring that administrative payments to the PBMs are not counted as medical benefits paid by the MCOs.

Finding Statement: *#5 Address affiliations between MCOs, PBMs and Pharmacies when defining conflict of interest*

Recommendation: *The Illinois Department of Healthcare and Family Services should address affiliations between MCOs, PBMs, and pharmacies when it defines conflict of interest in the Administrative Code as required by 305 ILCS 5/5-36(d).*

Response: The Department accepts the recommendation. Department management stated, Section 9.2 of the contracts defines "affiliations" for conflicts of interest; however, the Department can include affiliations when it develops the conflict of interest rules.

Contract language
9.2.30 Conflict of interest. In addition to any other provision in this Contract governing conflicts of interest, Contractor certifies that neither Contractor nor any party directly or indirectly affiliated with Contractor, including Contractor's officers, directors, employees, and subcontractors, and the officers, directors, and employees of Contractor's subcontractors, shall have or acquire any conflict of interest in performance of this Contract.
9.2.30.1 For purposes of this section 9.2.30, "conflict of interest" shall mean an interest of Contractor, or any entity described above, that may be direct or indirect, professional, personal, financial, or beneficial in nature; that, at the sole discretion of the Department, compromises, appears to compromise, or gives the appearance of impropriety with regard to Contractor's duties and responsibilities under this Contract. This term shall include potential conflicts of interest. A conflict of interest may exist even if no unethical or improper act results from it, or may arise where Contractor becomes a party to any litigation, investigation, or transaction that materially affects Contractor's ability to perform under this Contract. Any situation in which Contractor's role under the Contract competes with Contractor's professional or personal role may give rise to an appearance of impropriety. Any conduct that would lead a reasonable individual, knowing all the circumstances, to a conclusion that bias may exist or that improper conduct may occur, or that gives the appearance of the existence of bias or improper conduct, is a conflict of interest.
9.2.30.2 Contractor shall disclose in writing any conflicts of interest to the Department no later than seven (7) days after learning of the conflict of interest. The Department may initiate any inquiry as to the existence of a conflict of interest. Contractor shall cooperate with all inquiries initiated pursuant to this section 9.2.30. Contractor shall have an opportunity to discuss the conflict of interest with the Department and suggest a remedy under this section 9.2.30.
9.2.30.3 Notwithstanding any other provisions in this Contract, the Department shall, at its sole discretion, determine whether a conflict of interest exists or whether Contractor failed to make any required disclosure. This determination shall not be subject to appeal by Contractor. If the Department concludes that a conflict of interest exists, or that Contractor failed to disclose any conflict of interest, the Department may impose one or more remedies, as set forth below.
9.2.30.4 The appropriate remedy for a conflict of interest shall be determined at the sole discretion of the Department and shall not be subject to appeal by Contractor. Available

remedies shall include the elimination of the conflict of interest or the nonrenewal or termination of the Contract.

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