OFFICE OF THE AUDITOR GENERAL

May 17, 2023
Performance Audit
Report Highlights

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

Performance Audit of the

Administration of Pharmacy Benefit Managers

Background:

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

Key Findings:

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

Key Recommendations:

The audit report contains five recommendations:

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

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

Report Digest

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

Digest Exhibit 1
ASSESSMENT OF AUDIT DETERMINATIONS

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

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

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

Background

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

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

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

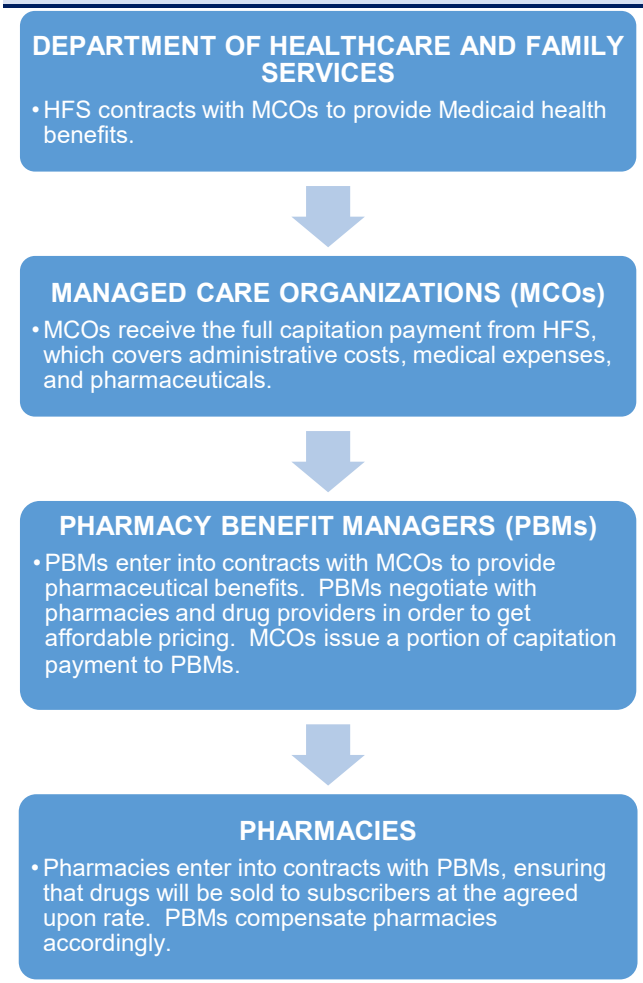
compliance with State and federal Medicaid regulations. HFS requires MCOs to offer at least the same set of services available to the fee-for-service population.

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

Pharmacy Benefit Managers

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

Digest Exhibit 2
PBM FUNDING PROCESS



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

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

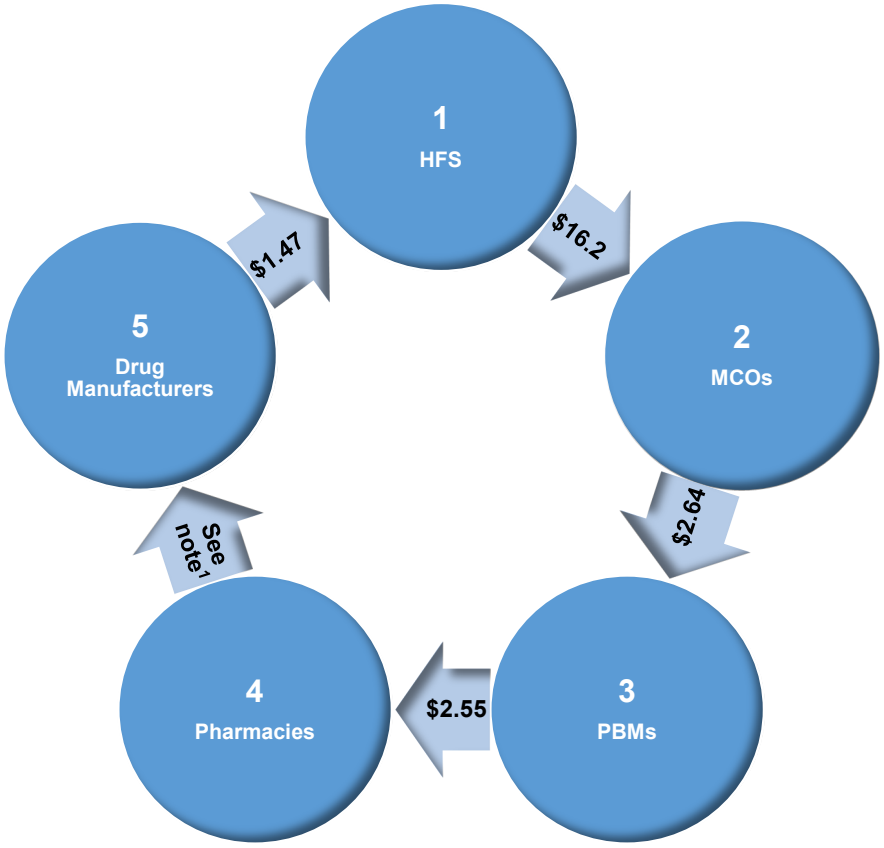
Digest Exhibit 2 flowcharts the PBM funding process. All MCOs in the State subcontract with at least one PBM. For instance, Aetna subcontracts with CVS Caremark as its PBM. Other PBMs may be subcontracted for long-term care or specialty drugs. Furthermore, MCOs might also own the PBM or pharmacy with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

Pharmaceutical Distribution and Payments

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

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

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



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

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

State and Federal Funds and Reimbursements

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

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

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

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

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

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

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

Contracts

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

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

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

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

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

HFS Oversight of Contracts and PBMs

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

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

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

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

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

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

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

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

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

Reimbursement Practices and Rates

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

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

Reimbursement Price Example

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

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

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

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

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

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

Affiliations

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

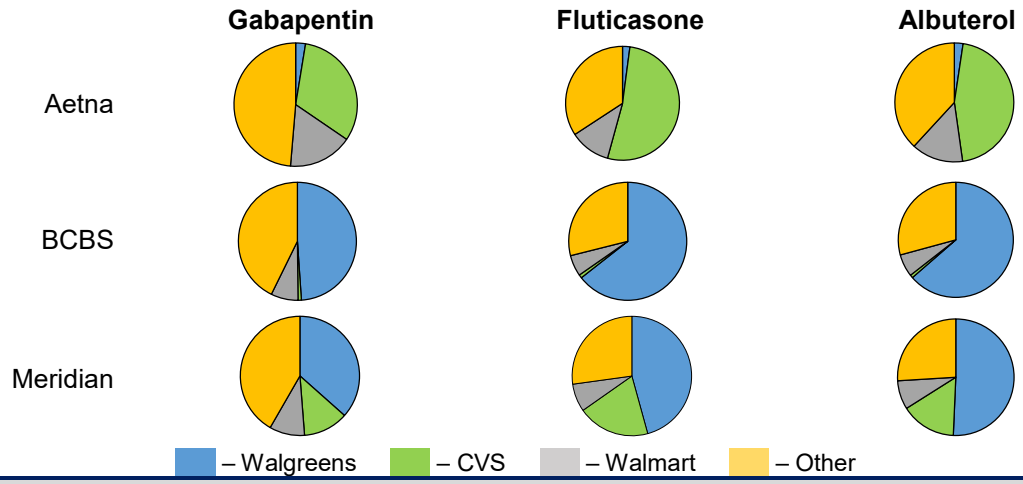
- **Aetna** - In November 2018, CVS acquired Aetna. CVS Caremark serves as the PBM for Aetna. As disclosed by Aetna, it is affiliated with the PBM (Caremark) and CVS network pharmacies.
- **Blue Cross Blue Shield** - Prime Therapeutics serves as the PBM for Blue Cross Blue Shield, which the MCO partially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

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

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

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

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



Source: Department of Healthcare and Family Services encounter data.

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

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

Audit Recommendations

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

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

SIGNED ORIGINAL ON FILE

JOE BUTCHER
Division Director

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

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:SAW