A Performance Audit of Texas Medicaid Managed Care Pharmacy Benefits Managers

For the Period
March 1, 2012 through April 30, 2012

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To the Texas Health and Human Services Commission (HHSC):

PHBV Partners LLP (PHBV) has completed a performance audit of three subcontracted Pharmacy Benefit Managers (PBMs). These PBMs provide pharmacy benefit services to the Texas Medicaid and Children's Health Insurance Program (CHIP) populations in certain geographical areas in the State of Texas who are enrolled with five Managed Care Organizations (MCOs) contracting directly with HHSC. The purpose of this engagement was to report on the results of our performance audit procedures applied to assess the three PBM's compliance with specific contractual requirements as set forth in the objectives of this performance audit. Our audit covered the period March 1, 2012 through April 30, 2012.

We are conducting this audit in accordance with the performance audit provisions of *Generally Accepted Government Auditing Standards (December 2011 Revision*) (GAGAS) issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Much of the documentation provided by the MCOs and PBMs and reviewed by us during the audit was labeled as proprietary and confidential by the MCOs and PBMs in an attempt to protect certain information, such as reimbursement practices, from disclosure to business competitors. The audit results included in our report intentionally omit certain details specific to any one MCO or PBM to protect the MCOs and PBMs claims regarding the proprietary and confidential nature of the information reviewed.

This report is intended solely for the information and use of HHSC, the Texas State Legislature, the MCOs participating in the Texas Medicaid Managed Care program, and is not intended to be, and should not be, used by anyone other than these specified parties.

PHBV Partners LLP

Austin, TX
December 20, 2012

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Executive Summary

Introduction

Effective March 1, 2012, the Texas Health and Human Services Commission (HHSC) carved certain Medicaid and Children's Health Insurance Program (CHIP) pharmacy benefits into the managed care service delivery model in accordance with Texas Senate Bill 7 provisions. The managed care organizations (MCOs), who contract with HHSC to deliver medical benefits to most of the State's Medicaid and CHIP populations, have subcontracted the pharmacy benefit management function to various Pharmacy Benefits Managers (PBMs).

HHSC contracted with PHBV Partners LLP (PHBV) to conduct a performance audit of three PBMs. The purpose of this report is to provide the results from our performance audit regarding the three PBMs' compliance with specific contractual obligations as set forth in the objectives of this performance audit.

Objectives, Scope and Methodology

The purpose of this engagement is to provide HHSC with an independent assessment of the following four defined objectives:

1. Review transparency of the PBM's pharmacy reimbursement practices and disclosures to ensure they are within contractual and industry standards.

2. Review the PBM's reimbursement practices and costs to determine if they are in accordance with the contractual agreement between the PBMs and MCOs, and that they are applied equitably between related party and independent pharmacies.

3. Review payment data reported to pharmacies and MCOs by the PBMs, and claims data from the pharmacies to the PBMs, to determine accuracy and completeness.

4. Assess the PBM's compliance with Senate Bill 7 provisions regarding: related party specialty pharmacy subcontractors; rebate negotiation/collection prohibition; employment of the vendor drug formulary; adherence to the preferred drug list and inclusion of the prior authorization procedure and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program. In addition, assess the PBM's compliance with the 2012-2013 General Appropriations Act provision requiring management of a prior authorization process that is no more stringent than the prior authorization processes used by the Medicaid Vendor Drug Program.

Our audit covered the period March 1, 2012 through April 30, 2012.

Our methodology for conducting the engagement included the following:

1. Review of model contract language between MCOs and HHSC;
2. Review of select pharmacy complaints provided by HHSC;
3. Selection of specific PBMs and MCOs to be audited;
4. Review of contracts between each MCO and PBM selected;
5. Sampling of specific pharmacies to be reviewed for each PBM and MCO combination;
6. Review of contracts between the PBMs and sampled pharmacies to compare to contractual reimbursement provisions between the PBMs and MCOs, to compare to standard industry practices, and to assess reimbursement consistency between related and unrelated pharmacies;
7. Review documentation from the PBMs to support contractually required disclosures related to reimbursement;
8. Review a sample of PBM rebate contracts with drug manufacturers to ensure PBM compliance with Senate Bill 7 rebate prohibitions, perform a walkthrough of PBM internal controls and compliance monitoring, and review practices in place to ensure compliance with rebate prohibition requirements;
9. Review a sample of claims data submitted by the pharmacy to the PBM and the associated PBM payments to the pharmacies as well as all associated payments from the MCOs to the PBM, to determine accuracy and completeness of reimbursements under the contract;
10. Compare the PBM's formularies to the Vendor Drug Program (VDP) formulary using our data analysis software;
11. Perform system walkthroughs at the PBMs for their adherence to the VDP Preferred Drug Listing (PDL);
12. Review PBM prior authorization (PA) records and determine if PA was properly administered;
13. Compare the PBM PDL to the VDP PDL to ensure the PBM is not implementing PA requirements prior to the VDP PDL effective dates;
14. Review of the PBM's policies and procedures regarding the use of PAs and analyze for compliance with regulatory requirements;

15. Review PA claims samples to determine if they meet timely response requirements;

16. Review claims data for adherence to 72-hour emergency supply dispensing requirements;

17. Review PA data and procedures to ensure PAs can be submitted via telephone, facsimile, or by electronic communication through the Internet;

18. Review clinical edits and related logic to ensure clinical edits utilized are no more stringent than the related VDP clinical edits.

Summary of Results

Are the PBM pharmacy reimbursement practices and disclosures transparent and within contractual and industry standards?

Some components of the PBM's reimbursement practices, such as the Average Wholesale Price (AWP) reimbursement and Usual and Customary reimbursement, are transparent because they are specified in the contracts with the pharmacies and AWP is based on widely published data. As a result, the pharmacies do need to search to obtain this information since the PBMs do not proactively provide it to them, but this information is readily available to those pharmacies who perform the search for it.

The Maximum Allowable Cost (MAC) component of the PBM's reimbursement practices was not transparent at the time of contract negotiations, but was available either upon request by pharmacies, or at the point of sale, depending on the PBM. The point of sale disclosure methodology is the least transparent practice since the unit reimbursement amount is not available to the pharmacy until the prescription is received and the pharmacy communicates the transaction to the PBM.

The use of the lesser-of logic methodology for determining reimbursement pricing is a standard reimbursement practice within the pharmacy benefit industry. It should be noted that while the lesser-of logic methodology is a standard reimbursement practice, the AWP discount percentages vary by PBM pharmacy contract and are based on negotiations, which is standard practice.

We found that the contracts do not contain specific disclosure requirements for reimbursement practices and that the PBMs are following standard industry practices relating to disclosures for reimbursement practices.

Survey the pharmacies to gain an understanding of the negotiating and contracting process between the PBMs and the pharmacies.

We surveyed 25 pharmacies and received 17 responses. Based on the survey responses received and follow-up communications with the pharmacies, there is little negotiation between the PBMs and the pharmacies. A majority of the pharmacies rely on a Pharmacy Services Administration Organization (PSAO) to negotiate for them, and are not involved in the negotiation process.

Are PBM reimbursement practices and costs to the pharmacies in accordance with the contractual agreements between the PBM and the MCOs? Are PBM reimbursement practices and costs applied equitably between pharmacies related to the PBM and independent pharmacies?

We reviewed the contracts between the pharmacies and the PBMs, and the contracts between the PBMs and the MCOs, and determined for all three of the PBMs the reimbursement practices and costs are compliant between both sets of contracts. For PBM B and PBM C, the contracts between the PBMs and their respective MCOs require a transparent pass-through reimbursement structure where the MCOs are charged the rate the PBM pays to the pharmacies. For PBM A, they have entered into a lock-in reimbursement between the PBM and the MCO which is not based on the amounts the PBM pays the contracted pharmacies. This arrangement is compliant with current regulatory guidance.

Based on our testing of the contracts of related party pharmacies and independent pharmacies, in conjunction with our independent recalculation of pharmacy claim payments (Objective 3), we concluded that the related party pharmacy reimbursement practices are consistent with those applied to unrelated parties and are in compliance with reimbursement practices required by the contract.

Are the payments reported to the pharmacies and the MCOs by the PBM accurate and complete? Is the claims data from the pharmacies to the PBM accurate and complete?

Through our testing of invoices, we concluded that the payments made to the pharmacies are accurately recorded at the PBM. Further, we concluded that the pharmacy payment is properly reflected on the invoice to the MCO from the PBM. In addition, we concluded that the payment to the PBM by the MCO is accurately recorded and ties to the invoice from the PBM. Finally, we independently recalculated the claims payments for a sample of claims and concluded that the payments were accurate.

Are the PBMs compliant with Senate Bill 7 provisions regarding: related party specialty pharmacy subcontractors; rebate negotiation and collection prohibition; employment of the vendor drug formulary; adherence to the preferred drug list (PDL) and inclusion of the prior authorization (PA) procedure and requirements prescribed by Sections 531.073(b), (c), and (g) for the vendor drug program?

PBM A and PBM B do not have related party pharmacies. PBM C does have related party specialty pharmacies and we verified that members have various network options for specialty pharmacies and are not required to utilize the PBM's related party specialty pharmacies. As a result, all three PBMs are in compliance with the provisions of Senate Bill 7.

Through our testing of the manufacturer contracts, rebate submissions, and manufacturer confirmations, we determined that the PBMs are not submitting Texas Medicaid and CHIP claims for rebates and are adhering to the rebate prohibition under Senate Bill 7.

Based on our testing to compare the PBM formularies to the HHSC VDP formularies, we found there are instances of non-compliance regarding PBM adherence to the HHSC formulary requirements. These issues arise because the PBMs are either adding or deleting NDCs based on NDC status in Medi-Span®. (See Finding #1)

We found that the PBMs did not adhere to all PDL requirements during the scope of our audit. One PBM had a non-preferred drug established as a preferred drug, allowing claims to adjudicate without a PA. (See Finding #2) Through our testing, we found that four of the five MCOs did not adhere to the PDL as prescribed by HHSC VDP during various periods. These PBMs and MCOs phased in the PDL PA logic during March and April, so there were periods where the PA process was not enforced. (See Finding #3) During our detailed testing of the PDL, we could not determine if claims paid correctly with a PA for a part of the sample at two PBMs as they were unable to provide support. (See Finding #4)

Are the PBMs compliant with the 2012-2013 General Appropriations Act provision requiring management of the prior authorization process that is not more stringent than the process used by the Medicaid Vendor Drug Program?

We found that one PBM's prior authorization process is not more stringent than the PA processes used by HHSC VDP and is in compliance with Senate Bill 7. For the other two PBMs, their prior authorization process was more stringent than the PA process used by HHSC VDP and was not in compliance with Senate Bill 7. (See Finding #5)

Background Information

HHSC provided a file of complaints received and a file of total pharmacy benefit dollar amounts paid by HHSC to each MCO subcontracted to provide benefits for Texas Medicaid and CHIP members. Based on review of the complaints received and dollar exposure, the following three PBMs and five MCOs were selected for testing:

- CaremarkPCS Health LLC (Caremark) (PBM)
- Navitus Health Solutions, LLC (Navitus) (PBM)
- US Script, Inc. (US Script) (PBM)
- AMERIGROUP Insurance Company (AMERIGROUP)
- Molina Healthcare, Inc. & Molina Healthcare of Texas, Inc. (Molina)
- Texas Children's Health Plan (TCHP)
- Community Health Choice, Inc. (CHC)
- Superior HealthPlan, Inc. and Bankers Reserve Life Insurance Company of Wisconsin d/b/a Superior HealthPlan Network (collectively "Superior")

For confidentiality reasons the PBMs and MCOs are not referred to in this order within the report.

Glossary of Terms

Average Wholesale Price (AWP) – A benchmark that has been used for over 40 years for pricing and reimbursement of prescription drugs for both government and private payers. AWP may be determined by several different methods. The drug manufacturer may report the AWP to the individual publisher of drug pricing data, such as Medi-Span®. The AWP may also be calculated by the publisher based upon a mark-up specified by the manufacturer that is applied to the wholesale acquisition cost (WAC) or direct price. AWP has often been compared to the "list price" or "sticker price", meaning it is an elevated drug price that is rarely what is actually paid due to the application of discounts from the AWP base in most pharmacy contracts.

Chain Pharmacy – Publicly traded retail pharmacies related through common ownership or control.

Claims Exposure – Prescription drug claim amounts paid on behalf of HHSC that meet specific audit testing criteria.

Drug Utilization Review (DUR) – An authorized, structured, ongoing review of prescribing, dispensing and use of medication. DUR encompasses a drug review against predetermined criteria that results in changes to drug therapy when these criteria are not met. It involves a comprehensive review of patients' prescription and medication data before, during and after dispensing to ensure appropriate medication decision-making and positive patient outcomes.

Formulary – A list of prescription drugs covered under a specific health insurance plan.

Independent Pharmacy – A retail pharmacy that is not directly affiliated with a chain of pharmacies and is not owned (or operated) by a publicly traded company.

Lock-in Reimbursement - A reimbursement arrangement where the amounts the MCO pays the PBM are based on the contract between the PBM and MCO and are not based on amounts the PBM actually pays their contracted network pharmacies.

Maximum Allowable Cost (MAC) – The unit reimbursement amount established by PBMs for multi-source drugs. MAC reimbursement schedules are PBM specific and typically involve no contractual requirements for what drugs are included or how the unit reimbursement is determined.

Medi-Span® – A provider of prescription drug information and drug interactions database solutions, including drug pricing benchmarks such as AWP and wholesale acquisition cost (WAC). Note that WAC pricing benchmarks are not utilized as the basis for pricing within the scope of this audit.

Pharmacy Buying Association (PBA) – An organization leverages purchasing power of a group of pharmacies to obtain discounts and rebates from preferred suppliers of drugs and other products.

Pharmacy Services Administration Organization (PSAO) –An organization that leverages negotiating power of a group of independent pharmacies to obtain higher drug reimbursement prices from payers. In addition, PSAOs may administer the contracts between the pharmacies and PBMs.

VDP Preferred Drug Listing (PDL) – A listing of certain drugs from the Vendor Drug Program formulary that includes drugs with preferred status (those that do not require prior authorization before claims will be approved for payment) and drugs with non-preferred status (those that require prior authorization before claims will be approved for payment) . Preferred status of a drug is based on recommendations from the Pharmaceutical and Therapeutics Committee, clinical efficacy of the drug, and comparisons of drug reimbursement.

Preferred Drug – A drug identified as having preferred status on the Vendor Drug Program Preferred Drug Listing.

Prior Authorization (PA) – The process of requiring a prescriber to confirm that certain criteria are satisfied for specific covered drugs prior to approving the related claims for payment. The PA process is utilized to ensure that specific criteria (treatment failure with preferred drugs, contraindication to preferred drugs, allergic reaction to preferred drugs, etc.) are satisfied before a drug identified as non-preferred on the VDP PDL will be approved for payment.

Related Party – Entities that are related to one another through common ownership or control.

Specialty Pharmacy – A pharmacy that has entered into an agreement with a PBM to dispense covered specialty drugs to Medicaid plan members.

Specialty Drugs – Typically high-cost drugs that are used to treat and diagnose rare or complex diseases, require close clinical monitoring, frequently require special handling and may have limited access or distribution.

Step-Therapy – The automated process by which a PBM evaluates the beneficiaries' prior drug treatment history to assess if the beneficiary has met the criteria (treatment failure with preferred drugs, contraindication to preferred drugs, allergic reaction to preferred drugs, etc.) for coverage of a non-preferred drug without requiring the prior authorization process.

Target Pricing – A contractual drug reimbursement guarantee offered by a PBM that limits reimbursement exposure to the MCOs. Actual results are reconciled periodically and costs deemed in excess of the target reimbursement guarantees (if applicable) are refunded to the MCOs.

Unrelated Party – Entities that have no relationship to one another, either through common ownership or control.

Usual and Customary (U&C) – A pharmacy's usual retail selling price for a prescription drug to cash paying customers.

Detailed Audit Results

Objective 1: Review transparency of the Pharmacy Benefit Managers (PBM) pharmacy reimbursement practices and disclosures to ensure they are within contractual and industry standards.

The Medicaid pharmacy benefits were carved into the Medicaid Managed Care contracts effective March 1, 2012. Shortly after the transition, pharmacies began to voice concerns regarding the lack of transparency of the reimbursement rates for drugs on the MAC lists and reimbursement practices that were inconsistent with the Vendor Drug Program prior to the Managed Care carve-in.

To address concerns raised by the pharmacies, we selected a sample consisting of related party pharmacies and unrelated pharmacies, including at least one pharmacy whose rates were negotiated by the MCO in order to meet network adequacy requirements, for each PBM and MCO combination. The samples were based on complaints received by HHSC, geographic considerations and payment amounts. We reviewed contracts for the sampled pharmacies to:

1. Determine if the pharmacy reimbursement practices are transparent;
2. Determine if the pharmacy reimbursement practices are consistent with standard industry practices; and
3. Ensure compliance with contractually required reimbursement disclosures.

In addition, we surveyed the pharmacies to gain an understanding of the negotiating and contracting process between the PBMs and the pharmacies. We surveyed 25 pharmacies and received 17 responses.

Objective 1 Conclusion

Some components of PBM reimbursement practices (AWP reimbursement and Usual and Customary reimbursement) are transparent because they are specified in the contracts with pharmacies and AWP is based on widely published data. As a result, the pharmacies do need to search to obtain this information since the PBMs do not proactively provide it to them, but this information is readily available to those pharmacies that perform the search for it. The MAC component of PBM reimbursement was not transparent at the time of contract negotiations, but was available either upon request by pharmacies or at the point of sale, depending on the PBM. The point of sale disclosure methodology is the least transparent practice since the unit reimbursement amount is not available to the pharmacy until the pharmacy submits the claim to the PBM. The use of the lesser-of logic methodology for determining reimbursement pricing is a standard reimbursement practice within the pharmacy benefit industry. It should be noted that while the lesser-of logic practice is a standard practice, the AWP discount percentages vary by PBM pharmacy contract and based on negotiations, which is also a standard practice. We found

that the contracts do not contain specific disclosure requirements for reimbursement practices including AWP reimbursement practices and MAC list details. We also found that the PBMs are following standard industry practices relating to disclosures for reimbursement practices.

Based on the survey responses received and follow-up communications with the pharmacies, there is little negotiation between the PBMs and the pharmacies. A majority of the pharmacies rely on a PSAO to negotiate for them and are not involved in the negotiation process. Of the three PBMs, only one PBM provides a higher reimbursement to the independent pharmacies than the chain pharmacies with their MAC reimbursement.

Objective 1 Detailed Results

Determine if the pharmacy reimbursement practices are transparent.

Based on our review of the sampled pharmacy contracts and communication with the three PBMs, some components of PBM reimbursement practices are transparent, such as the AWP reimbursement and the Usual and Customary reimbursement. For all three PBMs, however, their MAC reimbursement practices are not transparent with respect to pharmacy reimbursement practices and disclosures. Each pharmacy, pharmacy chain or Pharmacy Services Administrative Organization (PSAO) agrees to specific drug reimbursement parameters through contractual arrangement between the pharmacy, or PSAO, and their respective PBM. The pharmacy reimbursement practices are set out in these contracts. Contractual reimbursement parameters are based on externally published data, such as Average Wholesale Price (AWP), or based on pharmacy submitted data, such as submitted price or Usual and Customary (U & C) charges. The exception is for generic drugs, which may be subject to a PBM specific Maximum Allowable Cost (MAC) schedule.

Each PBM is slightly different in how they make the MAC unit reimbursement amounts available, but all three PBMs assert that their MAC reimbursement amounts are available to pharmacies. We found that MAC reimbursement details are provided to pharmacies only through a point-of-sale (POS) process or through written request by the pharmacy, depending on the PBM. The point-of-sale process only allows pharmacies to see the MAC reimbursement after they submit the claim to the PBM for reimbursement. Even when PBMs allow the pharmacies to obtain MAC lists through a written request, the pharmacies will not automatically receive updates to the MAC from the PBM, which can occur as frequent as daily. Therefore, although the reimbursement practices and costs are available, the PBMs do not proactively distribute the information and only those pharmacies that actively pursue the information will have it. However, there is no contractual or statutory requirement for the PBMs to provide their MAC reimbursement list to the pharmacies. While the PBMs are in compliance with contract and statutory provisions, they could increase the transparency of the reimbursement information to enhance the communications with the pharmacies.

Determine if the pharmacy reimbursement practices are consistent with standard industry practices.

For all three PBMs, the structure of contractual reimbursement arrangements with pharmacies includes a lesser-of-three logic between a discounted AWP reimbursement amount, a Usual and Customary (U & C) reimbursement amount, or a MAC reimbursement amount, for applicable generic drugs. The lesser-of logic is considered a standard reimbursement methodology within the pharmacy benefit industry.

AWP discount percentages vary by PBM pharmacy contract and are based on contract negotiations with specific pharmacies, pharmacy chains or with Pharmacy Services Administrative Organizations (PSAOs). In some cases, large chain pharmacies were able to negotiate higher reimbursement rates and dispensing fees. However, this was not always the case. For instance, at PBM A, we observed a large chain pharmacy with reimbursement rates ranging from 1.5 percent to 7.5 percent higher than the independent pharmacies sampled. At PBM C, a large chain had a reimbursement rate that was .5 percent lower than the independent pharmacies. At PBM B, the large chain pharmacy had the same reimbursement as the independent pharmacies. In cases where independent pharmacies participate in PSAOs, the contracts are between the PBM and the PSAOs and not between the PBM and the individual pharmacies. These reimbursement variations and contractual relationships are standard practices within the pharmacy benefit industry.

Contract negotiations include many factors and are not always focused on obtaining lower rates. As an example of how negotiated rates can impact reimbursement, one independent pharmacy sampled had negotiated rates that were higher in order for PBM A to meet network adequacy requirements. The PBMs may negotiate higher rates with pharmacies in order to meet their contractual obligation, under Uniform Managed Care Contract, Section 4.3.4- Access to Care, to have enrolled pharmacies that would satisfy the requirement for a network adequate to serve the beneficiaries. The Retail Brand Name AWP discount rate and the Retail Generic AWP discount rate were less for this pharmacy than the discount rates for the other sampled pharmacies; therefore, their reimbursement was higher.

MAC lists are applicable to certain generic drugs and are PBM specific. For each PBM sampled, there are no contractual requirements between the PBM and MCO, or between the PBM and the pharmacies, for what drugs are included on the PBM MAC lists. For each PBM sampled, we found that MAC list reimbursement was also not specified in pharmacy provider contracts or PBM and MCO contracts. As mentioned above, generic drugs are subject to the lesser-of-three logic and MAC list reimbursement is only utilized when a generic drug is on the PBM's MAC list and MAC reimbursement is less than the discounted AWP reimbursement and the U & C reimbursement. These MAC list practices are common within the pharmacy benefit management industry. For PBM A and PBM C, one MAC list is utilized for all

pharmacies within Texas. PBM B utilizes two separate MAC lists, one for chain pharmacies and one for independent pharmacies. This PBM asserted that the independent pharmacy MAC list provides greater reimbursement to independent pharmacies to account for the fact that they have less negotiating power when purchasing drugs. We compared the chain pharmacy MAC list to the independent pharmacy MAC list and confirmed the independent pharmacy reimbursement is higher than the chain pharmacy reimbursement.

Ensure compliance with contractually required reimbursement disclosures.

We reviewed the contracts between the sampled pharmacies and the three PBMs, and the contracts between the five MCOs and the three PBMs, to identify any requirements for reimbursement disclosures. We did not identify any disclosure requirement clauses in the contracts, including disclosures for changes in reimbursement practices. No additional disclosures are specified in the contracts for reimbursement changes due to changes in published AWP rates or changes in MAC rates. While there are no contractually required reimbursement disclosures in the contracts, per review of the sampled pharmacy contracts for all three PBMs tested, reimbursement schedules (for Retail, Mail order, Brand, Generic, etc) are specified in the pharmacy contracts with the PBMs. We found that the contracts do not contain specific disclosure requirements for reimbursement practices and that the PBMs are following standard industry practices relating to disclosures for reimbursement practices.

Survey the Pharmacies to gain an understanding of the negotiation and contracting practices between the PBMs and the pharmacies.

We surveyed five unrelated pharmacies for each of the five MCOs based on complaints received by HHSC, geographic considerations and payment amounts. Of the 25 pharmacies surveyed, we received survey responses from 17 pharmacies. We reached out to the remaining eight pharmacies through telephone calls and email, but did not receive a response to our follow-up request for the completed survey.

Specifically, we solicited information regarding contract negotiations with the PBMs and how or if negotiations took place regarding reimbursement rates. We asked the pharmacies to briefly discuss the process for determining contractual reimbursement rates with the PBM and to include information regarding PSAO negotiations (if applicable). We received the following responses:

- Nine pharmacies noted that they rely on their PSAO or Pharmacy Buying Association (PBA) to negotiate on their behalf. These pharmacies have outsourced their negotiating position to a third party and are not involved in the negotiation process between the PSAO/PBA and the PBM.

- Two pharmacies stated that they negotiate rates with the PBM. One pharmacy is a large chain and the other is an independent pharmacy that was involved in negotiations in order for the PBM to meet network adequacy requirements.

- Five pharmacies responded by stating that there is no negotiation process and that the process is "take it or leave it."

- One pharmacy did not respond to this specific question and did not respond to our follow-up attempts to obtain an answer.

We asked the pharmacies if the contracting of Medicaid and CHIP rates impacted the contracted rates with this PBM for other payer types. We received the following responses:

- Only 6 of 17 pharmacies responded that they did not have to accept lower rates for other payers with the same PBM.

- We received responses from the other 11 pharmacies however; their responses did not directly address this question.

We asked the pharmacies if they were required to accept the proposed Medicaid and CHIP rates in order to maintain network status with the PBM for other payer types. We received the following responses:

- Six pharmacies responded that they did not have to accept the Medicaid rates in order to maintain network status with the PBM for other payer types.

- Six pharmacies responded that they did have to accept the Medicaid rates in order to maintain network status with the PBM for other payer types.

- Three pharmacies responded that they did not know if they had to accept Medicaid rates in order to maintain network status with the PBM for other payer types.

- Two pharmacies responded that they did not have prior contracts with the PBMs.

Objective 2: Review PBM reimbursement practices and costs to determine if they are in accordance with the contractual agreement between the PBM and MCO and that they are applied equitably between related party and independent pharmacies.

After the carve-in of the pharmacy services into the Medicaid Managed Care contracts, pharmacies asserted that they were receiving a lower reimbursement rate than what they had previously received. The reimbursement rates are established by the contracts between the PBM and the pharmacy.

To address the concerns of the pharmacies assertion of lower reimbursement rates, we selected a sample of related party pharmacies and a sample of unrelated pharmacies, including at least one pharmacy where the MCO had negotiated its rates in order to meet network adequacy requirements, for each PBM and MCO combination. The samples were based on complaints received by HHSC, geographic considerations and payment amounts. We reviewed contracts for the sampled pharmacies to determine if the pharmacy contract reimbursement was in compliance with the contractual reimbursement arrangement between the PBM and MCO; and to assess reimbursement consistency between related and unrelated parties.

Objective 2 Conclusion

We reviewed contracts between the pharmacies and the PBMs and contracts between the PBMs and the MCOs and determined for two of the PBMs, the reimbursement practices are compliant with, and consistent between, both sets of contracts. For the third PBM, they have entered into lock-in reimbursement between the related party PBM and the MCO which is not based on the amounts the PBM pays the contracted pharmacies. This arrangement could result in the reimbursement price paid to the PBM by the related party MCO being greater than the reimbursement price paid to the contracted network pharmacies, generating profits for the PBM. However, this arrangement is compliant with current regulatory guidance. Based on our testing of the contracts of related party pharmacies and independent pharmacies, in conjunction with our independent recalculation of pharmacy claim payments (Objective 3), we concluded that the related party pharmacy reimbursement is consistent with unrelated parties and in compliance with contract reimbursement.

Objective 2 Detailed Results

Pharmacy contract reimbursement compliance with the contractual reimbursement arrangement between the PBM and MCO.

For all three of the PBMs, the contractual reimbursement parameters per the pharmacy contracts are in compliance with the contractual requirements between the PBM and the MCOs. Contracts between PBM B and PBM C and their respective four MCOs (MCO 2, MCO 3, MCO 4, and MCO 5) require a transparent pass-through reimbursement structure where the MCOs are charged the rate the PBM pays to the pharmacies. For PBM C, the contract establishes a target reimbursement arrangement that creates a reimbursement guarantee that may be different than the actual reimbursement paid to the pharmacies. These targets are in place to limit reimbursement exposure to MCO 4 and MCO 5. Actual results are reconciled at least annually and costs deemed in excess of the target reimbursement guarantees (if applicable) are refunded to the MCOs. Since the pharmacy carve-in to managed care didn't begin until March 1, 2012, there is not enough experience to test these reconciliations for compliance with contractual requirements within our scope period.

For PBM B, the reimbursement paid to the pharmacies is passed directly through to MCO 2 and MCO 3 with no reimbursement guarantee or periodic reconciliation.

PBM A entered into a lock-in reimbursement arrangement with their related party MCO (MCO 1) where the amounts the MCO pays the PBM are based on the PBM and MCO contract and are not based on amounts the PBM pays their contracted network pharmacies. This arrangement could result in the reimbursement being paid to the PBM by the related party MCO being greater than the reimbursement paid to the contracted network pharmacies, generating profits for the PBM. This arrangement is compliant with current regulatory guidance. As pharmacy reimbursement is not specifically addressed in the contract between the PBM and the MCO, analysis of pharmacy contract reimbursement compliance with the PBM and MCO contract is not applicable. However, the pharmacy contract reimbursement is compliant with the contractual pricing between the PBM and MCO.

Assess reimbursement consistency between PBM treatment of related and unrelated pharmacies.

Only PBM C had related party pharmacies. We reviewed related party pharmacy contracts and related party pharmacy reimbursement parameters. The related party pharmacy contracts and reimbursement parameters were similar to unrelated party pharmacy parameters and were not more preferential than reimbursement parameters for any unrelated pharmacies in our sample for this PBM.

For PBM A, although there are no related party pharmacies, there is a relationship between the PBM and MCO 1 through common ownership. The MCO pays the PBM based on lock-in reimbursement. The amount the MCO pays to the PBM is not related to the reimbursement the PBM pays its network pharmacies. Instead, it is based on contractual reimbursement parameters established with the related party PBM, and may result in profits to the related party PBM.

Objective 3: Review payment data reported to pharmacies and MCOs by the PBM, and claims data from the pharmacies to the PBM, to determine accuracy and completeness.

After pharmacy services were carved into the Medicaid Managed Care contracts effective March 1, 2012, pharmacies asserted that they began to see a reduction in their Medicaid reimbursement rates. This reduction was perceived by some pharmacies to be an error in reimbursement from the PBM.

To address the concerns of the reduced reimbursement rates, for the pharmacies sampled in Objective 1, we selected a sample of payments made by the PBM to the pharmacy to confirm the payment and ensure consistency between the pharmacy and PBM records. We tested the PBM's booking of the pharmacy payment to their general ledger and traced the payment information to the MCO invoices. For the same sample, we traced the PBM invoice amounts to the expense booked in the MCO's general ledger to ensure data integrity between amounts reimbursed to pharmacies and the amount reported to the MCOs. We independently recalculated the claims payments using pharmacy contract terms, published AWP data and PBM MAC lists. This

recalculation was performed for the top ten National Drug Code (NDC) drug payments for each pharmacy and for NDCs related to complaints received by HHSC regarding reimbursement.

Objective 3 Conclusion

Through our testing of invoices, payments, confirmations from the pharmacies, and review of PBM general ledgers, we concluded that the payments made to the pharmacies were accurately recorded at the PBM. Further, we concluded that the pharmacy payment was properly reflected on the invoice to the MCO from the PBM for two PBMs and four MCOs. However, for one PBM and one MCO, which are related parties and are engaged in a lock-in reimbursement agreement, the pharmacy payments are not invoiced to the MCO. Instead, the lock-in reimbursement rates are invoiced to the MCO, in accordance with their contract. This agreement may allow the PBM to make a profit from their related party MCO. In addition, we concluded that the payment to the PBM by the MCO is accurately recorded and ties to the invoice from the PBM. Finally, we independently recalculated the claims payments for a sample of claims and concluded that the payments were accurate.

Objective 3 Detailed Results

Pharmacy confirmation of claim detail and payment.

Of the 25 pharmacies solicited to confirm the PBM claims payments, we received 17 responses. All 17 responses confirmed that they received the individual claims payments as reflected in the PBM claims detail.

Consistency of pharmacy payments in the PBM general ledger, payment information, and invoices to the MCOs.

For all 25 pharmacies, we were able to trace the pharmacy payment to the PBM's general ledger and to the supporting invoice issued to the MCO. We verified copies of cancelled checks, wire transfers, and electronic payment support. We identified no instances of variances between the payment made to the pharmacy, the amount booked in the PBM general ledger, and the amount invoiced back to the MCO for PBM B and PBM C. For PBM A and related party MCO 1, there were no variances between the payment made to the pharmacy and the amount booked to the PBM general ledger, however we did identify that the amount invoiced back to MCO 1 was not the payment made to the pharmacy, but instead was the lock-in reimbursement amount, in accordance with their contract. The lock-in reimbursement agreement sets rates for all drugs to be invoiced to the MCO, regardless of what the PBM paid the pharmacy. This agreement could create revenues in excess of the actual pharmacy payment for the related party PBM.

Consistency of the PBM invoice, the booking of the expense into the MCO general ledger, and payment documentation.

For all 25 pharmacies, we were able to trace the PBM invoice to the MCO general ledger and to the supporting payment issued to the PBM. We verified copies of cancelled checks, wire transfers, and electronic payment support. We identified no instances of variances between the invoice amounts from the PBM, the amount booked in the MCO general ledger, and the amount paid to the PBM.

Independent recalculation of claim payments.

Using the five pharmacies sampled for each MCO in Objective 1, we independently recalculated the claims payments for a sample payment made from the PBM to the pharmacy. For all 25 pharmacies, claims were selected by identifying the ten NDCs with the largest reimbursement amount and selecting one claim from each group. In addition, we sampled NDCs with reimbursement related complaints received by HHSC. For the 25 sampled pharmacies, we used the contract terms between the pharmacy and the PBM to recalculate the claim payment and no variances were identified. We also tested preferred brand drugs that were in our sample to ensure that MAC reimbursement rates were not being used to calculate the claim payment, except where appropriate per the guidance provided by HHSC on January 10, 2012, and no variances were identified.

Objective 4: Assess the PBM's compliance with Senate Bill 7 provisions regarding: related party specialty pharmacy subcontractors; rebate negotiation and collection prohibition; employment of the vendor drug formulary; adherence to the preferred drug list and inclusion of the prior authorization procedure and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program. In addition, assess the PBMs compliance with the 2012-2013 General Appropriations Act provision requiring management of a prior authorization process that is no more stringent than the prior authorization processes used by the Medicaid Vendor Drug Program (VDP).

Pharmacies raised concerns that the PBMs were not adhering to the HHSC formulary and the preferred drug listing and were concerned over the prior authorizations that were being required before a drug could be dispensed.

We reviewed PBMs compliance with Senate Bill 7 provisions regarding exclusive contracts with related party specialty pharmacies.

We performed an observation and walkthrough of the rebate prohibition processes at each PBM. We reviewed and analyzed the PBM rebate contracts, invoices and procedures to ensure no rebates are negotiated or collected related to Texas Medicaid and CHIP drug utilization.

We tested the PBMs formulary to the HHSC VDP formulary to ensure the PBMs are utilizing the HHSC VDP formulary.

Using a sample of preferred drugs, we tested the administration of the PDL at each PBM. Additionally, we tested non-preferred alternative drugs to ensure prior authorizations (PA) were received and the VDP PA criteria were properly applied. We compared the VDP PA statistics prior to March 1, 2012, to the PBM PA statistics after March 1, 2012, for anomalies and trends. We tested the effective dates of preferred drugs to ensure that the effective dates were not prior to the VDP PDL effective dates.

We reviewed the PBM PA policies and procedures and compared them to regulatory requirements. We tested a sample of claims at each PBM to ensure the timeliness of a PA response. We reviewed the population of claims to ensure that the PBMs were allowing a 72-hour emergency supply without a PA. We tested a sample of claims to ensure that the pharmacies could submit a request for a PA via telephone, facsimile, or electronic communications through the Internet. We reviewed, at each PBM and MCO combination, the clinical edits (CE) in place and compared it to the VDP clinical edits to ensure there was no CE used by the PBM and MCO that was not used by VDP. We performed a walkthrough of two CE for each PBM and MCO combination to ensure the CE logic was not more stringent than the related VDP clinical edit logic.

Objective 4 Conclusion

Two of the three PBMs do not have related party pharmacies. For the one PBM that does have related party specialty pharmacies, we verified that members have various network options for specialty pharmacies and are not required to utilize the PBM's related party specialty pharmacies. As a result, all three PBMs are in compliance with these provisions of Senate Bill 7.

Through our testing of the manufacturer contracts, rebate submissions, and manufacturer confirmations, we determined that the PBMs are not submitting Texas Medicaid and CHIP claims for rebates and are adhering to the rebate prohibition under Senate Bill 7.

Based on our testing of the PBM formularies to the HHSC VDP formularies, we found there are instances of non-compliance regarding PBM adherence to the HHSC formulary requirements. These issues arise because the PBMs are either adding or deleting NDCs based on NDC status in Medi-Span®. (See Finding #1)

We found that the PBMs did not adhere to all PDL requirements during the scope of our audit. One PBM had a non-preferred drug established as a preferred drug, allowing claims to adjudicate without a PA. (See Finding #2) Through our testing, we found that four of the five MCOs did not adhere to the PDL as prescribed by HHSC VDP during various periods. The PBMs and MCOs phased in the PDL PA logic during March and April, so there were periods where the PA process was not enforced. (See Finding #3) During our detailed testing of the PDL, we could not determine if all sampled claims paid correctly with a PA for a part of the sample at two PBMs as they were unable to provide support. (See Finding #4)

Regarding compliance with the General Appropriations Act, we found that one PBM's prior authorization process is not more stringent than the PA processes used by HHSC VDP and is in

compliance with Senate Bill 7. For the other two PBMs, their prior authorization process is more stringent than the PA process used by HHSC VDP and is not in compliance with Senate Bill 7. (See Finding #5)

Objective 4 Detailed Results

Related Party Specialty Pharmacies

As part of our review, we prepared a questionnaire and interviewed the PBMs and MCOs about their compliance program procedures in place to ensure their organization is in compliance with the following Texas Government Code, Title 4, Subtitle I, Chapter 533, Subchapter A, Section 533.005 (a) (23) requirements:

- G(i) The managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program.

- G(ii) The managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network providers from the managed care organization.

PBM A asserted that neither the PBM, nor MCO 1, have any wholly or partially owned specialty pharmacies. The PBM and MCO are following the guidance adopted by the executive commissioner relative to specialty pharmacies and are in compliance with Senate Bill 7. We reviewed the contracts with the retail pharmacies and between the PBM and MCO and confirmed that there was a reimbursement provision for specialty pharmacy drugs.

PBM B asserted that they do not, in part or in whole, own a specialty pharmacy. The PBM adopted standard policies and procedures consistent with Texas Administrative Code (TAC) §354.1853 and Texas Senate Bill 7 requirements. The PBM relies on HHSC to publish any changes or additions to the list of specialty drugs on a quarterly basis. We reviewed the contract between MCO 2 and MCO 3 and PBM B and confirmed that there was a reimbursement provision for specialty pharmacy drugs for the retail pharmacies.

PBM C asserted that all pharmacies are participating as part of the existing retail network and are not part of a selective specialty pharmacy network. Their MCOs, MCO 4 and MCO 5, do not have an exclusive arrangement with a specialty pharmacy, whether PBM-owned or independent. We reviewed the contract between MCO 4 and MCO 5 and PBM C and reviewed a reimbursement schedule for specialty drugs, which did not include any language stating that the PBM's related party specialty pharmacies

have to be used exclusively. This corroborates the assertion made by the MCOs. In addition, we reviewed MCO 4 and MCO 5 websites that identify the network pharmacies available for members for different metropolitan areas. We noted that specialty pharmacies, unrelated to the PBM, were included as options for members to obtain specialty drugs. Therefore, PBM C is in compliance with G(i) and is not engaged in exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program. During the scope of our audit, HHSC had not yet published the list of specialty drugs.

We did not test compliance with G(ii) because HHSC had not published the specialty drug list during the scope of our audit.

Rebate prohibition adherence.

For each PBM, we performed a walkthrough of their rebate system controls. Each PBM has unique system controls to ensure Texas Medicaid and CHIP claims utilization is not included in their rebate submissions. Based on these unique systems, we reviewed manufacturer contracts, observed the rebate process, and tested the claim submissions for rebates to the manufacturers (or outsourced third party) and confirmed that no Texas Medicaid Managed Care claims were being submitted for rebate.

For all three PBMs, we reviewed a sample of the rebate contracts for terms that explicitly excluded the Texas Medicaid claims from receiving rebates.

- PBM A outsources their rebate function and does not have any direct contracts with manufacturers. We reviewed the contract between the PBM and their third-party rebate vendor and no terms were included specifically allowing or prohibiting the inclusion of Texas Medicaid and CHIP claims for rebate. Additionally, we reviewed submitted claims to the third party and verified that no Texas Medicaid and CHIP claims were included in the submission. The PBM is in compliance with Senate Bill 7 and is not submitting Texas Medicaid and CHIP claims for rebate to the third party rebate vendor.

- For PBM B and PBM C, we reviewed the base rebate contracts and all addendums for five sampled manufacturers at each PBM. Only one of these contracts had specific language regarding rebate prohibition for claims utilization related to Texas Medicaid and CHIP beneficiaries. This contract had an addendum, initiated by the manufacturer, which specifically stated that Texas Medicaid and CHIP utilization did not qualify for rebates under the rebate contract. PBM C asserted that the formulary requirements within the rebate contracts automatically disqualified Texas Medicaid and CHIP claims utilization from rebate

eligibility. As part of our review, we verified that the Texas Medicaid and CHIP claims did not qualify under the formulary requirements within the rebate contracts. PBM B's contracts are written so that plans must "opt-in" to the manufacturer rebate master plan list in order to be eligible for rebates, and the Texas Medicaid MCOs, MCO 2 and MCO 3, had not opted in to receive rebates for the Texas Medicaid and CHIP claims. We reviewed the master plan list for Texas Medicaid MCOs, MCO 2 and MCO 3, and verified that no Texas Medicaid MCOs are included. This supports the PBMs assertion that none of the Texas Medicaid MCOs have opted-in. PBM B and PBM C are in compliance with Senate Bill 7 and are not submitting Texas Medicaid and CHIP claims for rebate to the manufacturers.

For all three PBMs, we reviewed the first quarter calendar year 2012 rebate submissions to test effectiveness of the controls in place. The first quarter submissions include data from January 2012 through March 2012, however since the carve-in was effective March 1, 2012, and our scope was March 1, 2012 to April 30, 2012, our focus was on the data from March 1 through March 31, 2012. For two PBMs, PBM B and PBM C, we tested the first quarter rebate submissions for five sampled manufacturers. For PBM A, we tested the first quarter rebate submission to their third party rebate vendor. No instances of Texas Medicaid or CHIP claims from the MCOs utilization were observed in the sampled first quarter 2012 rebate submissions. This is in compliance with Senate Bill 7.

For all three PBMs, we obtained confirmations from a sample of manufacturers and a third party subcontractor to ensure that rebates were not paid to the PBMs or MCOs related to Texas Medicaid and CHIP claims utilization. In addition, we requested the manufacturers/rebate vendor to identify what controls, if any, they have in place to ensure they do not pay rebates related to the MCOs or PBMs for Texas Medicaid and CHIP claims utilization.

- PBM A subcontracts the rebate function to another PBM not included in this audit; and therefore does not directly contract with manufacturers for rebates. We received a confirmation from the third-party PBM confirming that, per their contractual agreement, they process claims that are sent to them for invoicing and they exclude claims per the exclusions the client communicates to them. The response from the third-party rebate vendor further supports our conclusion that the PBM is in compliance with Senate Bill 7.

- We sent confirmations to a sample of five manufacturers for each of PBM B and PBM C. Of the ten total confirmations sent, one manufacturer did not return the confirmation. Seven manufacturers confirmed that they did not pay any rebate amounts to the PBM for Texas Medicaid claims. One manufacturer (the same for each PBM) did

not sign the confirmation attesting that they had not paid any rebates on Texas Medicaid Managed Care claims. The manufacturers, in general, rely on the PBM to ensure that there are no Texas Medicaid Managed Care claims in the submission. Two of the manufacturers, as an added control, validate the data provided by the PBM to identify any Managed Medicaid utilization and remove any identified claims. The confirmation responses further support our conclusion that the two PBMs are in compliance with Senate Bill 7.

PBM adherence to the VDP formulary.

To ensure the PBMs are using the same formulary as VDP, we compared the PBM formulary files utilized for the period April 25, 2012 through April 30, 2012, to the HHSC VDP formulary files for the same period. We compared the formularies to determine if NDC codes are included on the VDP formularies that are not included on the PBM formularies or if NDC codes are on the PBM formularies that are not included on the VDP formularies. The HHSC formulary contains 19,280 NDC codes, of which 7,546 are listed as preferred drugs.

- For PBM A, we identified one NDC that was included in the PBM's formulary but not in the HHSC formulary. We reviewed the claims data provided and no claims were adjudicated with this NDC. We also identified 267 unique NDCs that were in the HHSC formulary but not in the PBM formulary. Per the PBM, 265 of these NDCs are either inactive in Medi-Span® and have been inactive for more than 48 months, or are not included in the Medi-Span® master drug database. They do not adjudicate NDCs that are inactive for more than 48 months. On a sample basis, we verified that the NDCs were inactive in the Medi-Span® master drug database. Two of the 267 NDCs were added to the PBM formulary after our scope period. (See Finding # 1) HHSC uses the First Data Bank drug reference files to compile their formulary, which may reflect different drug inactive dates than the Medi-Span® drug reference files. This may contribute to the variances between the PBM formulary and the HHSC formulary since inactive dates are generally specific to each drug data publishing company.

- For PBM B, we initially identified 426 NDCs in the PBM's formulary that were not in HHSC's formulary. Per the PBM, 394 of the 426 NDCs were discontinued NDCs from Medi-Span® data and not listed or not active in the claims adjudication system and cannot be adjudicated; were past the expiration date and do not pay in the adjudication system; or were expired and the expiration date was not reflected in their formulary. On a sample basis, we verified that NDCs were inactive in the Medi-Span® master drug database. We verified in the PBM's claim adjudication

system, on a sample basis, that the expiration dates for these NDC's were prior to or on March 1, 2012 and therefore no claims would adjudicate. We concluded that the 394 NDC codes were provided as a historical reference of the PBM's entire formulary and the date errors were a product of preparing the formulary document for PHBV. Therefore, we determined that the 394 NDCs were not part of the active pharmacy formulary in the claim adjudication system. Per the PBM, 32 of the 426 NDCs were typos, had adjudicated as DME products, or were a result of a timing issue. Timing issues result when the PBM has a minor, one or two day, delay in updating their formulary from the time they receive it from HHSC, due to the time to program and test the updated NDCs in their system. For the 32 remaining NDC code variances, we tested the PBMs explanation on a sample of the claims and determined that the 32 NDCs were either typos in the formulary extract provided to PHBV (not in the claim adjudication system), were properly tagged as DME using a script and were not included in the pharmacy encounter data, or were due to inaccurate expiration dates in the extract provided to PHBV and were accurate in the system. We noted no exceptions and therefore determined that the 32 NDCs were not part of the pharmacy formulary used for Texas Medicaid clients. We also reviewed the claims data provided and no claims were adjudicated for these 426 NDCs. We identified 61 NDCs in HHSC's formulary that were not in the PBM's formulary. For all 61 NDCs, the PBM noted the NDC was not in Medi-Span® and they are unable to adjudicate claims that do not have NDCs in Medi-Span®. On a sample basis, we verified that NDCs were inactive in the Medi-Span® master drug database. (See Finding #1)

- For PBM C, there were no NDCs included in the PBM's formulary in addition to those included in HHSC's formulary. However, we identified 751 NDCs in HHSC's formulary that were not included in the PBM's formulary. For all but one of these NDCs, the PBM noted the NDC was either inactive or did not exist in Medi-Span®. On a sample basis, we verified that NDCs were inactive in the Medi-Span® master drug database. For one of these NDCs, the PBM claims it was on their formulary, however, it was not included in the formulary file provided. (See Finding #1)

PBM adherence to the Preferred Drug List (PDL).

We performed a walkthrough of each PBM's PDL controls. Each PBM has a unique system of controls to ensure they comply with the HHSC VDP PDL. It is the practice of all three PBMs to update their formulary file on a frequent basis, from three times a week to daily. All three PBMs have a system in place to verify changes

made in the coding of the system and test the updates and changes to the PDL. At all three PBMs, we verified a sample of preferred drugs to observe how they are set up in the claim adjudication system during our scope period. The sampled drugs selected by HHSC were Lovenox, Xopenex, Tricor, Adderall XR, Combivent, Imitrex (nasal, injection), Cipro Suspension, and Proventil HFA. At each PBM, we selected the first and last NDC listed in numerical order for each of the eight sampled drugs to test how the NDC was set up in their system for claim adjudication. For the NDCs tested, all were set up with no restrictions, allowing the preferred drug to adjudicate without a prior authorization (PA) and no exceptions were noted.

To test the effectiveness of how the NDCs were set up in the system, we judgmentally sampled one non-preferred alternative claim for each of the eight preferred drugs from the PBM claims history to perform a walkthrough of the claim at each PBM.

- For PBM A, all eight claims tested adjudicated correctly due to a PA assigned by the PBM, a PA assigned by HHSC (prior to March 1, 2012), or an authorization for a 72-hour emergency supply.

- For PBM B, their PA requirements were phased in from March 1, 2012 through March 15, 2012 (See Finding #3). All of the sampled claims adjudicated correctly because the PBM received the claims history from HHSC showing a preferred drug had previously been dispensed and therefore no prior authorization was needed, because a PA had been issued by HHSC, or because a 72-hour emergency code had been entered by the pharmacist.

- For PBM C, PDL edits were phased in during April 2012 (See Finding #3). Because the PBM did not require PAs prior to April 4, 2012, claims adjudicated without a PA and the member's claims history was relied upon for evidence of the drug, or a preferred drug within the same class, being previously dispensed. One claim adjudicated correctly for a 72-hour emergency refill. Two NDCs were set up as preferred drugs, instead of non-preferred alternative drugs, in April and the claims paid with no prior authorization. (See Finding #2)

For all five MCOs we tested a judgmental sample of claims, based on the NDCs with the highest utilization, during our scope period from the following categories: (1) non-preferred alternatives (to the sampled preferred drugs) that paid without a PA, (2) non-preferred alternatives that had a PA, (3) preferred drugs that had a PA number in the data provided to us, and (4) preferred drugs that were denied or rejected. We verified there were no PA requirements for the eight preferred drugs selected by HHSC (Lovenox, Xopenex, Tricor, Adderall XR, Combivent, Imitrex

(nasal, injection), Cipro Suspension, and Proventil HFA); and we verified that PAs were received and proof of criteria was met for non-preferred alternative drugs.

For the first sample of non-preferred drugs paid without a PA, we tested for why a non-preferred drug would pay without a PA present. In the second sample, non-preferred drugs that had a PA (non-preferred alternative drugs to the preferred drugs listed above), we tested the appropriateness of the issued PA. For the third sample of preferred drugs that appeared to have a PA, we reviewed the claim to see why a preferred drug would appear to have a PA. For the last sample, preferred drugs that were denied, we verified the appropriateness of the denial. In all instances, we reviewed the member's claims history, transaction inquiry screens, and prior authorization screens in the claims adjudication systems.

We observed that it is common practice to implement the PA requirements through step-therapy, which allows a non-preferred drug to be adjudicated if the member's claim history provided by HHSC reflects the non-preferred drug was previously dispensed, or a preferred drug was previously dispensed. HHSC provided guidance to the MCOs and PBMs allowing the use of automated PA systems to review beneficiary claims history as part of the PA determination process. If a beneficiary had used a preferred drug at any point in time in the past 6 months, the system can assume the client "failed" on the preferred drug and can allow authorization of a non-preferred drug without the need for an actual PA.

- For MCO 1, the first sample (non-preferred alternatives without PAs), no claims were processed without a PA and no issues were identified. For the second sample (non-preferred drug alternatives with a PA), all 67 sampled claims adjudicated correctly.

- For MCO 2, the first sample (non-preferred alternatives without PAs), 26 of the 40 claims tested processed correctly without a PA through the automated PA process. Thirteen claims tested processed improperly without a PA because the PBM did not have the PA requirements implemented timely (See Finding #3). For one of the 40 claims tested, we were unable to determine if the claim improperly paid without a PA because the PBM was not able to provide documentation (See Finding #4). For the second sample (non-preferred alternatives with a PA), all 23 claims adjudicated correctly.

- For MCO 3, the first sample (non-preferred alternatives without PAs), 22 of the 36 claims tested processed correctly without a PA through the automated PA process. Nine claims tested processed improperly without a PA because the PBM did not have the PA requirements implemented timely (See Finding #3). For five of the 36 claims tested, we were unable to determine if the claim improperly paid without a PA because the PBM was not able to provide adequate documentation

(See Finding #4). For the second sample (non-preferred alternatives with a PA), all 26 claims adjudicated correctly.

- For MCO 4, the first sample (non-preferred alternatives without PAs), 53 of the 65 claims tested processed correctly without a PA through the automated PA process. Six claims tested processed incorrectly without a PA because the PBM did not have PA requirements implemented timely. In addition, claims adjudicated during the transition period (March 1, 2012 through April 13, 2012 while the PA requirements were relaxed) would allow subsequent non-preferred drugs to adjudicate without a PA due to the use of claims history for the automated step therapy process (See Finding #3). There were three additional non-preferred claims for which the PBM was unable to provide documentation supporting how the claim processed (See Finding #4). For the second sample (non-preferred alternatives with a PA), three of five claims adjudicated correctly. One claim tested improperly processed without a PA because the PBM did not have PA requirements implemented timely (See Finding #3).

- For MCO 5, the first sample (non-preferred alternatives without PAs), 58 of the 72 claims tested processed without a PA correctly through the automated PA process. Nine claims tested processed improperly without a PA because the PBM did not have PA requirements implemented timely. In addition, claims adjudicated during the transition period (March 1, 2012 through April 18, 2012 while the PA requirements were relaxed) would allow subsequent non-preferred drugs to adjudicate without a PA due to the use of claims history for the automated step therapy process. (See Finding #3). There were five additional claims for which the PBM was unable to provide documentation supporting how the claim processed (See Finding #4). For the second sample (non-preferred drug alternatives that had a PA), 8 of 16 claims adjudicated correctly. There were five claims for which the PBM was unable to provide documentation supporting a valid PA and the claim adjudicated correctly (See Finding #4). Last, there were three claims that adjudicated incorrectly after March 1, 2012, but before the PDL edits were enforced. These three claims should have been subject to a PA process (See Finding #3).

- For all five MCOs, for the third sample (preferred drugs with a PA), we tested the following number of claims:

MCO	Number of Claims
MCO 1	34
MCO 2	20
MCO 3	17
MCO 4	2
MCO 5	5

All claims adjudicated correctly and no exceptions were noted.

- For all 5 MCOs, for the fourth sample (preferred drug denials), we tested the following number of claims:

MCO	Number of Claims
MCO 1	19
MCO 2	21
MCO 3	19
MCO 4	16
MCO 5	18

For all claims, the reason for denial (days supply limits, refill too soon, etc.) was appropriate.

We compared the PA statistics generated by HHSC prior to March 1, 2012 for the months of December 2011, January 2012, and February 2012 to the PA statistics for March 2012 and April 2012 for each MCO. The average percentage of approved PAs (including Automatic PAs) by HHSC between December and February was 68.43 percent.

- For MCO 1, the average percentage of approved PAs for March and April was 34.92 percent, 33.52 percent lower than HHSC's average. This MCO did not provide Auto PA data.

- For MCO 2, the average percentage of approved PAs (including Auto PAs) for March and April was 89.44 percent, 21.01 percent higher than HHSC's average.

- For MCO 3, the average percentage of approved PAs (including Auto PAs) for March and April was 86.07 percent, 17.64 percent higher than HHSC's average.

- For MCO 4, the average percentage of approved PAs for March and April was 90.00 percent, 21.57 percent higher than HHSC's average. This MCO did not provide Auto PA data.

- For MCO 5, the average percentage of approved PAs for March and April was 80.77 percent, 12.34 percent higher than HHSC's average. This MCO did not provide Auto PA data.

For all three PBMs, we reviewed and compared the effective dates of preferred drugs on the PBM's formulary file or PDL listing, to the effective dates of preferred drugs on the VDP PDL to verify prior authorization requirements were not implemented prior to the VDP PDL effective dates. HHSC provided a PDL database as of April 30, 2012, detailing effective dates, end dates, and PDL status. We extracted all NDC's with an effective date after March 1, 2012 in order to compare only NDC's that were added in March and April. The PBMs also provided formulary files identifying the PDL, or a separate PDL file, for March and April that contains PDL status with begin and end dates. We extracted all of the PBM NDCs with a PDL effective date after March 1, 2012, in order to compare only NDCs that were added in March and April. We then compared the two files created in the prior procedures to test if prior authorization requirements were implemented prior to the VDP PDL effective dates.

- For PBM A, no exceptions were noted in our test work.
- For PBM B, the PDL was implemented in segments beginning March 1, 2012 through March 15, 2012. HHSC expected all PDL requirements to be in place beginning on March 1, 2012. (See Finding #3) We were able to verify that PA requirements were not implemented prior to the VDP PDL effective dates.
- For PBM C, the PDL was implemented in segments for both of their MCO clients during the months of March and April. HHSC expected all PDL requirements to be in place beginning on March 1, 2012. (See Finding #3) We were able to verify that PA requirements were not implemented prior to the VDP PDL effective dates. The NDCs per the two MCOs' PDL were effective either after the newly implemented NDCs, per HHSC PDL, or had not been implemented as of April 30, 2012.

PBM adherence to the Prior Authorization procedures and requirements.

For all of the PBM and MCO combinations, we reviewed the policies and procedures in place and compared them to various regulatory requirements identified for review by HHSC.

- We reviewed the policy and procedures for attributes defined in the Texas Government Code Section 531.073 (b)(2), which requires a response to a request for prior authorization by telephone or other telecommunication device within 24 hours after receipt of a request for

prior authorization. All five MCOs included this language in their policy and procedures.

- We reviewed the policy and procedures for attributes defined in the Texas Government Code Section 531.073 (b)(3), which requires that a 72-hour supply of the drug prescribed in an emergency or if the commission does not provide a response within the time required by Subdivision (2). All five MCOs included this language in their policy and procedures.

- We reviewed the policy and procedures for attributes defined in the Texas Government Code Section 531.073 (c), which requires "The commission shall ensure that a prescription drug prescribed before implementation of a prior authorization requirement for that drug for a recipient under the child health plan program, the Medicaid program, or another state program administered by the commission or a health and human services agency or for a person who becomes eligible under the child health plan program, the Medicaid program, or another state program administered by the commission or a health and human services agency is not subject to any requirement for prior authorization under this section unless the recipient has exhausted all the prescription, including any authorized refills, or a period prescribed by the commission has expired, whichever occurs first." None of the five MCOs included this language in their policy and procedures. PBM B, representing MCO 2 and MCO 3, states that this is a timing issue as their policy and procedures are based on the HHSC Managed Care Contract v2.0. They believe the updated version v2.1 added the Section 531.073 (c) reference and their policy would be updated to reflect the contract language. Two additional MCOs, MCO 4 and MCO 5, state that they consider this a "grandfathering," which is allowing the members to continue on drugs when the formulary/PDL status of a drug changes. They rely on HHSC to give them direction as to when certain drugs are affected.

- We reviewed the policy and procedures for attributes defined in the Texas Government Code Section 531.073 (g), which requires a prior authorization may be submitted by telephone, facsimile, or electronic communications through the Internet. Two MCOs, MCO 2 and MCO 3, included this language in their policy and procedures. Three MCOs did not include language in their policies regarding electronic communications through the internet. Two of the three MCOs, MCO 4 and MCO 5, confirmed that they do not have electronic PAs, however they are currently working with their PBM to provide ePAs through a third party subcontractor. The third, MCO 1, is currently conducting a study to provide the electronic submissions.

- We reviewed the policy and procedures for attributes defined in the 2012-2013 General Appropriations Act (Article II, Health and Human Services Commission, Rider 81, H.B. 1, 82 Legislature, Regular Session, 2011), which requires a capitated managed care organization in STAR, STARHealth, STAR+PLUS and CHIP to manage prior authorization for prescription drugs in a manner that is no more stringent than those prior authorization processes used by the Health and Human Services Commission (HHSC) in its administration of the Medicaid Vendor Drug Program. All five MCOs included this language in their policy and procedures.

For each MCO, we randomly selected a sample of five approved and five denied claims to test the PBMs required 24 hour response time to the PA request. We also tested to ensure a request was allowed to be made via one of the three acceptable methods (telephone call, facsimile, or communication through the internet). For all five MCOs, all PAs tested were requested via one of the three acceptable methods and a response was provided within 24 hours.

For each MCO, we reviewed the claims data in total and identified that they were in fact allowing 72-hour emergency drug supplies without a PA. We reviewed the claims data for the week of April 24, 2012 for claims with only a three day supply. All five MCOs and PBMs are allowing a 72-hour emergency supply without a PA.

For each MCO, we reviewed the CE they had in place and compared it to the CE on the VDP website to ensure that the MCO and PBM did not have CEs in place that were not authorized by HHSC VDP. Additionally, we performed a detailed walkthrough in each PBM's system of the clinical edit logic for two CEs to ensure that the PBM logic was no more stringent than the logic used by HHSC VDP.

- For MCO 1, we identified 20 clinical edits in use in their system. Upon review of the clinical edits, we identified one edit, Duplicate Therapy – Pletal that was not on the HHSC VDP website. This clinical edit was terminated January 31, 2011 and should not have been implemented by the PBM. We performed a walkthrough of two clinical edits, Xyrem and Januvia. This PBM, with the exception of Duplicate Therapy – Pletal, used the exact criteria that is on the VDP website, and therefore is no more stringent than the VDP logic. (See Finding #5)

- For PBM B, representing MCO 2 and MCO 3, we identified 32 clinical edits in use in their system. Upon review of the clinical edits, we identified Duplicate Therapy - Pletal that was not on the HHSC VDP website. This clinical edit was terminated January 31, 2011 and should not have been implemented by the PBM. The PBM states that they will remove the edit. We performed a walkthrough of two clinical edits, Cox-2 Inhibitors and Altabax. This MCO and PBM, with the exception of

Duplicate Therapy – Pletal, used the exact criteria that is on the VDP website, and therefore is no more stringent than the VDP logic. (See Finding #5)

- For MCO 4, we identified 19 clinical edits in use in their system. We performed a walkthrough of two clinical edits, Byetta and Oxycontin. This MCO and PBM did not have clinical edits in addition to those included on the HHSC website and used the exact criteria that is on the VDP website. The clinical edits are no more stringent than the VDP logic.

- For PBM C and MCO 5 combination, the MCO and PBM did not implement any clinical edit criteria until May 2012, outside of our scope period. However, we did test two of the clinical edits in use in their system, Antipsychotics and Revatio. This MCO and PBM used the exact criteria that is on the VDP website, and is no more stringent than the VDP logic.

Findings Summary

Findings represent events of non-compliance with specific requirements that we deemed significant.

Finding # 1 - PBM Adherence to the HHSC VDP Formulary File

Condition

The PBMs should have adhered to the HHSC formulary. The HHSC formulary for our scope period included 19,280 NDCs. We tested 100% of the NDCs for inclusion on the formulary and found:

PBM A included one NDC code in their formulary that was not included in the HHSC VDP formulary. In addition, their formulary did not include 267 (1.38%) NDC codes from the HHSC VDP formulary.

PBM B did not include 61 (.32%) NDC codes from the HHSC VDP formulary file in their formulary.

PBM C did not include 751 (3.90%) NDC codes from the HHSC VDP formulary file in their formulary.

Cause

PBM A added an NDC code to their formulary because they assert it was added by HHSC as a retroactive NDC. This NDC code is not included in the file of retroactively applied NDC codes provided by HHSC. This PBM also excluded 267 NDC codes from their formulary because the PBM claims the NDCs were inactive in Medi-Span® and have been inactive for more than 48 months, or they removed them because they were not included in the Medi-Span® master drug database.

PBM B asserted that, for all 61 HHSC VDP NDC codes excluded from their formulary, the PBM noted the NDC codes were not in Medi-Span® and they are unable to adjudicate claims that do not have NDC codes in Medi-Span®.

PBM C indicated one of the 751 NDC codes was on their formulary; however, it was not included on the formulary file provided and no additional documentation was provided to support this assertion. For the remaining 750 NDC codes, the PBM asserted the NDC codes were either inactive or did not exist in Medi-Span®.

Criteria

Texas Government Code, Title 4, Subtitle I, Chapter 533, Subchapter A, Section 533.005 (a) (23): A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain, subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients that: 1. (A) exclusively employs the

vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under the Medicaid program.

Effect

The MCOs were not in compliance with regulations governing the Medicaid managed care pharmacy program at the time of the review. The subcontracted PBMs could have adjudicated claims for drugs that were not on the VDP formulary, or incorrectly rejected claims for drugs that were on the VDP formulary, if they did not maintain a formulary file that was identical to the VDP formulary file.

For PBM A, we confirmed that no claims adjudicated for the one NDC on their formulary that was not on the VDP formulary. We are unable to determine what impact, if any, the exclusion of 267 VDP NDC codes from the PBM formulary may have caused since no claims would have adjudicated related to these.

For PBM B, we are unable to determine what impact, if any, the exclusion of 61 VDP NDC codes from the PBM formulary may have caused since no claims would have adjudicated related to these.

For PBM C, we are unable to determine what impact, if any, the exclusion of 751 VDP NDC codes from the PBM formulary may have caused since no claims would have adjudicated related to these.

Recommendation

We recommend that the MCOs ensure their PBM has adequate controls in place to employ a formulary file that is identical to the VDP file, in accordance with the regulatory requirements.

Finding # 2 - PBM Adherence to the HHSC VDP PDL

Condition

The PBMs should have adhered to the HHSC PDL. The HHSC PDL for our scope period included 7,546 NDCs. We tested a sample of NDCs to verify the accuracy of the set up and found:

For PBM C, we identified two NDC codes, in our sample of eight NDC codes, incorrectly set up as preferred drugs when they should have been set up as non-preferred drug alternatives requiring a PA.

Cause

One PBM did not properly establish all non-preferred drugs in their claim adjudication system as non-preferred alternative drugs requiring a PA. The PBM was not able to provide documentation to support the root cause of the error.

Criteria

The MCO is required to adhere to the Texas Government Code, Title 4, Subtitle I, Chapter 533, Subchapter A, Section 533.005 (a) (23) which states, "…A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain, subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients that: …2. (B) adheres to the applicable preferred drug list adopted by the commission under Section 531.072."

Effect

MCO 4 and MCO 5 were not in compliance with regulations governing the Medicaid managed care pharmacy program at the time of the review. The subcontracted PBM allowed non-preferred drug claims to adjudicate without a PA due to having non-preferred drugs set up incorrectly in the claims adjudication system.

The PBM adjudicated claims for two MCOs. MCO 5 had claims exposure of $136,636.15, and MCO 4 had claims exposure of $50,795.56, for both NDCs incorrectly set up as preferred drugs during the period of March 1, 2012 to April 30, 2012. These claims exposure amounts represent total cost related to the applicable NDC codes, though only a sample of these were tested during the audit. The actual error, the difference between the cost of the non-preferred drugs dispensed and the preferred drugs that potentially should have been dispensed, is not readily determinable since multiple preferred drugs are available in these therapeutic classes. The MCOs are paid a capitated rate that includes pharmacy benefits. The two NDCs that were incorrectly adjudicated did not result in any direct financial impact to the state since the initial capitated rates are based on prior year experience from the Vendor Drug Program. If the current claims experience is used as the basis for future capitation rates, these errors may impact future state payments.

Our results reflect issues identified in a targeted sample. Additional NDC codes, which were not the focus of our samples, could have also been impacted by the non-preferred drug set up errors identified.

Recommendation

We recommend the MCOs ensure their subcontracted PBMs have set up all non-preferred drugs correctly in their claim adjudication system requiring a PA to process.

Finding # 3 - PBM Adherence to the HHSC VDP PDL

Condition

Four of the five sampled MCOs, representing two subcontracted PBMs, did not implement the HHSC VDP PDL logic on March 1, 2012 as required by HHSC.

For MCO 2 and MCO 3 (which use the same PBM, PBM B), PDL edits were implemented on March 15, 2012.

For MCO 4, PDL edits were implemented starting on March 19, 2012 and were completed on April 13, 2012.

For MCO 5, PDL edits were implemented starting on April 4, 2012 and were completed on April 18, 2012.

Cause

MCO 2 and MCO 3 (which utilize the same PBM, PBM B), state that HHSC allowed them to relax the PDL PA edits to allow for continuity of care because the PBM did not have the historical PA files from HHSC on March 1, 2012. The PBM states they did not receive the historical PA files until the second week of March 2012. The PBMs believed the guidance provided by HHSC allowed them to implement the PDL PA requirements in phases and in a manner that was least disruptive to the beneficiaries.

MCO 4 and MCO 5 (which utilize the same PBM, PBM C), both state they were deliberate in their roll out plan, phasing in the requirements based on the volume of utilization and anticipated provider questions, related to each class of drugs, and minimized the number of complaints as a result. They further state that the officials at HHSC instructed them to make every effort possible to keep at a minimum any disruption of the provider community. The phased in implementation was the mechanism chosen, given that there was very little (if any) historical pharmacy data, including PA history, made available to the MCOs at the time of implementation.

Criteria

The MCO is required to adhere to the Texas Government Code, Title 4, Subtitle I, Chapter 533, Subchapter A, Section 533.005 (a) (23) which states, "…A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain, subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients that: …2. (B) adheres to the applicable preferred drug list adopted by the commission under Section 531.072."

Effect

The MCOs were not in compliance with regulations governing the Medicaid managed care pharmacy program at the time of the review. Staggering the implementation of the PDL PA edits during a period of time allowed non-preferred drugs to adjudicate without proper prior authorization. Once a non-preferred drug is present in a member's claims history, the member could access the non-preferred drug without meeting the approved PA criteria.

Because the PDL edits were not implemented beginning March 1, 2012, errors were identified in the following two sample categories: (1) non-preferred alternatives (to the sampled preferred

drugs) that paid without a PA, and (2) non-preferred alternatives that had a PA reflected in the member's claims history.

For MCO 2, 13 claims tested in the first category adjudicated improperly without a PA.

For MCO 3, nine claims tested in the first category adjudicated improperly without a PA.

For MCO 4, six claims tested in the first category adjudicated improperly without a PA and one claim for the second category adjudicated incorrectly without a PA. For the second category, the PA reflected in the claims history was a PA number added by the pharmacy and was unrelated to the PDL requirements.

For MCO 5, nine claims tested in the first category adjudicated improperly without a PA and three claims for the second category adjudicated incorrectly without a PA. For the second category, the PA reflected in the claims history was a PA number added by the pharmacy and was unrelated to the PDL requirements.

Our results reflect issues identified in a targeted sample. Additional NDC codes, that were not the focus of our samples, may also be impacted by the delays in PDL implementation.

Recommendation

We recommend the MCOs ensure their subcontracted PBMs have fully implemented the HHSC VDP PDL and that all future changes to the HHSC VDP PDL are implemented timely.

Finding # 4 – Missing PA support

Condition

Four MCOs were unable to provide, or did not provide, adequate documentation to support proper application of prior authorization requirements for some of the claims included in the audit samples.

Cause

PBM B, representing MCO 2 and MCO 3, asserted they were unable to retrieve the necessary information from their system due to corrupted files.

PBM C, representing MCO 4 and MCO 5, did not provide documentation to support the root cause for the processing of certain claims.

Criteria

The Uniform Managed Care Contract- Terms & Conditions, Article 9, Section 9.01, *Record retention and audit*. MCO agrees to maintain, and require its Subcontractors to maintain, records, books, documents, and information (collectively "records") that are adequate to ensure that services are provided and payments are made in accordance with the requirements of this

Contract, including applicable Federal and State requirements (e.g., 45 CFR §74.53). Such records must be retained by MCO or its Subcontractors for a period of five (5) years after the Contract Expiration Date or until the resolution of all litigation, claim, financial management review or audit pertaining to this Contract, whichever is longer.

Effect

The MCOs were not in compliance with regulations governing the Medicaid managed care pharmacy program during the scope period. Maintenance of documentation is critical to support that services are provided, and payments are made, in accordance with contractual and regulatory requirements.

For PBM B, we were unable to determine if a claim paid properly with a PA for six claims (one claim for MCO 2 and five claims for MCO 3).

For PBM C, we were unable to determine if a claim paid properly with a PA for thirteen claims (three claims for MCO 4 and ten claims for MCO 5).

Recommendation

We recommend the MCOs ensure their subcontracted PBMs enhance internal controls regarding documentation retention, to enable HHSC, or their designated representatives, to test services and/or payments for compliance with contractual and regulatory requirements.

Finding # 5 – PBM adherence to Prior Authorization Requirements

Condition

Three MCOs utilized one clinical edit, Duplicate Therapy – Pletal, in addition to those included on the HHSC VDP website.

Cause

PBM A, for MCO 1, states that they used the PAXPress website, which shows the edit should be required.

PBM B, that adjudicates claims for MCO 2 and MCO 3, states that the edit was on the VDP website prior to "go-live." They claim they did not receive a notification that this edit was no longer in effect; however, they agree that it is currently not listed and will be removing the edit from their system.

Per our discussion with HHSC and support provided from HHSC, Pletal CE criteria were termed January 31, 2011.

Criteria

2012-2013 General Appropriations Act (Article II, Health and Human Services Commission, Rider 81, H.B. 1, 82 Legislature, Regular Session, 2011): It is the intent of the Legislature that capitated managed care organizations in STAR, STARHealth, Star+PLUS and CHIP manage prior authorization for prescription drugs in a manner that is no more stringent than those prior authorization processes used by the Health and Human Services Commission (HHSC) in its administration of the Medicaid Vendor Drug Program.

Effect

The MCOs were not in compliance with regulations governing the Medicaid managed care pharmacy program. Having clinical edits in place beyond those required by HHSC could lead to improper denial, or delays, in access to care for members.

Recommendation

We recommend the MCOs, and their subcontracted PBMs where applicable, enhance internal controls to ensure adequate processes are in place for periodic verification of clinical edits required by HHSC VDP and proper system updates to reflect changes to the required edits. We recommend the MCOs ensure existing clinical edits for Duplicate Therapy – Pletal are properly removed.

Appendix I

MCO 2 Management Responses

Finding #1 PBM Adherence to the HHSC VDP Formulary File

MCO 2 disputes this finding.

The 61 NDCs that were identified as included on the VDP file and not on the PBM B file, do not exist in Medi-Span®. In addition, PBM B did confirm that these NDCs were not active with the FDA at the time of the audit. It is likely that these are old NDCs that were not removed from the VDP file. Since the NDCs are not active with the FDA, no members were adversely impacted and the claims were adjudicated correctly.

We dispute the recommendation that PBM B does not have adequate controls in place. We contend that all of these NDC discrepancies have been explained and that neither members nor claims were impacted by them. We do have several quality controls in place and are in full compliance with the regulatory requirements.

PHBV Partners LLP's Response to MCO Disagreements

Regulation requires the PBM exclusively employ the vendor drug program formulary. Additions or deletions from the VDP formulary file are a deviation from the regulatory requirement. While we understand the PBM's reasoning for excluding the 61 NDC codes from their formulary file, additions or deletions of NDC codes from the VDP formulary file represent a deviation from VDP formulary file and we feel our finding and related recommendation accurately reflect this deviation.

Finding # 3 - PBM Adherence to the HHSC VDP PDL

MCO 2's actions were the direct result of receiving the prior authorization file from HHSC on February 29, 2012, for an effective date of March 1, 2012. Due to the complexity of integrating the outstanding prior authorizations to the PBM B system, HHSC was made fully aware that at least ten (10) business days was needed to program these authorizations. Because the authorization file was received one (1) day prior to the authorizations becoming effective, MCO 2 in consultation with its Medical Director, determined that it was in the best interest of the Members to dispense medications as written by the prescriber, to avoid inappropriate denials, until the prior authorization file could be loaded.

PBM B was not provided the historical claims and prior authorization data from HHSC with the advance noticed described in the attached minutes from HHSC and timeline below:

Date:	Action:
2/7/12	HHSC/PBM/F2F (Austin Texas) **pulled from HHSC minutes**: *Historical PA discussion:* *PA File – What is the state's contingency plan if the MCOs do not receive the PA file on time? MCOs/PBMs noted that they need a 10 days to process all the PAs and the medication history. MCOs/PBM suggest an open PA policy during the short period of time in which they are still processing the PAs.*
2/22/12	First historical PA files were provided to the MCO's by HHSC. MCO's posted the files to the PBM B site for review. PBM B picked up the historical PA Files and performed an analysis.
2/23/12	PBM B notified Alan Scantlen and VDP that our findings were only 5% of the expected PAs were received on the 2/22/12 file. Alan and VDP acknowledged the issues and indicated that would get back to us when resolved and new files will be produced.
2/27/12	VDP and Alan S sent a notification to all MCO's that new PA files would be produced and posted for pick up overnight 2/28/12.
2/29/12	PBM B opened PA restrictions per MCO's and HHSC's guidance/approval on 2/7/12
2/29/12	MCO's began receiving the PA files and posting the PBM B site for pick up.
2/29/12	PBM B began the analysis, stage and load of new PA files
3/14/12	PA file loads complete

PHBV Partners LLP's Response to MCO Disagreements

MCO 2 disagrees with Finding # 3 due to their belief that HHSC guidance allowed them to relax the prior authorization requirements. No regulatory requirements, or other program guidance, exist to support the relaxing of prior authorization requirements. Our finding accurately reflects instances of non-compliance during the scope period of the engagement and our recommendation is accurate based on the finding.

Finding # 4 – Missing PA support

PBM B is aware of the issue and has taken the appropriate steps to ensure proper controls are in place. While the term corrupted was submitted as a reason that term does not accurately reflect the situation that occurred during the audit.

Finding # 5 – PBM adherence to Prior Authorization Requirements

MCO 2 requests that PHBV remove this finding, in light of the circumstances. In an effort to fully disclose to HHSC the clinical edits MCO 2 had in place effective March 1, 2012, [MCO's] PBM, PBM B, provided HHSC with a document stating which Clinical Edits would be in place on 03/01/2012. Please see Memo dated 11/15/2011 which lists the Duplicate therapy edit (Pletal is included in that edit). PBM B did not receive any communication from HHSC or VDP that this edit was not approved or that it had been changed.

On 02/27/2012 (3 days prior to go-live), PBM B reviewed the Vendor Drug website and at that time the Duplicate – Therapy Pletal edit was still listed. (See attached screen shot)

At the time of the audit in September, we agree that the Duplicate Therapy – Pletal edit was no longer posted but we cannot confirm it was not on the website in March and April 2012. As of 11/08/2012, the Duplicate Therapy – Pletal edit was still listed as active on the PAXpress website. This website is linked off of the VDP Clinical Edit page and contains additional information related to VDP's clinical edits for providers. Please see the following link and the Duplicate Therapy Edit is listed on the right hand side.

https://paxpress.txpa.hidinc.com/apex/f?p=1000:1:4406539648331111

As soon as PBM B was made aware that the clinical edit for Pletal was not in effect, it was removed immediately from the PBM B system.

On 08/06/2012, HHSC issued an announcement titled "HHSC MCO Website for Managed Medicaid". This website now provides the MCOs and their PBMs with updates when a Clinical Edit is added, changed or deleted. We have updated our processes to include this new communication method in our processes. We content that our internal controls are adequate to ensure the Clinical Edits are being administered appropriately.

PHBV Partners LLP's Response to MCO Disagreements

MCO 2 disagrees with Finding # 5 due to not receiving notification from HHSC of the removal of the related edit. No regulatory requirements, or other program guidance, exist requiring HHSC to notify the MCOs of changes to the published clinical edits. It is the responsibility of the MCOs to monitor the published clinical edits and update their systems accordingly and our finding and recommendation reflect the instance of non-compliance observed.

MCO 3 Management Responses

Finding #1 PBM Aherence to the HHSC VDP Formulary File

The 61 NDCs that were identified as included on the VDP file and not on the PBM B file, do not exist in Medi-Span®. In addition, PBM B did confirm that these NDCs were not active with the FDA at the time of the audit. It is likely that these are old NDCs that were not removed from the VDP file. Since the NDCs are not active with the FDA, no members were adversely impacted and the claims were adjudicated correctly.

We dispute the recommendation that PBM B does not have adequate controls in place. We contend that all of these NDC differences have been explained fully. We do have several quality controls in place. We are in full compliance with all regulatory requirements related to formulary and the PDL.

PHBV Partners LLP's Response to MCO Disagreements

Regulation requires the PBM exclusively employ the vendor drug program formulary. Additions or deletions from the VDP formulary file are a deviation from the regulatory requirement. While we understand the PBM's reasoning for excluding the 61 NDC codes from their formulary file, additions or deletions of NDC codes from the VDP formulary file represent a deviation from VDP formulary file and our finding and related recommendation accurately reflect this deviation.

Finding # 3 - PBM Adherence to the HHSC VDP PDL

MCO 3's actions were the direct result of receiving the prior authorization file from HHSC on February 29, 2012, for an effective date of March 1, 2012. Due to the complexity of integrating the outstanding prior authorizations to the PBM B system, HHSC was made fully aware that at least ten (10) business days were needed to program these authorizations. Because the authorization file was received one (1) day prior to the authorizations becoming effective, MCO 3 in consultation with its Medical Director, determined that it was in the best interest of the Members to dispense medications as written by the prescriber, to avoid inappropriate denials, until the prior authorization file could be loaded.

PBM B was not provided the historical claims and prior authorization data from HHSC with the advance noticed described in the attached minutes from HHSC and timeline below:

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2/22/12	First historical PA files were provided to the MCO's by HHSC. MCO's posted the files to the PBM B site for review. PBM B picked up the historical PA Files and performed an analysis.
2/23/12	PBM B notified Alan Scantlen and VDP that our findings were only 5% of the expected PAs were received on the 2/22/12 file. Alan and VDP acknowledged the issues and indicated that would get back to us when resolved and new files will be produced.

Date:	Action:
2/27/12	VDP and Alan S sent a notification to all MCO's that new PA files would be produced and posted for pick up overnight 2/28/12.
2/29/12	PBM B opened PA restrictions per MCO's and HHSC's guidance/approval on 2/7/12
2/29/12	MCO's began receiving the PA files and posting the PBM B site for pick up.
2/29/12	PBM B began the analysis, stage and load of new PA files
3/14/12	PA file loads complete

PHBV Partners LLP's Response to MCO Disagreements

MCO 3 disagrees with Finding # 3 due to their belief that HHSC guidance allowed them to relax the prior authorization requirements. No regulatory requirements, or other program guidance, exist to support the relaxing of prior authorization requirements. We feel our finding accurately reflects instances of non-compliance during the scope period of the engagement and our recommendation is accurate based on the finding.

Finding # 4 – Missing PA support

PBM B is aware of the issue and has taken the appropriate steps to ensure proper controls are in place. While the term corrupted was submitted as a reason that term does not accurately reflect the situation that occurred during the audit.

Finding # 5 – PBM adherence to Prior Authorization Requirements

MCO 3 requests that PHBV remove this finding, in light of the circumstances. In an effort to fully disclose to HHSC the clinical edits MCO 3 had in place effective March 1, 2012, [MCO's] PBM, PBM B, provided HHSC with a document stating which Clinical Edits would be in place on 03/01//2012. Please see Memo dated 11/15/2011 which lists the Duplicate therapy edit (Pletal is included in that edit). PBM B did not receive any communication from HHSC or VDP that this edit was not approved or that it had been changed.

On 02/27/2012, PBM B reviewed the Vendor Drug website and at that time the Duplicate – Therapy Pletal edit was still listed. (See attached screen shot)

At the time of the audit in September, we agree that the Duplicate Therapy – Pletal edit was no longer posted but we can't confirm it wasn't on the website in March and April 2012. As of 11/08/2012, the Duplicate Therapy – Pletal edit was still listed as active on the PAXpress website. This website is linked off of the VDP Clinical Edit page and contains additional information related to VDP's clinical edits for providers. Please see the following link and the Duplicate Therapy Edit is listed on the right hand side.

https://paxpress.txpa.hidinc.com/apex/f?p=1000:1:4406539648331111

As soon as PBM B was made aware that the clinical edit for Pletal was not in effect, it was removed immediately from the PBM B system.

It wasn't until 08/06/2012 when HHSC issued an announcement titled "HHSC MCO Website for Managed Medicaid" that a formal process was developed to inform MCOs and their PBMs of updates to Clinical Edit including information as to when an edit is added, changed, or deleted. We have updated our processes to include this new communication method. We contend that our internal controls are adequate to ensure the Clinical Edits are being administered appropriately.

PHBV Partners LLP's Response to MCO Disagreements

MCO 3 disagrees with Finding # 5 due to not receiving notification from HHSC of the removal of the related edit. No regulatory requirements, or other program guidance, exist requiring HHSC to notify the MCOs of changes to the published clinical edits. It is the responsibility of the MCOs to monitor the published clinical edits and update their systems accordingly and our finding and recommendation reflect the instance of non-compliance observed.

MCO 4 Management Responses

Finding # 1 - PBM Adherence to the HHSC VDP Formulary File

The root cause of the 751 NDCs not found in the PBM C formulary file is related to the differences in the drug database sources. Our understanding is that VDP utilizes First Data Bank, while PBM C utilizes Medi-Span®, a common database used throughout the PBM industry. The databases do not have every NDC incorporated, and they do not reflect the same obsolete dates. These discrepancies are well recognized in the industry, and are the cause of your findings. Medi-Span® either no longer recognizes the NDCs in question or considers them to be "inactive".

Each database is dependent on the drug manufacturers and labelers for their information. If an NDC is not represented in the data, it is due to the manufacturer not registering it with each database vendor. Also, the obsolete dates are not consistently reported. Each manufacturer/labeler must coordinate the information related to their specific products with each vendor. Our PBM is not in the position to add these NDCs/drugs to the Medi-Span® database itself. Procedurally, our file processing accurately represents all available NDCs in the formulary and those not included are beyond our control for the reasons cited above.

We understand that the Effect section of your finding reflects a blinded summary of the findings across all MCOs/PBMs reviewed, and that all may not necessarily reflect findings specific to MCO 4. While we appreciate your need to speak globally, we would like to clarify that PBM C was not found during the course of the audit to have adjudicated claims for non-formulary NDCs. Your findings identified VDP Formulary NDCs that were not in our PBM's system. Per our discussions with you, no NDCs were identified in our PBM's system that were not VDP formulary NDCs.

PHBV Partners LLP's Response to MCO Disagreements

MCO 4 responded to Finding # 1 but did not identify a specific disagreement. We understand the MCO's explanation that the differences are caused by the PBM's use of a different database than HHSC. However, regulation requires exclusive employment of the vendor drug program formulary. Our finding and corresponding recommendation are correct as stated.

Finding # 2 - PBM Adherence to the HHSC VDP PDL

The status of these 2 NDC's is mostly attributable to the way the PDL status codes were treated. MCO 4 was instructed on the various PDL status codes, PDL, NPD and NAP. We understand that VDP requires a call for a NAP coded drug, but it was not clear at the time that MCO's were required to apply the same logic. This resulted in a situation that if a member had a preferred NDC in history for the drug, the logic would allow a non-preferred NAP NDC to pay. This was later clarified and MCO 4 has instructed PBM C and ensured that PBM C has updated the system coding to process the NAP PDL NDCs according to clarified instructions. Additionally, changes in our methodology for treating NAP drugs have been communicated to HHSC in recent months.

Finding # 3 - PBM Adherence to the HHSC VDP PDL

The deliberate roll out of PDL edits was a conscious decision by the PBM C-affiliated MCOs. PBM C implemented these edits per our instructions; therefore, this is not a measure of process control adequacy. Additionally, as stated in the "Condition" section, this took place over a specific period of time. It is not indicative of a persistent condition, or one that extends to today. It is a past event; therefore, any assumptions that the MCOs and/or the PBM are currently not in compliance would be unfounded.

We agree with the statements in the Cause Section regarding the deliberate schedule to minimize member and provider disruption. MCO 4 has reviewed our implementation schedule with HHSC, providing details using specific drug examples. Generally, we believe this review of compliance with PDL edits was premature, focusing on a time during which transitional benefits were common for many Texas Medicaid MCOs. We fully support PHBV's direction to review this portion of the pharmacy program, but believe HHSC's direction to review this particular time period did not provide an accurate representation of the program in its fully functional state.

Specific to the claims reviewed, MCO 4 would like to clarify the process established at initial implementation based on the delay in receipt of claims history and authorization files. Because VDP authorization files were not available prior to the operational start date, the MCOs did not have complete information regarding medications members had been receiving. However, we did receive claims history files from VDP concurrent with the start date so we had some ability to extrapolate based on history. In the absence of authorization information, we were able to review a member's history to identify prior use of a preferred or non-preferred medication. Using prior history as a proxy for knowledge regarding any authorizations, we were able to override authorization requirements during the initial weeks of implementation.

PHBV Partners LLP's Response to MCO Disagreements

It appears MCO 4 disagrees with the period selected by HHSC for review. PHBV Partners has no control over the period selected for review and has no response to this disagreement.

Finding # 4 – Missing PA support

Our understanding was that the purpose of this section of the audit was to examine certain claims that paid with a Prior Authorization (PA) and the circumstances that led to their approval, including timing. We know, based on our work with PHBV, that this was a challenging section given how different fields in a paid claim may be interpreted. We would like to take this opportunity to re-state that MCO 4 provided all materials/records that it had regarding these claims in order to assist PHBV with its review. No records were withheld. MCO 4 and PBM C also made every effort to explain the differences between how overrides or PAs may be entered straight into the Pharmacy Claims System vs. how they would be entered in the Pharmacy Prior Authorization Software Application system, including the scenarios under which one may be used instead of the other. Additionally, there was specific mention that when a call comes in live over the phone vs. a fax, different systems may be used depending on the circumstance and that can impact the amount of information available for review in the system regarding the claim in

question. For example, limited "notes field" information in the Pharmacy Claims System versus a detailed paper trail initiated by an incoming fax in the Pharmacy Prior Authorization Software Application. As such, we would like to take this opportunity to request that the "Criteria" and "Effect" sections of this finding be changed to reflect that MCO 4 and PBM C were not in violation of our contract with HHSC by not retaining records. All records were retained and those that were in existence were provided to PHBV for its review.

In regard to the specific claims in question,

1. Two of the seven claims identified did not adjudicate with a PA. These claims more appropriately fall under Finding 3 since the members were able to get non-preferred drugs without a PA due to the timing of coding the PDL edit(s). We believe that PBM C has already communicated this to you.

2. For the remaining 5 claims, it was determined that the prior auths were worked by MCO 4 employees; however, none of them were worked through the Pharmacy Prior Authorization Software Application system due to the nature of the request. Four of these claims had notes in the notes section of Pharmacy Claims System and those screen shots were provided to PHBV via email on 10/23.

PHBV Partners LLP's Response to MCO Disagreements

Taking into consideration the additional support provided on October 23, 2012, we agree with the MCO on four of the questioned transactions and have revised our finding to note that only three PAs are not adequately documented. While we did receive additional support for the other three transactions, the support did not contain specific documentation necessary to verify certain regulatory requirements (that a proper PA was received, that the proper medium was utilized to accept the PA, and that the approved PA criteria were met). The PBM and MCO request that two of the transactions be reclassified to Finding #3 because there is no support for the PA due to the PDL requirements being relaxed during the time under review. We disagree because these three claims indicated that either an over ride or a PA was performed. Documentation must be maintained in order to support compliance with these regulatory requirements. This documentation was requested from the PBM after review of the October 23, 2012 documentation submission and no additional documentation was provided. Our finding and recommendations, based on the revised wording described above, accurately reflects the lack of documentation to support compliance with the regulatory requirements for these three samples.

MCO 5 Management Responses

Finding # 1 - PBM Adherence to the HHSC VDP Formulary File

Based on our discussions with you, we understand the Effect section of your finding reflects a blinded summary of the findings across all MCOs/PBMs reviewed. While we appreciate your need to speak globally, we would like to clarify that PBM C was not identified as having paid claims for non formulary NDCs. Your findings identified VDP Formulary NDCs that were not in our PBM's system. Per our discussions with you, no NDCs were identified in our PBM's system that were not VDP formulary NDCs.

The root cause of the 751 NDCs not found in the PBM C formulary file is related the differences in the drug database sources. Our understanding is that VDP utilizes First Data Bank and PBM C utilizes Medi-Span®. The databases do not have every NDC incorporated, and they do not reflect the same obsolete dates. These discrepancies are well recognized in the industry, and are the cause of your findings.

Each database is dependent on the drug manufacturers and labelers for their information. If an NDC is not represented in the data, it is due to the manufacturer not registering it with each database vendor. Also, the obsolete dates are not consistently reported. Each manufacturer/labeler must coordinate the information related to their specific products with each vendor.

Procedurally, our file processing accurately represents all available NDCs in the formulary and those not included are beyond our control for the reasons cited above.

PHBV Partners LLP's Response to MCO Disagreements

MCO 5 responded to Finding # 1 but did not identify a specific disagreement. We understand the MCO's explanation that the differences are caused by the PBM's use of a different database than HHSC; however, the regulation requires exclusive employment of the vendor drug program formulary. Our finding and corresponding recommendation are correct as stated.

Finding # 2 - PBM Adherence to the HHSC VDP PDL

For NDC 16571015050, eight claims were identified. One had a previous fill prior to March 1, 2012. The others did not reject for PDL PA as the PDL edits had not yet been activated (see response for # 3).

For NDC 59310057920, two claims had fill dates for the same NDCs prior to March 1, 2012 and two had PA's on file, with an effective date prior to March 1, 2012.

The disposition if the remainder of claims for these 2 NDC's is attributable to the way the PDL status codes were treated. MCO 5 was instructed on the various PDL status codes, PDL, NPD and NAP. We understand that VDP requires a call for a NAP coded drug, but it was not clear that MCO's were required to apply the same logic. This resulted in a situation that if a member had a

preferred NDC for the drug, the logic would allow a non preferred NAP NDC to pay. This has been clarified and MCO 5 has instructed PBM C and ensured PBM C has updated the system coding to process the NAP PDL NDCs according to clarified instructions.

Finding # 3 - PBM Adherence to the HHSC VDP PDL

We agree with the statements in the Cause Section regarding the deliberate schedule to minimize member and provider disruption. MCO 5 has reviewed our implementation schedule with HHSC, providing details using specific drug examples. Generally, we believe this review of compliance with PDL edits was premature, focusing on a time during which transitional benefits were common. We fully support PHBV's direction to review this portion of the pharmacy program, but believe HHSC's direction to review this particular time period did not provide an accurate representation of the program in its fully functional state.

Specific to the claims reviewed, MCO 5 would like to clarify the process established at initial implementation based on the delay in receipt of claims history and authorization files. Because VDP authorization files were not available prior to the operational start date, the MCOs did not have complete information regarding medications members had been receiving. However, we did receive claims history files from VDP concurrent with the start date so we had some ability to extrapolate based on history. In the absence of authorization information, we were able to review a member's history to identify prior use of a preferred or non-preferred medication. Using prior history as a proxy for knowledge regarding any authorizations, we were able to override authorization requirements during the initial weeks of implementation. Further research regarding the claims identified in this Finding has revealed that 1 claim in the first category has a prerequisite preferred drug filled prior to 3/1/12, making an override of a PA appropriate. For category 2, we found two of the three identified claims had a prerequisite drug filled prior to 3/1/12, again indicating the PA should be overridden. Additionally, note that the PA codes submitted by the pharmacy in the Category 2 claims did not in any way impact the claim disposition. While a PA may show in the system, only a valid code will affect the actual disposition of the claim.

PHBV Partners LLP's Response to MCO Disagreements

It appears MCO 5 disagrees with the period selected by HHSC for review. PHBV Partners has no control over the period selected for review and has no response to this disagreement.

Finding # 4 – Missing PA support

This finding relates to prior authorizations for PDL PA drugs. Some of the drugs did not reject for PDL PA as MCO 5 made the business decision to delay implementing the PDL edits during the initial implementation period for the afore mentioned reasons. For the drugs that did pay due to a PA override, there is no record of these in the Pharmacy Prior Authorization Software Application PA management tool as these were managed outside of the standard process. These PA's were authorized as part of our implementation transition process to assure no interruptions or access to care issues. These were reviewed on a case by case basis by an MCO 5 pharmacist and PA overrides were entered into the pharmacy claims adjudication under their direction. The

remaining claims were paid prior to the time the PDL were turned on, so they paid without requiring a PA. Now that the edits have all been implemented, these drugs will require a PA.

PHBV Partners LLP's Response to MCO Disagreements

The PBM and MCO request that two of the transactions be reclassified to Finding #3 because there is no support for the PA due to the PDL requirements being relaxed during the time under review. Specific documentation necessary to verify certain regulatory requirements (that a proper PA was received, that the proper medium was utilized to accept the PA, and that the approved PA criteria were met) was not provided. Documentation must be maintained in order to support compliance with these regulatory requirements.