Special Report

Arkansas Legislative Audit

Review of Selected Financial Records and State Funding

Pharmacy Benefit Managers

For the Period January 1, 2018 through June 30, 2019

INTRODUCTION

This report is being issued pursuant to a request, approved by the Executive Committee of the Legislative Joint Auditing Committee, that Arkansas Legislative Audit (ALA) review and analyze financial records and other documentation concerning state funding of pharmacy benefit managers (PBMs). A glossary of the acronyms used in this report is provided in **Appendix A**.

OBJECTIVES

The objectives of this report were to:

1. Provide an overall perspective on how PBMs are regulated in Arkansas.
2. Identify state programs using PBMs and determine how state funds flow through PBMs, pharmacies, and insurance companies.
3. Test PBMs for compliance with state laws and regulations.
4. Compare Arkansas laws and regulations related to PBMs with those of other states.
5. Review complaints received by state agencies and program management regarding PBMs.

REPORT HIGHLIGHTS

- In Arkansas, pharmacy benefit managers (PBMs) are primarily regulated by the Arkansas Insurance Department (AID), which issues licenses, reviews reimbursement rate appeals, and receives required reports from PBMs. The Arkansas Attorney General's Office (AG) and Arkansas State Board of Pharmacy have a limited amount of regulatory authority over PBMs.
- Due to Medicaid fee-for-service's structure, payments flow directly from the Department of Human Services' fiscal agent to pharmacies, rather than through a PBM. Funds from the Employee Benefits Division (EBD), Provider-led Arkansas Shared Savings Entity (PASSE), and Arkansas Works flow through PBMs before being received by pharmacies.
- Both ALA and actuaries contracted with AID noted spread pricing by certain PBMs for the PASSE and Arkansas Works programs. Arkansas Code prohibits spread pricing for state-funded pharmacy benefits.
- Relationships among PBMs and the pharmaceutical industry may create conflicts of interest if PBMs make drug formulary decisions. EBD utilizes UAMS-EBRx as a neutral party to provide formulary recommendations.
- Based on legislation enacted in other states, the General Assembly may wish to consider PBM-related legislation regarding areas such as fiduciary duty, claim payment processing time, claim data usage, conflict of interest disclosure, drug manufacturer rebates, and Medicaid managed care programs.
- AID received a total of 237 PBM-related complaints in 2019 and 2020, with the majority being resolved as of report date. The AG received over 5,000 complaints from pharmacies from 2018 through early 2020 regarding low reimbursement rates by PBMs.

ARKANSAS LEGISLATIVE AUDIT
500 Woodlane Street, Suite 172, Little Rock, AR 72201
Phone: 501-683-8600 • Fax: 501-683-8605
www.arklegaudit.gov

Report ID: SPSR00418 Report Date: May 7, 2021

SCOPE AND METHODOLOGY

This review was conducted for the period January 1, 2018 through June 30, 2019. ALA staff interviewed representatives from state agencies in Arkansas and other states, as well as pharmaceutical industry stakeholders. Additionally, ALA staff reviewed selected state-funded pharmacy claims, relevant Arkansas law, contracts between state-funded entities and health insurers/PBMs, health plan documents, industry publications, reports issued by other states concerning PBMs, and publicly available documentation regulating PBMs in other states. Finally, for testing during the first six months of 2019 and solely in relation to the Arkansas Works and Provider-led Arkansas Shared Savings Entity (PASSE) pharmacy claims, ALA staff relied upon the services provided by an actuarial firm to the Department of Commerce – Arkansas Insurance Department (AID). ALA staff also performed additional testing of the Arkansas Works program for calendar year 2018 and of the PASSE program for 2019 in certain areas.

Key Terms
Pharmacy Benefit Managers (PBMs): Entities that (1) administer or manage a pharmacy benefits plan or program or (2) provide claims processing services or other prescription drug or device services for health benefit plans.
Self-Funded Health Insurance Plan: Costs of benefit claims are paid by contributions from the employer and employee premiums, and the insurance company manages the payments; plans are regulated by federal law (i.e., the Affordable Care Act and ERISA).
Fully-Insured Health Insurance Plan: The employer purchases a health insurance plan, and the insurance company takes on the costs of benefit claims and manages the payments; plans are regulated by both federal and state law.
Government-Funded/Public Benefit Plan: The government takes on most or all costs of benefit claims; such plans include Medicare and Medicaid.

Since state-funded PBMs are involved in various public benefit plans and employee health insurance plans in Arkansas, this report's primary focus, for the flow of funds and testing of PBMs for compliance with state law, was the following four plans, which encompassed approximately 94% of annual government-funded pharmacy expenditures:

- Medicaid fee-for-service.
- Arkansas Works.
- The PASSE Managed Care program.
- The Employee Benefits Division (EBD) employee health insurance plan.

BACKGROUND

Pharmacy benefit managers (PBMs) are the most commonly-known intermediaries between third-party healthcare payers (i.e., health insurance companies, self-funded health plans, government-funded health coverage) and pharmacies.[1] The three largest PBMs in the United States are Caremark (CVS), Express Scripts, and OptumRx. PBMs assist health care plans with prescription drug coverage by processing pharmacy claims, maintaining pharmacy networks, and providing expert knowledge regarding benefit coverage. In addition, PBMs often negotiate rebates from drug manufacturers and remit these funds to the third-party payers.

Profit-Generating Practices

PBMs have come under increased scrutiny due to potentially lucrative and little-known practices for generating profits from their intermediary role between healthcare payers and pharmacies. Eight of these practices are explained below:

[1] Pharmacy services administrative organizations (PSAOs), a lesser known intermediary between third-party healthcare payers and pharmacies, are more commonly utilized by independent pharmacies than chain pharmacies. PSAOs assist pharmacies with administrative services ranging from negotiating contracts with PBMs, assisting with claims reimbursements, providing auditing assistance and marketing support, and acting as a central payment point between PBMs and network pharmacies. Also, PSAOs are sometimes affiliated with pharmaceutical drug wholesalers.

1. **Spread pricing**: Through this most well-known practice, a pharmacy is compensated less than the amount paid by the health care payer, and the PBM retains the difference. Many times, the profits generated from spread pricing are increased or created by utilizing maximum allowable cost (MAC) price lists that vary between the pharmacy and the third-party payer. Furthermore, low MAC prices can cause pharmacies to lose money on filling certain prescriptions.
2. **Post-claim adjudication reconciliation**: Related to spread pricing, this practice initially originated in the Medicare Part D reimbursement process. This industry practice entails adjusting the pharmacy reimbursed claim amount after – perhaps months after – the initial payment of the claim. The reimbursement amount for a subset of drugs (i.e., generic drugs or name brand drugs) can be reduced or increased to a different amount (known as an "effective rate"). Typically, this is a contracted reimbursement rate between the pharmacies and PBMs based on the performance of a pharmacy or group of pharmacies meeting a market-based reimbursement amount on a subset of drugs. Profits (or losses) generated from this retroactive adjudication are generally not adjusted back to the third-party payer originally reimbursing the claim.
3. **Drug rebate retention**: Portions of the drug rebate paid by manufacturers for drug usage and formulary placement may be retained directly by the PBM or indirectly through an affiliated sub-contractor (known as rebate aggregators or intermediaries). Alternatively, PBMs can receive other forms of payment from drug manufacturers that are not included in the contractual definition of rebates (i.e., administrative fees) but relate to formularies utilized or prescriptions paid by third-party payers.
4. **Co-pay clawbacks**: This lesser-known practice occurs when an insured/covered member pays a co-pay to a pharmacy in an amount greater than the pharmacy is reimbursed by the PBM, effectively causing the pharmacy to remit a portion of the co-pay to the PBM (e.g., a patient pays a $10 co-pay for a prescription, but the pharmacy only gets to keep $4 and remits $6 to the PBM).
5. **Gag clauses**: PBM contracts with pharmacies sometimes prevent pharmacists from informing an insured/covered member that paying for the prescription out-of-pocket would be cheaper than having the pharmacist utilize insurance coverage.
6. **Auditing high-cost drugs**: This practice occurs when only high-cost drugs are selected for testing by PBMs and then questioned as being incorrectly filled based on what seem to be trivial errors. The amounts paid with the questioned claims are then reimbursed to the PBM.
7. **Preferential pharmacy designations**: Some PBMs have generated additional profits by requiring or encouraging the use of mail-order or specialty pharmacies that are affiliates of the PBM or by reimbursing affiliated pharmacies more than non-affiliated pharmacies.
8. **Use of pharmacy claims data**: A few PBMs have been accused of utilizing pharmacy claims data to steer patients toward affiliated pharmacies or of de-identifying and selling claims data to unaffiliated third parties.

It is important to note that all of these industry practices are typically addressed in proprietary contracts between either the third-party payer and PBM or the third-party administrator and PBM. Through all of these practices, PBMs can use their intermediary role between pharmacies and third-party payers to increase profits. Finally, these payments are in addition to a standard per-prescription fee paid for adjudicating pharmacy claims (except for spread pricing, which typically occurs as an alternative to the per-prescription fee).

RESULTS OF REVIEW

Federal statutory law and interpreting court decisions have significantly restricted Arkansas's ability to regulate the PBM industry in the State.

Prior to discussing Arkansas's regulation of PBMs, it is important to understand that the impact of the U.S. Supreme Court's (Court) decision concerning the ability of states to regulate PBMs is still uncertain. The Court's decision in *Rutledge v. Pharmaceutical Care Management Association* (PCMA) upheld Arkansas's Act 900 of the Regular Session of 2015, which addresses the regulation of MAC laws and PBMs' compliance with various reimbursement requirements. According to the Court, as long as state legislation is merely a form of cost regulation and not "govern[ing] a central matter of plan administration or infer[ing] with nationally uniform plan administration," the law is not preempted by federal law or, more specifically, the Employee Retirement Income Security Act of 1974 (ERISA).[2] Otherwise, federal law preempts any state-level regulation of any health benefit plans paid for by a self-funded insurance plan. Therefore, if a private entity provides medical benefits to its own employees via a self-funded health insurance plan, any enforcement action regarding the PBMs' activities is subject to legal challenge, aside from the requirements in Act 900 that were recently upheld by the Court.

According to AID, approximately 15-20% of issued policies in Arkansas are regulated by state insurance law, with the rest regulated by federal insurance law (e.g., ERISA or Medicare). Act 706 of the Regular Session of 2019 requires the covered member's insurance identification card to indicate whether the health benefit plan is fully-insured or self-funded; this information can assist pharmacies and pharmacists in determining whether any state laws apply to the PBM at the time of processing a specific prescription fill.

Objective 1: Provide an overall perspective on how PBMs are regulated in Arkansas

Discussed below are PBM regulations in Arkansas, organized by the agency with regulatory authority.

Department of Commerce – Arkansas Insurance Department

Currently, certain PBMs are licensed by AID. Under the current laws and promulgated rules, licensing requirements encompass the traditional fee payments, surety requirements, and disclosure of contact and business formation information *in addition to* the following practices specific to the pharmaceutical industry:

- Adequate network management.
- Review and approval of rates charged to health insurance plans.
- Assurances that prohibited activities directed toward pharmacists by PBMs (see the **Background section on pages 2 and 3**) are not part of the PBM's business model.[3]

[2] See *Rutledge v. Pharm. Care Mgmt. Ass'n,* 141 S.Ct. 474, 480-481 (2020).

[3] While not covered by currently promulgated regulations but deemed illegal as a result of recent legislation (Act 994 of 2019), spread pricing has been prohibited since July 24, 2019. Furthermore, spread pricing has been illegal for state-funded plans since 2009.

- Demonstration of an internal appeals process for pharmacies to challenge inadequate PBM reimbursements, typically caused by the industry practice of setting a maximum drug reimbursement amount based on a PBM's assessment of the drug's market value (i.e., maximum allowable cost (MAC)) that is insufficient to cover the pharmacy's costs for the drug.

After licensure, one of the primary tasks of AID is to provide a second level of review over reimbursement rate appeals. If the pharmacy is not satisfied with the PBM's internal appeals process, the pharmacy can bring a complaint to AID for review.

Finally, required reporting imposed on PBMs must be made to AID:

1. PBMs must report statistical information concerning MAC appeals quarterly.
2. State-funded health plans must report claims. AID rules incorporate this reporting into the All-Payer Claims Database (APCD) process handled by the Arkansas Center for Health Improvement (ACHI).
3. Licensed PBMs are required to report rebates received from manufacturers and detailed pharmacy claims information. Currently, AID is drafting rules to address the rebate reporting requirement.

Indirectly, AID can regulate a PBM-industry practice that relates to shifting covered patients to mail-order prescriptions. While mail-order prescriptions may have some positive benefits for the plan (e.g., adherence rates or lower costs), some mail-order pharmacies are PBM affiliates, and the ability to shift the pharmaceutical market from retail to mail-order pharmacies allows the PBM to increase the profits and market share of its affiliates. Under Ark. Code Ann. § 23-79-149, an insurance policy cannot have preferential cost-sharing health coverage provisions (coinsurance, co-pays, or deductibles) or quantity limitations that apply just to a subset of eligible pharmaceutical providers; this rule indirectly prevents PBMs from such practices as offering 90-day supplies of medication for only two co-pays for mail-order prescriptions but requiring three co-pays for retail/walk-in pharmacies. Under this Code section, the Insurance Commissioner can impose penalties for violations.

Arkansas Attorney General's Office

The Arkansas Attorney General's Office has the ability to regulate PBM practices relating to MAC reimbursements and preferential pricing to PBM-owned pharmacies via litigation under the Deceptive Trade Practices Act. Furthermore, under a law passed in 2009, the Attorney General may sue PBMs conducting spread pricing in state-funded benefit plans.

Department of Health – Arkansas State Board of Pharmacy

Arkansas Code provides certain rights to pharmacies regarding PBM audits. These provisions are embedded in an area of law over which the State Board of Pharmacy has authority; however, any enforcement efforts by the Board could result in Board members having conflicts of interest due to contractual relationships with PBMs in their professional roles.

Issue: While rights exist for pharmacists in Arkansas Law when facing audits from PBMs, there appears to be a gap in any kind of enforcement authority to ensure compliance by PBMs with these statutory rights.

See **Appendix B** for a summary of relevant Arkansas legislative acts and **Appendix C** for a summary of relevant Arkansas statutory provisions.

Objective 2: Identify state programs using PBMs and determine how state funds flow through PBMs, pharmacies, and insurance companies

PBMs play unique roles in the various state-funded programs and health plans in Arkansas. The different types of state-funded pharmacy benefits can be grouped into two main types: (1) public benefit plans and (2) employee benefit plans. See **Exhibit I below** and **Exhibit III on page 17** for a visual representation of PBMs in each main type.

Public Benefit Plans

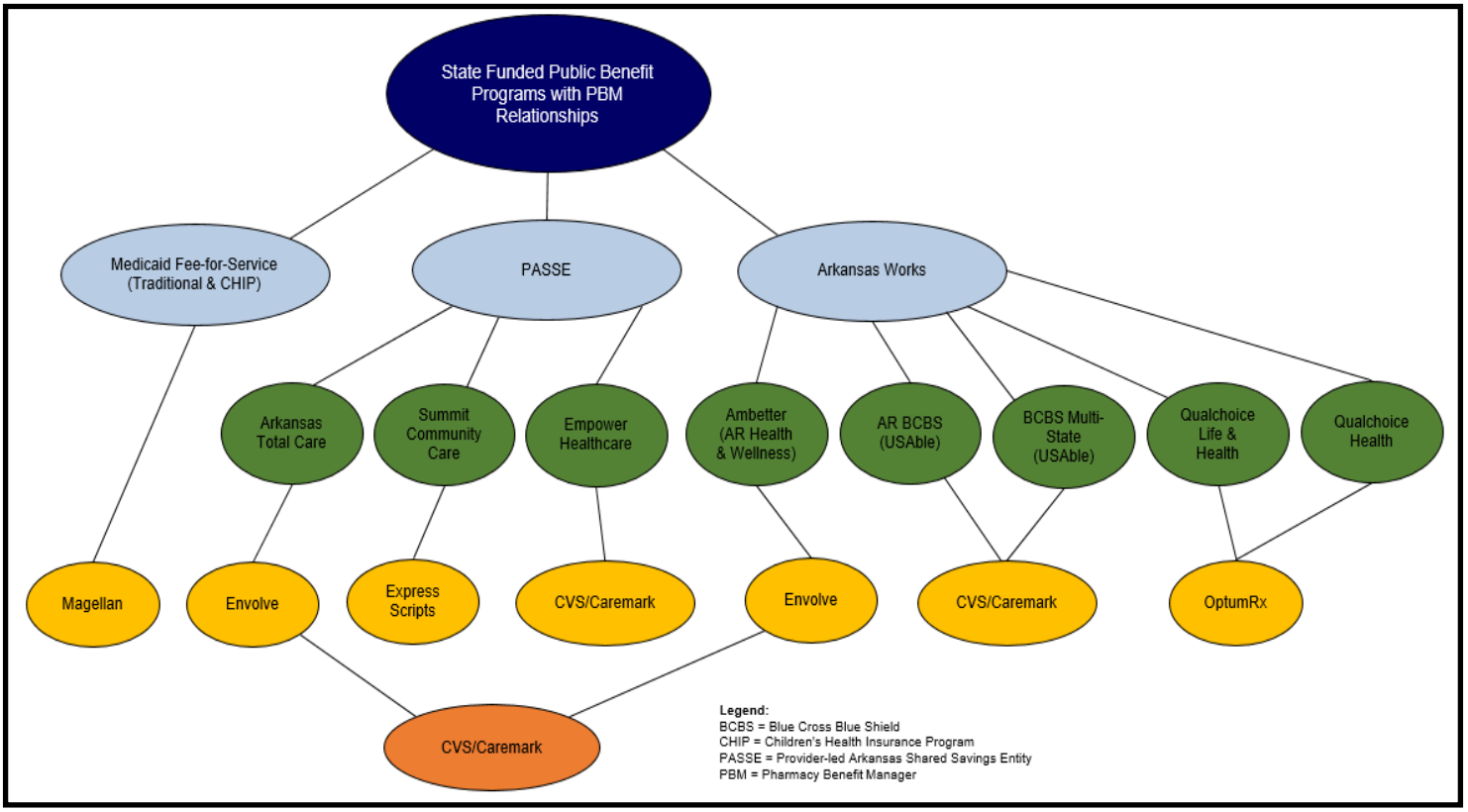
Medicaid Fee-for-Service

Pharmacy Benefits Manager[4]

In general, Arkansas Medicaid fee-for-service pharmacy claims have a state match funding component of approximately 30% (i.e., the federal government pays approximately 70% of the expense). The services provided by Magellan, the PBM for the fee-for-service program, include the following:

Exhibit I

Relationships of Pharmacy Benefit Managers with Public Benefit Plans in Arkansas
As of June 30, 2019



Source: *Information obtained from the Department of Human Services and the Arkansas Insurance Department (unaudited by Arkansas Legislative Audit)*

[4] Department of Human Services (DHS) staff indicated to auditors on various occasions that Magellan is a "pharmacy benefit administrator" as opposed to a "pharmacy benefit manager" since funds do not flow through Magellan and Magellan administers DHS's required formulary and reimbursement policies. However, Magellan would be considered a PBM under the PBM Licensure Act, if not for being specifically excluded. Therefore, this report refers to Magellan as a PBM throughout and acknowledges that no funds, known to ALA staff, flow between the drug manufacturers and Magellan or between Magellan and the pharmacies in relation to this plan.

- Maintaining the formulary (i.e., the list of covered drugs, including those on the preferred drug list) but not approving the drugs.
- Processing claims.
- Running system edits.
- Identifying the pricing amount at the point of sale.
- Approving prior authorizations.
- Aiding in the rebate process.

During state fiscal years 2017, 2018, 2019, and 2020 Magellan received approximately $8.4 million, $8.8 million, $8.7 million, and $10.0 million, respectively, for processing Medicaid fee-for-service pharmacy claims.

The contract with Magellan began on March 1, 2014. During state fiscal years 2017, 2018, 2019, and 2020, Magellan received approximately $8.4 million, $8.8 million, $8.7 million, and $10.0 million, respectively. It is ALA's understanding that this is the only compensation Magellan receives for the services provided, and pharmacists pay no additional fees to Magellan to process a Medicaid fee-for-service pharmacy claim. It is also important to note that in January 2021, Centene announced its plans to purchase Magellan. Centene's relationships with the other public benefit plans are illustrated in **Exhibit II on page 12.**

Magellan has a unique role in this public benefit plan since no funds flow through Magellan. Rather, Magellan obtains information electronically each day on eligible recipients and providers from the Department of Human Services (DHS). The pharmacist logs into the point-of-sale screen (which interfaces with Magellan) and instantly knows if a drug can be filled and how much the reimbursement amount will be. The transaction is captured by Magellan daily and transferred to DHS to be uploaded into DHS's Medicaid Management Information System (MMIS). Then, Gainwell Technologies, DHS's fiscal agent, pays the provider pharmacist directly, similar to other Medicaid claims. Because there are signed contracts between DHS and pharmacies (or pharmacists) to be Medicaid providers, the pharmacies do not sign any additional contract with Magellan covering these fee-for-service claims.

Magellan is responsible for providing recommendations to statutorily defined committees regarding preferred drug list status, as well as cost efficiencies and financial modeling of the drugs. In addition, Magellan solicits state supplemental rebates from drug manufacturers, notifies drug manufacturers of solicitations, and receives and reviews all rebate proposals. Finally, Magellan invoices the manufacturers for the federal and state supplemental drug rebates; however, the manufacturers pay the rebate amounts directly to DHS, rather than through Magellan. Furthermore, Magellan is contractually prohibited from receiving additional rebates from the manufacturers.

Essentially, all outpatient drugs are covered under the Medicaid program if they are in accordance with the Social Security Act of 1927 and not specifically excluded. Covered drugs must be made by manufacturers who have a signed rebate agreement with the Centers for Medicare and Medicaid Services (CMS). All covered outpatient drugs, as defined by CMS, have a federal rebate.

Cost-Sharing Requirements

Beneficiaries aged 21 years and older are limited to three Medicaid-paid prescriptions per calendar month. Certain prescriptions, such as those related to family planning, do not count toward this monthly prescription limit. In addition, the limits do not apply to residents in long-term care facilities or to those beneficiaries under age 21 in the Child Health Services/Early and Periodic Screening, Diagnosis and Treatment Program. In addition, those recipients in the

Living Choices Assisted Living program are eligible for up to nine medically necessary prescriptions per month. For medically necessary maintenance medications, Arkansas Medicaid staff can approve extensions of the prescription drug monthly benefit limit up to a maximum of six prescriptions per calendar month for individuals aged 21 and older. However, after the authorized monthly benefit limit has been met, the recipient is responsible for paying for any and all additional prescriptions for the remainder of the month.

For recipients aged 18 and older who are not in the Working Disabled or ARKids B category, a tiered beneficiary co-payment is required for prescriptions:

- $0.50 for prescriptions where the Medicaid maximum amount is $10.00 or less.
- $1.00 for prescriptions between $10.01 and $25.00.
- $2.00 for prescriptions amounts between $25.01 and $50.00.
- $3.00 for prescriptions above $50.01.

There is no co-pay requirement for those under age 18, except for those in the ARKids B or Working Disabled category. Those in the Working Disabled category are between the ages of 16 and 64.

Those in the Working Disabled category with gross incomes below 100% of the Federal Poverty Level (FPL) have the same co-pay responsibilities as regular Medicaid beneficiaries described above. Those with gross incomes at or above 100% of the FPL have a co-pay of $10.00 for generics and $15.00 for brand name drugs. For those in ARKids B, the prescription co-pay is up to $5.00 per prescription, and generics must be used.

Drug Utilization Review (DUR) Board

Each state must establish a Drug Utilization Review (DUR) Board, as required by 42 CFR § 456.716. According to the Arkansas DUR Board's bylaws, the DUR Board shall strive to improve the quality of care of Arkansas Medicaid beneficiaries receiving prescription drug benefits under Title XIX of the Social Security Act and shall strive to conserve program funds while ensuring therapeutically and medically appropriate pharmacy care for beneficiaries. The Board reviews clinical information and assists in building criteria for determining drug approval.

The DHS Director, with input from Medicaid leadership, appoints all members of the DUR Board, the composition of which must be in accordance with 42 CFR § 456.716 (b). The Board meets quarterly to recommend any additional restrictions on the utilization of the covered drugs; however, DHS retains the authority to accept, reject, or amend these recommendations.

The DUR Board bylaws require that members follow Ark. Code Ann. §§ 21-8-301, -1001 regarding mandatory disclosure of conflicts of interest. Each member shall complete, sign, and submit a Disclosure of Conflict of Interest form to the Board Chair at the beginning of the meeting so that any conflict of interest, or lack thereof, shall be disclosed. (See **Appendix D** for a list of the DUR Board members.)

Preferred Drug List

The preferred drug list identifies preferred drugs when more than one option is available for treatment. The purpose of the preferred drug list is to provide appropriate, safe, and effective pharmaceutical care in a cost-effective manner. The manufacturer incentive for being on the preferred drug list is larger market share. Except in emergency situations, prior authorization must be obtained from Magellan to fill a non-preferred drug when a preferred drug is available.

Two groups participate in creating the preferred drug list. First is the Drug Review Committee (DRC), which consists of seven voting members: three licensed and actively practicing physicians and four licensed and actively practicing pharmacists. The DHS Director appoints DRC members, with input from Medicaid leadership. The DRC Chairperson is appointed by the DHS Director or her designee. Serving in an advisory capacity to the Medicaid Program, the DRC reviews various information, including comparative evidence-based data from Clinical Evidence Reports developed by the State and Magellan, to make clinical recommendations as to whether drugs should have preferred status.

DRC Committee bylaws require that members follow Ark. Code Ann. §§ 21-8-301, -1001 regarding disclosure of conflicts of interest. Each member shall complete, sign, and submit a Disclosure of Conflict of Interest form to the Chair at the beginning of the meeting so that any conflict of interest or lack thereof is disclosed. (See **Appendix D** for a list of DRC members.)

Second, as an internal committee at DHS, the Drug Cost Committee adds total cost as a factor for consideration and makes the final recommendation to the Medicaid Pharmacy Program Director. Ultimately, DHS determines preferred status.

Reimbursements

As outlined in the Arkansas pharmacy provider manual, individual reimbursement amounts are determined based on the lesser of four amounts:

1. National Average Drug Acquisition Costs (NADAC), plus the established professional dispensing fee.
2. Usual and Customary.
3. Affordable Care Act Federal Upper Limit (ACA FUL), plus the established professional dispensing fee.
4. State Actual Acquisition Costs (SAAC), formerly MAC, plus the established professional dispensing fee.

Typically, reimbursements are based upon NADAC, a pricing benchmark published by CMS that calculates ingredient average acquisition costs experienced by retail community providers across the country.

The professional dispensing fee is currently $9 for brand and non-preferred brand drugs and $10.50 for brand preferred and generic drugs. As required by federal law and by special language in the DHS-Division of Medical Services (DMS) appropriation,[5] this pharmaceutical dispensing fee is based on a survey performed by a CPA firm in June 2016.[6]

Audits

Unlike typical PBM to third-party payer relationships, a separate contractor (Optum), rather than the PBM, performs the pharmacy audits. Furthermore, any funds recouped as a result of the audits follow the same reimbursement process as other Medicaid expenditure recoupments, which do not flow through Magellan.

See **Appendixes E and F** for the flow of funds concerning the Arkansas Medicaid fee-for-service plan.

[5] See, for example, section 8 of Act 719 of the Regular Session of 2019.

[6] One exception to the reimbursement model is related to the Federal Public Health Services 340B Drug Pricing Program (340B). All covered entities that participate in 340B, which serves Medicaid recipients, are required to bill Medicaid using their 340B actual invoice price for drugs (actual invoice price plus the established professional dispensing fee minus the beneficiary's co-pay).

Arkansas Works

The Arkansas Works program[7] is a premium assistance program for the purchase of qualified health plans. It is not managed care but a Section 1115 demonstration waiver authorized by CMS. According to DHS staff, since coverage is under a qualified health plan, the plan is regulated by AID and must align with the essential health benefits of the Affordable Care Act, which include pharmacy benefits. The program was 100% federally funded for calendar years 2014 through 2016 and required a 5%, 6%, 7%, and 10% state match for calendar years 2017, 2018, 2019, and 2020, respectively.

Carriers have sole responsibility for the pharmacy claims of Arkansas Works recipients. DHS pays the carriers' premiums for Arkansas Works recipients, and the carriers, through their PBMs, pay for the recipients' pharmacy claims.

Of the five carriers offering Arkansas Works plans in 2018 and 2019, two used CVS Caremark as their PBM, two used OptumRx, and one used Envolve partnered with CVS Caremark. However, as of January 1, 2020, the two carriers who were utilizing OptumRx are now using CVS Caremark. Centene, the parent company for Ambetter through wholly-owned subsidiary Arkansas Health and Wellness, purchased the two QualChoice plans effective April 1, 2019, and switched to CVS Caremark on January 1, 2020. See **Exhibit I on page 6** and **Exhibit II on page 12** for visual representations of these relationships.

DHS pays the carriers' premiums for Arkansas Works recipients, and the carriers, through their PBMs, pay for the recipients' pharmacy claims. DHS determines recipient eligibility and communicates it to the carriers. The carriers and their PBMs have their own network of providers, and DHS has no role in determining those providers.

Pharmacy Claims

Carriers have sole responsibility for the pharmacy claims of Arkansas Works recipients; in other words, there are no pharmacy services covered by the Medicaid fee-for-service program outside of the Arkansas Works plan. According to DHS staff, DHS does not have a role in determining pharmacy coverage for these recipients. Furthermore, DHS does not provide requirements related to drug formularies or pricing reimbursements; rather, the plans must comply with all applicable federal and state laws and are regulated by AID.

According to Amendment 1 to the 2019 Memorandum of Understanding (MOU) between DHS and the carriers, the carriers were required to provide historical Arkansas Works data directly to DHS by July 2019 and continue remitting data quarterly.

The amendment provides that DHS can request any other additional data necessary to implement, monitor, and evaluate the Arkansas Works program, if DHS or AID provides at least 60 days prior written notice. However, DHS was informed by one of the carriers that the payment amounts between the PBM and the pharmacies are owned and controlled by the PBM and can only be released by it. In other words, this information is not available to nor available for production by the carriers.

Section 5.2 of the 2020 MOU between DHS and the carriers required that the carriers agree to provide DHS with the Arkansas Works data in the most current All-Payer Claims Database (APCD) format, as defined by the APCD Data Submission Guide, on a quarterly basis by submitting the data directly to DHS through a secure file transfer protocol on the last day of the fourth month following the quarter of data to be submitted.

[7] The program was originally known as the Private Option when it began on January 1, 2014, but was changed to Arkansas Works on January 1, 2017.

As of January 2021, DHS confirmed that it had received Arkansas Works data from all of the carriers covering the period April 4, 2014 through June 30, 2020.

Pharmaceutical Manufacturer Rebates

DHS does not receive pharmacy rebates from the carriers.

Audits and Compliance

A medical loss ratio (MLR) rule is required for health plans under the Affordable Care Act. At least 80% of premiums must be spent on patient care, and no more than 20% may be kept by the carrier for administrative expenses. As a result of MLR compliance audits, conducted by the Center for Consumer Information and Insurance Oversight of CMS, carriers should refund Medicaid any amounts over the 20%, with the appropriate portion refunded to the federal government. Federal regulations indicate that the numerator in the MLR calculation includes incurred claims; however, prescription drug rebates *received by the issuer* must be deducted from the incurred claims. Rebates that are not received by the issuer (but retained by the PBMs) are not addressed. Regulations further indicate that any amounts paid to a PBM that exceed amounts paid to the provider (spread) must not be included in the incurred claims.[8]

See **Appendixes G and H** for the flow of funds concerning the Arkansas Works plan.

PASSE

On March 1, 2019, Arkansas's first full-risk managed care program, the Provider-Led Arkansas Shared Savings Entity (PASSE), began for certain behavioral health and developmental disabilities recipients. The state match funding component for PASSE is approximately 30% (i.e., the federal government pays 70%). During the first four months of the program, the three PASSE entities each utilized a different PBM:

- Arkansas Total Care utilized Envolve Pharmacy Solutions (Envolve) as its PBM, but Envolve entered into an agreement with CVS Caremark to process pharmacy claims.
- Empower Healthcare Solutions directly utilized CVS Caremark as its PBM.
- Summit Community Care (Summit) utilized Express Scripts as its PBM but, as of October 1, 2019, switched to IngenioRx, a PBM owned by Anthem. Additionally, Anthem owns 49% of Summit. However, for assistance in processing claims, IngenioRx has partnered with CVS Caremark.

See **Exhibit I on page 6** and **Exhibit II on page 12** for visual representations of these relationships. Note also that Centene announced in January 2021 that it was purchasing Magellan, which is the PBM for the Medicaid fee-for-service plan.

Covered Drugs

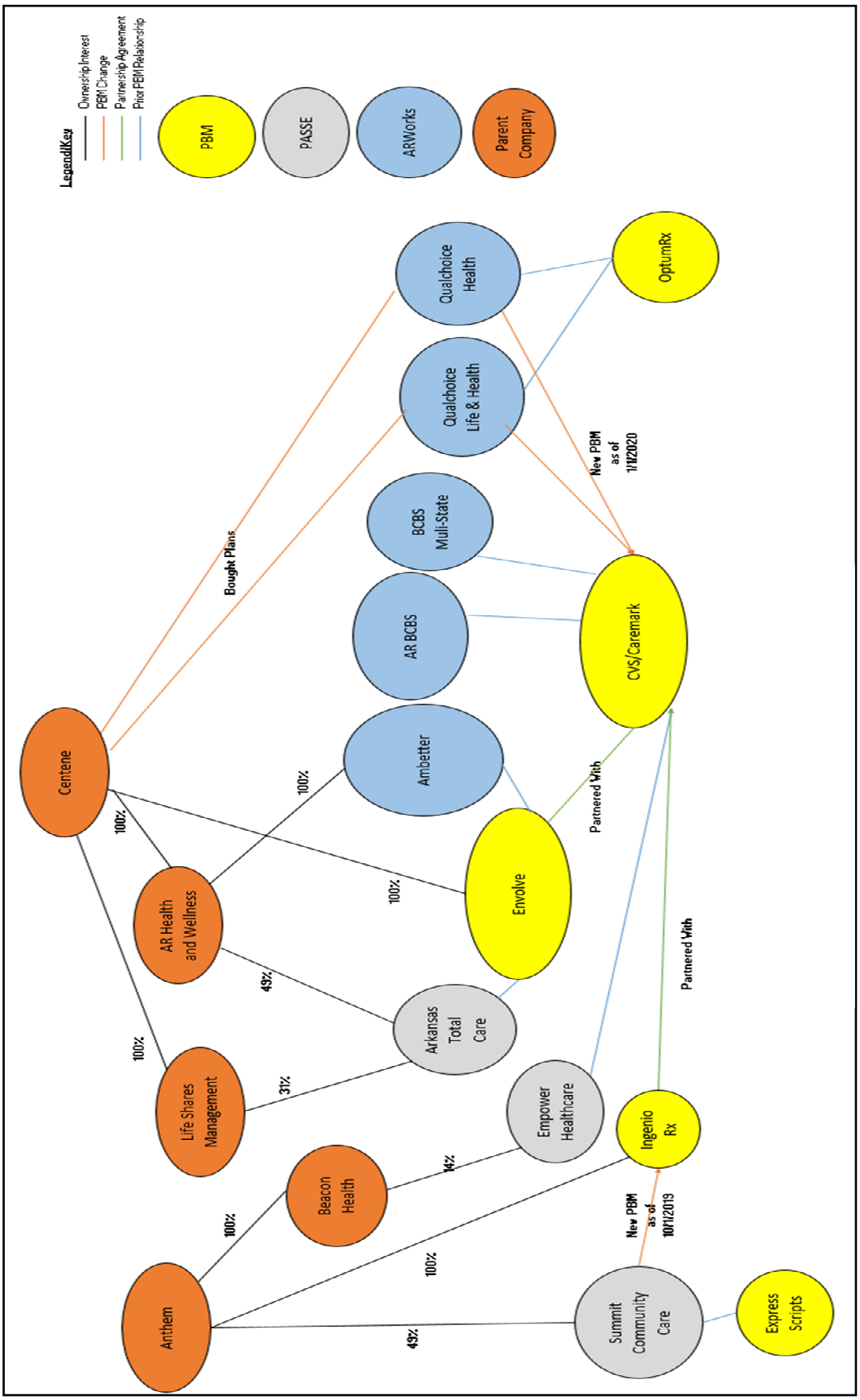
According to the agreements between each PASSE and DHS, the PASSE must cover all federal Food and Drug Administration (FDA) approved drugs for enrolled members as set forth in the Social Security Act. However, drugs shall not be covered if there is no federal funding for the drugs pursuant to the Social Security Act. The PASSE must cover all therapeutic classes of drugs covered by the preferred drug list for the Arkansas Medicaid pharmacy benefit program. The preferred drug list is determined by DHS and subject to change. DHS provides

The PASSE must cover all FDA-approved drugs for enrolled members, unless there is no federal funding for the drugs. The PASSE must also cover all therapeutic classes of drugs on the Arkansas Medicaid preferred drug list.

[8] See 45 CFR § 158.221 and 45 CFR § 158.140 for further details.

Exhibit II

Entity Relationships in Arkansas Works and the Provider-led Arkansas Shared Savings Entity (PASSE)
As of June 30, 2019 (unless otherwise noted)



Source: *Information obtained from the Department of Human Services and the Arkansas Insurance Department (unaudited by Arkansas Legislative Audit)*

the PASSE entities with a weekly data file that indicates the preferred or non-preferred status of each national drug code, but the PASSE must stay abreast of the changes. The PASSE must update its pharmacy claims system within one business day of receiving the data file to avoid creating a more restrictive pharmacy plan than the Medicaid fee-for-service program, which is not allowed by the agreement between DHS and each PASSE. All drugs on the Arkansas preferred drug list must be covered without prior authorization unless they are subject to clinical or utilization edits.

Each PASSE is required to maintain a drug formulary to meet the needs of its members. The formulary must be developed and reviewed at least annually by the PASSE's Drug Utilization Review (DUR) Committee, as discussed below. The reviewed formulary must be submitted to DHS for input at least 30 days prior to implementation, and any changes to the formulary, including changes to prior authorizations and quantity limits, must also be submitted to DHS for input within the 30 days.

The PASSE may require prior authorization for drugs not on the Arkansas preferred drug list but covered by the Social Security Act. Drugs not defined by the Social Security Act may be excluded, as long as doing so is consistent with the Arkansas Medicaid State Plan. At minimum, the PASSE must cover the over-the-counter drugs listed in the Medicaid State Plan Amendment. Furthermore, the PASSE agreement indicates that the PASSE must have authorization procedures in place that allows providers to access drugs outside of the PASSE formulary, if medically necessary.

Drug Utilization Review (DUR) Committee

According to the PASSE agreement, the PASSE must develop and maintain a Drug Utilization Review (DUR) program. Each PASSE's DUR Committee is responsible for fulfilling the DUR requirements defined in the Social Security Act. The DUR Committee is responsible for ensuring safe, appropriate, and cost-effective use of pharmaceuticals for enrolled members in the PASSE.

The DUR Committee must meet at least biannually and provide DHS with the meeting minutes within 30 days of the meeting. The DUR Committee must also include a voting representative from DHS. All members of the committee must complete a financial disclosure form annually, which is reviewable by DHS upon request. The DUR Committee must also complete and submit the DUR Annual Report as required by CMS and provide this report to DHS no later than 45 days prior to the CMS due date. (See **Appendix D** for a list of each PASSE's DUR board members.)

Pharmacy Rates

The PASSE agreement indicates that the rates paid to providers by the PASSE are negotiated between the PASSE and the provider. Recipient co-pays are not allowed under this program.

Recipients

DHS determines recipient eligibility for the PASSE program. Optum, a DHS contractor, performs the independent assessments to determine the individual's care level (1, 2, or 3). Level 2 and 3 individuals must receive services through PASSE. DHS provides recipient eligibility information to the various PASSEs nightly, Monday through Friday. The recipient eligibility information is then uploaded into the PASSE system so that it can be available to the various providers to confirm recipient eligibility.

Providers

Providers under the PASSE program must be enrolled Medicaid providers, although this status does not guarantee being part of the PASSE network. A provider that is not part of the PASSE network is considered an out-of-network provider for the particular PASSE. If in-network, the provider receives the benefit of the PASSE negotiated rates and the use of the PASSE's portal for billing. Recipients

can see out-of-network providers as long as they are enrolled with Medicaid. However, the out-of-network provider must agree to accept whatever payment the PASSE provides for the service. Regardless, the PASSE recipient will have no additional liability to the out-of-network provider for the services rendered.

At least monthly, PASSEs must submit to DHS an electronic file of the PASSE provider network; this information should also be on the PASSE entities' websites. The individual PASSEs have separate contracts with their in-network providers, as well as their PBM. As stated by the PASSE agreement, PASSE entities are required to submit all subcontracts and proposed delegation of responsibility to DHS for approval; therefore, the subcontracts between each PASSE and their PBM should have been submitted to DHS for approval.

Issue: Although DHS indicated that many of the subcontracts were hand delivered for approval, the Agency was not able to provide documentation of approval of any of the PBM contracts for the three PASSEs in effect from March 1, 2019 until June 30, 2019. In addition, the Agency was able to provide documentation (i.e., an unsigned contract) of only one PBM contract for one of the PASSE entities.

Claims Data

The PASSE agreements also address the reporting of PASSE pharmacy claims to DHS. The agreements state that, for all pharmacy claims, contracted health plans must report to DHS the actual amount paid to the pharmacy provider per claim, including, but not limited to, the cost of drug reimbursement, dispensing fees, and the amount charged to the plan sponsor for each claim by its PBM. Additionally, per the PASSE agreements, if DHS identifies a difference per claim between the amount paid to the pharmacy provider and the amount charged to the PASSE plan sponsor by its PBM, the PASSE must report an itemization of all administrative fees, rebates, or processing charges associated with the claim. Each month, DHS will notify the health plan when this report is required. Health plans are required to provide such reports by the 15th of each month or the next business day. Although the agreement indicated that DHS should be the responsible party for identifying these variances, DHS required the PASSE entities to identify the variances and attest to whether any variances existed that would require submission of the itemized claims report.

Once received, the pharmacy data should flow from the PASSEs or their PBMs to Magellan to the DHS Decision Support System (DSS, which is contracted with Optum). Although the pharmacy data were provided to DHS as required, much of the initial data needed to be updated and corrected. According to DHS management, all data had been corrected and submitted to DHS as of July 2020.

Issue: Based on ALA staff review of documentation available from DHS, Empower and Arkansas Total Care did not identify any spread pricing in their submissions to DHS. However, documentation for the Summit PASSE, which utilized ExpressScripts as its PBM, indicated spread pricing. ALA staff calculation of spread pricing, as shown in these submissions, indicated a total of $2,109,368. Ark. Code Ann. § 4-88-803 prohibits spread pricing by state-funded pharmacy benefits, and the impact of this issue should be considered when addressing future capitation rate calculations.

Pharmacy Rebates

The agreement between each PASSE and DHS specifically prohibits each PASSE from negotiating rebates for drugs if a Medicaid rebate agreement is already in place. This includes both the federal rebates as well as the state supplemental rebates applicable to those drugs

included on the preferred drug list. Therefore, regardless of whether the PASSE or its PBM has an existing manufacturer rebate agreement, all items that are already covered by a rebate (federal or state supplemental) are rebatable exclusively to Arkansas Medicaid. Similar to the Medicaid fee-for-service pharmacy claims, PASSE entities (or their PBMs) submit pharmacy claims data to Magellan (DHS's PBM) so that Magellan can bill for the federal and state supplemental rebates on behalf of DHS.

PASSEs are prohibited from negotiating rebates for drugs on the Arkansas preferred drug list. However, PASSEs have the ability to initiate their own formularies for non-preferred drugs.

However, PASSE entities can initiate their own formularies for non-preferred drugs. The PASSE can add to the preferred drug list but cannot take away from the Medicaid preferred drug list. According to the Agency, rebates are not addressed in the PASSE annual contract for non-preferred drug list items; therefore, it is possible that the PASSE entities are billing for rebates for drugs not on the Arkansas Medicaid preferred drug list.

Based on DHS management representations, no PASSE entity has made any additions to the Medicaid preferred drug list, reducing the likelihood of additional rebates. Additionally, based on AID's review of PASSE entities and PBMs, no PASSE entity nor corresponding PBM is receiving any additional drug manufacturer rebates.

Medical Loss Ratio and Risk Corridor

DHS anticipated that the PASSE entities would calculate the medical loss ratio (MLR) and report it to DHS beginning in the spring of 2020. The MLR for all three PASSEs was calculated as expected. The formula utilized in this MLR calculation was in accordance with items allowed per federal law. Although no prescribed MLR ratio must be met, a risk corridor program, based upon benefit expenditure reports, was put into place to control the risk associated with this new program. Payments made to providers for services directly rendered to enrolled members are included in the benefit expenditure reports, and certain community investments may also be included. The target ratio is 92.5%, based upon an administrative allowance of 4%, profit margin of 1.0%, and state premium tax of 2.5%. The MLR will not be used for risk-corridor calculations. The risk-corridor settlement will occur after the calendar year 2019 agreement period has ended and enough time has passed to collect and validate calendar year 2019 PASSE encounter and financial data.

PASSE Agreement

As previously stated, PASSE entities and DHS entered into an annual agreement that was reviewed and approved by CMS. ALA was provided with signed copies of the agreements with each PASSE. The agreement was uniform for all three PASSEs and covered the period March 1, 2019 through December 31, 2021. The following additional items from this agreement have not been previously mentioned:

The agreement outlines some of the following responsibilities of DHS:

- Overseeing the operations of MMIS, contracting with the State's fiscal agent to exchange data with the PASSE, enrolling Medicaid providers, and establishing standards and requirements to ensure receipt of complete and accurate data for program administration.
- Administering the Medicaid prescribed drug program, including negotiating supplemental rebates and favorable net pricing for drugs on the Medicaid preferred drug list and maintaining the review of drug options to maintain an array of choices for prescribers within each therapeutic class.

The agreement also outlines some of the responsibilities of the PASSE entities:

- Complying with all reporting requirements, whether regular or ad hoc, as specified by DHS, and verifying that all data and information submitted are accurate, truthful, and complete. All responses to data requests must be submitted within 30 days of the request, unless otherwise specified by DHS.
- Posting the Arkansas preferred drug list and the PASSE drug formulary on each individual PASSE's website. All pharmacy information must be current and searchable and must include the following:
    a) PASSE maximum allowable cost (MAC) pricing.
    b) Instructions on whom to contact for questions regarding filling a prescription and how to make contact.
    c) A provider guideline for pharmacy claims submission that includes, at a minimum:
        - A payer sheet.
        - A toll-free call center number with applicable hours.
        - Paper claim submission requirements.
        - Compound prescription requirements.
        - Prospective DUR response requirements.
- Establishing policies and procedures for general notifications to participating providers and enrolled members of revisions to the formulary and prior authorization requirements. Notification of changes and revisions must be provided to all affected participating providers and enrolled members at least 30 calendar days prior to the effective date of the change.
- Submitting weekly pharmacy claims for all covered services provided by participating and non-participating providers. For submission, 95% of the PASSE's claim lines must pass National Council for Prescription Drug Programs (NCPDP) and the DHS specified pharmacy benefits system edits. The NCPDP edits are in the NCPDP Telecommunications Standards Guidelines, and the DHS pharmacy benefit system edits are defined on Magellan's website.

See **Appendixes I and J** for the flow of funds concerning the PASSE program.

Employee Benefit Plans

Department of Transformation and Shared Services – Employee Benefits Division

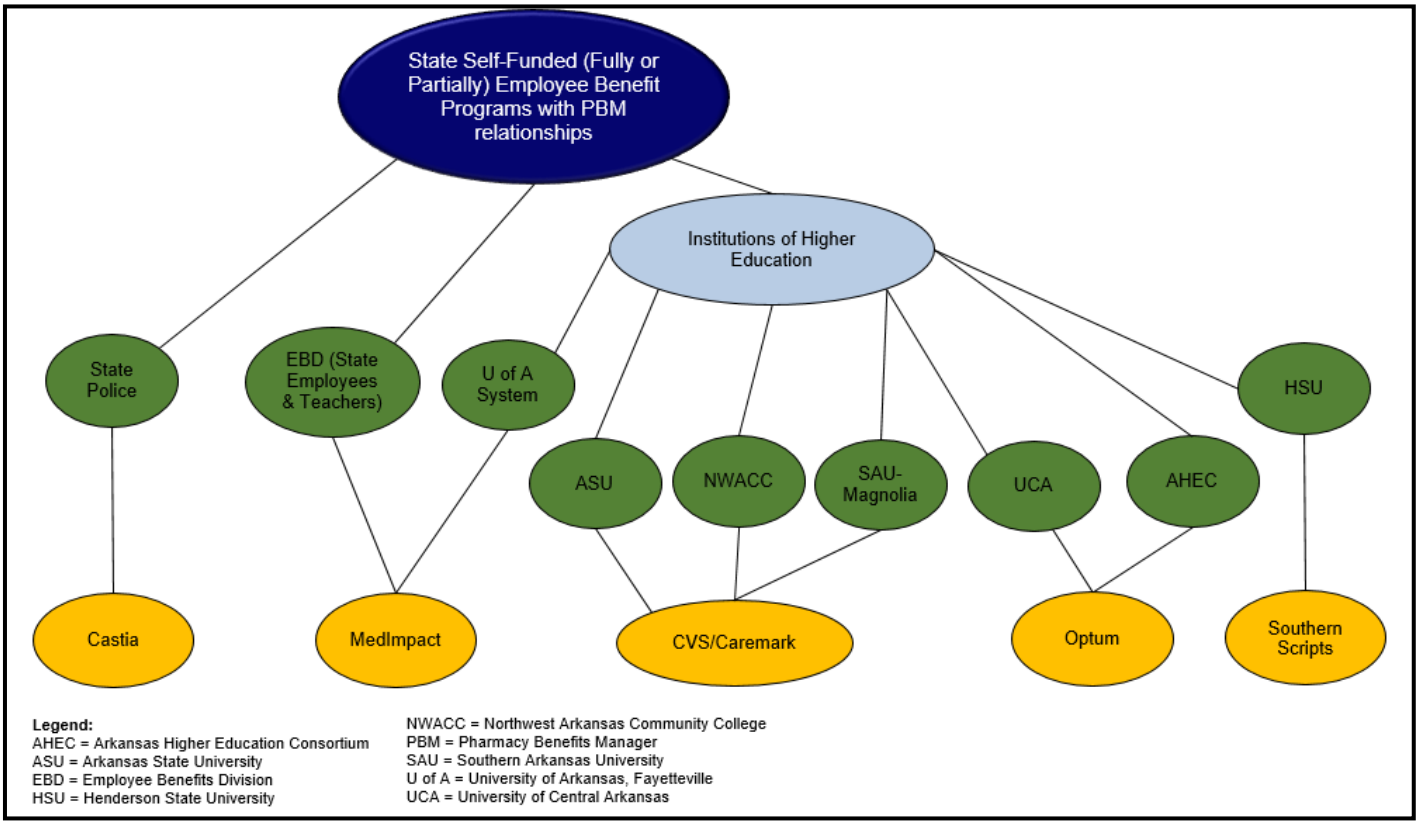
The Employee Benefits Division (EBD) plan covers eligible state agency and public school employees and retirees. The plan is self-funded, which means that all expenses incurred by the plan are paid using contributions from the employer and employee premiums. **Exhibit III on page 17** illustrates the relationship between PBMs and employee benefits plans in Arkansas.

EBD's current plan design is a traditional point of service (POS) plan with the following four-tier drug formulary: generic, preferred brand, non-preferred brand, and specialty drug. The plan includes the following restrictions for some drugs to help control costs:

- Prior Authorization.
- Quantity Limits.
- Daily Dose Edits.
- Reference Pricing.
- Step Therapy.

Exhibit III

Relationships of Pharmacy Benefit Managers with Employee Benefit Plans in Arkansas
As of December 31, 2018



Source: *Information obtained from the Arkansas State Police, Employee Benefits Division, and the various institutions of higher education (unaudited by Arkansas Legislative Audit)*

EBD contracted with the PBM MedImpact Healthcare Systems, Inc. (MedImpact), beginning in February 2016 and has the option to continue until December 2022. The total projected cost, including extensions, is $21 million. EBD is billed on a per member, per month (PMPM) basis, which is currently $1.38. EBD also reimburses MedImpact monthly for certain services provided by MedImpact employees. EBD currently has one MedImpact employee being billed (a pharmacy claims specialist).

MedImpact responsibilities include maintaining a sufficient network of pharmacies and adjudicating member claims. The EBD-approved formulary is provided by the Evidence-Based Prescription Drug Program (EBRx), without input from MedImpact, and sent to the network pharmacies to provide the necessary data for processing prescriptions. Once MedImpact adjudicates a pharmacy claim, the pharmacy processes the prescription and collects the applicable co-pay. Simultaneously, a claim for reimbursement is sent to MedImpact. MedImpact then submits a detailed claim file to EBD, which includes any paid, reversed, and rejected claims. Payment is then issued to MedImpact for all approved claims to distribute back to the pharmacies.

For all claims, MedImpact is required to pass on the entire EBD payment to the network pharmacies and not retain any of the payment amount. MedImpact is also responsible for pursuing collection of any overpayments to pharmacies.

In April 2016, the EBD State and Public School Life and Health Insurance Board (EBD Board) adopted MedImpact's proposed reimbursement rates for pharmacies, which is as follows:

- Average wholesale price (AWP) – 15.65% for brand (13.65% for certain rural pharmacies).
- Dispensing fee of $1.50.
- New MAC pricing.

The EBD Board defined *rural pharmacies* as Arkansas pharmacies in cities with a population of less than 5,000, only one Arkansas pharmacy in the city limits, and no other pharmacy within 20 miles of the city center.

Formulary and Rebating

As previously mentioned, EBD has a contract with EBRx, a division of the University of Arkansas for Medical Sciences (UAMS), which provides an evidence-based approach to the design and function of the prescription drug program.

The EBRx contract started in July 2016 and has the option of continuing until June 2023. The total projected cost, including extensions, is $12,775,000. EBD is billed on a per contract, per month (PCPM) basis, which is currently $1.51.

At least a portion of 18 EBRx staff members are allocated to the EBD plan, including two employees located onsite at EBD to provide support for pharmacy operations, prior authorizations, and other formulary and claims processing issues.

EBRx reviews the current drug utilization, researches new drugs, and presents recommendations for formulary changes to the Drug Utilization and Evaluation Committee (DUEC), a statutory committee (Ark. Code Ann. § 21-5-404) with full ownership of the formulary. DUEC reviews drugs for formulary management, along with evaluation of the financial impact of any recommendations. (See **Appendix D** for a list of committee members.)

Formulary changes for existing covered medications should only be made at the beginning of a plan year, unless there is a significant clinical, access, or financial reason for the change. New drugs can be added to the formulary after a clinical review and DUEC approval.

A subgroup of EBRx is the Delivery Coordination Workgroup (DCWG). The DCWG consists mostly of EBRx employees but also has a representative from BlueCross BlueShield. This subgroup reviews claims for specialty drugs that can be paid as either a health insurance claim or a pharmacy claim. One objective of the DCWG is to ensure prior authorizations for these drugs are handled consistently. In addition, the DCWG has been tasked with determining if there are classes of drugs where rebate contracts are possible.

Rebates

For identified drug classes, EBRx issues a request for proposal (RFP) for rebates to the pharmaceutical drug manufacturers of covered drug classes. The EBRx Director reviews the bids received and analyzes the brand cost, with the rebates compared against other brands in the same category. If the brand cost with rebates is lower than the other brands in the category and selecting that product is consistent with the DUEC's clinical determination, then UAMS enters into a rebate agreement with the pharmaceutical drug manufacturer.

For drugs with manufacturer rebate agreements, EBRx sends an invoice quarterly with all applicable claims information for all plans covered by the agreements. (See the subsequent discussion

concerning the Arkansas State Police health insurance plan and the Arkansas State University health insurance plan utilizing EBRx.) The manufacturer then sends the rebate payment via wire transfer to the UAMS treasury department. UAMS then wires the rebate payment to EBD within 72 hours, and EBRx sends the corresponding detail of claims that were rebated.

Pharmacy Reimbursements

Although the RFP utilized by EBD in soliciting the contract with MedImpact states that "EBD and its clinical consultant (currently EBRx) shall be the sole determiner of [MAC] pricing," MedImpact currently determines all MAC list pricing for the EBD plan. If requested by EBD, the price is adjusted by MedImpact. In addition, EBD has one employee who compares the MedImpact-provided MAC prices to the reimbursed claims to check for accuracy. The current MAC list only has a subset of generics. All pricing must incorporate the following "lesser than" logic to ensure the lowest price is paid for prescription drugs for the plan:

Brand drugs should be reimbursed at the lesser of:

- The submitted usual and customary cost, which equals the submitted ingredient cost plus the submitted dispensing fee, or
- The average wholesale price (AWP) cost, which equals the discounted AWP rate plus the contracted dispensing fee.

Generic drugs should be reimbursed at the lesser of:

- The submitted usual and customary cost, which equals the submitted ingredient cost plus the submitted dispensing fee,
- The AWP cost, which equals the discounted AWP rate plus the contracted dispensing fee of $1.50, or
- The MAC price, which equals the plan specific MAC cost plus the contracted dispensing fee of $1.50

All pricing and processing logic should remain identical within mail, retail, and specialty pharmacies, unless specified by EBD. Prices should not be different for subsidiaries or pharmacies owned by MedImpact, unless specified by EBD.

Based on questions submitted by ALA staff, MedImpact stated that it may perform periodic reconciliations of payments to pharmacies to determine compliance with pharmacy contract defined terms, and these periodic reconciliations could include EBD prescription claims. As stated by MedImpact, this reconciliation and the inclusion of EBD claims, however, will vary depending on the individual contracts between MedImpact and the specific pharmacy. While this subsequent inclusion may be legal (due to the inapplicability of the PBM Licensure Act to the EBD plan), the intent of the RFP utilized to select the PBM for this plan was to prohibit any such practice, and the RFP includes terms that likely prohibit such reconciliations. However, no confirmations received by ALA staff or complaints provided by pharmacies indicated any subsequent reconciliations were occurring in relation to the EBD plan.

MedImpact does perform regular audits of pharmacies for compliance with certain regulations. However, the reversal of claim amounts (i.e., amounts due from the pharmacy) is generally netted against any amounts owed to the pharmacy for current claims.

See **Appendixes K and L** for the flow of funds concerning the EBD health insurance plan.

Department of Public Safety – Division of Arkansas State Police

Arkansas State Police (ASP) has a self-funded health insurance plan that provides coverage to uniformed ASP employees and families. Currently, the plan covers approximately 3,038 individuals, with QualChoice as the third-party administrator. In calendar year 2018, CastiaRx (formerly known as Leehar Distributors, LLC – LDI) was the PBM for the health plan. The plan had $3,542,497 in pharmacy claims during calendar year 2018 and received $328,738 in rebates. Based on these amounts, the plan had an average cost of prescriptions (net of rebates) of $88.15 PMPM and a 9.27% rebate as a percentage of gross paid claims. As contractually agreed to, the PBM retained 10% of the drug manufacturer rebates. In addition, the PBM was prohibited from conducting spread pricing, and the plan paid $3 per prescription to the PBM for these services.

In addition to the PBM services, the plan paid $2 per prescription to RxResults, LLC, for formulary management and prior authorizations for pharmacy claims, in essence acting as an independent benefit consultant, similar to EBRx discussed in the EBD section above. For both the Arkansas State University (ASU) health plan (discussed below) and EBD health plan, EBRx provides the additional service of negotiating and billing for manufacturer drug rebates; with these plans, EBRx charges $1.20 PMPM to ASU and $1.51 PMPM to EBD. Founded in 2008, RxResults is a for-profit company that commercialized the UAMS-EBRx pharmacy benefit model and continues working closely with UAMS-EBRx today.

As of January 1, 2020, ASP significantly changed its contractual relationships for the employee health plan. ASP utilized the cooperative purchasing authority under Arkansas Procurement Law to piggyback onto EBD's health plan contracts. As of this date, ASP changed its health plan administrator to Health Advantage, PBM to MedImpact, and pharmacy benefit consultant and drug manufacturer rebate negotiator to UAMS-EBRx. ASP began paying $1.38 PMPM for PBM services and $1.20 PMPM for UAMS-EBRx services.

Higher Education

In calendar year 2018, eight Arkansas universities had an insurance plan that utilized a PBM; two of these eight universities operated on a fully-insured model. An additional eight entities participated in a multiple employer healthcare plan administered by the Arkansas Higher Education Consortium (AHEC).

See **Appendix M** for a summary of information received from the various institutions of higher education.

Eight Arkansas universities have an insurance plan that utilizes a PBM, with two being fully-insured. An additional eight entities participate in a multiple employer healthcare plan administered by the Arkansas Higher Education Consortium (AHEC).

Fully-Insured Health Benefit Plan

With this model of insurance benefits, the amount paid for pharmacy claims and the rate paid to the PBM are handled exclusively by the insurance provider. Any expenses associated with the pharmacy claims would affect the insurance premium rate charged by each university. The two universities that operated on a fully-insured model in calendar year 2018 were Arkansas Tech University (ATU) and Southern Arkansas University Tech (SAU-Tech). Based on information provided by ATU, the university hired Stephens, Inc., to assist in evaluating plan costs and determining whether to move toward a self-funded plan.

Self-Funded and Partially Self-Funded Single-Employer Health Benefit Plans

With both of these models of insurance benefits (self-funded and partially self-funded), all funds are accumulated into a university fund designated for paying all health insurance claims, including pharmacy. With the "partially self-funded" plans, an insurance policy is acquired to limit the maximum amount of exposure for health claims.

Of the six plans utilizing the self-funded/partially funded model, only one plan (University of Arkansas System) did not provide the PBM with the authority to decide which drugs to cover; instead, a pharmacy benefit consultant was utilized to assist in determining coverage. Beginning in 2019, a second plan (ASU) changed its health insurance business model and now utilizes UAMS-EBRx to provide assistance on drug coverage. Beginning in 2020, a third plan (University of Central Arkansas [UCA]) switched PBMs to Magellan, which is a more transparent pass-through arrangement for pharmacy benefits.[9] Additionally, as of January 2020, one plan (Henderson State University) switched to a fully insured plan and now utilizes CVS-Caremark as the plan's PBM.

During calendar year 2018, three plans utilized Caremark, one plan utilized Southern Scripts, one plan utilized Optum, and one plan utilized MedImpact. According to the information provided, no plan knew of rebates being retained by the PBM, with two of the plans reporting that it was unknown whether the PBM retained any rebates.

Arkansas Higher Education Consortium (AHEC)
(Partially Self-funded, Multi-Employer Health Benefit Plan)

In calendar year 2018, the following eight entities participated in this plan administered by AHEC:

- Arkansas Community Colleges (a nonprofit organization).
- Arkansas Northeastern College.
- Black River Technical College.
- East Arkansas Community College.
- National Park College.
- North Arkansas College.
- Ozarka College.
- South Arkansas Community College.

The total number of covered individuals was approximately 1,272. This plan was partially self-funded since it has a stop loss insurance policy. QualChoice was the health plan and assisted with the collection of premiums and payment of claims. OptumRx was the PBM for the plan and was compensated for its services via spread pricing in calendar year 2018; however, based on representations made by QualChoice, the pricing model for calendar year 2019 is now considered a "transparent arrangement."

The plan was originally described by plan documents as an ERISA-covered plan. If the plan were indeed an ERISA-covered plan, the state laws applicable to other university health care plans would be subject to a federal law preemption challenge. Based on ALA staff understanding, self-insured health insurance plans are generally covered by ERISA; however, governmental plans are exempt from a majority of this federal law. If the AHEC plan is a "governmental plan" as defined by federal law, then state laws regulating health insurance plans would be applicable to this plan and not pre-empted by ERISA. After ALA brought this plan and the potential ERISA issue to AID's attention during fieldwork, AID worked with the plan director, insurance broker, and third-party administrator to develop a process (effective January 1, 2020) for complying with all state laws applicable to other self-funded state university plans, including MAC laws, spread pricing laws, claims reporting laws, and co-pay clawback laws.

[9] One additional institution – Northwest Arkansas Community College (NWACC) – stated that it utilizes a pharmacist employed by the health plan administrator to assist with coverage decisions, but a review of contract documents provided with the health plan did not include assurances addressing conflicts of interest in decisions made with respect to the PBM and pharmacy benefits.

ALA staff also noted that one contract between a university and corresponding PBM indicated an exemption from state regulation due to ERISA, but the summary plan description did not indicate the ERISA distinction. Furthermore, this same university has since made significant changes to the health plan, which makes the particular contract in question no longer applicable. While this ERISA designation in the PBM contract does not create pre-emption issues concerning state law, this provision in the contract does create confusion and potential noncompliance with state laws due to this misclassification.

Objective 3: Test PBMs for compliance with state laws and regulations

As discussed in the **Scope and Methodology section** of the report, the focus of testing for compliance with laws and regulations was the Medicaid fee-for-service, Arkansas Works, PASSE, and EBD programs. Other issues concerning legal compliance are specifically mentioned below. In addition, ALA staff relied exclusively on the work performed by an actuarial firm as a contractor for the AID for testing of the Arkansas Works and PASSE programs for the first six months of 2019. ALA staff performed additional testing of the Arkansas Works program for calendar year 2018 and of the PASSE program for 2019 in certain areas.

The AID contractors performed testing of Arkansas Works for a more recent period than that covered by ALA staff. However, the analysis of certain aspects of Arkansas Works, such as spread pricing, did not include any national pharmacy chains, while ALA's testing of confirmed pharmacy claims included independent pharmacies, regional pharmacies, and national pharmacy chains.

Additionally, the PBM practice of "post-claim adjudication reconciliations," discussed in the Introduction section of this report, can affect testing. AID referred to this practice as "DIR/ Clawback," and only one regional pharmacy chain was able to provide data associated with this practice. AID's report states that "[m]ultiple pharmacies contacted the [AID] auditors stating that the PBMs had locked the pharmacies out of accessing this information on [the pharmacies'] access portals." While the AID contractors were able to acquire this data for one pharmacy chain, ALA's testing did not specifically address this practice or acquire this data from the pharmacies.

Reporting of Pharmacy Claims to the Arkansas All-Payer Claims Database (APCD)/ Arkansas Center for Health Improvement (ACHI) (Ark. Code Ann. § 4-88-803)

Adopted in the Second Extraordinary Session of 2018, with an effective date of March 15, 2018, Ark. Code Ann. § 4-88-803 was amended to require PBMs to provide AID with an annual report of the amounts paid to pharmacies. Ark. Code Ann. § 4-88-803(d) provides that the annual report of claims data should be made "pursuant to the timing, format, and requirements issued by rule of the State Insurance Department." Under Rule 118 issued by AID, this reporting requirement is, in effect, incorporated with the required reporting under the Arkansas Transparency Initiative Act, which requires that health plan information be reported to the All-Payer Claims Database (APCD) administered by the Arkansas Center for Health Improvement (ACHI). However, this rule only applies to the Arkansas Works program. Based on ALA's understanding, no rules have been promulgated that address this reporting requirement for the other state-funded health plans.

However, when claims are reported to the APCD/ACHI for the other plans, the guidance issued to health care entities lacks sufficient clarity to ensure that the correct pharmacy data are reported for state-funded plans. While this law requires that the actual amount paid to the pharmacy be reported, either the health plan administrator or the PBM can submit the

pharmacy claims data to the APCD, under the current interpretation of this rule and current reporting practices. Within the data submission requirements is a field entitled "Paid Amount," but the guidance only defines this field as the amount paid by the submitting entity or insurance carrier for the claim line. As a result, the amount reported to the APCD could be either (a) the amount the PBM paid the pharmacy or (b) the amount the health plan administrator paid the PBM, depending on which entity submitted the data and how the guidance was interpreted.

Considering this issue, ALA staff tested the pharmacy claims paid under the various state-funded health plans to determine whether the amounts being reported to the APCD (which should be the amounts paid to the pharmacy) were in compliance with Ark. Code Ann. § 4-88-803. Results of this testing are discussed below.

Medicaid Fee-for-Service

ALA staff tested 40 claims from the period January 1, 2018 through June 30, 2019 (which includes claims reported prior to the effective date of Ark. Code Ann. § 4-88-803), and determined that all 40 claims were reported to the APCD/ACHI for the correct amount.

Arkansas Works

ALA staff were able to obtain pharmacy-confirmed amounts paid for 91 Arkansas Works claims from calendar year 2018. ALA staff tested 22 claims from Carrier One, 24 claims from Carrier Two, 22 claims from Carrier Three, and 23 claims from Carrier Four and noted the following:

- 28 claims (13 claims for Carrier One, 12 claims for Carrier Two, and 3 claims for Carrier Three) were correctly reported to APCD/ACHI as the amount paid to the pharmacy.
- 21 claims (2 claims for Carrier Two, 8 claims for Carrier Three, and 11 claims for Carrier Four) were not reported to APCD/ACHI as the amount paid to the pharmacy. These claims were for dates of service on or after the effective date of this law, in noncompliance with Ark. Code Ann. § 4-88-803.
- 42 claims (9 claims for Carrier One, 10 claims for Carrier Two, 11 claims for Carrier Three, and 12 claims for Carrier Four) were reported to the APCD/ACHI for amounts that were not what the pharmacy was paid. However, since these claims were for dates of service prior to the effective date of this legislation, these items are not considered violations of Ark. Code Ann. § 4-88-803.

PASSE

ALA staff obtained pharmacy-confirmed paid claims for all three of the PASSE entities from the supporting documentation utilized by AID in generating the aforementioned report. ALA staff tested 94 claims for the period March 1, 2019 through June 30, 2019 – 30 from each PASSE entity and an additional 4 for PASSE Entity Two – and noted the following:

PASSE Entity 1

- For 29 claims found in the APCD/ACHI system, the amount reported did not match what the pharmacy was paid.
- One claim could not be found in the APCD/ACHI system.

PASSE Entity 2

- For 32 claims found in the APCD/ACHI system, the amount reported matched what the pharmacy was paid.

- For 1 claim found in the APCD/ACHI system, the amount reported did not match what the pharmacy was paid. The variance was less than $1 and likely due to the pharmacy-confirmed amount not including the cents paid on the claim (pharmacy-confirmed amount was in whole dollars only for this claim). If the cents were not taken into account, the amount for this claim would match what the pharmacy confirmed as the paid amount.
- One claim could not be found in the APCD/ACHI system.

PASSE Entity 3

- For 25 claims found in the APCD/ACHI system, the amount reported matched what the pharmacy was paid.
- For 3 claims found in the APCD/ACHI system, the amount reported did not match what the pharmacy was paid. The variance was less than $1 and likely due to the pharmacy-confirmed amount not including the cents paid on the claim (pharmacy-confirmed amount was in whole dollars only for these three claims). If the cents were not taken into account, the amounts for these three claims would match what the pharmacy confirmed as the paid amount.
- Two claims could not be found in the APCD/ACHI system.

EBD

ALA staff tested 40 claims for the period January 1, 2018 through June 30, 2019, prior to the reporting requirement under Ark. Code Ann. § 4-88-803. Of these 40 claims, 38 were appropriately reported to APCD/ACHI in the correct amount, and 2 claims could not be found in the APCD/ACHI system. After further investigation and assistance from EBD, it was determined that the 2 claims could not be found due to a programming error. As a result of this error, no claims submitted to the PBM on the first day of each month were reported to APCD. EBD began fixing this issue immediately upon being informed of it during the course of fieldwork.

Other Information

AHEC (Optum), Northwest Arkansas Community College (Caremark), SAU – Magnolia (Caremark), UCA (Optum), and Arkansas State Police (Castia) did not report any pharmacy claims information as required by Ark. Code Ann. § 4-88-803.

Spread Pricing Prohibited for State-funded Plans (Ark. Code Ann. § 4-88-803)

Under Ark. Code Ann. § 4-88-803, Arkansas law has required since 2009 that a PBM pay the amount it receives for pharmacist services to the pharmacies or pharmacists that provided the service. This law is only applicable to state-funded benefit plans. While not naming the practice, “spread pricing” is effectively prohibited under this law as a PBM cannot pay a lesser amount than the amount the PBM received for the same pharmacist service. ALA staff tested the state-funded benefit plans to determine whether the amount paid by the plan administrator, insurer, or PASSE to the PBM was the same as the amount as received by the pharmacy for the same prescription claim. Results of this testing are discussed below.

Medicaid Fee-for-Service

Because funds to pay for pharmacy claims are not paid first to the PBM to be distributed to the pharmacies but are paid directly from the DHS fiscal agent to the pharmacies, there is no opportunity for spread pricing in the Medicaid fee-for-service program.

Arkansas Works

Calendar Year 2018

ALA staff obtained pharmacy-confirmed paid amounts for 91 Arkansas Works claims from calendar year 2018: 22 claims from Carrier One, 24 claims from Carrier Two, 22 claims from Carrier Three, and 23 claims from Carrier Four. The following are the overall results of that testing:

- Of the 91 claims, the carriers paid a total of $3,742. However, only $2,690 was remitted to the pharmacies. The difference of $1,052 (28% of the total amount paid) was retained by the PBM or other intermediaries. This difference was composed of 50 claims with "positive spread" and 13 claims with "negative spread."[10]
- Of the 50 claims with "positive" spread, the 4 largest spread totals were comprised of a claim from each of the four different carriers as shown below, followed by the percentage of the total amount paid by the carrier for the claim:
    - $333 for Carrier Four (85%).
    - $223 for Carrier Three (85%).
    - $96 for Carrier Two (75%).
    - $70 for Carrier One (82%).

The following list provides the testing results for the individual carriers:

- Of the 22 confirmed claims for Carrier One, the carrier paid a total of $817, with $735 remitted to the pharmacies. The net variance of $82 (10% of the total amount paid) was applicable to 7 claims with positive spread and 2 claims with negative spread, with no spread noted for the remaining 13 claims. All 9 spread claims had fill dates prior to March 15, 2018.[11]
- Of the 24 confirmed claims for Carrier Two, the carrier paid a total of $507, with $339 remitted to the pharmacies. The net variance of $168 (33% of the total amount paid) was applicable to 11 claims with positive spread and 1 claim with negative spread, with no spread noted for the remaining 12 claims. Of the 12 spread claims, 10 had fill dates prior to March 15, 2018, and the remaining 2 had fill dates on or after March 15, 2018.
- Of the 22 confirmed claims for Carrier Three, the carrier paid a total of $860, with $540 remitted to the pharmacies. The net variance of $320 (37% of the total amount paid) was applicable to 14 claims with positive spread and 5 claims with negative spread, with no spread noted for the remaining 3 claims. Of the 19 spread claims, 11 had fill dates prior to March 15, 2018, while the remaining 8 had fill dates on or after March 15, 2018.
- Of the 23 confirmed claims for Carrier Four, the carrier paid a total of $1,558, with $1,076 remitted to the pharmacies. The net variance of $482 (31% of the total amount paid) was applicable to 18 claims with positive spread and 5 claims with negative spread. Of the 23 spread claims, 12 had fill dates prior to March 15, 2018, while the remaining 11 had fill dates on or after March 15, 2018.

[10] "Positive spread" occurs when the plan pays the PBM more than the PBM pays the pharmacy, while "negative spread" occurs when the plan pays the PBM less than the PBM pays the pharmacy. When the amounts are the same, no spread occurs.

[11] ALA staff identified March 15, 2018, as an important date in the analysis because it is the effective date for Acts 1 and 3 of the Second Extraordinary Session of 2018 ("An Act to Create the Arkansas Pharmacy Benefits Manager Licensure Act").

The following additional items of interest were noted:

- For six items, the pharmacy indicated there were additional fees associated with the claim. One was an additional $1 fee, and the other five were PBM fees ranging from 0.6% to 6.9%, such as transmission fees, service fees, and DIR fees. The pharmacies could not provide a per-claim breakdown; therefore, ALA staff could not determine whether these fees were related to Arkansas Works or non-Arkansas Works plans.
- Pharmacies provided various other comments, including statements that (a) they were not paid enough on the claim to cover the costs of the label and bottle, in addition to the time required to fill a prescription; (b) reimbursement amounts for the same prescription subsequently decreased on the additional refills; (c) the margins were thin; and (d) there were more current fills for the same drug, resulting in net losses for the pharmacy.

January 1 through June 30, 2019—AID Contractor Testing

ALA staff relied exclusively on the work performed by an actuarial firm contracted with AID for the coverage of Arkansas Works for the first six months of 2019.

The spread pricing analysis results can be seen on pages N-23 through N-24 of the contractor's report located in **Appendix N**. Tables 5 and 6 of the report include information for the PBMs for the Arkansas Works program, as well as the PASSE program. The columns for BCBSAR and QualChoice are solely related to the Arkansas Works program, while the column for Centene contains information for both the Arkansas Works program (Ambetter) and the PASSE program (AR Total Care).

Table 5 provides the known results and indicates that for 63 claims for BCBSAR, 14 claims for Centene, and 1 claim for QualChoice, spread was identified in the population of total pharmacy matched claims reviewed; the total spread calculated was $8,299, $593, and $2, respectively.

Table 6 provides the projected results of the total estimated spread based upon the results from Table 5. Table 6 indicates that an estimated 5,069 claims for BCBSAR, 1,324 claims for Centene, and 105 claims for QualChoice in which spread is likely to have occurred. The estimated total spread calculated was $5,149, $45,146, and $6,347 for BCBSAR, Centene, and QualChoice, respectively.

<u>PASSE</u>

ALA staff relied exclusively on the work performed by an actuarial firm contracted with AID for the testing of this area for PASSE programs for the first six months of 2019. Note that full-risk coverage began for PASSE effective March 1, 2019.

The spread pricing analysis results can be seen on pages N-23 through N-24 of the contractor's report located in **Appendix N**. As previously mentioned, Tables 5 and 6 of the report include information for the PBMs for both the Arkansas Works and PASSE programs. The columns for Empower and Summit are solely related to the PASSE program, while the column for Centene contains information for both the Arkansas Works program (Ambetter) and the PASSE program (AR Total Care).

Table 5 provides the known results and indicates that for 14 claims for Centene, 4 claims for Empower, and 1,290 claims for Summit, spread was identified in the population of total pharmacy matched claims reviewed; the total spread calculated was $593, $65, and $29,363, respectively.

Table 6 provides the projected results of the total estimated spread based upon the results from Table 5. Table 6 indicates an estimated 1,324 claims for Centene, 133 claims for Empower, and 89,210 claims for Summit in which spread is likely to have occurred. The estimated total spread calculated was $45,146, $3.46 and $1,799,632, for Centene, Empower, and Summit, respectively.

EBD

ALA staff tested 40 claims for the period January 1, 2018 through June 30, 2019 and determined that no spread occurred. For all claims, the amounts paid by the plan to the PBM matched the amounts paid per confirmations received from the pharmacies. Additionally, based on the confirmations received from the pharmacies, the PBMs charged the pharmacies no additional fees.

Other Information

Based upon responses to survey questions sent to the university plans, AHEC utilized spread pricing during calendar year 2018 but switched to the transparent pricing model for calendar year 2019. While the new plan administrator starting in calendar year 2020 intends to comply with Arkansas law and not consider itself exempt from Arkansas regulations due to ERISA preemption, the plan documents from calendar year 2018 issued under the prior administrator indicate an ERISA-covered plan status.

Based on a review of the Summary Plan Description for 2018, spread pricing was an allowable practice with one plan (ASU), but the plan has since switched to a different PBM and indicated that it did not pay spread pricing during calendar year 2018. For a second plan (UCA), the contract between the PBM and the University allowed for spread pricing. However, University management indicated that spread pricing occurred only in relation to mail order and specialty pharmacy claims but not retail claims, and the University switched PBMs to Magellan as of January 1, 2020.

Co-pay Clawback (Ark. Code Ann. § 4-88-1004)

As described previously, co-pay clawbacks occur when a pharmacy is able to retain a lesser amount for pharmacist services than the patient co-pay amount. Since 2015, Ark. Code Ann. § 4-88-1004 has prohibited an individual from paying an amount greater than the pharmacist or pharmacy is able to retain from all payment sources. To ensure compliance with this requirement, ALA staff confirmed with pharmacies the amounts represented as co-pays in the selected claims and compared these amounts to the confirmed ingredient costs and dispensing fees to ensure that the co-pay did not exceed the sum of these two amounts.

Medicaid Fee-for-Service

Since pharmacy claim funds do not flow through the PBM but, rather, through the DHS fiscal agent, there is no opportunity for co-pay clawback in the Medicaid fee-for-service program.

Arkansas Works

Calendar Year 2018

ALA staff confirmed paid amounts, including any co-pays, with pharmacies for 91 claims from calendar year 2018: 22 claims from Carrier One, 24 claims from Carrier Two, 22 claims from Carrier Three, and 23 claims from Carrier Four. For all 91 claims, the co-pay amounts confirmed by the pharmacies matched the amounts in the various carriers' records. By confirming that the amounts matched, this addresses the risk that a higher co-pay was actually collected by the pharmacy and remitted to the PBM.

In addition, ALA staff reviewed the 91 confirmed claims for instances in which the co-pay amount exceeded the sum of the overall approved amount (ingredient cost plus dispensing fee). No noted exceptions of co-pay clawback were identified as result of the procedures performed.

January 1 through June 30, 2019

ALA staff relied exclusively on the work performed by an actuarial firm contracted with AID for the testing of this area for Arkansas Works for the first six months of 2019.

Instead of solely focusing on co-pay clawback, the contractor reviewed for all clawback fees associated with the pharmacy claims reviewed. As noted on page N-9 of the contractor's report included in **Appendix N**, "Direct and Indirect Remuneration (DIR) or 'clawback' are retroactive fees assessed by the PBMs on the dispensing pharmacy after the prescription is dispensed. DIR fees can be in numerous forms (e.g., service fees, network access fees, administrative fees, reconciliation fees, etc.) that are often unclear to pharmacies, which are forced to accept the fees in the pharmacy network agreement." According to the contractor's report, "most pharmacies are unable to accurately reconcile DIR fees back to the original prescription claim to ensure DIR fees were imposed correctly per the contract because the PBMs do not provide claim-level reporting to pharmacies for the DIR fees." Additionally, the contractor's report notes that DIR/clawback data were only provided by one regional pharmacy chain, and multiple pharmacies stated that the PBMs had locked them out of accessing this information on their access portals. Finally, the report notes that "claims with DIR reported were totaled and reported as percentage of clawed back compared to the total spent."

Table 3 of the report on page N-19 of **Appendix N** indicates the number of claims with clawback data. As noted in the table, 2,806 of the 16,600 (17%) matched claims for BCBSAR were claims with clawback data. Of the 5,427 matched claims for Centene, 482 (9%) were claims with clawback data. The Centene data contained information for the Arkansas Works program as well as the PASSE program. No claims with clawback data were reported for QualChoice.

Table 7 of the report on page N-25 of **Appendix N** shows the percentage of clawback dollars compared to the total PBM spend for the claims with clawbacks that were at least $0.05. The percentages of clawback for BCBSAR and Centene were 9.79% and 9.57%, respectively. As previously noted, no claims with clawback data were reported for QualChoice.

Table 8 of the report on page N-26 of **Appendix N** shows the extrapolated amounts for the entire six-month period. The estimated total clawback amount is $8,614,934 for BCBSAR and $3,390,666 for Centene. As there were no claims with clawback data reported for QualChoice, no amounts could be estimated.

PASSE

ALA staff relied exclusively on the work performed by an actuarial firm contracted with AID for the coverage of testing of clawbacks for the PASSE program. As previously discussed, full-risk coverage began for PASSE effective March 1, 2019, and there are no recipient co-pays for the PASSE program.

As noted above, the contractors focused on overall clawbacks rather than just those associated with co-pays. Again, only one regional pharmacy chain could provide the DIR/ Clawback data, and multiple pharmacies stated that the PBMs had locked them out of accessing this information on their access portals. As noted on page N-18 of the report, "claims with DIR reported were totaled and reported as the percentage clawed back compared to the total spent."

Table 3 of the report on page N-19 of **Appendix N** indicates the number of claims with clawback data. As noted in the table, 1,134 of the 3,470 (33%) matched claims for Empower and 798 of the 1,730 (46%) matched claims for Summit were claims with clawback data. Of the 5,427 matched claims for Centene, 482 (9%) were claims with clawback data. The Centene data contained information for both the Arkansas Works program as well as the PASSE program.

Table 7 of the report on page N-25 of **Appendix N** shows the percentage of clawback dollars compared to the total PBM spend for the claims with clawbacks that were at least $0.05. The percentage of clawback for Empower, Summit, and Centene were 9.79%, 4.55%, and 9.57%, respectively.

Table 8 of the report on page N-26 of **Appendix N** shows the extrapolated amounts for the entire six-month period. The estimated total clawback amount is $858,560 for Empower, $536,124 for Summit, and $3,390,666 for Centene.

EBD

ALA staff confirmed paid amounts, including any co-pay amounts, with pharmacies for 40 claims for the period January 1, 2018 through June 30, 2019. The co-pay amounts confirmed by the pharmacies matched the co-pay amounts per the plan's records without exception. By confirming that the amounts matched, this addresses the risk that a higher co-pay was actually collected by the pharmacy and remitted to the PBM.

Additionally, ALA staff reviewed 100% of the EBD claims, for the period January 1, 2018 through June 30, 2019, for instances in which the co-pay amount exceeded the sum of the overall approved amount (ingredient cost plus dispensing fee). ALA noted no instances of co-pay clawback as a result of the procedures performed.

Non-preferential Reimbursement Treatment of Affiliated Pharmacies (Ark. Code Ann. § 17-92-507)

Ark. Code Ann. § 17-92-507(d) states:

> A pharmacy benefit manager shall not reimburse a pharmacy or pharmacist in the state an amount less than the amount that the pharmacy benefits manager reimburses a pharmacy benefits manager affiliate for providing the same pharmacist services. The amount shall be calculated on a per unit basis based on the same generic product identifier or generic code number.[12]

Medicaid Fee-for-Service

No PBM-affiliated pharmacies that were also Medicaid enrolled providers were identified based upon procedures performed by ALA auditors and confirmed by DHS.

Arkansas Works

ALA staff relied exclusively on the work performed by an actuarial firm contracted with AID for testing of this area for Arkansas Works. As noted on page N-10 of **Appendix N**, these procedures were referred to as testing of Differential Reimbursements (i.e., differences in reimbursement rates from the PBM to the pharmacies). The contractor's analysis compared the reimbursement amounts of national, regional, and independent pharmacies[13] and the one PBM-affiliated pharmacy (CVS Caremark) with non-PBM-affiliated pharmacies.

[12] The same statutory prohibition concerning affiliated pharmacy reimbursements is contained within the PBM Licensure Act. See Ark. Code Ann. § 23-92-506(b)(4).

[13] As noted on page N-16 of **Appendix N**, an *independent pharmacy* was defined as a pharmacy that had three or fewer locations. A *national pharmacy* was defined as one being distributed throughout the United States. A *regional chain* was defined as having more than 3 locations in Arkansas but being not a national chain.

Table 4 on pages N-21 through N-22 of **Appendix N** includes the results of the differential pricing analysis. The information in the BCBSAR and QualChoice columns applies only to Arkansas Works; the information in the Empower and Summit columns applies only to the PASSE program; and the information in the Centene column applies to both the Arkansas Works and PASSE programs. The contracted auditors only considered differential reimbursement of 5% or greater to be material, as disclosed at the bottom of page N-20 of the report.

As noted on page N-22 of **Appendix N**, there was a small preference in pricing toward the national and regional chains compared to the independent pharmacies for BCBSAR and Centene (both CVS Caremark), but the preference was not deemed material. There was a material preference to the national chain compared to both the regional and independent pharmacies for Empower (CVS Caremark), QualChoice (OptumRx), and Summit (ESI). There was no material variance noted for preferential treatment of the PBM-affiliated pharmacy CVS Caremark compared to the independent pharmacies. Full testing results for this area in the report are included in **Appendix N**.

PASSE

ALA staff relied exclusively on the work performed by the actuarial firm contracted with AID for testing of this area for the PASSE program, as discussed in the preceding section.

EBD

ALA staff identified MedImpact Direct as an affiliated pharmacy of EBD's PBM (MedImpact). For the review period, this affiliated pharmacy received reimbursements totaling $254,363, which was comprised of reimbursements from the EBD plan and member co-pays.

ALA staff reviewed all claims paid to non-affiliated pharmacies that had the same fill date and the same 14-digit generic product identifier (GPI) as a claim paid to MedImpact Direct. ALA staff calculated the per unit cost by dividing the total amount paid to the pharmacy (whether by the plan or patient and inclusive of the dispensing fee) by the total number of units billed. All claims paid a lower amount to a non-affiliated pharmacy were excluded when it was caused by a lower "usual and customary" amount. Based on this testing, a non-affiliated pharmacy was reimbursed less than the affiliated pharmacy in 2,048 instances, in apparent noncompliance with Ark. Code Ann. § 17-92-507(d).

It appears that some of the exceptions were attributable to the affiliated pharmacy and the non-affiliated pharmacy using different brands of drugs. For example, ALA staff reviewed one GPI representing glucose blood test strips that accounted for 132 (approximately 6%) of the 2,048 exceptions. Some of the brands reimbursed under this GPI included Contour Next, Prodigy, Wavesense, TRUEtrack, TRUE Metric, Accu-Chek, Embrace, and OneTouch test strips. The majority of these exceptions occurred when MedImpact Direct received a higher per unit reimbursement for the Contour Next test strips than non-affiliated pharmacies received for non-Contour Next test strips.

ALA staff noted 346 additional instances in which the exact same national drug code (i.e., same labeler, product, and package size) was dispensed at both MedImpact Direct and non-affiliated pharmacies on the same date. However, the per-unit amount paid to the non-affiliated pharmacies was lower than the per-unit amount paid to MedImpact Direct due to the reimbursement formula utilized by the EBD plan and the flat $1.50 dispensing fee. The $1.50 dispensing fee is not pro-rated based on the quantity dispensed. To illustrate, Drug A was filled by and reimbursed to MedImpact Direct at $9.60 for 24 units (equating to a per-unit cost of $0.40). On the same day, Drug A was filled by and reimbursed to a non-affiliated pharmacy at $82.50 for 240 units (equating to a per-unit cost of $0.34375). However, if the $1.50 dispensing fee is removed from both reimbursements, the per-unit cost for both pharmacies is $0.3375.

Finally, ALA staff noted some instances of a different average wholesale price amount for two drugs from the same labeler but packaged in different quantities (meaning the national drug code was the same except for the last two digits). This price difference created a higher per-unit reimbursement amount to MedImpact Direct than to the non-affiliated pharmacies. However, ALA staff were unable to determine the cause for these variances for all 2,048 exceptions noted.

Non-preferential Cost Sharing Policies for Select Pharmacies (Ark. Code Ann. § 23-79-149)

Ark. Code Ann. § 23-79-149 prohibits an "insurance policy" from having preferential cost sharing provisions or differing quantity limits for any subset of pharmacies. For instance, an insurance policy is prohibited from allowing for only two co-pay amounts to be remitted for a 90-day refill at a mail order pharmacy while requiring three co-pay amounts to be made for a 90-day refill at a local or brick and mortar pharmacy.

Due to the definitions of "insurance policy," this Code section is not applicable to any of the programs or plans covered by this report, except for possibly the PASSE, as discussed below. However, there are no recipient co-pays in the PASSE program.

Medicaid Fee-for-Service

Even if this provision were applicable to the Medicaid fee-for-service program, Medicaid co-pays are determined by the Arkansas Medicaid program, and the amount of the co-pay depends on the category through which the recipient is deemed eligible. There are no co-pay or quantity limit variations among different providers.

Arkansas Works

Ark. Code Ann. § 23-79-149 is not applicable to the Arkansas Works program based on representations made by the carriers and AID's interpretation of the law due to federal preemption under the Patient Protection and Affordable Care Act. If this Code section were applicable, violations would have been noted based on publicly available information, namely mail order pharmacies having preferential co-pay amounts in comparison to retail prescription refills.

PASSE

As previously stated, while this Code section could be applicable to the PASSE program, there are no recipient co-pays in the PASSE program subject to this prohibition.

EBD

While Ark. Code Ann. § 23-79-149 is not applicable to EBD, it should be noted that the summary plan description for the EBD plan does not contain any preferential co-payment amounts.

Other Information

Summary plan descriptions for two universities (SAU-Magnolia and UCA) indicated preferential mail order pricing for prescription drugs. However, Ark. Code Ann. § 23-79-149 arguably does not apply to the self-funded plans, as the definition of *insurance policy* does not appear to encompass this type of coverage.

Furthermore, AHEC's summary plan description indicated preferential co-pay rates for only certain pharmacies and mail order pharmacies, but the potential ERISA preemption challenge and the aforementioned statutory language issue make this law inapplicable.

Arkansas Works MOU

As previously noted, according to Amendment 1 to the 2019 Memorandum of Understanding (MOU) between DHS and the carriers, the carriers were required to provide historical data for Arkansas Works directly to DHS by July 2019 and subsequently submit data quarterly. Section 5.2 of the 2020 MOU between DHS and the carriers required that the carriers agree to provide DHS with the Arkansas Works data in the most current All-Payer Claims Database (APCD) format as defined by the APCD Data Submission Guide.

ALA reviewed 120 claims with fill dates during calendar year 2018, consisting of 30 claims each from Carriers One, Two, Three, and Four, to ensure that DHS had received the information required by the terms of the MOU. As a result of this review, ALA concluded that DHS received:

- All 30 claims for Carrier One.
- 29 of the 30 claims for Carrier Two.
- 29 of the 30 claims for Carrier Three.
- All 30 claims for Carrier Four.

For all 118 claims, paid amounts in the information received by DHS matched the paid amounts per the APCD/ACHI records. It should be noted that the amounts reported to APCD/ACHI were not always the same as the amounts paid to the pharmacies, as previously discussed.

PASSE Agreement

As previously noted, the PASSE agreements address the reporting of PASSE pharmacy claims to DHS. The agreements state that, for all pharmacy claims, contracted health plans must report to DHS the actual amount paid to the pharmacy provider per claim, including, but not limited to, the cost of drug reimbursement, dispensing fees, and the amount charged to the plan sponsor for each claim by its PBM. The claims data reported to DHS, along with other items, will be utilized by the actuarial firm with which DHS contracts to determine future monthly payment amounts that DHS will pay to each PASSE on behalf of each covered recipient participating in the program. As such, overinflated claims data could lead to overinflated future monthly capitation rates.

ALA's review consisted of 94 claims with fill dates from March 1 through June 30, 2019: 30 from PASSE Entity One, 34 from PASSE Entity Two, and 30 from PASSE Entity Three. ALA reviewed the 94 claims to ensure that the amounts paid to the pharmacy matched the amounts reported to DHS by each PASSE entity. The review results were as follows:

- All 30 claims for PASSE Entity One were included in the claims data submitted to DHS. Of the 30 claims, 28 matched the paid amount confirmed by the pharmacy, and 2 did not.
- 32 of the 34 claims for PASSE Entity Two were included in the claims data submitted to DHS. Of the 32 claims, 31 matched the paid amount confirmed by the pharmacy, and 1 did not.
- All 30 claims for PASSE Entity Three were included in the claims data submitted to DHS. Of the 30 claims, 27 matched the paid amount confirmed by the pharmacy, and 3 did not.

For all claims that did not match the paid amount confirmed by the pharmacy, the variance was less than $1 and is likely due to the pharmacy confirmed amount not including the cents paid on the claim (pharmacy confirmed amount was in whole dollars only for this claim). If the cents were not taken into account, the amount for this claim would match what the pharmacy confirmed as the paid amount as well.

Objective 4: Compare Arkansas laws and regulations related to PBMs with those of other states

Where Arkansas and Other States Regulate

During ALA interviews with various stakeholders in Arkansas, many individuals commented that Arkansas is on the forefront of regulating PBMs. Furthermore, ALA staff noted that many of the provisions from other states have already been enacted in Arkansas, including the following:

- The licensure of PBMs (Acts 1 and 3 of the Second Extraordinary Session of 2018).
- Providing rights to pharmacies during audits (Act 843 of the Regular Session of 2007 and Act 769 of the Regular Session of 2009).
- Preventing gag clauses in contracts with pharmacies (Acts 1 and 3 of the Second Extraordinary Session of 2018).
- Banning the clawback of co-pays (Act 1025 of the Regular Session of 2015).
- Prohibiting the preferential treatment of PBM-affiliated pharmacies versus non-affiliated pharmacies (Act 900 of the Regular Session of 2015 and Acts 1 and 3 of the Second Extraordinary Session of 2018).
- Providing equity in the filling of prescriptions between retail and mail-order pharmacies (Act 1486 of the Regular Session of 1999).
- Regulating the process for publishing and updating PBM maximum allowable cost (MAC) reimbursement amounts (Act 1194 of the Regular Session of 2013, Act 900 of the Regular Session of 2015, and Acts 1 and 3 of Second Extraordinary Session of 2018).
- Allowing a pharmacist to decline to fill a prescription that would result in a loss (Act 900 of the Regular Session of 2015 and Act 994 of the Regular Session of 2019).
- Requiring PBMs to report claims and rebate data to a state-level regulator (Acts 1 and 3 of the Second Extraordinary Session of 2018 and Act 994 of the Regular Session of 2019).
- Prohibiting PBMs from requiring additional accreditation standards or certification from pharmacies beyond those required by a state regulator of pharmacists (Acts 1 and 3 of the Second Extraordinary Session of 2018).

Where Other States Have Regulated and Arkansas Has Not

Before considering states' legislation relating to PBMs, it is important to note that even though the recent U.S. Supreme Court decision regarding Act 900 of 2015 affirmed the ability of states to regulate PBMs if it is merely a form of cost regulation, any legislation that "governs a central matter of plan administration or interferes with nationally uniform plan administration" will be subject to challenge as being pre-empted by ERISA. Furthermore, some states (i.e., New Hampshire and Vermont) have created a commission to study the prescription drug market and role of PBMs, which Arkansas could consider.

ALA staff noted the following six areas concerning regulating PBMs that other states have addressed via legislation and Arkansas has not:

1. Fiduciary Duty – Some states have enacted legislation mandating that PBMs act as fiduciaries in their role of managing pharmacy benefits for health plans. In general

terms, fiduciary laws require PBMs to act in the best interest of the insurance plan in managing the funds, as opposed to acting in self-interest. Based on ALA's understanding of the pharmaceutical benefits industry, typical fiduciary responsibilities are often disclaimed in contracts between health insurance providers (third-party administrators) and PBMs. Examples of some of the state laws providing for fiduciary duties (or the duty of good faith and fair dealing[14]) include the following:

- *California* – Recently enacted law imposes the duty of "good faith and fair dealing" on PBMs.
- *District of Columbia* – Law enacted in 2004 provided that a PBM "owes a fiduciary duty to a covered entity," but this law was invalidated in 2010 by the federal D.C. Circuit Court due to pre-emption by federal law (i.e., the ERISA pre-emption discussed above).
- *Iowa* – Law requires, as of January 2018, that a PBM perform its "duties exercising good faith and fair dealing in the performance of its contractual obligations toward the covered entity."
- *Maine* – First enacted in 2003, law mandated that a PBM "owes a fiduciary duty to a covered entity and shall discharge that duty in accordance with the provisions of state and federal law." While this law withstood an ERISA preemption challenge in the federal First Circuit Court, the Maine Legislature repealed it in 2011. In June 2019, Maine enacted legislation, effective January 1, 2020, that re-imposes the fiduciary duty by providing that a "carrier that contracts with a [PBM] to perform any activities related to the carrier's prescription drug benefits is responsible for ensuring that, under the contract, the [PBM] acts as the carrier's agent and owes a fiduciary duty to the carrier in the [PBM's] management of activities related to the carrier's prescription drug benefits."
- *Minnesota* – Legislation effective on July 1, 2019, provided that a PBM "must exercise good faith and fair dealing in the performance of its contractual duties." Furthermore, a "provision in a contract between a [PBM] and a health carrier or a network pharmacy that attempts to waive or limit this obligation is void."
- *Nevada* – Law enacted in 2017 and effective January 1, 2018 imposed a fiduciary duty on PBMs. However, the 2019 Nevada session amended this provision by "remov[ing] this fiduciary duty and instead impos[ing] on a [PBM] an obligation of good faith and fair dealing toward a third-party or pharmacy when performing contractual duties."
- *South Dakota* – Since 2004, South Dakota has required that each PBM "shall perform its duties exercising good faith and fair dealing toward the covered entity."
- *Vermont* – Since 2007, Vermont has required that a PBM "that provides pharmacy benefit management for a health plan shall discharge its duties with reasonable care and diligence and be fair and truthful under

[14] The duty of good faith and fair dealing is arguably different from the traditional fiduciary duties of care and loyalty, so Arkansas fiduciary law should be thoroughly researched before deciding on any language of potential legislation. See for example Ark. Code Ann. §§ 4-28-618, 4-47-305, 4-47-408. Furthermore, discussions surrounding the legislation in Nevada that changed the statute from "fiduciary" to "good faith and fair dealing" could help in drafting any potential legislation.

> the circumstances then prevailing that a [PBM] acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims."

It should be noted that, according to a January 2019 publication from a PBM industry association (the Pharmaceutical Care Management Association), mandating fiduciary responsibilities "would increase projected drug expenditures by an estimated 5.8% over the next 10 years." However, ALA cannot provide assurance regarding the accuracy of this projection.

2. Claim Payment Processing Time – Some states require that payment from a PBM to a pharmacy for prescription claims be made within a specific timeframe. Some examples include the following:

    - *Mississippi* – PBMs are required to pay any "clean" claims that were electronically submitted within 15 days of receipt or notify the pharmacist or pharmacy of the reason why the claim was not considered "clean." For paper forms, the time limit is extended to 35 days.
    - *Texas* – State law requires electronic payments be made within 18 days of receipt for electronically submitted claims and within 21 days of receipt for non-electronic claims.
    - *Vermont* – State law requires that a PBM pay or reimburse a claim or notify the pharmacy in writing that the claim is contested or denied within 14 calendar days of receiving a pharmacy claim.

It should be noted that one pharmaceutical industry publication indicated a willingness to support prompt payment laws as long as there were "exemptions that would allow a health plan or PBM to suspend payment when there is credible evidence of fraud."

3. Claims Data Usage – A PBM is in a unique position to acquire large amounts of information that could potentially be utilized to market to PBM-affiliated pharmacies, thereby increasing the PBM's earnings. A few states had legal provisions relating to the use of pharmacy claims data for marketing or other purposes. The following are some noted examples of state laws prohibiting this type of activity:

    - *Georgia* – In general terms and with some exceptions, Georgia law prohibits a PBM from marketing an affiliated pharmacy to patients or transferring or sharing prescription information with affiliated pharmacies for commercial purposes. This law became effective January 1, 2020.
    - *Hawaii* – Since 2013, Hawaii has prohibited a PBM from utilizing pharmacy benefit claims data to market the services of a preferred pharmacy to existing patients. The statute provides for restrictions on sharing information with pharmacies affiliated with the PBM, selling or disseminating health information, and directly marketing to individuals. The statute contains a consent exception.
    - *Louisiana* – A PBM in Louisiana is prohibited from "exploit[ing] prescription drug information obtained from beneficiaries for monetary gain or economic power over beneficiaries, pharmacists, or pharmacies" and "sell[ing], exchang[ing], or us[ing] in any manner prescription drug information regarding a beneficiary obtained through a beneficiary's use of a prescription for purposes of marketing, solicitation, consumer

steering, referral, or any other practice or act ... that provides the [PBM] or any of its affiliates or subsidiaries economic power or control over pharmacists or pharmacies or interfer [sic] in the free choice of a beneficiary." This legislation was passed in 2019 and became effective July 1, 2020.

- *New Hampshire* – Law provides that "[r]ecords relative to prescription information containing patient-identifiable and prescriber-identifiable data shall not be licensed, transferred, used, or sold by any [PBM], insurance company, electronic transmission intermediary, retail, mail order, or Internet pharmacy or other similar entity, for any commercial purpose, except for the limited purposes of pharmacy reimbursement; formulary compliance; care management; utilization review by a health care provider, the patient's insurance provider or the agent of either; health care research; or as otherwise provided by law. Commercial purpose includes, but is not limited to, advertising, marketing, promotion, or any activity that could be used to influence sales or market share of a pharmaceutical product, influence or evaluate the prescribing behavior of an individual health care professional, or evaluate the effectiveness of a professional pharmaceutical detailing sales force."

It is important to consider the potential of a First Amendment challenge to any commercial, content-based prohibition.[15]

4. Conflict of Interest Disclosure – Due to the vertical integration of PBMs in the pharmaceutical industry, a plan sponsor should be aware of potential conflicts of interest when contracting with PBMs. As a result, some states have required PBMs to self-disclose any arrangements that present a conflict of interest, as follows:

    - *California* – Starting January 1, 2020, a PBM in California will have to "notify a health care service plan in writing of any activity, policy, or practice of the [PBM] that directly or indirectly presents a conflict of interest that interferes with the discharge of the [PBM's] duty to the health care service plan…."
    - *Iowa* – Since 2008, Iowa law has required that a PBM "notify the covered entity in writing of any activity, policy, practice ownership interest, or affiliation of the [PBM] that represents any conflict of interest."
    - *Minnesota* – Effective July 1, 2019, a PBM in Minnesota "must notify a health carrier in writing of any activity, policy, or practice of the [PBM] that directly or indirectly presents a conflict of interest…."

It is important to also consider conflicts of interest in relation to the pharmacy and therapeutics committee (P&T committee), which makes formulary decisions for health benefit plans. Federal laws only require 20% of P&T committees to be free from conflicts of interest, although state laws or contracts could further regulate this issue. However, further research in this area is needed (see 45 CFR § 156.122). This issue is relevant in relation to PBMs if the health plan is utilizing the PBM for formulary decisions. In Arkansas, EBD utilizes UAMS-EBRx to provide formulary recommendations to committees, while DHS utilizes the Arkansas Medicaid Drug Review Committee for formulary decisions based on recommendations provided by DHS's PBM.

[15]See Vermont Statute 18 V.S.A. § 4631 and *Sorrell v. IMS Health Inc.*, 564 U.S. 552 (2011).

See **Exhibit II on page 12** for a visual depiction of some of the entity relationships in Arkansas Works and PASSE.

5. Drug Manufacturer Rebates – Already addressed in Arkansas law is the reporting of rebate information to AID. While some states have enacted this same type of requirement for PBMs, Maine recently enacted legislation stipulating that all compensation from manufacturers to PBMs must be remitted to the covered person at the point of sale or remitted to the carrier to be applied to offset premiums, since rebates from manufacturers are considered "compensation." This legislation became effective January 1, 2020.

It is important to understand the industry practice of utilizing rebate aggregators (or intermediaries) when drafting potential legislation. With some health plans, rebate aggregators are sub-contractors of the PBM that assist in billing and collecting drug rebates from manufacturers, but these aggregators may also be affiliates of the PBM. While the contract with a PBM could require that 100% of manufacturer rebates received by the PBM be paid to the health plan, this contractual provision may allow for an affiliated rebate aggregator of the PBM to retain a portion of the rebates. During review of the higher education plans, ALA staff noted that rebate aggregators (or intermediaries) were mentioned in contracts with three plans, but there was not enough information to indicate whether an aggregator was utilized or if any affiliation with the PBM existed. Conflict of interest disclosures could provide insight into any such relationships between PBMs and rebate aggregators.

6. Medicaid Managed Care – Many states have refined their laws and regulations relating exclusively to Medicaid "managed care" programs (i.e., PASSE) and PBMs. The following were considered noteworthy:

    - *Illinois* – Effective January 1, 2020, Illinois requires a PBM to "notify the Department [that manages Medicaid] in writing of any activity, policy, or practice of the [PBM] that directly or indirectly presents a conflict of interest that interferes with the discharge of the [PBM's] duty to a managed care organization to exercise its contractual duties. 'Conflict of interest' shall be defined by rule by the Department."
    - *Kentucky* – Any PBM under contract is required to disclose all entities in which the PBM has any form of ownership or over which it has any control. Additionally, the State of Kentucky approves the contract between the managed care company and PBM – as opposed to just receiving a copy – and approves the contracts between the PBMs and pharmacies providing pharmaceutical services under the Medicaid managed care program.
    - *Texas* – A uniform contract for managed care companies is utilized by the department handling Medicaid. Embedded within the contract are provisions that classify PBMs as "material subcontractors" and then impose additional duties upon them (i.e., providing copies of contracts and amendments to the contracts between the managed care company and PBM to the Medicaid managing agency, providing the agency with PBM entity information, providing information relating to how the managed care company will monitor the PBM, and ensuring no conflicts of interest exist).
    - *Kentucky and Ohio* – Both of these states recently enacted legislation that requires the state to contract with one PBM to serve all of the managed care organizations. ALA staff noted that a similar recommendation was contained in Arkansas Interim Study Proposal 2005-149 published by the Bureau of

Legislative Research (BLR). This recommendation from EBD suggested that "[t]he state hav[e] its own PBM for all of the public entities' prescription drug plans." While this suggestion seems directed at the employee benefit plans addressed in the BLR report, the same recommendation could be considered in relation to the public benefit plans.

- *Various states* – Pharmacy benefits can be either supplied by the managed care companies ("carve-ins") or handled separately from the medical claims and paid like traditional fee-for-service Medicaid claims by the Medicaid administering state agency ("carve-outs"). Some stakeholders argue that carve-ins save money, and other stakeholders argue that carve-outs save money. Among managed care in Arkansas, only the PASSE program offers pharmacy benefits, and it would be considered a "carve-in" program. While ALA staff are unable to evaluate which methodology would be more cost effective for Arkansas, a recent actuarial report (amended April 2, 2019) prepared for the State of West Virginia indicated potential savings of $54.4 million with the recent implementation of a "carve-out" program for its Medicaid managed care program.

Objective 5: Review complaints received by state agencies and program management regarding PBMs

The following paragraphs summarize the various sources and types of complaints that ALA obtained from representatives of each entity.

Department of Commerce – Arkansas Insurance Department

Starting in the fall of 2018, AID began receiving and reviewing complaints related to the maximum allowable cost (MAC) law. The complaints were related to the PBM, the pharmacy/complainant, the date the case was closed, and any amount recovered as a result of the complaint. AID provided ALA with its actions concerning the 2019 and 2020 complaints. Of the 171 complaints AID received in 2019, 57 had recoveries, 70 were ERISA related, 6 were Medicare Part D plan related, 36 resulted in no action, and 2 were still pending. Overall, $208,929 in recoveries were made, and a $50,000 fine was received. Of the 66 complaints received in 2020, 8 had recoveries, 13 were ERISA related, 4 were Medicare Part D plan related, 16 resulted in no action, and 25 were still pending. Overall $68,986 in recoveries were received. In addition, it was disclosed that one old file was still open as the PBM indicated that it was returning $1.6 million to the PSAOs to return to the pharmacies. AID is determining how to track the return of these funds.

Arkansas Attorney General's Office

From 2018 through March 2020, the Attorney General's Office received 5,028 complaints from pharmacies alleging that the pharmacy was reimbursed by the PBMs below the acquisition cost of generic prescription drugs. Although updated complaint information was requested from the Attorney General's Office in early 2021, ALA had not received it as of report date. The law to which these complaints relate (Ark. Code Ann. § 17-92-507 and Act 900 of 2015) was challenged by a PBM industry association (i.e., the Pharmaceutical Care Management Association) and deemed inapplicable to ERISA plans by the federal 8th Circuit Court of Appeals. However, the U.S. Supreme Court's decision in *Rutledge v. Pharmaceutical Care Management Association* (PCMA) upheld Act 900 of the Regular Session of 2015, which addresses the regulation of MAC laws and PBMs complying with various reimbursement requirements. According to the Attorney General's Office, the Court's decision clarified the already existing legislation in that Ark. Code Ann. § 17-92-507 is applicable to ERISA plans. Regarding any enforcement action relating to these complaints, the Attorney General's Office indicated that it was currently working with AID to evaluate the data and anticipated some type of action to occur within the next year.

Arkansas Pharmacists Association

The Arkansas Pharmacists Association generally receives 3 to 5 calls per month regarding complaints about PBM auditing practices. The Association also receives around 10 to 14 questions or complaints per week about PBMs, health plans, or insurance via e-mail, social media, and phone calls. The Association helps answer or resolve these questions and complaints but does not maintain any tracking document.

Department of Health – Arkansas State Board of Pharmacy

Although the State Board of Pharmacy primarily receives complaints about pharmacists from the public, it also receives complaints from pharmacies related to PBM audits. One type of complaint occasionally received is that the PBMs incorrectly interpret the Board's rules for pharmacy audits and claim recoupment purposes, and the Director provides clarification of what the rules actually mean. These complaints, which have decreased in number over time, are received via phone or e-mail, and the Board does not track them. Additionally, the Board has no enforcement authority over PBMs, so it does not appear to be the appropriate venue to adequately address PBM complaints.

Arkansas Medicaid

- **Fee for service** – According to the Arkansas Medicaid Pharmacy Director, the only complaints received for the PBM Magellan (for the fee-for-service pharmacy claims) are from pharmacists or physicians trying to obtain prior authorizations, which Magellan processes. However, complaints are few, and there were no other programmatic issues communicated to ALA staff.
- **Arkansas Works** – Arkansas Medicaid would not receive PBM complaints for the Arkansas Works plans as the plans are considered qualified health plans and monitored by AID. See the item above for complaints received by AID.
- **PASSE** – The annual PASSE agreement requires that each PASSE have a process in place for receiving and resolving complaints made by members or direct service providers. DHS must approve this process prior to implementation. Each PASSE must follow up on complaints by the close of business on the business day following receipt of the complaint. The PASSE must also maintain a complete and accurate record of all complaints that is available, upon request, from DHS or CMS. Each PASSE must report all complaints, grievances, and appeals to DHS as specified in the agreement and submit a grievance log quarterly. The quarterly logs were obtained for each of the three quarters ended December 31, 2019, and each of the four quarters ended December 31, 2020. The logs contained no pharmacy provider complaints.

  In addition to the quarterly PASSE complaint logs, DHS maintains a log of various PASSE-related communications in its in-house JIRA system, tracks these communications, and works with each PASSE to resolve any issues. DHS provided ALA staff with a list of the pharmacy-related communications for the PASSE program on February 27, 2020. The list did not include a date field, so ALA staff were unable to determine when the communication was received. Based upon the information provided, there were two primary types of communications: (a) those related to provider support and (b) those that were primarily recipient related. Of the 700 communications provided, 287 were classified as provider support, and 413 were classified as Task (all others). The most common types of

resolutions for provider support were classified as (a) resolved – educated provider, (b) referred to PASSE Pharmacy Team, and (c) referred to PASSE Provider Team. The most common types of resolutions for Task/all others were (a) resolved by Ombudsman, (b) client educated, (c) questions answered, and (d) referred to PASSE.

The items included in the list relate to various topics, including issues with recipient coverage, provider billing, provider enrollment, and provider reimbursement. The items were not directed toward the PASSE's PBMs. However, upon review of the detail of some items, ALA staff identified three instances of note:

- In one instance, a pharmacy provider contacted DHS regarding a reimbursement that was lower than the pharmacy's costs. The documented resolution stated that the matter was referred to the PASSE Pharmacy Team.
- In one instance, a PASSE recipient contacted DHS because the pharmacy being utilized would no longer fill the recipient's prescription because the PASSE would not reimburse the pharmacy for its cost. The documented resolution stated the issue was resolved by Ombudsman.
- In one instance in which a pharmacy provider contacted DHS on behalf of a recipient to receive clarification on whether the recipient had to utilize mail order prescriptions, as the recipient had been told by the PASSE. The documented resolution stated the matter was resolved by educating the provider.

Department of Transformation and Shared Services – Employee Benefits Division

According to EBD management, neither EBD nor UAMS-EBRx receives direct complaints from pharmacies relating to PBMs, although they may receive pharmacy concerns via the Pharmacists Association or legislators. EBD management was unsure if complaints are logged. UAMS-EBRx representatives did not recall ever receiving a complaint from a pharmacy about a PBM; their calls primarily relate to drug coverage or formulary issues. Management indicated that most complaints would be directed to AID, since it is responsible for enforcing the PBM legislation, or to the Pharmacists Association or a legislator.

SUMMARY

Pharmacy benefit managers (PBMs) serve as intermediaries between pharmacies and health insurance entities by processing pharmacy claims, maintaining pharmacy networks, and providing expert knowledge regarding benefit coverage. PBMs have come under increased scrutiny for practices such as spread pricing that could be lucrative for the PBMs. ALA's review focused primarily on the four plans that encompass approximately 94% of annual government-funded pharmacy expenditures: Medicaid fee-for-service, Arkansas Works, PASSE managed care program, and EBD employee health insurance plan.

Exhibit I on page 6 illustrates the PBM relationships for Medicaid fee-for-service, Arkansas Works, and PASSE, while **Exhibit III on page 17** shows PBM relationships for state self-funded employee benefit programs, which includes EBD, as well as Arkansas State Police and institutions of higher education. For Medicaid fee-for service programs, funds flowing directly from DHS's fiscal agent to pharmacies, without passing through Magellan (see **Appendixes E and F**). Funds flow through the PBMs before reaching pharmacies for Arkansas Works (see **Appendixes G and H**), PASSE (see **Appendixes I and J**), and EBD (see **Appendixes K and L**).

ALA found limited instances of noncompliance with laws and regulations regarding reporting of pharmacy claims to APCD/ACHI. The actuaries contracted with AID noted instances of clawbacks for Arkansas Works and PASSE. Both ALA and the AID contractors noted spread pricing by certain PBMs for the PASSE and Arkansas Works programs, which Arkansas Code prohibits. ALA also noted differential pricing analysis for EBD, while the AID contractors identified this same practice for Arkansas Works and PASSE. The AID contractors' report is provided in **Appendix N**.

AID received a total of 237 PBM-related complaints in 2019 and 2020, with the majority being resolved as of report date. The Attorney General's Office received over 5,000 complaints from pharmacies from 2018 through early 2020 regarding low reimbursement rates by PBMs. Although the Arkansas Pharmacists Association and State Board of Pharmacy have received some complaints, they have no enforcement authority and do not maintain records of complaints received.

Based on legislation enacted in other states, the General Assembly may wish to explore further PBM-related legislation regarding areas such as fiduciary duty, claim payment processing time, claim data usage, conflict of interest disclosure, drug manufacturer rebates, and Medicaid managed care programs. However, federal statutory law and interpreting court decisions have significantly restricted Arkansas's ability to regulate the PBM industry in the State.

THIS PAGE LEFT INTENTIONALLY BLANK

APPENDICES

Appendix A – Glossary of Acronyms

Appendix B – Arkansas Legislative Acts Related to Pharmacy Benefit Managers

Appendix C – Arkansas Statutory Provisions Related to Pharmacy Benefit Managers

Appendix D – Drug Utilization Review (DUR), Drug Review Committee (DRC), and Drug Utilization and Evaluation (DUEC) Board Members – As of January 2021

Appendix E – Arkansas Medicaid Fee-for-Service Flowchart – Primarily Medicaid Processes Only

Appendix F – Arkansas Medicaid Fee-for-Service Flowchart – All Other Processes

Appendix G – Arkansas Works Flowchart – Primarily Medicaid Processes Only

Appendix H – Arkansas Works Flowchart – All Other Processes

Appendix I – PASSE Flowchart – Primarily Medicaid Processes Only

Appendix J – PASSE Flowchart – All Other Processes

Appendix K – Employee Benefits Division (EBD) – Primarily EBD Processes Only

Appendix L – Employee Benefits Division (EBD) – All Other Processes

Appendix M – Summary of Information Received from the State's Higher Education Institutions – For Calendar Year 2018

Appendix N – Arkansas Insurance Department Limited Scope Examination of Pharmacy Benefit Managers Report

Appendix O – Management Response – Department of Human Services

Appendix P – Management Response – Department of Transformation and Shared Services – Employee Benefits Division

Appendix A

Glossary of Acronyms

ACHI	Arkansas Center for Health Improvement
AHEC	Arkansas Higher Education Consortium
APCD	All-Payer Claims Database
AWP	Average Wholesale Price
DIR	Direct and Indirect Remuneration
DRC	Drug Review Committee
DUR	Drug Utilization Review
ERISA	Employee Retirement Income Security Act of 1974
GPI	Generic Product Identifier
MAC	Maximum Allowable Cost
MLR	Medical Loss Ratio
MMIS	Medicaid Management Information System
PASSE	Provider-led Arkansas Shared Savings Entity
PBM	Pharmacy Benefit Manager
PCPM	Per Contract Per Month
PMPM	Per Member Per Month

Appendix B

Arkansas Legislative Acts Related to Pharmacy Benefit Managers

Legislation	Title - Subtitle	Effect/Summary	Effective Date	Covered Plans/Entities	Named Enforcement Entity	Additional Auditor Comments
Act 1486 of 1999	An Act to Require Equity in Prescription Drug Benefits	"The act requires any pharmacy operating outside the state which routinely sends prescription drug orders into the state to have on staff an Arkansas licensed pharmacist. The act authorizes the Arkansas State Board of Pharmacy to promulgate regulations to enforce the act"; co-pay and coinsurance equity; removal of prescription limits, except for uniform application, insurance commissioner can determine reasonableness of coinsurance, co-payment and deductible factors	7/30/1999	Any individual, group, or blanket policy	**Insurance Commissioner**	None
Act 843 of 2007	An Act to Establish an Arkansas Pharmacy Audit Bill of Rights	"The act creates the "Arkansas Pharmacy Audit Bill of Rights" and provides a pharmacy with certain rights concerning an audit of its records conducted by a managed care company, an insurance company, or a third-party payor. The law will not apply to audits, reviews, or investigations that involve alleged fraud, willful misrepresentation, or abuse." **At least one week notice, overpayment can be projected if part of a settlement by a pharmacy, treats all pharmacies the same, 30-day period to contest discrepancies, 24-month scope only, cannot be within first week of the month, required delivery of audit report with timelines, cannot use extrapolation, required appeal process, mandatory delivery of audit report to plan sponsor.**	7/31/2007	"Managed care company, an insurance company, a third-party payor, or any entity that represents such companies or groups"	**None - included in Pharmacy law, so Ark. Code Ann. § 17-92-106 could apply and the State Board of Pharmacy could seek an injunction.**	None
Act 769 of 2009	An Act Regarding State Funded Pharmacy Benefit Plans (Fair Disclosure of State Funded Payments for Pharmacists' Services Act)	"The act requires that a state-funded pharmacy benefit plan itemize payments made in regard to pharmacy services and that a state-funded pharmacy benefit plan pay the amounts the plan receives for pharmacist services to the pharmacy or pharmacist that provided the services." **Prohibits spread pricing on state-funded plans**	7/31/2009	"Any plan or program that is funded by state dollars"	Arkansas Attorney General - Deceptive Trade Practices Act	None
Act 517 of 2011	An Act to Clarify the Procedures for Recoupment of Costs Under the Arkansas Pharmacy Audit Bill of Rights	"The act limits the documentary evidence that may be used in determining recoupment of costs under the Arkansas Pharmacy Audit Bill of Rights, and requires that all recouped moneys be paid to the responsible party." **Audit fees cannot be based upon amount recouped.**	7/27/2011	"Managed care company, an insurance company, a third-party payor, or any entity that represents such companies or groups."	**None - included in Pharmacy law, so Ark. Code Ann. § 17-92-106 could apply and the State Board of Pharmacy could seek an injunction.**	None

Legislation	Title - Subtitle	Effect/Summary	Effective Date	Covered Plans/Entities	Named Enforcement Entity	Additional Auditor Comments
Act 1007 of 2011	An Act to Preserve the Professional Independence of a Pharmacist and a Pharmacy; To Prohibit Interference with the Pharmacist-Patient Relationship or the Practice of Medicine	"The act prohibits a pharmacy benefits manager from interfering with a pharmacist's or pharmacy's exercise of the pharmacist's or pharmacy's professional responsibilities to a patient."	7/27/2011	PBM refers to a non-governmental entity that administers or manages a pharmacy benefits plan or program.	**None - included in Pharmacy law, so Ark. Code Ann. § 17-92-106 could apply, and the State Board of Pharmacy could seek an injunction.**	None
Act 1194 of 2013	An Act to Provide for the Transparency of Maximum Allowable Cost Lists for Prescription Drugs; To Regulate Pharmacy Benefits Managers' Maintenance and Use of Maximum Allowable Costs Lists for Prescription Drugs	"Regulates the maintenance and use of Maximum Allowable Cost Lists for prescription drugs by pharmacy benefits managers." **MAC List disclosure, MAC List updating, appeal of MAC List.**	8/16/2013	All except Medicaid MAC	**Deceptive and unconscionable trade practice under Ark. Code Ann. § 4-88-101 et seq. (Ark. Code Ann. § 17-92-507(e)) - Acts 1 and 3 of 2018 add this to the Insurance Department's purview.**	None
Act 689 of 2015 (See **Additional Auditor's Comments**)	An Act to Modify the Definition of a Third-Party Administrator Used by Multiple Employer Trusts and Self-Insured Plans	"Modifies the definition of "third-party administrator" to include a pharmacy benefits manager; defines a "pharmacy benefits manager" and a "pharmacy benefits plan or program"; and clarifies that the State Insurance Department does not regulate third-party administrators for self-insured plans, multiple employer trusts, or multiple employer welfare arrangements."	7/22/2015	All PBMs except self-insured and multiple employer trusts	Insurance Department	This Act was amended with Acts 1 and 3 of 2018, and the relevant language was deleted from Ark. Code Ann. § 23-92-201.
Act 900 of 2015	An Act to Amend the Laws Regarding Maximum Allowable Cost Lists; To Create Accountability in the Establishment of Prescription Drug Pricing	"Amends the maintenance and use of Maximum Allowable Cost Lists for prescription drugs by pharmacy benefits managers." **Prohibits PBM preferential pricing; allowed for declining to prescribe when losing money.**	7/22/2015	All PBMs, except EBD or Medicaid (unless PBM manages MAC List for these entities)	**Deceptive and unconscionable trade practice under Ark. Code Ann. § 4-88-101 et seq. (Ark. Code Ann. § 17-92-507(e)) - Acts 1 and 3 of 2018 add this to the Insurance Department's purview.**	None
Act 1025 of 2015	An Act to Modify the Responsibilities of a Pharmacy Benefit Manager and Patients Rights Regarding Payment for Pharmacists Services	"Creates the Patient Rights Regarding Payment for Pharmacists Services Act and requires a pharmacy benefits manager to obtain an individual's express consent to alter or change provider choice within a pharmacy benefits plan or program. The act also limits patient payments for pharmacist services and authorizes the Insurance Commissioner to seek an injunction against a pharmacy benefits manager to enforce the act." **Prevents co-pay clawback and restricts PBM-mandated pharmacy switching.**	7/22/2015	All PBMs	Insurance Department	None

Legislation	Title - Subtitle	Effect/Summary	Effective Date	Covered Plans/Entities	Named Enforcement Entity	Additional Auditor Comments
Acts 1 and 3 of 2018	An Act to Create the Arkansas Pharmacy Benefits Manager Licensure Act; To Regulate and License Pharmacy Benefits Managers; To Authorize Penalties and Fines Regarding the Regulation and Licensure of Pharmacy Benefits Managers	**Requires PBM licensure; requires network adequacy; Insurance Department approves reimbursement to pharmacy to ensure fair and reasonable; ensures no additional requirements above State Board for pharmacies to operate; prohibits PBM preferential pricing; prevents retroactive adjudication of claims; prevents gag clauses; adds MAC price laws into Insurance Department purview and Insurance's Trade Practice law; requires State Funded PBMs to send info to Insurance Department (APCD).**	3/15/2018 (with exception) - clauses effective for 9/1/18 and after	Excludes Medicaid Fee-for-Service	Insurance Department	None
Act 994 of 2019	An Act to Clarify the State Insurance Department's Regulatory and Enforcement Authority Concerning Pharmacy Benefits Managers; To Modify the Arkansas Pharmacy Benefits Licensure Act	"Clarifies the State Insurance Department's regulatory and enforcement authority concerning pharmacy benefits managers; extends the time for pharmacists and pharmacies to file an administrative appeal to challenge a maximum allowable cost list and for the pharmacy benefits manager to respond and resolve the appeal; **prohibits a pharmacy benefits manager from spread pricing; prohibits a pharmacy benefits manager from reducing payments for pharmacist services by a pharmacy benefits manager or a healthcare insurer made directly or indirectly to a pharmacy under a reconciliation process to an effective rate of reimbursement**; and makes the Arkansas Pharmacy Benefits Manager Licensure Act applicable to an organization or entity directly or indirectly providing services to patients under the Medicaid Provider-Led Organized Care Act or any other Medicaid managed care program in Arkansas." **Requires filing a Rebates report; requires reporting payments to/from Health plans and pharmacies; prohibits PBM reimbursing below NADAC (or WAC if NADAC unavailable); expands "gag" clauses to included PASSE Medicaid providers; ensures PASSE Medicaid providers are included in PBM Licensing; re-enacted allowing for declining to prescribe if losing money.**	7/24/2019	Clearly includes PASSE in PBM Regulation under Insurance Department	Insurance Department	None
Act 706 of 2019	An Act to Require a Healthcare Payor to Disclose on a Member Identification Card Whether a Health Benefit Plan is Insured or Self-Funded	"Establishes the Healthcare Payor Identification Card Act to require disclosure on member identification cards of whether the health benefit plan is an insured or self-insured plan." **This will assist the pharmacist and industry with identifying ERISA plans vs. non-ERISA plans.**	4/4/2019	No Medicaid or dental/eye/vision care plans	N/A - Embedded in Insurance Law; Insurance Department	None

Source: *Various legislative acts and the "Summary of General Legislation" published following every General Session by the Bureau of Legislative Research (https://www.arkleg.state.ar.us/bureau/)*

Appendix C

Arkansas Statutory Provisions Related to Pharmacy Benefit Managers

Code Section(s)	Applicability of Law	Criteria	EBD	Fee-for-Service	Arkansas Works	PASSE	Ark. State Police and Higher Education Health Plans	AHEC
Ark. Code Ann. § 4-88-803	All State-Funded Plans	PBM administering a pharmacy benefit plan utilizing state funds shall provide support of itemized individual claims when seeking payment from the payor.	✓	✓	✓	✓	✓	③
		PBM administering a pharmacy benefit plan utilizing state funds shall file with the Insurance Department (Arkansas Center for Health Improvement/All-Payer Claims Database) a report of claims actually paid to pharmacies.	✓	✓	✓	✓	✓	③
		PBM shall pay the amount it receives for pharmacist services to the pharmacy (spread pricing prohibited).	✓	✓	✓	✓	✓	③
Ark. Code Ann. § 4-88-1004	All PBMs	An individual cannot pay more to the pharmacy than the pharmacy gets to keep (co-pay clawback prohibited).	✓	✓	✓	✓	✓	③
Ark. Code Ann. § 17-92-507	All PBMs	PBM shall provide access to its maximum allowable cost (MAC) list to each pharmacy subject to it.	**N/A**	**N/A**	✓	✓	✓	③
		PBM shall update its MAC list timely	**N/A**	**N/A**	✓	✓	✓	③
		PBM shall provide the updates of the MAC list to pharmacies.	**N/A**	**N/A**	✓	✓	✓	③
		PBM shall provide an appeals process for MAC list prices that are below the pharmacy acquisition cost.	**N/A**	**N/A**	✓	✓	✓	③
		If a PBM doesn't change its decision in favor of the pharmacy, it must provide the pharmacy with a wholesaler providing the drug below the PBM MAC price.	**N/A**	**N/A**	✓	✓	✓	③
		A PBM shall not reimburse non-affiliate pharmacies less than affiliate pharmacies.	✓	✓	✓	✓	✓	③
		A pharmacy can decline to fill a prescription if the pharmacy would be filling below its acquisition cost.	**N/A**	**N/A**	✓	✓	✓	③

Code Section(s)	Applicability of Law	Criteria	EBD	Fee-for-Service	Arkansas Works	PASSE	Ark. State Police and Higher Education Health Plans	AHEC
Ark. Code Ann. § 17-92-1201	All PBMs	A pharmacy must be given at least 1 week notice prior to the on-site audit.	✓	✓	✓	✓	✓	③
		No extrapolation of exceptions is allowed.	✓	✓	✓	✓	✓	③
		Audits shall be limited to 25 randomly selected prescriptions, with some exceptions.	✓	✓	✓	✓	✓	③
		Audits can only be performed twice per calendar year, with some exceptions.	✓	✓	✓	✓	✓	③
		Recoupment cannot be based on documentation requirements above those of the State Board of Pharmacy.	✓	✓	✓	✓	✓	③
		PBM must audit all pharmacies (affiliated or non-affiliated) under the same standards and parameters.	✓	✓	✓	✓	✓	③
		A pharmacy must be given 30 days after a preliminary audit report to produce additional documentation.	✓	✓	✓	✓	✓	③
		Period of audit cannot exceed the prior 24 months.	✓	✓	✓	✓	✓	③
		Audits cannot be conducted during the first 7 calendar days of the month.	✓	✓	✓	✓	✓	③
		Preliminary audit report and final audit report must be provided within specified time-periods.	✓	✓	✓	✓	✓	③
		Recoupment cannot occur before the final audit report and appeals process have been terminated.	✓	✓	✓	✓	✓	③
		An appeals process must be provided concerning audit reports.	✓	✓	✓	✓	✓	③
		PBM must provide audit report to the plan sponsor after the completion of any review process.	✓	✓	✓	✓	✓	③
		Recouped amounts must be remitted to the responsible party.	✓	✓	✓	✓	✓	③
		Audit charge cannot be based on amount recouped (i.e., no audit recovery commissions), with the exception noted below.	✓	✓	✓	✓	✓	③
		PBM and plan sponsor can allow for PBM to keep audit recovery amounts if the contract explicitly states the percentage amount.	✓	✓	✓	✓	✓	③
Ark. Code Ann. § 23-79-149	All insurance policies	Insurance policy cannot have preferential cost sharing (i.e., co-pays) for any subset of pharmacies (i.e., mail-order vs. retail pharmacies).	**N/A**	**N/A**	②	✓	**N/A**	**N/A**
		Insurance policy cannot have different quantity limits for any subset of pharmacies (i.e., mail-order vs. retail pharmacies).	**N/A**	**N/A**	②	✓	**N/A**	**N/A**
Ark. Code Ann. § 23-79-1801, et al.	Health Benefit Plans	Insurance card must identify whether the plan is self-funded or fully insured.	✓	**N/A**	✓	✓	✓	✓

Code Section(s)	Applicability of Law	Criteria	EBD	Fee-for-Service	Arkansas Works	PASSE	Ark. State Police and Higher Education Health Plans	AHEC
Ark. Code Ann. § 23-92-501, et al.	All non-ERISA PBMs and Medicaid fee-for-service excluded; PASSE added in 2019	PBM must be licensed.	①	N/A	✓	✓	①	③
		PBM must have adequate network coverage.	①	N/A	✓	✓	①	③
		PBM shall report to Insurance rebate information (amount received and distributed).	①	N/A	✓	✓	①	③
		PBM shall report to Insurance amount paid to pharmacies and from health plans (spread pricing review).	①	N/A	✓	✓	①	③
		PBM is prohibited from spread pricing.	①	N/A	✓	✓	①	③
		Insurance Commissioner approves PBM compensation.	①	N/A	✓	✓	①	③
		PBM cannot require additional standards of pharmacies in addition to those of the State Board of Pharmacy.	①	N/A	✓	✓	①	③
		PBM cannot reimburse non-affiliate pharmacies less than affiliate pharmacies.	①	N/A	✓	✓	①	③
		PBM cannot reimburse for less than the national average drug acquisition cost (NADAC) (EBD specifically excluded).	①	N/A	✓	✓	①	③
		PBM cannot perform a reduction of payment under a reconciliation process to reduce reimbursed amounts to effective rates.	①	N/A	✓	✓	①	③
		Pharmacy may provide insured information about the total cost for drug, and any contract cannot limit this ability (i.e., gag clause banned).	①	N/A	✓	✓	①	③

Acronyms

AHEC	Arkansas Higher Education Consortium
EBD	Employee Benefits Division
PASSE	Provider-led Arkansas Shared Savings Entity
PBM	Pharmacy Benefit Manager

Legend

✓	This law is applicable to the state-funded plan.
①	This law is only applicable to "health insurance plans issued or delivered by a healthcare insurers." Healthcare insurer is limited to "an insurance company, health maintenance organization, or hospital and medical service corporation." Therefore, it can be argued legally that the PBM Licensure laws (Title 23, Chapter 92, Sub-Chapter 500) are inapplicable to the government self-funded employee health plans.
②	Under 45 CFR § 156.122(e)(2), a "health plan may charge enrollees a different cost-sharing amount for obtaining a covered drug at a retail pharmacy…." Furthermore, commentary issued by the Centers for Medicare and Medicaid Services (CMS) with this regulation states that the requirement of the CFR still allows "a health plan to charge a different cost-sharing amount when an enrollee obtains a drug at an in-network retail pharmacy than he or she would pay for obtaining the same covered drug at a mail-order pharmacy." Since these policies are governed by the Patient Protection and Affordable Care Act, the Insurance Department's opinion is that this CFR preempts the state law and is inapplicable to the Arkansas Works prescription drug copays.
③	Prior to ALA fieldwork, this plan referred to itself as an ERISA-covered plan, which would make state laws subject to challenge as being pre-empted by federal law. However, after the Insurance Department was made aware of this plan and ERISA status by ALA staff, the Insurance Department worked out a process with the health plan director, third-party administrator, and insurance broker to fully comply with all state laws that are applicable to the higher education health plans. The third-party administrator that took over the plan on January 1, 2020, has provided assurances to the Insurance Department that the plan will follow state laws related to spread pricing, pharmacy claims reporting, MAC pricing, and co-pay clawback.
N/A	This provision of law is not applicable to the plan, either due to a statutory exception in law or statutory definitions utilized.

Source: *Arkansas Code Annotated*

Appendix D

Drug Utilization Review (DUR), Drug Review Committee (DRC), and Drug Utilization and Evaluation (DUEC) Board Members
As of January 2021

Medicaid Fee-for-Service

Drug Utilization Review Board (DUR)

Geri Bemberg, Pharm.D.
Clint Boone, Pharm.D.
Lana Gettman, Pharm.D.
Jill Johnson, Pharm.D.
Brian King, Pharm.D.
James Magee, M.D
Michael J. Mancino, M.D.
Laurence Miller, M.D.
Paula Podrazik, M.D.

Non-Voting DUR Board Members

Shannon Burke, Pharm.D.
Lauren Jimerson, Pharm.D.
Kristin Pohl, Pharm.D.

Non-Voting and Ex-Officio Members in an Advisory Capacity

William Golden, M.D.
José Romero, M.D.

Drug Review Committee (DRC)

Jordan Brazeal, Pharm. D.
Grace Marable, Pharm.D.
Melissa Max, Pharm.D.
Laurence Miller, M.D.
Tonya Robertson, Pharm.D.
Chad Rodgers, M.D
Daniel Pace, M.D.

Non-Voting DRC Members

Shannon Burke, Pharm.D.
Lauren Jimerson, Pharm.D.
Kristin Pohl, Pharm.D.

Medicaid PASSE

Empower Drug Utilization Review Board (DUR)

Brad Diner, M.D.
Jerry Jones, Pharm.D.
Cinnamon Pearson, Pharm.D.
Sylvia Sherrill
Suzanne Tipton
Greg Lueck

Arkansas Total Care Drug Utilization Review Board (DUR)

Kristin Garner, M.D.
Kacey Hunt, Pharm.D.
Jamie McConnell, Pharm.D.
Katheryn Nance, M.D.
Cinnamon Pearson, Pharm.D.
Kristen Pohl, Pharm.D.

Summit Drug Utilization Review Board (DUR)

Danielle Bell, M.D.
Erica Booth, RN
Brandi Buchy, RN
Evan Delaney, Pharm.D.
Lauren Jimerson, Pharm.D.
Stephanie Martin, RN
Cinnamon Pearson, Pharm.D.
Jeff Allen
Stephanie Carpenter
Jason Miller
Catherine Silva

Employee Benefits Division

Drug Utilization and Evaluation Committee (DUEC)

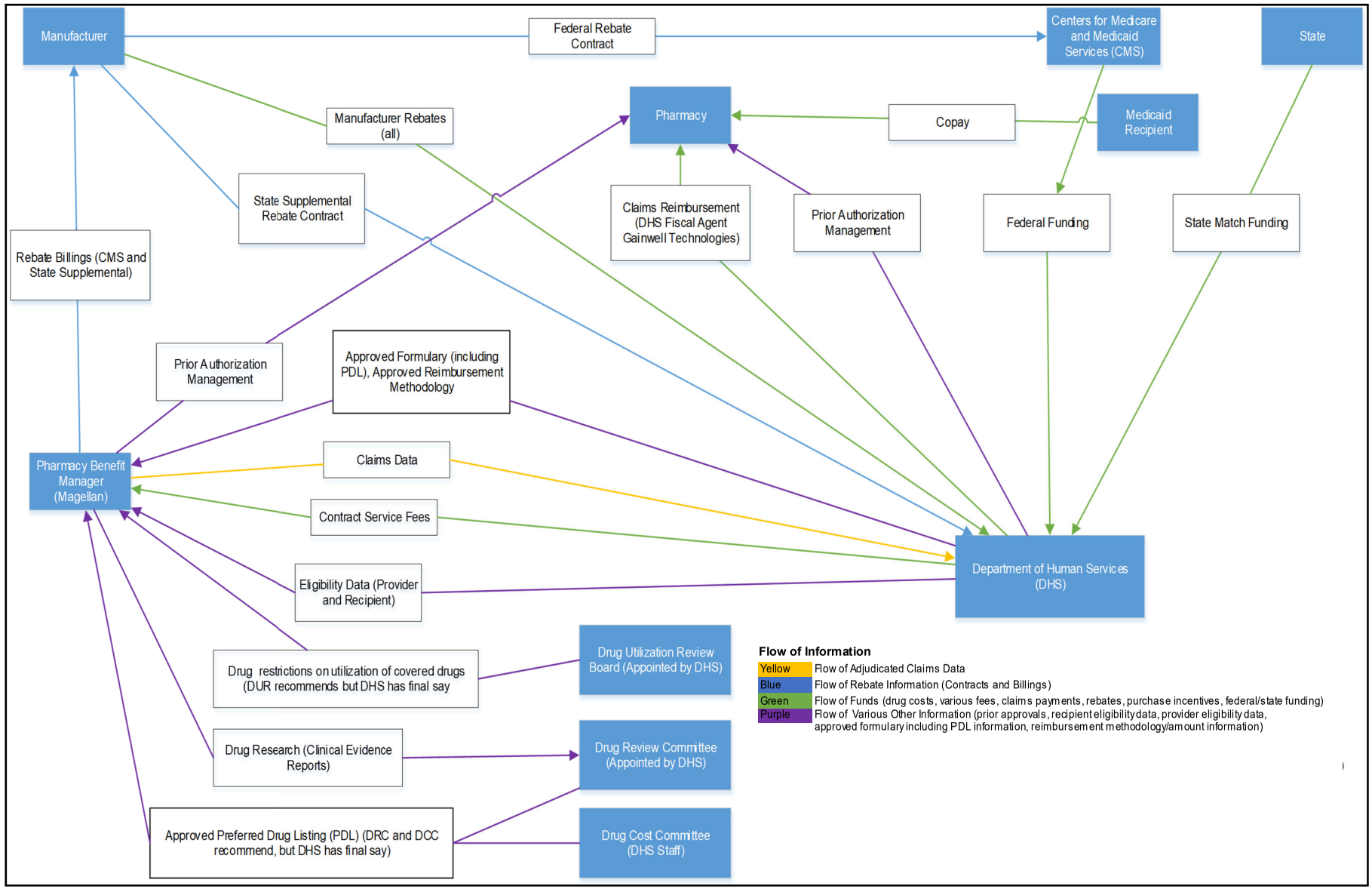
The Executive Director of the Arkansas State Board of Pharmacy or designee
The Dean of the UAMS College of Pharmacy or designee
A pharmacist selected by the Arkansas Pharmacists Association
The Senior Associate Hospital Director of UAMS or designee
The Medical Director of the Arkansas Poison and Drug Information Center or designee
A physician selected by the Arkansas Medical Society
The Dean of the UAMS College of Nursing
One state employee appointed by the board
Two public school employees appointed by the board.

PASSE = Provider-led Arkansas Shared Savings Entity
UAMS = University of Arkansas for Medical Sciences

Source: *Information obtained from the Department of Human Services and Employee Benefits Division (unaudited by Arkansas Legislative Audit)*

Appendix E

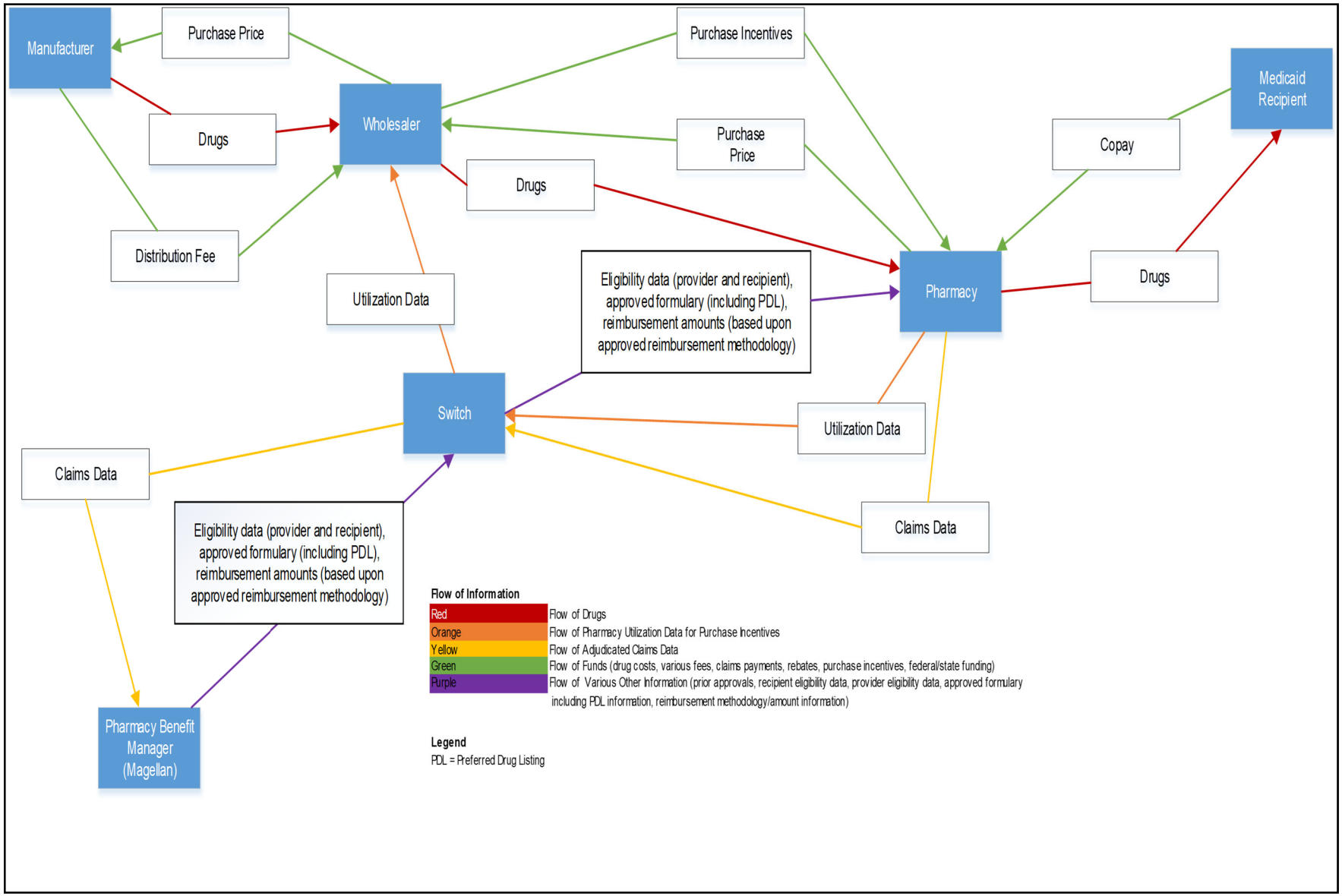
Arkansas Medicaid Fee-for-Service Flowchart – Primarily Medicaid Processes Only



Source: *Information obtained from the Department of Human Services and various other industry stakeholders (unaudited by Arkansas Legislative Audit)*

Appendix F

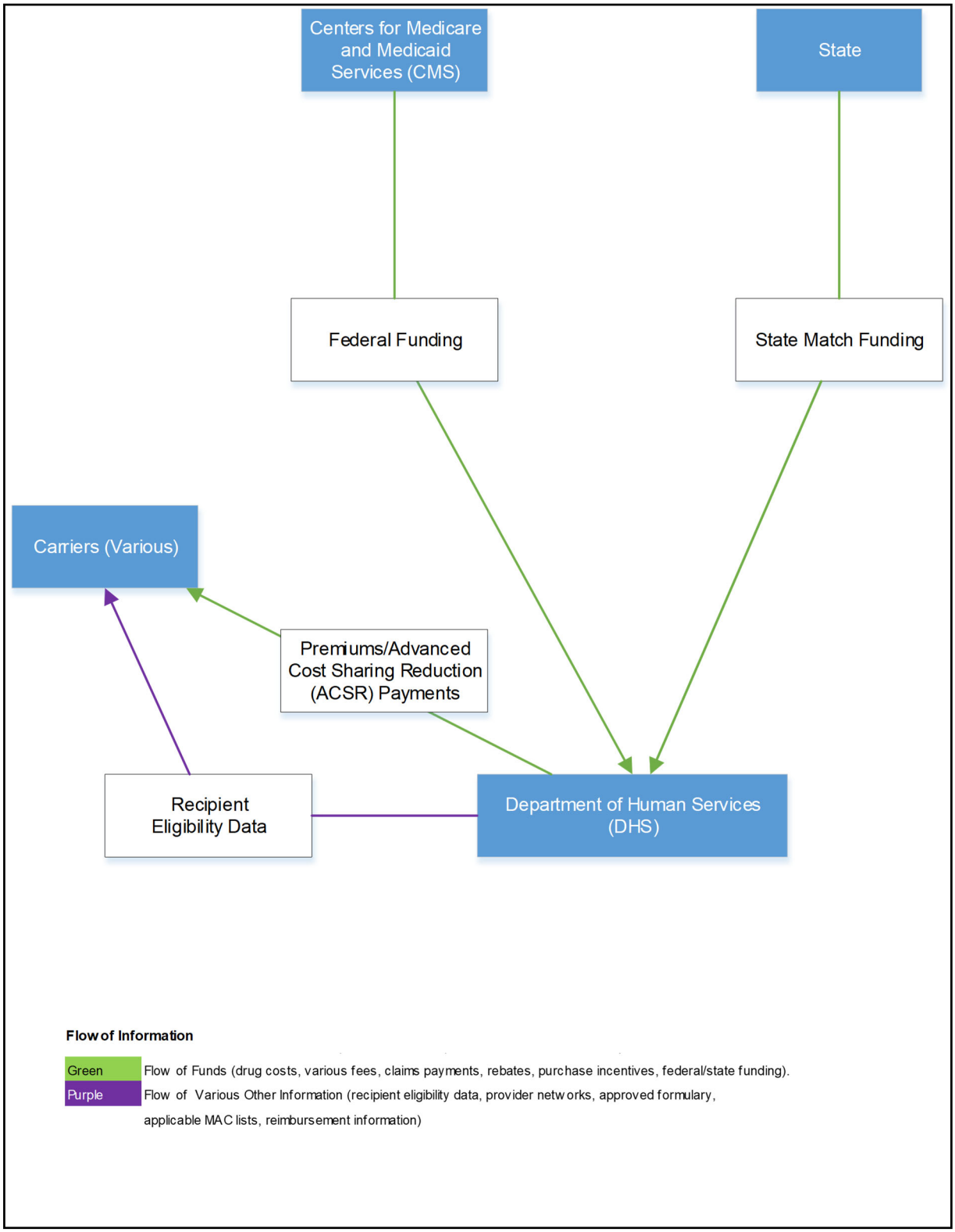
Arkansas Medicaid Fee-for-Service Flowchart – All Other Processes



Source: *Information obtained from the Department of Human Services and various other industry stakeholders (unaudited by Arkansas Legislative Audit)*

Appendix G

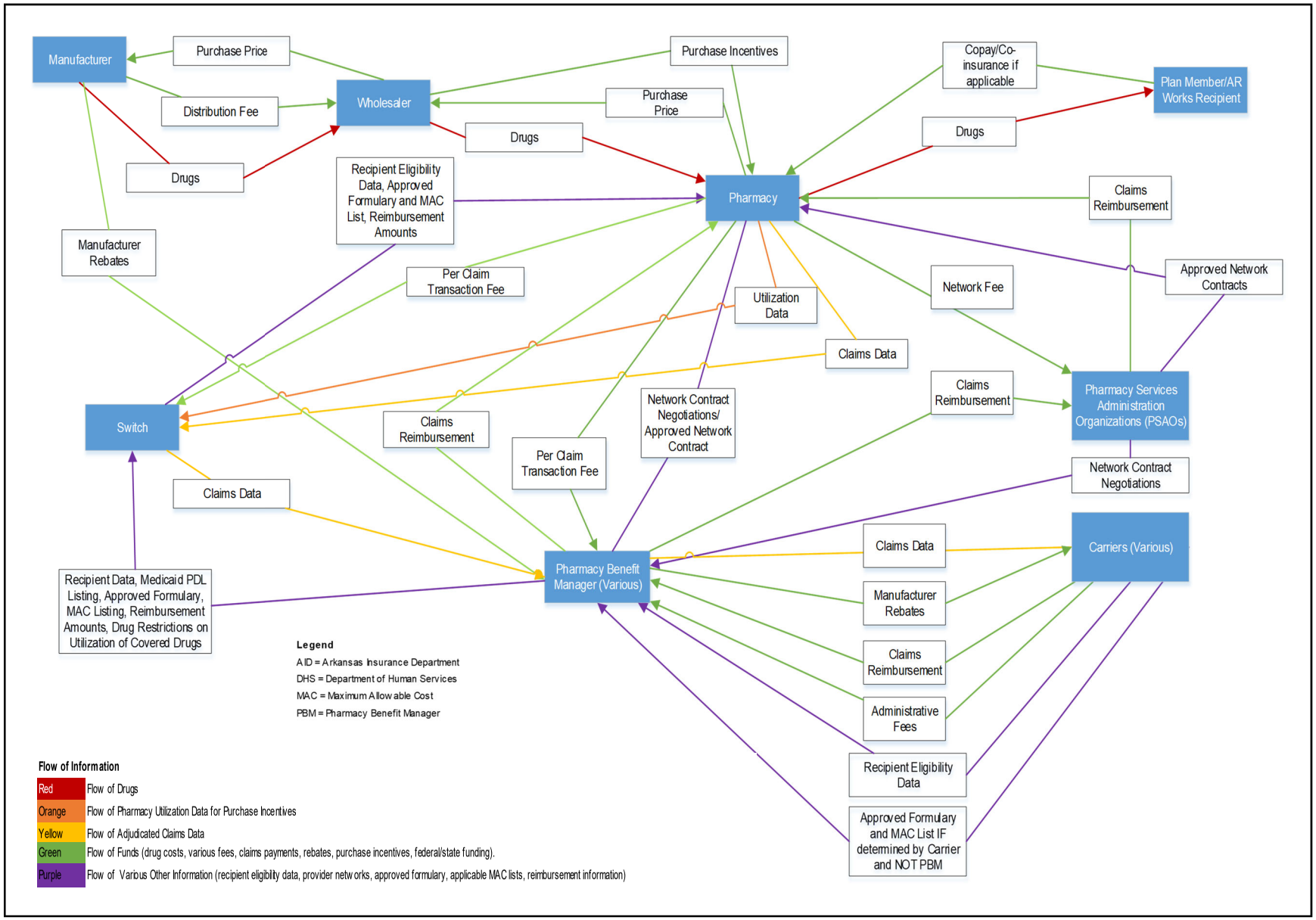
Arkansas Works Flowchart – Primarily Medicaid Processes Only



Source: *Information obtained from the Department of Human Services and various other industry stakeholders (unaudited by Arkansas Legislative Audit)*

Appendix H

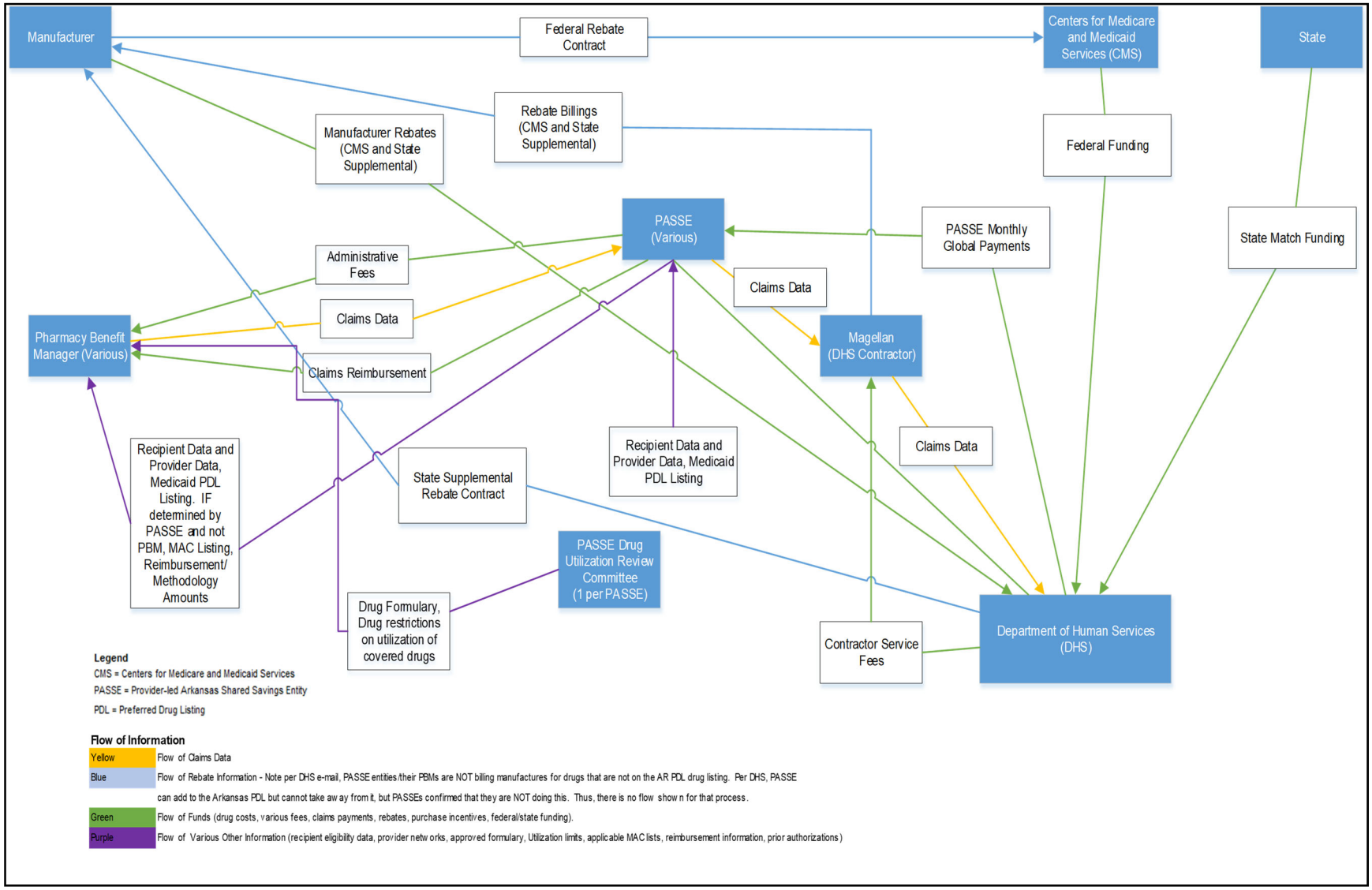
Arkansas Works Flowchart – All Other Processes



Source: *Information obtained from various industry stakeholders (unaudited by Arkansas Legislative Audit)*

Appendix I

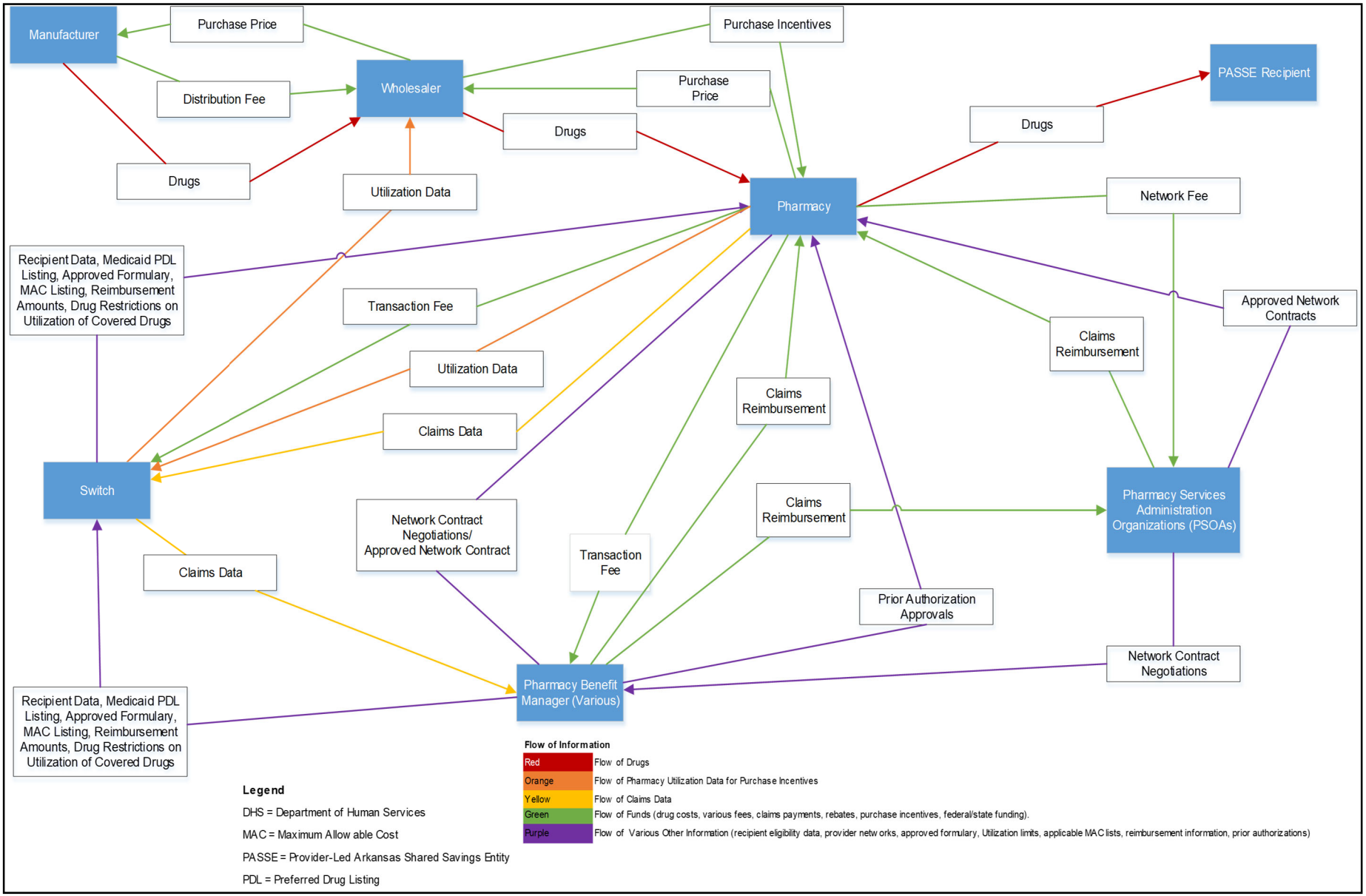
PASSE Flowchart – Primarily Medicaid Processes Only



Source: *Information obtained from the Department of Human Services and various other industry stakeholders (unaudited by Arkansas Legislative Audit)*

Appendix J

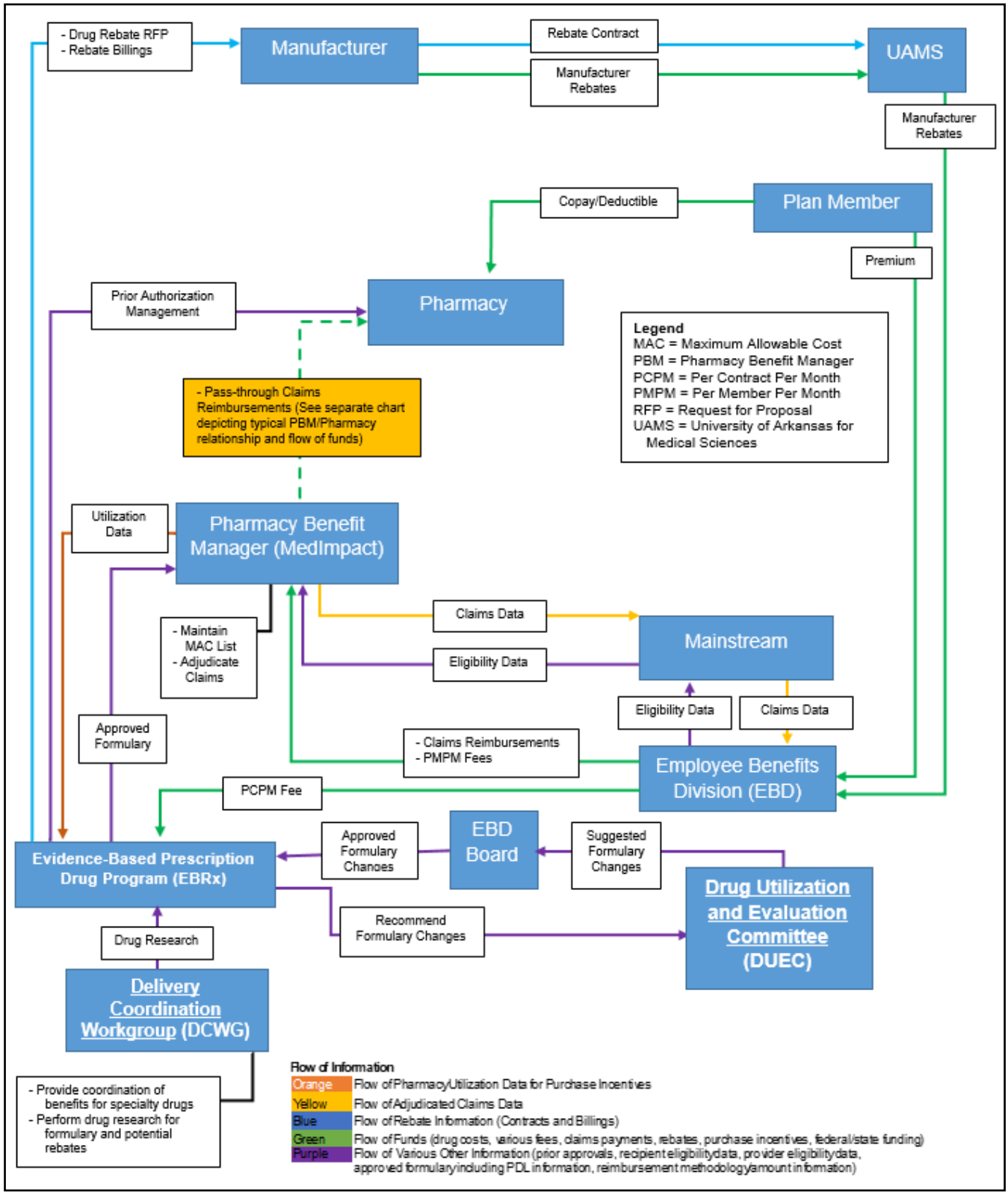
PASSE Flowchart – All Other Processes



Source: *Information obtained from various industry stakeholders (unaudited by Arkansas Legislative Audit)*

Appendix K

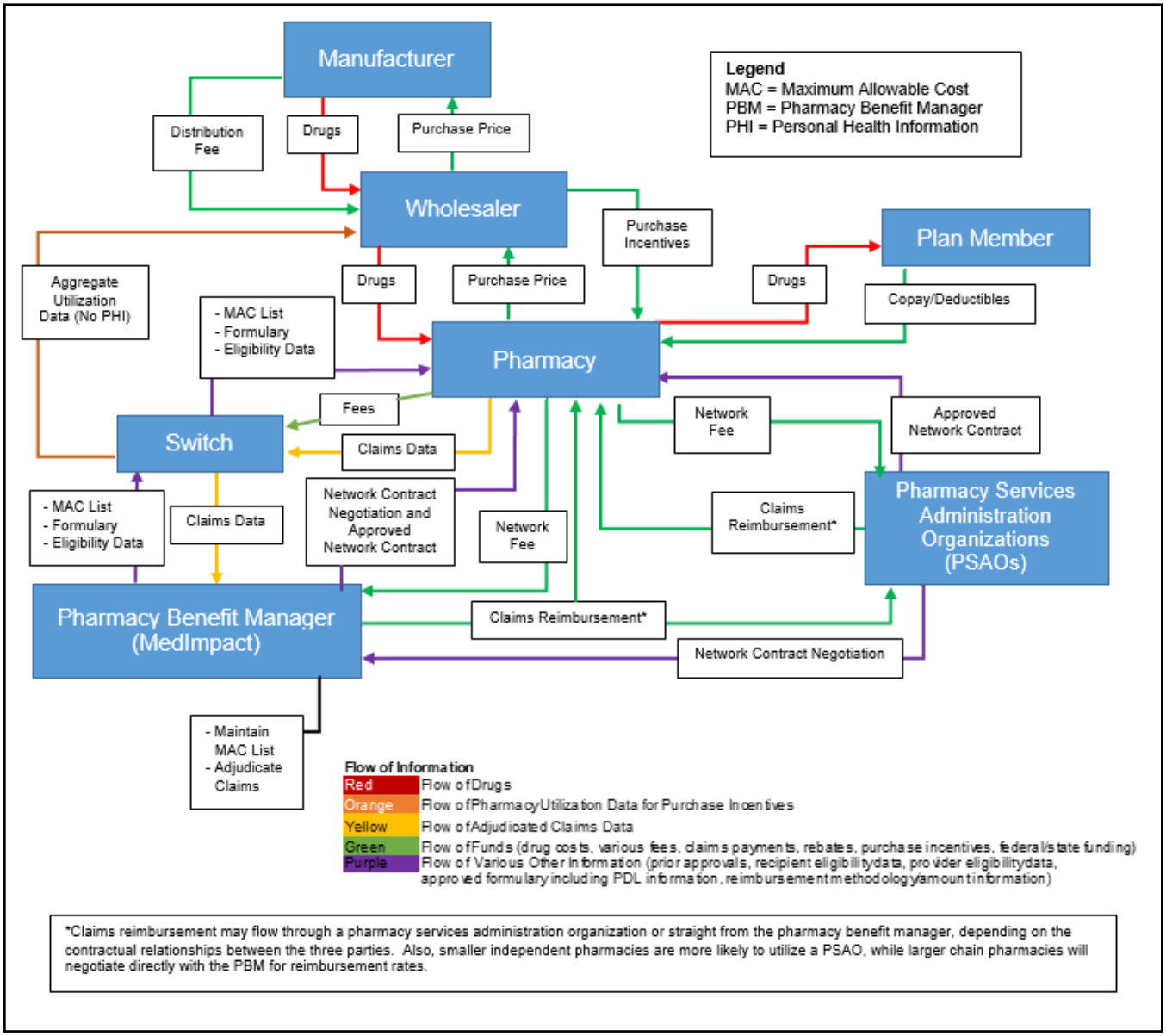
Employee Benefits Division (EBD) – Primarily EBD Processes Only



Source: *Information obtained from the Employee Benefits Division and various other industry stakeholders (unaudited by Arkansas Legislative Audit)*

Appendix L

Employee Benefits Division (EBD) – All Other Processes



Source: *Information obtained from the Employee Benefits Division and various other industry stakeholders (unaudited by Arkansas Legislative Audit)*

Appendix M

Summary of Information Received from the State's Higher Education Institutions
For Calendar Year 2018

	Self-Insured / Partially Self-Insured						Fully-Insured Plans		Multi-Employer	
	ASU	**Henderson**	**NWACC**	**SAU-Mag**	**UCA**	**U of A System**	**ATU**	**SAU-Tech**	**AHEC**	**Total**
Health Plan Administrator (HPA)	Cigna	UMR******	BlueAdvantage	BlueAdvantage	UHC	UMR	BCBS	Health Advantage	QualChoice	
Pharmacy Benefit Manager (PBM)	Caremark	Southern Scripts	Caremark	Caremark	Optum***	MedImpact	Unknown	Caremark	Optum	
Pharmacy Benefit Decision-Maker	PBM	PBM	HPA	HPA	PBM	Univ. Advisory Cmt.	BCBS	PBM	PBM	
Pharmacy Benefit Consultant Service Provider	None*	None	None**	None	Stephens Inc.****	Aon Consulting	None*****	None	None	
Number of **Currently** Covered Lives (Members)	4,297	580	815	626	2,500	36,000	1,445	214	1,272	**47,749**
2018 Calendar Year										
PBM Admin. Fees Paid	***Note 1***	$ 96,648	***Note 3***	***Note 1***	***Note 1***	$ 1,118,524	***Note 2***	***Note 2***	***Note 4***	**$ 1,215,172**
Pharmacy Claims Paid	$ 5,865,456	$ 786,823	$ 951,658	$ 1,144,379	$ 2,763,971	$ 34,409,976	$ 2,510,857	$ 293,263	$ 1,907,713	**$ 50,634,096**
Rebates Received by Plan	$ 1,086,658	$ 13,396	$ 214,028	$ 199,957	$ 772,112	$ 2,096,964	**N/A**	**N/A**	$ 511,782	**$ 4,894,897**
Rebates Retained by PBM	Unknown	None	None	Unknown	None	None	**N/A**	**N/A**	None	
Net Pharmacy Expense	**$ 4,778,798**	**$ 870,075**	**$ 737,630**	**$ 944,423**	**$ 1,991,859**	**$ 33,431,536**	**$ 2,510,857**	**$ 293,263**	**$ 1,395,931**	**$ 46,954,371**
See **DISCLAIMER** below										
Average cost of prescriptions, PMPM (net of rebates)	**$ 92.68**	**$ 125.01**	**$ 75.42**	**$ 125.72**	**$ 66.40**	**$ 77.39**	**$ 144.80**	**$ 114.20**	**$ 91.45**	**$ 81.95**
Rebates as a percentage of gross paid claims	**18.53%**	**1.70%**	**22.49%**	**17.47%**	**27.93%**	**6.09%**	**N/A**	**N/A**	**26.83%**	**9.67%**

ASU = Arkansas State University
Henderson = Henderson State University
SAU-Mag = Southern Arkansas University - Magnolia
UCA = University of Central Arkansas
U of A System = University of Arkansas System
ATU = Arkansas Tech University
SAU-Tech = Southern Arkansas University Tech
AHEC = Arkansas Higher Education Consortium

* Since 1/1/19, ASU has used MedImpact as its PBM and EBRx as a pharmacy benefit consultant and rebate negotiator.
** NWACC utilizes a pharmacist employed by the health plan administrator to assist with coverage recommendations.
*** UCA is currently in the procurement process of soliciting proposals for a new PBM, which may also require switching health plan administrators. The purpose is to move toward a transparent pass-through arrangement.
**** Stephens, Inc., assists UCA with prescription co-pay determinations and other cost issues. However, the PBM determines all formulary, prior authorizations, dosage limits, etc., and, based on representations, does not allow UCA to have a role in these decisions.
***** In May 2019, ATU hired Stephens, Inc., to assist in evaluating plan costs and determining whether to move toward a self-funded plan. If this route is chosen, the stated intent would be to utilize a pass-through arrangement.
****** HSU decided on October 9, 2019, to transition from a self-insured plan to a fully-insured plan. The university plans on using Blue Cross Blue Advantage.

Note 1: The pharmacy administration fee and rate/method of reimbursement were included as part of the health plan administrator contract, so the amount paid to the PBM for its services is unknown, which could result in the per member, per month (PMPM) cost being lower than actual.
Note 2: ATU utilizes a fully-insured insurance model for covering its employees. The total amount of insurance premiums paid by ATU relating to health insurance in 2018 was $7,610,557. The total amount paid by SAU-Tech was $1,527,278.
Note 3: NWACC pays BlueAdvantage an administration fee of $0.65 per paid prescription. However, the amount paid to the PBM for the pharmacy administration services is unknown.
Note 4: Spread pricing was utilized in calendar year 2018 as the method of compensating the PBM for its services. Since 1/1/2019, the pricing model has changed to a transparent arrangement.

DISCLAIMER: This chart does not take into account any coverage or cost sharing variances between the plan participants and the plan relating to pharmacy benefits (i.e., covered drugs, copays, deductibles, co-insurance). Also, any conclusions regarding plan performance should include an evaluation of the covered members and any medical outliers in the population. Finally, all amounts are unaudited and were self-reported by the universities.

Source: *Information obtained from Arkansas institutions of higher education (unaudited by Arkansas Legislative Audit)*

LIMITED SCOPE EXAMINATION OF PHARMACY BENEFIT MANAGERS

July 27, 2020

Prepared for the:

ARKANSAS Insurance Department

By:

LEWIS & ELLIS Actuaries and Consultants

DAVE DILLON, FSA, MAAA, MS

IDEAL HEALTH STRATEGIES

CASEY NELSON, PharmD
TODD KRUEGER, PharmD
DAVE HANSON, PharmD

REGULATORY INSURANCE ADVISORS

HOLLY BLANCHARD, FLMI, AINS, AIRC, CCP
PIETER WILLIAMS, JD, MCM

Executive Summary 1
Purpose & Scope 3
Background and Scope 3
Limits on Distribution and Utilization 4
Confidentiality of Review & Reliances 5
Definitions of PBM Pricing Practices Evaluated 7
Audit Procedures 10
Data Collection 10
Data Normalization 14
Data Analysis Approach 15
Audit Results 17
Data Demographics 17
Differential Pricing Analysis Results: 18
Conclusions 25
ASOP 41 Disclosures 26
Appendices 28
Appendix 1. Examiner Verification 29
Appendix 2. BCBSAR (CVS Caremark) Summary Data Tables 30
Appendix 3. Centene (CVS Caremark) Summary Data Tables 31
Appendix 4. Empower (CVS Caremark) Summary Data Table 32
Appendix 5. Summit Community Care (Express Scripts) Summary Data Table 33
Appendix 6. QualChoice (Optum Rx) Summary Data Table 34

EXECUTIVE SUMMARY

Health insurers utilize the services of Pharmacy Benefit Managers ("PBMs") to manage prescription drug benefits on their behalf. While PBMs were originally designed to reduce administrative costs in administering a prescription drug program, PBMs have grown and now have substantial profitmaking ability through price spreading and rebates.

Amid concerns about PBM practices, the state of Arkansas passed the 2018 *PBM Licensure Act* which authorizes the Arkansas Insurance Commissioner ("Commissioner") to license and regulate the activities of PBMs. Subsequently, the Arkansas Insurance Department ("AID") issued Rule 118: *Pharmacy Benefits Managers Regulation* which licenses and regulates the activities of PBMs. Additionally, the Arkansas State Legislature passed Act 994 of 2019 which explicitly prohibited spread pricing as of July 24, 2019. Additional guidance surrounding this was provided in AID Bulletin No. 7-2019.

In 2019 the Commissioner engaged Lewis & Ellis, Inc. ("L&E") and its subcontractors, Ideal Health Strategies ("IHS") and Regulatory Insurance Advisors, LLC, ("RIA"), (collectively the "auditors" or "examiners") to perform a limited scope market conduct examination to review spread pricing[1] and other reimbursement activities of PBMs providing prescription coverage for state funded health plans issued through either the Arkansas Works ("AR Works") program (Arkansas Works Act of 2016, Ark. Code Ann. §§ 23-61-1001 et seq) or the Provider-led Arkansas Shared Savings Entity (PASSE) system created by Act 775 of 2017. The PBMs subject to the examination were Optum Rx, CVS/Caremark, and Express Scripts, Inc. (ESI)

The differential pricing analysis showed that National Chain pharmacies were reimbursed more (defined as greater than 5% difference) than Regional Chain and Independent Pharmacies for the same drug product unit (i.e. tablet, capsule).

The spread pricing analysis showed that one of the three PBMs being audited, ESI, was employing significant spread pricing practices during the audit time frame. Specifically, ESI was charging the health benefit plan an estimated 15.26% more than was being paid to the pharmacies.

[1] "spread pricing" is defined in AID Rule 118 to mean "the model of prescription drug pricing in which the pharmacy benefit manager charges a health benefit plan a contracted price for prescription drugs although the contracted price may differ with the amount the pharmacy benefits manager pays the pharmacist"

The Direct and Indirect Remuneration (DIR) or "clawback" analysis showed that both CVS Caremark (9.71%) and ESI. (4.55%) assessed DIR or "clawback" fees to the pharmacies during the audit timeframe. OptumRx's clawback pricing could not be evaluated.

While the report focuses on several pharmaceutical pricing practices, it does not provide a complete picture of pharmacy costs and PBM compensation. There are a number of additional factors that impact PBM revenues and pharmacy reimbursements that were either outside of the scope of this report or unavailable due to the lack of PBM response. These additional factors include rebates, additional insurer fees, and pharmacy fees.

PURPOSE & SCOPE

BACKGROUND AND SCOPE

Health insurers utilize the services of Pharmacy Benefit Managers ("PBMs") to manage prescription drug benefits on their behalf. PBMs offer a variety of services, including but not limited to claim adjudications; customer service or call centers; clinical services such as prior authorizations; drug utilization reviews; and mail-order and specialty pharmacies.

PBMs provide many cost-cutting measures to health insurers, e.g. by establishing pharmacy networks. These networks give PBMs purchasing power, allowing them to negotiate discounted prescription coverage for insurers and their customers. PBMs can also negotiate manufacturer rebates directly with the pharmaceutical company to further reduce prescription drug costs. These services allow PBMs to generate revenue through several approaches, including administration and service fees charged to insurers for processing prescriptions, through operation of their own mail-order and specialty pharmacies, and on the margin between the amount charged to insurance plan sponsors and the amount paid out to pharmacies for a prescription.

While PBMs were originally designed to reduce administrative costs in administering a prescription drug benefit program, PBMs have grown and now have substantial profitmaking ability through price spreading and rebates, which are payments negotiated directly with pharmaceutical manufacturers. It can be difficult for health insurers to oversee compliance with prescription benefit programs outsourced to PBMs in part because they are not subject to industry-wide regulation. Exact terms of the financial arrangements for pharmacy services are obscured in part by the sheer number of entities involved in every transaction including insurers, PBMs, pharmacies, wholesalers, manufacturer, and by the contract provisions that keep most of the transactional details confidential. These issues result in a lack of transparency in the expenditure of Arkansas's dollars spent on public pharmaceutical programs.

Therefore, amid growing concerns about PBM practices, the state of Arkansas passed Act One (1) and Act Three (3) of the Second Extraordinary Session of 2018 by the Ninety-First (91st) Arkansas General Assembly, "*An Act To Create The Arkansas Pharmacy Benefits Manager Licensure Act*," (hereafter, the "PBM Licensure Act") which authorizes the Arkansas Insurance Commissioner ("Commissioner") to license and regulate the activities of pharmacy benefits managers ("PBMs").

The PBM Licensure Act was amended by Act 994 of 2019. On August 18, 2018, AID issued a rule licensing and regulating the activities of PBMs in AID Rule 118: "Pharmacy Benefits Managers Regulation".

Pursuant to the PBM Licensure Act and AID Rule 118, in 2019 the Commissioner engaged Lewis & Ellis, Ideal Health Strategies, and Regulatory Insurance Advisors to perform a limited scope market conduct examination to review spread pricing and other reimbursement activities of PBMs providing prescription coverage for state funded health plans issued through either the Arkansas Works ("AR Works") program (Arkansas Works Act of 2016, Ark. Code Ann. §§ 23-61-1001 et seq) or the Provider-led Arkansas Shared Savings Entity (PASSE) system created by Act 775 of 2017.

This examination is authorized to be conducted under the following Arkansas Code and Arkansas Insurance Department (AID) rules:

- Ark. Code Ann. § 23-61-201 for health insurance issuers.
- Ark. Code Ann. § 23-76-122 for health maintenance organizations.
- AID Rule 117, Section 7 (A)(7) for PASSE organizations, and
- Ark. Code Ann. § 23-92-508 and AID Rule 118, Section 8 for PBMs.

The Health Plans and their contracted PBMs included in this examination are defined in Table 1 below.

Table 1. Arkansas Health Plans and PBMs Examined

Arkansas Health Plan	Program	PBM
Arkansas Total Care	PASSE	CVS Caremark
Celtic Insurance Company d/b/a/ Arkansas Health & Wellness	Arkansas Works	CVS Caremark
Empower Healthcare Solutions	PASSE	CVS Caremark
QCA Health Plan	Arkansas Works	OptumRx
QualChoice Life and Health Insurance Company	Arkansas Works	OptumRx
Summit Community Care	PASSE	Express Scripts (ESI)
USAble Mutual Ins Co d/b/a/ Arkansas Blue Cross Blue Shield	Arkansas Works	CVS Caremark

LIMITS ON DISTRIBUTION AND UTILIZATION

This report has been prepared for the use of the AID regarding the financial examination of health insurers and PBMs specifically participating in either the Arkansas Works or PASSE programs. A review of ERISA plans, Commercial Markets and comparable markets was not performed. The data and information presented is not appropriate for any other purpose.

Any user of this report must possess a certain level of expertise in health insurance, pharmacy services, actuarial science, and/or financial examinations, so as not to misinterpret the data presented. Any distribution of this report should be made in its entirety. Any third party with access to this report acknowledges, as a condition of receipt, that the authors do not make any

representations or warranties as to the accuracy or completeness of the material. Any third party with access to these materials cannot bring suit, claim, or action against the authors, under any theory of law, related in any way to this material.

CONFIDENTIALITY OF REVIEW & RELIANCES

Examination records of AID are considered confidential and privileged under §§ 23-61-207, 23-61-107, 23-61-103(d), provisions which are applicable to both health insurers under examinations, and PBMs, pursuant to Rule 118, Section 8, and Ark. Code Ann. § 23-92-508.

The auditors were required to share and access data, records, work papers and other information, from this limited scope examination. The auditors agreed to accept the same restrictions limiting the disclosure of any of the above referenced data, records, and information as are applicable to AID.

The term "confidential data" includes all working papers, recorded information, documents, and copies produced by, obtained by, or disclosed to the Commissioner or any other person during this examination.

The auditors certified that they would use the confidential data received pursuant to this Agreement for the sole purpose of the examination and not for any other purpose, and in no event shall the auditors disseminate or communicate the confidential data in any form to any other person or entity, other than to AID.

The auditors certified that they would not use or disclose any confidential data with any of its personnel or departments that are not directly engaged in the examination.

The auditors certified that any claims data or rebate information received in the course of the examination shall only be disclosed to persons within its organization who: (1) are required to protect and otherwise not disclose or use the confidential data except as provided in the examination; and (2) need to know the confidential data.

Confidential data was held in the strictest confidence at all times and will not be divulged to any party other than the auditors, including but not limited to, other employees, officers, directors or agents of the auditors, and will not be used for any purpose other than the examination.

The auditors' work was based upon data and information obtained through the AID, the insurers, the PBMs, and Pharmacies. The auditors did not perform a complete audit of the data provided. The auditors relied upon the above parties to attest to the accuracy of the information provided. The auditors did review the data for overall appropriateness. If there were any material inaccuracies in the data provided, the conclusions reached in this report may be invalid.

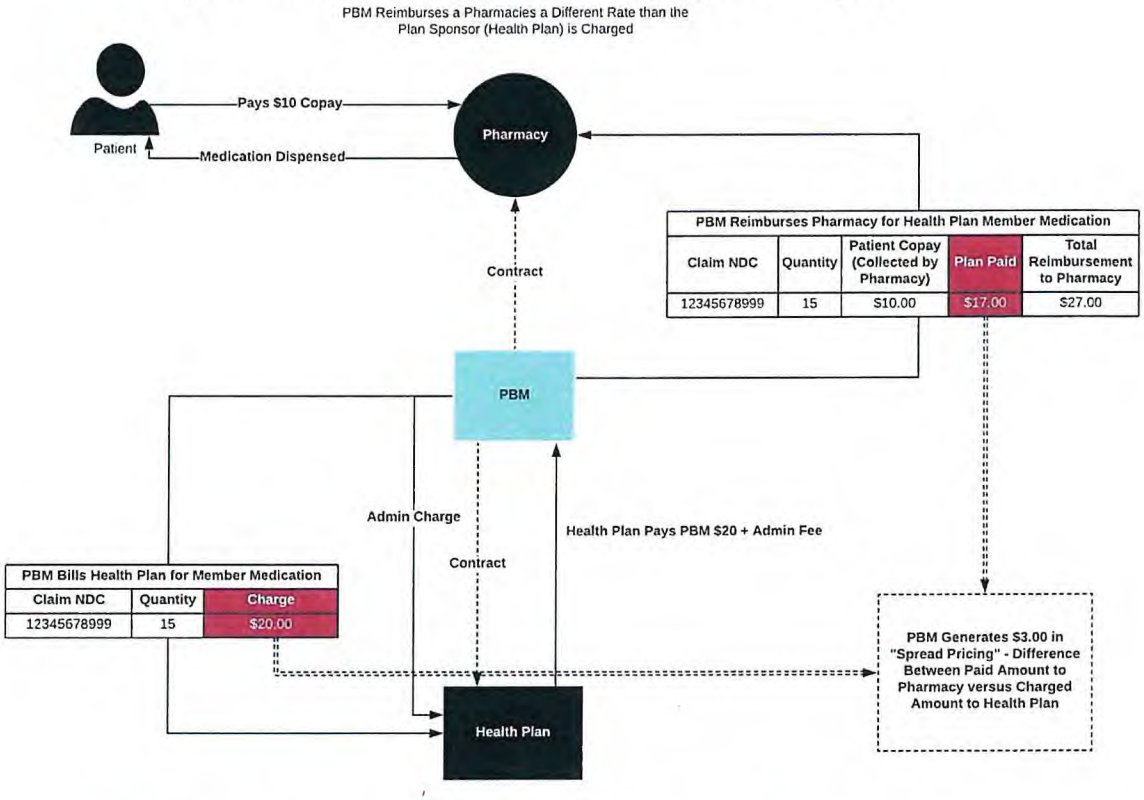
As examiners appointed by you pursuant to Ark. Code Ann. § 23-61-201 et seq, L&E and its subcontractors Ideal Health Strategies (IHS) and Regulatory Insurance Advisors, LLC (RIA) shall have immunity from liability for any statements made or conduct performed in good faith while carrying out the provisions of the examination statutes stated above.

DEFINITIONS OF PBM PRICING PRACTICES EVALUATED

SPREAD PRICING

Spread pricing is the PBM practice of charging the health plan a certain amount for a prescription but reimbursing the pharmacy at a lower rate and retaining the difference ("spread") as profit. Figure 1 provides an illustration of PBM spread pricing.

Figure 1: PBM Spread Pricing Example

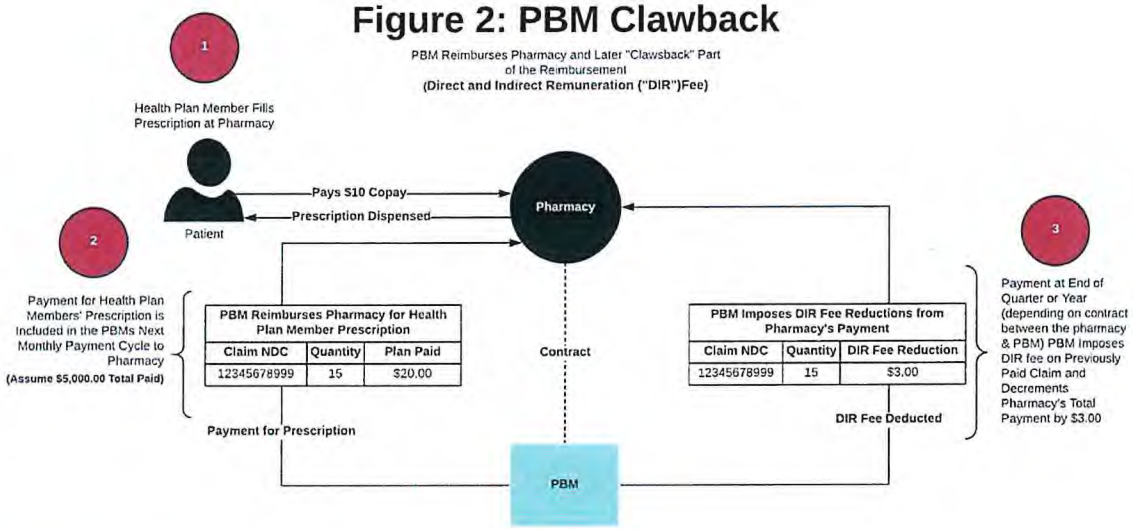


DIRECT AND INDIRECT REMUNERATION (DIR) OR "CLAWBACK" FEES

Direct and Indirect Remuneration (DIR) or "clawback" are retroactive fees assessed by the PBMs on the dispensing pharmacy after the prescription is dispensed. DIR fees can be in numerous forms (e.g. service fees, network access fees, administrative fees, reconciliation fees, etc.) that are often unclear to pharmacies who are forced to accept the PBMs DIR fees in the pharmacy network agreement.

DIR fees are difficult for the pharmacy to quantify and reconcile due to the lack of transparency in the pharmacy's agreement with the PBM. Most pharmacies are unable to accurately reconcile DIR fees back to the original prescription claim to ensure DIR fees were imposed correctly per the contract because the PBMs do not provide claim-level reporting to pharmacies for the DIR fees[2]. DIR fees are often assessed months after the point of sale and add to the PBM profit at the cost of the pharmacies. Figure 2 provides an illustration of PBM DIR/Clawback fees.

Figure 2: PBM Clawback



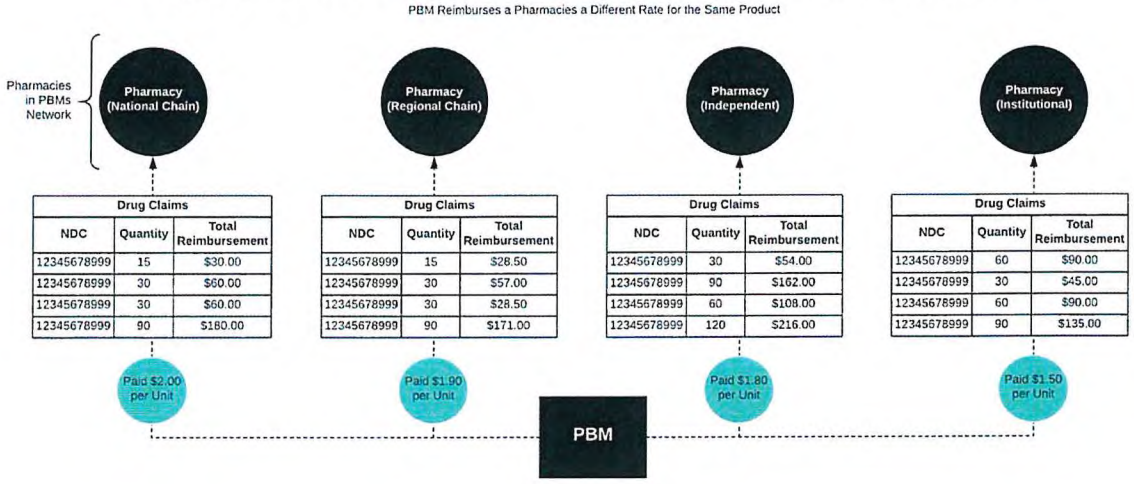
DIFFERENTIAL REIMBURSEMENT

For the purposes of this audit, "differential reimbursement" refers to differences in reimbursement rates from the PBM to the pharmacies. The analysis compares the reimbursement of drugs down to the drug unit cost level (i.e. individual drug tablet, capsule, mg, etc.) between national, regional and independent pharmacies, as well as differences between pharmacies affiliated with the PBM, specifically CVS Caremark, and non-PBM affiliated pharmacies.

The purpose of the differential reimbursement analysis was to determine if the PBMs were providing reimbursement to certain pharmacies at higher reimbursement rate versus other pharmacies. Figure 3 provides an illustration of differential reimbursement.

[2] Direct and Indirect Remuneration (DIR) Performance and the Impact on Pharmacies Serving Medicare Part D Beneficiaries. A White Paper by INMAR Intelligence® February 2019, Revised July 2019. A White Paper by Inmar Intelligence, commissioned by NACDS (National Association of Chain Drug Stores). Accessed June 2020, https://www.nacds.org/pdfs/government/2019/DIR-Whitepaper.pdf.

Figure 3: PBM Differential Reimbursement Example



AUDIT PROCEDURES

DATA COLLECTION

Beginning in July 2019, data was requested from the Arkansas sponsored health plans and the PBMs that provide prescription benefit management to the health plans as detailed in Table 1.

The data requested included:

HEALTH PLAN

- PBM contracts and amendments.
- All pharmacy claims.
    - These claims were requested from the health plans, but provided, directly or indirectly, by the PBMs

PHARMACY BENEFIT MANAGERS (PBM)

- Complete and unredacted PBM management agreements, amendments, and appendices.
- A listing of all reimbursement agreements with pharmacies in the State of Arkansas.
- Complete and unredacted copies of all pharmaceutical rebate agreements between the PBM and pharmaceutical manufacturers.
- A complete set of pharmacy claims for all Arkansas health plans for the audit timeframe of January 1 through June 30, 2019. This time frame was chosen because the AID assumed oversight of the PBMs on January 1, 2019.
- The pharmacy paid claims tape for each Arkansas health plan.
- A copy of actual paid claims tape report to support pharmacy payments for the month of March 2019.
- Pharmacy claims processing information for all Arkansas health plans.
    - Bank Identification Number (BIN)
    - Processor Controller Number (PCN)
    - Group #/Group ID

Pharmacies

A sample of 100 Arkansas pharmacies were chosen to receive the pharmacy data request. The data requested was for March 2019. This shortened timeframe was chosen to assist the pharmacies with the management of the volume of data requested. It was also determined that by reviewing a truncated timeframe, the information would still lead to confirmation of spread

pricing and clawback disparities. The pharmacies are not under the oversight of the AID, so any data submitted by the pharmacies was voluntary.

The 100 pharmacies were sent a letter requesting pharmacy claims processing data specific to the information above. The purpose of the pharmacy data request was to acquire the pharmacies claim system level data so that it could be compared to the data provided by the PBMs. Beginning February 20, 2020, a letter was sent to the pharmacies requesting the following data:

- Claims level detail for each of the Arkansas sponsored insurance companies (carriers or PASSE entities) that were processed by the pharmacy during the month of March 2019. Key data points that were requested included:
  - Processing information (BIN/PCN/Group ID) to identify the PBM that covered the claim.
  - All payment information (e.g. patient copay, amount paid by carrier, total received by the pharmacy, dispensing fee paid to pharmacy).
  - Any retroactive fees (DIR, etc.) assessed on the pharmacy by the PBM.
- Unredacted copies of pharmacy contracts with each of the PBMs evaluated by the audit, namely CVS Caremark, OptumRx and Express Scripts.
- The name and contact information for the pharmacy contact person.

The data received or omitted from the Health Plans and the PBMs included:

HEALTH PLANS

- Arkansas Blue Cross Blue Shield (CVS Caremark)
  - Provided PBM contracts and amendments
  - Provided full set of claims, but data set was provided to health plan by CVS Caremark
- Empower (CVS Caremark)
  - All data was provided by CVS Caremark
- Centene
  - All data was provided by CVS Caremark
- QualChoice (Optum Rx)
  - Provided PBM contracts and amendments
  - Provided full set of claims, but data set was provided to health plan by OptumRx

- Summit (Express Scripts)
    - All data provided by Express Scripts

PHARMACY BENEFIT MANAGERS

- CVS Caremark
    - Provided copies of PBM agreements with health plans (BCBSAR, Empower, Centene)
    - Provided a list of reimbursement agreements with pharmacies in the State of Arkansas
    - Provided complete and unredacted copies of all agreements between the PBM and pharmaceutical manufacturers regarding rebates. However, these were not provided until May 28, 2020 (requested in July of 2019)
    - Provided a complete set of pharmacy claims for all Arkansas health plans for the audit timeframe of January 1 through June 30, 2019
    - Provided pharmacy paid claims tape for each Arkansas health plan
    - Provided a copy of actual paid claims tape report to support pharmacy payments for the month of March 2019
    - Provided processing information for all Arkansas health plans
    - Processing information (BIN/PCN/Group ID) for CVS Caremark plans:
        - Arkansas BCBS
            - 004336/ADV/RX3961
            - 004336/-/RX3956
        - Centene
            - Ambetter – 004336/-/RX5448
            - Arkansas Total Care – 004336/MCAIDADV.RX5476
        - Empower
            - 004336/ADV/RX2798
- OptumRx
    - Provided copies of PBM agreements with health plan, however all specialty pricing was redacted from contracts and amendments
    - Provided a list of reimbursement agreements with pharmacies in the State of Arkansas
    - Provided copies of agreements between the PBM and pharmaceutical manufacturers regarding rebates. These documents were uploaded May 26, 2020 (Requested in July of 2019). Due to timing, these documents have *not* been reviewed for completeness.
    - Provided a complete set of pharmacy claims for all Arkansas health plans for the audit timeframe of January 1 through June 30, 2019.

- Did *not* provide pharmacy paid claims tape for each Arkansas health plan.
- Provided a copy of actual paid claims tape report to support pharmacy payments for the month of March 2019.
- Provided processing information for all Arkansas health plans.
- Processing information (BIN/PCN/Group ID) for OptumRx plans:
  - QualChoice
    - 005947/-/QCAQHP
    - 005947/-/QCA

- Express Scripts
  - Provided copies of PBM agreements with health plan (Summit), however all specialty pricing was redacted from contracts and amendments.
  - Provided a list of reimbursement agreements with pharmacies in the State of Arkansas.
  - ESI did *not* provide any manufacturer rebate agreements stating that there are no rebates for PASSE entities.
  - Provided a complete set of pharmacy claims for all Arkansas health plans for the audit timeframe of January 1 through June 30, 2019. However, this data was *not* provided in the format (24 data fields) or with the terminology requested. Rather, the claims were submitted in a set with 284 individual data fields using ESI terminology, which added complexity to the audit due to having to identify the data fields relevant to the analysis.
  - Provided pharmacy paid claims tape for each Arkansas health plan.
  - Did *not* provide a copy of actual paid claims tape report to support pharmacy payments for the month of March 2019.
  - Provided processing information for all Arkansas health plans. However, the spreadsheet provided had 123,872 individual BIN/PCN/Group ID combinations. Upon discussion with one of the pharmacies in our subset, auditors were informed that there was only one BIN/PCN/Group ID combination relevant to the State funded plan.
  - Processing information (BIN/PCN/Group ID) for ESI plans:
    - Summit
      - 020107/NS/WPKA

PHARMACY SUBSET

- Thirty-six (36) of the 100 pharmacy companies (representing 51 pharmacies), to whom data requests were sent provided meaningful responses (claims and/or contracts) to the data request.

- Pharmacies that responded to the data request represented a mix of independent pharmacies and regional pharmacy chains. *No* national chains responded to the request.
- Summary of responses provided:
    - Claims data - 51 pharmacies provided claims data with PBM payment information
    - DIR/Clawback data - Only one regional pharmacy chain was able to provide DIR/Clawback data
        - Multiple pharmacies contacted the auditors stating that the PBMs had locked the pharmacies out of accessing this information on their access portals.
    - PBM Contracts - Only 10 pharmacy companies provided copies of their PBM contract
        - Several pharmacies contacted the auditors stating that the PBMs had instructed them that their contracts were proprietary and that they were not allowed to share the contracts with auditors under threat of contract termination.

DATA NORMALIZATION

Data files from PBMs by carrier were uploaded to a secure Citrix ShareFile site for the auditors to analyze. All claims data sets were converted to Excel spreadsheets, if necessary. Claims data from each PBM were converted into a standard and consistent data layout and formatting.

Negative claims (reversals and rejections) were removed along with the matched positive claims to net only fully adjudicated claims. For the Optum claims set, a large number of reversed claims did not have an equal number of positive (e.g. processed) claims. As an example, RX number 129140 had 20 reversals at the same pharmacy on 3/8/2019, but no positive processed claim in the data set. This did not affect our analyses as there were net positive claims to match the pharmacy data set. However, this does affect the overall summary of net claims. After data normalization was performed, the individual pharmacy claims sets were combined into a single claims data set.

For the purposes of the differential pricing analysis, pharmacies in the PBM data set were classified as either an Independent (I), National Chain (N), or a Regional Chain (R).

An independent pharmacy was defined as a pharmacy that had 3 or less locations. A national chain was defined as a company with pharmacies equally distributed throughout the United States (e.g. CVS, Walgreens, Wal-Mart). A regional chain was defined as a pharmacy company not defined as a national chain with more than 3 locations in the state of Arkansas.

Claims from March 2019 were isolated from each of the PBM data sets for the Spread Pricing and DIR/Clawback Analysis.

DATA ANALYSIS APPROACH

During the audit analysis, it was discovered that a portion of claims information received from the health plans included claims that were outside the Arkansas Works plans. The auditors were able to obtain from the Arkansas All-Payer Claims Database (APCD) the percent of claims from each health plan that were applicable to Arkansas Works plans.

The APCD data was applied to the total data set of claims submitted by Blue Cross Blue Shield of Arkansas (CVS), Centene (CVS), Empower (CVS) and QualChoice (Optum) to estimate the actual number and total spend of AR Works claims. It should be noted that Summit (Express Scripts) participates in the PASSE program only and does not participate in AR Works.

While the auditors did not use the insurers' National Association of Insurance Commissioners (NAIC) Annual Statement data for the analysis, the NAIC statement information is available publicly and contains information regarding market penetration for pharmacy data.

DIFFERENTIAL PRICING

For each PBM data set, claims were calculated to the unit cost level for each drug product national drug code (NDC) (e.g. NDC 00597015230 - JARDIANCE TAB 10MG, Claim Quantity 90, Total paid = $1375.04, Calculated Unit Cost = 15.28 ($1375.04/90)) to accurately compare the amount paid to the pharmacy for each drug product. Claims for each drug vary by the quantity dispensed so the unit cost calculation normalizes the data for comparison of reimbursement across drugs and pharmacies.

The auditors categorized the pharmacies associated with each claim into "Pharmacy Type" categories to compare the reimbursement of the individual drug unit costs based upon the type of pharmacy. These categories were:

- National chain pharmacy.
- Regional chain pharmacy.
- Independent pharmacy.
- Specialty pharmacy, and
- Institutional pharmacy (e.g. hospital pharmacies and native American tribal pharmacies).

The focus of the differential pricing analysis was to compare the PBMs' reimbursement for each drug between national chain pharmacies, regional chain pharmacies, and independent pharmacies operating within Arkansas. Claims for specialty pharmacies and institutional pharmacies were excluded from the differential pricing analysis since the normal drug reimbursement for these types of pharmacies have inherent high volatility across pharmacies and by drug type.

Comparative analytics were completed based upon the pharmacy type (national chain pharmacies, regional chain pharmacies, and independent pharmacies) and the corresponding unit cost for each drug product dispensed across the pharmacies.

SPREAD PRICING

The individual PBM datasets from March 2019 were combined with the pharmacy data, matching claims based on prescription number, fill number and date filled. To identify the presence of "spread", the "total paid" to the pharmacy from the pharmacy claims data set was subtracted from the "total paid" to the pharmacy from the PBM claims data set. Any difference between the "total paid" numbers was defined as "spread".

Spread is reported both as a total amount, as well as the percentage of total paid of the claims in the matched data set. Percent of claims with spread pricing is also presented.

The pharmacy data set represents claims from a subset of pharmacies from a single month of the audit timeframe. The results from this subset analysis was extrapolated to estimate the total spread amount from January 1st through June 30th, 2019.

DIR/CLAWBACK

"DIR/Clawback Fees" was a data field in both the PBM and the Pharmacy data request. Claims with DIR reported were totaled and reported as the percentage clawed back compared to the total spent.

The pharmacy data set represents claims from a subset of pharmacies from a single month of the audit timeframe. The results from this subset analysis was extrapolated to estimate the total spread amount from January 1st through June 30th, 2019.

AUDIT RESULTS

DATA DEMOGRAPHICS

PBM DATA

The claims data submitted by the PBMs is summarized in Table 2 below.

Table 2. PBM Data Demographics (Claim Records)

PBM	CVS Caremark			OptumRx	Express Scripts
Health Plan	BCBSAR	Centene	Empower	QualChoice	Summit
Total Claims	1,626,536	705,177	144,476	318,724	110,003
Total Claims by Pharmacy Type					
Independent	490,998	196,380	55,121	73,001	40,757
Regional Chain	281,090	119,818	57,506	53,376	24,147
National Chain	833,393	380,040	29,865	184,860	42,096
Other	21,055	8,939	1,984	7,487	3,003

Claims from CVS Caremark-covered health plans accounted for most claims (85.16%) from Arkansas Works plans. Due to incomplete data, the reported claims were removed from the Express Scripts (6,207 claims) and OptumRx (70,208 claims).

PHARMACY DATA

The claims submitted by the pharmacies are summarized in Table 3 below.

Table 3. Pharmacy Data Demographics (Claim Records)

	All Plans	CVS Caremark			OptumRx	Express Scripts
		BCBSAR	Centene	Empower	QualChoice	Summit
Total Claims	32,257	16,600	5,427	3,470	3,901	1,730
Claims with Clawback Data	5,203	2,806	482	1,134	0	798

Fifty-one (51) pharmacies submitted a total of 32,257 claims for the timeframe of March 1st through March 31st, 2019. A small number of claims (1,129) were submitted by pharmacies that were from marketplace plans not part of Arkansas Works plans. These claims were excluded.

LIMITATIONS OF DATA:

- PBM Data.
  - There were zero DIR/Clawback fees reported by the PBMs for the audit timeframe.
- Pharmacy Data
  - Claims data received from the pharmacies represents a small sample size (1.7%) of the total audit claims data set.
  - No national chain pharmacies submitted claims data, so that section of retail pharmacies could not be evaluated.
  - Only one pharmacy company submitted DIR/Clawback data. That data set does not include any claims from OptumRx, so auditors are unable to evaluate DIR/Clawback results for OptumRx.

DIFFERENTIAL PRICING ANALYSIS RESULTS:

The results of the differential pricing analysis are summarized in Table 4 below. The analysis uses negative numbers to represent pharmaceutical pricing approaches that favor certain pharmacy types over another (e.g. favors National Chain Pharmacies over Independent Pharmacies).

Pharmacies participate in the PBMs pharmacy network by contractual agreement. The agreement defines the guaranteed average wholesale price (AWP) and maximum allowable cost (MAC) reimbursement rates in which the PBM will reimburse the pharmacy for claims submitted for PBM members. The PBMs agreements with pharmacies will vary in regard to the reimbursement rate guarantees based upon the number of pharmacies participating, estimated volume of PBM member claims processed and timing (i.e. when the agreement was signed). PBMs may apply different contractual language in the agreement with the pharmacy which allows the PBM to classify certain drug products differently (i.e. brand versus generic) and/or apply different MAC lists. Overall, the difference in reimbursement rates between pharmacies should be minimal, differing by only a few percentage points. The auditors consider differential reimbursement of 5% or greater to be material.

Table 4. Differential Pricing Analysis Summary

	CVS Caremark			OptumRx	Express Scripts
	BCBSAR	Centene	Empower	QualChoice	Summit
Independent vs National					
All Claims	-3.69%*	-3.69%*	-17.70%*	0.70%#	0.09%#
Brand Claims	-0.36%*	-0.36%*	-12.79%*	-12.74%*	-17.60%*
Generic Claims	-4.76%*	-4.76%*	-24.56%*	3.20%#	1.78%#
Specialty	-0.56%*	-0.56%*	-2.49%*	-20.51%*	N/A

*Independent Pharmacies were Paid Less than National Chains, # Independent Pharmacies were Paid More than National Chains

	CVS Caremark			OptumRx	Express Scripts
	BCBSAR	Centene	Empower	QualChoice	Summit
Independent vs. Regional					
All Claims	-0.30%*	-0.30%*	-8.86%*	-9.80%*	-18.86%*
Brand Claims	0.00%	0.00%	-26.44%*	-4.47%*	-2.63%*
Generic Claims	-0.54%*	-0.54%*	-5.20%*	-10.58%*	-20.18%*
Specialty	-2.89%*	-2.89%*	-1.38%*	-5.31%*	N/A

*Independent Pharmacies were Paid Less than Regional Chains, # Independent Pharmacies were Paid More than Regional Chains

	CVS Caremark			OptumRx	Express Scripts
	BCBSAR	Centene	Empower	QualChoice	Summit
Regional vs. National					
All Claims	-4.56%*	-4.56%*	-21.60%*	-4.66%*	-0.78%*
Brand Claims	0.58%#	0.58%#	-3.38%*	-8.99%*	-2.03%*
Generic Claims	-6.04%*	-6.04%*	-26.94%*	-3.84%*	-0.66%*
Specialty	-0.27%*	-0.27%*	-12.78%*	-6.26%*	N/A

*Regional Pharmacies were Paid Less than National Chains, # Regional Pharmacies were Paid More than National Chains

	CVS Caremark			OptumRx	Express Scripts
	BCBSAR	Centene	Empower	QualChoice	Summit
Independent vs. CVS-Owned					
All Claims	-0.71%*	-1.16%*	28.80%#	N/A	N/A
Brand Claims	-1.62%*	1.25%#	0.19%#	N/A	N/A
Generic Claims	-0.49%*	-1.73%*	33.34%#	N/A	N/A
Specialty	-0.44%*	-4.48%*	N/A	N/A	N/A

*Independent Pharmacies were Paid Less than CVS Pharmacies, # Independent Pharmacies were Paid More than CVS Pharmacies

For the BCBSAR and Centene plans (both CVS Caremark), the data set shows a small preference in pricing toward the National Chain and Regional Chain pharmacies over the Independent Pharmacies. The auditors consider the difference to be acceptable. However, the Regional Chain pharmacies were paid less (-6.04%) than National Chain pharmacies for generic claims which is considered material as the difference is greater than 5%.

For the Empower (CVS Caremark), QualChoice (OptumRx) and Summit (ESI) data sets, the pricing advantage to the larger pharmacy entities (i.e. National Chains) is much more pronounced versus Regional Chains and Independent Pharmacies. The auditors consider the difference to be material since it is greater than 5%.

Overall, the BCBSAR and Centene plans (both CVS Caremark) data sets demonstrated a small reimbursement difference based upon the pharmacy type which is considered normal and acceptable. The exception is Regional Chain pharmacies were paid less (-6.04%) than National Chain pharmacies for generic claims which is considered material as the difference is greater than 5%. Please refer to Table 4.

Empower (CVS Caremark), QualChoice (OptumRx), and Summit (ESI) almost always reimbursed national pharmacies at higher rates than the rates at which they reimbursed regional or independent pharmacies. Not only were national pharmacies reimbursed at higher rates, Table 4 illustrates that the difference in rates usually resulted in national pharmacies being compensated for the same drug at a rate often 5% higher, if not more than 5% higher, than the rate provided to regional or independent pharmacies.

The auditors also compared the reimbursement between Arkansas operating CVS Caremark owned pharmacies (CVS Pharmacies) versus Arkansas Independent Pharmacies to determine if CVS Caremark was reimbursing its' owned pharmacies more than locally owned and operated Arkansas pharmacies. The difference in reimbursement for the BCBSAR and Centene data sets

is considered acceptable. For the Empower data set the Independent Pharmacies were paid significantly more than the CVS Pharmacies.

LIMITATIONS OF ANALYSIS

- Auditors were unable to obtain copies of contracts between PBM and pharmacy to assess whether pricing is in line with individual pharmacies contracted pricing.
- No "specialty" indicator on ESI claims to assess differences in pricing.
- For CVS Caremark and OptumRx data set, the number of matching specialty NDC's between pharmacy types was extremely small.

SPREAD PRICING ANALYSIS

The results of the spread pricing analysis are summarized in Table 5 below by health plan and PBM.

Table 5. Arkansas Works/PASSE PBM Analysis Summary – Pharmacy Data Set March 2019

PBM	CVS Caremark			OptumRx	Express Scripts
Health Plan	BCBSAR	Centene	Empower	QualChoice	Summit
Total Matched Claims - Pharmacy Data	13,342	4,995	2,910	1,522	1,542
Claims w/ Spread	63	14	4	1	1,290
Total $ Spread	$8,299	$593	$65	$2	$29,363
Total PBM Spend	$669,469	$1,304	$227,558	$4.94	$160,976
% Spread	**1.24%**	**45.45%**	**0.03%**	**47.77%**	**18.24%**
% of Claims w/ Spread	**0.47%**	**0.28%**	**0.14%**	**0.07%**	**83.66%**

Overall, the auditors did not see significant spread pricing practices with CVS Caremark or OptumRx plans.

Conversely, there was significant spread pricing found in the ESI-administered PASSE plan. More than 83% of claims in the pharmacy data subset showed spread pricing practices. This spread accounted for more than an 18% difference between the amount that the health plan was charged and the amount the pharmacy was paid.

These results were extrapolated to the full claims set from the six-month audit timeframe to provide an estimate of spread pricing over the entire audit period. The results are summarized in Table 6 below.

Table 6. Arkansas Works/PASSE PBM Analysis Summary - January 1st-June 30th, 2019

PBM	CVS Caremark			Optum	Express Scripts
Health Plan	BCBSAR	Centene	Empower	QualChoice	Summit
Total Claims in Data Set	1,626,536	705,177	144,476	248,516	106,637
Total Health Plan Spend	$133,285,068	$52,894,989	$13,089,025	$14,637,357	$11,793,275
Average $/RX	$81.94	$75.01	$90.60	$58.90	$110.59
% AR Works	66.00%	67.00%	67.00%	66.00%	100%
Approximate RX's – ARW	1,073,514	472,469	96,799	164,021	106,637
Total Health Plan Paid ARW	$87,968,145	$35,439,642	$8,769,647	$9,660,655	$11,793,275
Approximate Claims w/ Spread	5,069	1,324	133	105	89,210
Estimated Total Spread Amount	**$5,149**	**$45,146**	**$3.46**	**$6,347.34**	**$1,799,632**
Percent of Total Spend	**0.004%**	**0.085%**	**0.000%**	**0.043%**	**15.26%**

LIMITATIONS OF ANALYSIS

- Claims data received from the pharmacies represents a small sample size (1.7%) of the total audit claims data set.
- No claims were submitted by any national chain pharmacies.

DIR/CLAWBACK PRICING ANALYSIS

The results of the DIR/Clawback pricing analysis are summarized in Table 7 below.

Table 7. Arkansas Works/PASSE PBM Analysis Summary – Pharmacy Data Set March 2019

PBM	CVS Caremark			Optum	Express Scripts
Health Plan	BCBSAR	Centene	Empower	QualChoice	Summit
Claims w/ DIR Reported (>/ $0.05)	2,319	400	891	0	592
Total Clawbacks Assessed	$12,224	$2,951	$73,957	0	$3,748
Total PBM Spend on Claims w/ DIR Fees	$124,820	$30,841	$7,241	0	$82,436
% Clawback Assessed	9.79%	9.57%	9.79%	N/A	4.55%

Only one pharmacy submitted DIR/Clawback information. There were no claims covered by OptumRx in this pharmacy's claims dataset. Therefore, no DIR/Clawback analysis can be completed for OptumRx.

Both CVS Caremark and ESI assessed DIR/Clawback fees on the pharmacies during the audit timeframe. Across the 3 Arkansas Works plans, CVS Caremark's average DIR/Clawback fees were 9.72% of the total amount paid by the applicable health plan. ESI's average DIR fees averaged 4.55% over the sample period.

These results were extrapolated to the full claims set from the 6-month audit timeframe to provide an estimate over the entire audit period. The results are summarized in Table 8 below.

Table 8. Arkansas Works/PASSE PBM Analysis Summary - January 1st-June 30th, 2019

PBM Health Plan	BCBSAR	CVS Caremark Centene	Empower	Optum QualChoice	Express Scripts Summit
Total Claims in Data Set	1,626,536	705,177	144,476	248,516	106,637
Total Health Plan Spend	$133,285,068	$52,894,989	$13,089,025	$14,637,357	$11,793,275
Average $/RX	$81.94	$75.01	$90.60	$58.90	$110.59
% AR Works	66.00%	67.00%	67.00%	66.00%	100%
Approximate RX's - ARW	1,073,514	472,469	96,799	164,021	106,637
Total Health Plan Paid ARW	$87,968,145	$35,439,642	$8,769,647	$9,660,655	$11,793,275
Estimated Total Clawback	**$8,614,934**	**$3,390,666**	**$858,560**	**N/A**	**$536,124**

LIMITATIONS OF ANALYSIS

- Claims data received from the pharmacies represents a small sample size (1.7%) of the total audit claims data set. Only one pharmacy submitted DIR/Clawback data for analysis, which further reduced the sample size.
- No DIR/Clawback data was available for OptumRx plans so no analysis could be performed on that PBMs pricing practices.
- No claims were submitted by any national chain pharmacies.

CONCLUSIONS

The differential pricing analysis showed that National Chain pharmacies were reimbursed more (defined as greater than 5% difference) than Regional Chain and Independent Pharmacies for the same drug product unit (i.e. tablet, capsule).

The spread pricing analysis showed that one of the 3 PBMs being audited, Express Scripts Inc., was employing significant spread pricing practices during the audit time frame. Specifically, ESI was charging the health benefit plan an estimated 15.26% more than was being paid to the pharmacies.

The DIR/"clawback" analysis showed that both CVS Caremark (9.71%) and Express Scripts Inc. (4.55%) assessed DIR or "clawback" fees to the pharmacy during the audit timeframe. OptumRx's clawback pricing could not be evaluated.

While the report focuses on several pharmaceutical pricing practices, it does not provide a complete picture of pharmacy costs and PBM compensation. There are a number of additional factors that impact PBM revenues and pharmacy reimbursements that were either outside of the scope of this report or unavailable due to the lack of PBM response. These additional factors include rebates, additional insurer fees, and pharmacy fees.

ASOP 41 DISCLOSURES

The Actuarial Standards Board (ASB), vested by the U.S.-based actuarial organizations [3], promulgates Actuarial Standards of Practice for use by actuaries when providing professional services in the United States.

Each of these organizations requires its members, through its Code of Professional Conduct [4], to observe the ASOPs of the ASB when practicing in the United States. ASOP No. 41 provides guidance to actuaries with respect to actuarial communications and requires certain disclosures which are contained in the following.

1. IDENTIFICATION OF THE RESPONSIBLE ACTUARY

The responsible actuaries are:

- Dave Dillon, FSA, MAAA, MS, Senior Vice President & Principal at Lewis & Ellis, Inc.

The actuaries are available to provide supplementary information and explanation.

2. IDENTIFICATION OF ACTUARIAL DOCUMENTS

The date of this document is July 27, 2020. The date (a.k.a. "latest information date") through which data or other information has been considered in performing this analysis is April 28, 2020.

3. DISCLOSURES IN ACTUARIAL REPORTS

- The contents of this report are intended for the use of the Arkansas Insurance Department. Any third party with access to this report acknowledges, as a condition of receipt, that they cannot bring suit, claim, or action against L&E, under any theory of law, related in any way to this material.
- Lewis & Ellis Inc. is financially and organizationally independent from the PBMs under examination. L&E is not aware of anything that would impair or seem to impair the objectivity of the work.
- The purpose of this report is to assist the AID with the limited financial examination of Pharmacy Benefit Managers.
- The responsible actuary identified above is qualified as specified in the Qualification Standards of the American Academy of Actuaries.

[3] The American Academy of Actuaries (Academy), the American Society of Pension Professionals and Actuaries, the Casualty Actuarial Society, the Conference of Consulting Actuaries, and the Society of Actuaries.
[4] These organizations adopted identical Codes of Professional Conduct effective January 1, 2001.

- Lewis & Ellis has reviewed the data provided for reasonableness but has not audited it. L&E nor the responsible actuaries assume responsibility for items that may have a material impact on the analysis. To the extent that there are material inaccuracies in, misrepresentations in, or lack of adequate disclosure by the data, the results may be accordingly affected.
- L&E is not aware of any subsequent events that may have a material effect on the findings.

4. ACTUARIAL FINDINGS

The actuarial findings of the report can be found in the body of this report.

5. METHODS, PROCEDURES, ASSUMPTIONS, AND DATA

The methods, procedures, assumptions, and data used by the actuary can be found in the body of this report.

6. ASSUMPTIONS OR METHODS PRESCRIBED BY LAW

This report was prepared as prescribed by applicable law, statutes, regulations, and other legally binding authority.

7. RESPONSIBILITY FOR ASSUMPTIONS AND METHODS

The actuary does not disclaim responsibility for material assumptions or methods.

8. DEVIATION FROM THE GUIDANCE OF AN ASOP

The actuary does not believe that material deviations from the guidance set forth in an applicable ASOP have been made.

APPENDIX 1. EXAMINER VERIFICATION

State of Texas)

)ss

County of Collin)

EXAMINER VERIFICATION

David Dillon being first duly sworn, upon his oath deposes and says; that he is an Examiner engaged by the Insurance Department of the State of Arkansas; that an examination was made of the affairs of:

Arkansas Health Plan	PBM
Arkansas Total Care	CVS Caremark
Celtic Insurance Company d/b/a/ Arkansas Health & Wellness	CVS Caremark
Empower Healthcare Solutions	CVS Caremark
QCA Health Plan	OptumRx
QualChoice Life and Health Insurance Company	OptumRx
Summit Community Care	Express Scripts (ESI)
USAble Mutual Ins Co d/b/a/ Arkansas Blue Cross Blue Shield	CVS Caremark

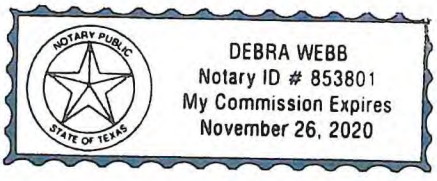
authorized under the laws of the State of Arkansas, pursuant to authority vested in a Certificate of Authority issued by Alan McClain, Insurance Commissioner of the State of Arkansas; that he was the Examiner of said examination and that the enclosed report of examination is a true and complete report.

David Dillon

Examiner in Charge

Subscribed and sworn before me this

27th Day of July, 2020.



Debra Webb

Notary Public

Appendix O

Management Response – Department of Human Services

The Arkansas Department of Human Services, Division of Medical Services (DMS) appreciates the opportunity to review and respond to the Special Report prepared by Arkansas Legislative Audit (ALA) regarding pharmacy benefit managers. In this response, DMS details areas of the report where issues were identified or DMS believes there is a discrepancy in what is reported.

Magellan is Pharmacy Benefits Administrator:

In footnote 4 located on page 6, Magellan is referred to as a pharmacy benefits manager (PBM), while acknowledging that no funds flow through Magellan to providers or to the State.

DMS disagrees with characterization of Magellan as a Pharmacy Benefits Manager in the same capacity as PBMs addressed by the PBM licensure Act found in A.C.A. § 23-92-500 et seq. As noted throughout the report, Magellan does not engage in any of the prohibited practices, as it is not the fiscal agent for the state. All claims are paid through the Medicaid MMIS billing system, which is operated by Arkansas Medicaid's fiscal agent, Gainwell Technologies. Therefore, DMS contends that Magellan is a Pharmacy Benefits Administrator (PBA).

Identified Arkansas Works Issues:

There were some issues identified regarding Arkansas Works. However, it is also noted in the report that the Qualified Health Plans (QHPs) are regulated by the Arkansas Insurance Department, and that DMS purchases health care coverage for Arkansas Works eligible Medicaid clients through the QHPs. The coverage purchased is the same as that made available to individuals in the marketplace under the Affordable Care Act (ACA). Additionally, on page 26, ALA notes that they were unable to determine which fees are related to Arkansas Works, which is funded by Medicaid dollars, and which are related to individual marketplace.

Identified PASSE Issues:

Page 14 notes two issues in the Provider Led Arkansas Shared Savings Entity (PASSE) program:

Issue 1 states that "[a]lthough DHS indicated that many of the subcontracts were hand delivered for approval, the Agency was not able to provide documentation of approval of any of the PBM contracts for the three PASSEs in effect from March 1, 2019 until June 30, 2019. In addition, the Agency was able to provide documentation (i.e., an unsigned contract) of only one PBM contract for one of the PASSE entities."

DMS Response: DMS is implementing controls to obtain all subcontracts required under the Agreement.

Issue 2 states that "[b]ased on ALA staff review of documentation available from DHS, Empower and Arkansas Total Care did not identify any spread pricing in their submissions to DHS. However, documentation for the Summit PASSE, which utilized ExpressScripts as its PBM, indicated spread pricing. ALA staff calculation of spread pricing, as shown in these submissions, indicated a total of $2,109,368. Ark. Code Ann. § 4-88-803 prohibits spread pricing by state-funded pharmacy benefits, and the impact of this issue should be considered when addressing future capitation rate calculations."

As this report acknowledges, the law that prohibits spread pricing went into effect on July 24, 2019. All claims analyzed for this report pre-date that law. For the PASSE's, this report analyzed claims dating from March 1, 2019, to June 30, 2019. The PASSE's were aware that spread pricing would be prohibited by the new law. DMS Pharmacy Unit continues to monitor for differences between the amount paid to the pharmacy and the amount charged to the plan by its PBM.

On pages 23-24, the report details that some PASSE claims were not appropriately submitted to the All Payors Claims Database (APCD). This process is regulated by AID and the PASSEs submit claims directly to the APCD, so DMS has limited oversight into this process.

On page 29, the report notes there were claims noted with clawback data. Specifically, there was an estimated total of $858,560 in clawbacks for Empower, $536,124 for Summit, and $3,390,666 for Centene (Arkansas Total Care). The current PASSE Agreement does not address clawback or some of the other practices described in the special report, such as direct and indirect renumeration. DMS is investigating whether to address such items in the PASSE Agreement, as well as other items to address identified issues.

Appendix P

Management Response – Department of Transformation and Shared Services – Employee Benefits Division

A. Objective 2; EBD; Pharmacy Reimbursements

"Based on questions submitted by ALA staff, MedImpact stated that it may perform periodic reconciliations of payments to pharmacies to determine compliance with pharmacy contract defined terms, and these periodic reconciliations could include EBD prescription claims. As stated by MedImpact, this reconciliation and the inclusion of EBD claims, however, will vary depending on the individual contracts between MedImpact and the specific pharmacy."

Response: EBD, per contract with Medimpact, does not allow "effective" pricing or payment reconciliations to pharmacies. Per ALA, Medimpact has stated that EBD claims may be included in outside contracts regarding payment reconciliations, but EBD does not have authority outside of its own contract. EBD is not aware of any instances in which payment reconciliations have occurred in relation to the Plan.

B. Reporting of Pharmacy Claims to the Arkansas All-Payer Claims Database (APCD/ Arkansas Center for Health Improvement (ACHI)

Finding #1: ALA staff tested 40 claims for the period of January 1, 2018 through June 30, 2019, prior to the reporting requirement under Ark. Code Ann. 4-88-803. Of these 40 claims, 38 were appropriately reported to APCD/ACHI in the correct amount, and 2 claims could not be found in the APCD/ACHI system. After further investigation and assistance from EBD, it was determined that the 2 claims could not be found due to a programming error. As a result of this error, no claims submitted to the PBM on the first day of each month were reported to APCD. EBD began fixing this issue immediately upon being informed of it during the course of fieldwork.

Response: In the original process, EBD would receive prescription claims data from MedImpact at approximately 3:00am each day for the previous days' claims. Additionally, EBD's data management vendor, Mainstream, would provide prescription claims detail to APCD/ACHI on the first calendar day of each month. A timing issue was identified between the file transfers from MedImpact and Mainstream that resulted in the absence of two claims. This data transfer process was adjusted immediately to resolve this gap and to ensure all claims were transferred to APCD/ACHI.

C. Spread Pricing Prohibited for State-funded Plans

No Findings

D. Co-pay Clawback

No Findings

E. Non-preferential Reimbursement Treatment of Affiliated Pharmacies

Finding #2: ALA's dataset of claims analyzed revealed 2,048 instances where non-affiliated pharmacies were reimbursed less than the affiliated pharmacy (e.g. MedImpact Direct). Of the 2,048 instances, 132 instances involved claims for different drugs within the same class.

Response: ALA's evaluation of the claims dataset employed Medispan, a propriety drug database grouper product that is used to appropriately categorize all drug products. Medispan, using its propriety intellectual property, assigns each drug a 14-digit Generic Product Indicator (GPI) value. This 14-digit number is broken into 2-digits segments. The first two digits of a GPI number identifies the broadest drug category in which the individual drug belongs. The next two digits narrows the categorization to the drug's pharmacological category and the subsequent 2-digit segments progress to the individual drug name, strength, dosage form/route of administration, etc. Ultimately, the 14-digit GPI number provides the most specificity of description for any given drug.

With most drug categories (e.g. statins), specific medications within the category would differ in GPI value beginning at the GPI-6 level. GPI-8 and higher further segregate individual drugs (e.g. Crestor, Lipitor, Zocor, etc.) into specific GPI-10, 12, and 14 subgroups. Any given product, (e.g. Crestor 40mg tablets) will have its own GPI-14 designation. It is important to know in this specific example that Crestor 40mg tablet AND all generic versions of rosuvastatin 40mg tablets will possess the same GPI-14 value.

In the case of non-drug categories, (e.g. blood glucose test strips), it is common to group similar products in the same GPI classification as such products possess little notable differences. Therefore, a variety of brands of test strips manufactured by multiple companies exist in the same GPI category and the reimbursement comparison in this audit would have been across different brand-name products – which was acknowledged by ALA in the report. ALA's report indicated "the majority of these exceptions occurred when MedImpact Direct received a higher per unit reimbursement for Contour Next test strips than non-affiliated pharmacies received for non-Contour Next test strips. This outcome would be expected since such products would have been produced by different manufacturers.

Finding #3: ALA staff noted 346 additional instances in which the exact same national drug code was dispensed at both MedImpact Direct and non-affiliated pharmacies on the same date.

Response: The national drug code (NDC number) for a particular drug contains 11 digits. The first 5 digits identify the manufacturer, the next 4 digits identify the drug, and the last 2 digits pertain to the specific package size. As acknowledged by ALA, the packages evaluated included the same first 9 digits (manufacturer and drug) of the NDC, but not the last 2 digits (package size). Larger package sizes (e.g. 1,000s) tend to have a lower price/unit value than smaller package sizes. In the example provided in the evaluation, the drug dispensed at MedImpact Direct in the 24-unit quantity had a higher per-unit cost than the 240-unit prescription dispensed at the non-affiliated pharmacy. This finding would normally be expected.

*EBD, per contract with MedImpact, does not allow the vendor to price claims differently for any affiliated pharmacy. With all variables in a prescription drug claim being equal, EBD is not aware of any pricing discrepancies.

F. Non-preferential Cost Sharing Policies for Select Pharmacies

No Findings


LEGISLATIVE AUDIT
REGNAT POPULUS
MERCY
JUSTICE
ARKANSAS