Audit Report

Managed Care Organization Reimbursements to Pharmacy Benefit Managers

Superior HealthPlan, Inc. and
Superior HealthPlan Network

May 28, 2021
OIG Report No. AUD-21-012

Inspector General

Texas Health and Human Services

HHS OIG
TEXAS HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WHY OIG CONDUCTED THIS AUDIT

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of Superior. The audit focused on reimbursements for prescription expenses under the Uniform Managed Care Contract (UMCC). In its 2019 FSRs, Superior reported serving an average of 1,032,184 Medicaid and CHIP members each month during the year, for which it received more than a billion dollars in pharmacy capitation payments.

The audit objective was to determine whether Superior had controls in place to ensure its payments to its subcontracted PBM (a) were based on actual amounts paid to pharmacies, (b) were accurately reported to the state, and (c) complied with other applicable requirements related to spread pricing. The scope covered Medicaid and CHIP pharmacy benefit services provided by Superior and its subcontracted PBM for state fiscal year 2019.

WHAT OIG RECOMMENDS

Superior should (a) accurately report pharmacy benefit transactions on its FSRs, (b) work with HHSC Financial Reporting and Audit Coordination to determine the appropriate method of classifying pharmacy benefit transactions on its FSRs and determine the amounts to report on its 2019 FSRs, and (c) strengthen its policies and procedures for FSR reporting.

MANAGEMENT RESPONSE

Superior indicated it would work with HHSC Financial Reporting and Audit Coordination to ensure it accurately reports discount guarantees, per-claim credits, and rebates on future FSRs.

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MANAGED CARE ORGANIZATION REIMBURSEMENTS TO PHARMACY BENEFIT MANAGERS

Superior HealthPlan, Inc. and Superior HealthPlan Network

WHAT OIG FOUND

Superior HealthPlan Inc. and Superior HealthPlan Network (Superior) had controls in place to ensure that reimbursements to Envolve Pharmacy Solutions, Inc. (Envolve), Superior's pharmacy benefit manager (PBM), for Medicaid and Children's Health Insurance Program (CHIP) prescription expenses were (a) based on actual amounts paid to pharmacies for dispensing fees and ingredient costs and (b) accurately reported to the state on Superior's financial statistical reports (FSRs) and in its encounter data. Superior accurately reimbursed Envolve for the actual amounts paid to pharmacies for dispensing fees and ingredient costs, and Superior accurately reported those reimbursements on its 2019 FSRs and in its encounter data. For 2019, Superior reported prescription paid claims expense of $881,811,438 on its 334-day FSRs.

However, Superior did not report other payments that affect its overall reported cost of prescriptions as required, which overstated pharmacy-related expenses on its FSRs. In addition, Superior incorrectly classified other reported expenses on its FSRs.

Specifically, on its 2019 FSRs, Superior:

- Did not report the fiscal year 2019 portion of $2,074,063 in discount guarantee payments it received. Discount guarantee payments are calculated payments that offset portions of Superior's reported cost of prescriptions in excess of contractually determined market rates.
- Incorrectly classified $10,108,911 in payments for per-claim credits and rebates as recoveries from third-party insurers. These include per-claim credits that Superior receives for certain claims processed by Caremark PCS Health, L.L.C. (Caremark) and manufacturer rebates that Superior receives for certain home health supplies.

The FSRs are the primary statements of financial results that the managed care organizations (MCOs) submit to the Texas Health and Human Services Commission (HHSC). The reports provide (a) the basis for calculating the amount an MCO may owe the state through profit-sharing experience rebates and (b) a key source of claims and administrative expense information used to set the amount of capitation paid to MCOs. Overstating expenses on FSRs can affect HHSC's ability to understand the components of Superior's income and expenses, and could result in increased pharmacy capitation payments, and decreased profit-sharing through experience rebates that Superior may pay to the state.

BACKGROUND

HHSC requires each MCO to subcontract with a PBM to process prescription claims and administer its prescription drug program. The state also requires MCOs to base their reimbursements to their PBMs on the actual amounts paid to pharmacies for dispensing fees and ingredient costs. This does not prohibit the MCO from paying the PBM reasonable administrative and transactional costs. These requirements prohibit the practice known as spread pricing. Spread pricing exists when the amount the MCO pays to the PBM for prescription claims costs differs from the amount the PBM pays to the pharmacy.

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INTRODUCTION

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior). The audit focused on reimbursements for Medicaid and Children's Health Insurance Program (CHIP) prescription expenses under the Uniform Managed Care Contract (UMCC).

Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31. For state fiscal year 2019, the period is September 1, 2018, through August 31, 2019.

Superior is a managed care organization (MCO) contracted by the Texas Health and Human Services Commission (HHSC) to provide comprehensive health care services to its members, including prescription drugs. The managed care contracts relevant to this audit include the Uniform Managed Care Contract, the State of Texas Access Reform (STAR) Kids Contract, the STAR Health Contract, the STAR+PLUS Expansion Contract, the STAR+PLUS Medicaid Rural Service Area (MRSA) Contract, and the CHIP Rural Service Area Contract. For the purpose of this report, the Uniform Managed Care Contract is used for referencing contract requirements. See Appendix A for a map of Texas areas where Superior provides services.

Under the managed care model, MCOs receive monthly capitation payments for each member enrolled. In its 2019 financial statistical reports (FSRs), Superior reported serving an average of 1,032,184 Medicaid and CHIP members each month during the year. Table 1 summarizes Superior's pharmacy capitation payments received and expense information for 2019.

Table 1: Summary of Superior's Reported Information for 2019

FSR-Reported Information	Amount
Pharmacy Capitation Payments Received	$ 1,012,639,646
Prescription Expenses (excluding PBM Administrative Fees)	866,842,059
PBM Administrative Fees	22,111,351

Source: Superior's 2019 334-day FSRs[1]

HHSC requires each MCO, including Superior, to subcontract with a pharmacy benefit manager (PBM) to process prescription claims and administer its prescription drug program. The state also requires MCOs to base their reimbursements to their PBMs on the actual amounts paid to pharmacies for dispensing fees and ingredient costs. This does not prohibit the MCO from paying

[1] According to HHSC, the state fiscal year 2019 334-day FSRs were not final at the time of this audit. Draft reports were used for the purposes of this audit.

the PBM reasonable administrative and transactional costs. These requirements prohibit the practice known as spread pricing. Spread pricing exists when the amount the MCO pays to the PBM for prescription claims costs differs from the amount the PBM pays to the pharmacy.[2]

MCOs are required to submit encounter data and FSRs to HHSC. HHSC uses the information reported in its processes for calculating (a) capitation payments to MCOs, including pharmacy capitation payments, and (b) experience rebates.[3]

- Encounter data—MCOs submit encounter data to HHSC on a monthly basis. An encounter is a covered service or group of covered services delivered by a provider to a member during a visit between the member and provider. The encounter data contains detailed member, provider, procedure, and payment information for services provided to Medicaid and CHIP clients. Encounter data is a key source of claims expense information used to set the capitation payments to MCOs.

- FSRs—MCOs submit FSRs quarterly and annually. Those reports are the primary statements of financial results that the MCOs submit to HHSC. The reports provide (a) the basis for calculating the amount an MCO may owe the state through profit-sharing experience rebates and (b) a key source of claims and administrative expense information used to set the amount of capitation paid to MCOs. The cost of prescriptions, as represented in the encounter data, is reported on the FSRs as prescription paid claims expenses.

[2] Centers for Medicare and Medicaid Services, "CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers" (May 15, 2019), https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not (accessed Apr. 13, 2021).

[3] An "experience rebate" is the portion of the MCO's net income before taxes that is shared with the state based on profit-sharing provisions in HHSC's contracts with the MCO.

Superior, a subsidiary of Centene Corporation (Centene), contracts with Envolve Pharmacy Solutions, Inc. (Envolve), which is also a subsidiary of Centene, as its PBM. Under Envolve, CaremarkPCS Health, L.L.C. (Caremark) provides certain services, including managing networks of pharmacies and claims administration, through contracts with another Centene subsidiary.[4] See Appendix A for an illustration of Superior's organizational structure related to Superior's pharmacy services. See the text box for a description of the services provided by each entity.

Envolve performs pharmacy services for Superior, including:

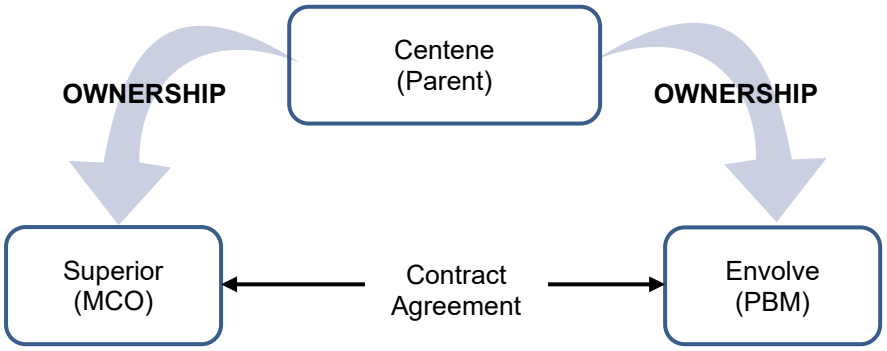
- Benefits management
- Prior authorization
- Appeals
- Eligibility management
- Utilization management

Caremark performs pharmacy services, under Envolve, including:

- Claims processing
- Pharmacy network administration
- Rebate management

Figure 1 illustrates the relationships among Centene, Superior, and Envolve.

Figure 1: Relationships Among Centene, Superior, and Envolve



Source: OIG Audit

Objective and Scope

The audit objective was to determine whether Superior had controls in place to ensure its payments to its subcontracted PBM were based on actual amounts paid to pharmacies for dispensing and ingredient costs, were accurately reported to the state in its FSRs and encounter data, and complied with other applicable requirements related to spread pricing.

The audit scope covered Medicaid and CHIP pharmacy benefit services provided by Superior and its subcontracted PBM for the period from September 1, 2018,

[4] Caremark provides services to Envolve through its contract with Health Net Pharmaceutical Services (Health Net), a subsidiary of Centene. Health Net is not involved in the delivery of pharmacy benefit services discussed in this report. See Appendix A for more information.

through August 31, 2019, under the STAR, STAR+PLUS,[5] STAR Kids, STAR Health, and CHIP programs. The audit included a review of Superior's internal control as well as testing of controls that were significant within the context of the audit objectives.

Methodology

Audit fieldwork was conducted from June 2020 through March 2021. The audit methodology included conducting interviews with Superior's management and staff; reviewing Superior's contracts and policies and procedures; collecting, reviewing, and analyzing Superior's FSRs, encounter data, claims data, and supporting financial data; and performing selected tests and other procedures, including:

- Reviewing Superior's system of internal controls, including components of internal control,[6] within the context of the audit objectives.
- Reviewing audits and supporting information that Envolve uses to ensure Caremark's claims data is reliable.
- Testing a sample of Envolve's weekly payments to Caremark to determine whether payments are supported, accurate, and appropriately reviewed.
- Reviewing Superior's general ledger to determine whether:
    - Pharmacy-related transactions were accurately reported on Superior's FSRs and in Superior's encounter data.
    - Superior accurately reimburses Envolve.
- Reconciling Superior encounter data to Caremark claims data with service dates in 2019.
- Tracing significant prescription expense-related fields on Superior's FSRs to the encounter data.
- Reviewing supporting documentation for Superior's FSRs to ensure the FSRs are supported and were appropriately prepared.
- Testing a sample of Caremark's claims to determine whether they are supported and accurately reflect the amount paid to the pharmacy.

[5] Pharmacy benefit services provided under the STAR+PLUS Medicare-Medicaid Plan are outside the scope of the audit.

[6] For more information on the components of internal control, see the United States Government Accountability Office's "Standards for Internal Control in the Federal Government," (Sept. 2014), https://www.gao.gov/assets/gao-14-704g.pdf (accessed Apr. 16, 2021).

OIG Audit determined that the data used in this audit were sufficiently reliable for the purposes of the audit. Details about the testing methodology are given in Appendix B.

OIG Audit presented audit results, issues, and recommendations to Superior in a draft report dated May 14, 2021. Superior provided a management response indicating it would work with HHSC Financial Reporting and Audit Coordination (FRAC) to ensure it accurately and completely reports discount guarantees, per-claim credits, and rebates it received on its FSRs. Superior's management response is included in the report following the issue and is reproduced in full in Appendix C.

Criteria

OIG Audit used the following criteria to evaluate the information provided:

- Uniform Managed Care Contract, v. 2.26 (2018) through v. 2.28 (2019)
- STAR Health Contract, v. 2.7 (2018) through v. 2.9 (2019)
- STAR Kids Contract, v. 1.7 (2018) through v. 1.9 (2019)
- STAR+PLUS Expansion Contract, v. 1.30 (2018) through v. 1.32 (2019)
- STAR+PLUS Medicaid Rural Service Area Contract, v. 1.15 (2018) through v. 1.17 (2019)
- CHIP Rural Service Area Contract, v. 1.24 (2018) through v. 1.26 (2019)
- Uniform Managed Care Manual, Chapter 2.2, v. 2.8 (2016)
- Uniform Managed Care Manual, Chapter 5.3.1.60, v 2.1 (2018)
- Uniform Managed Care Manual, Chapter 5.3.1.70, v 2.1 (2018)
- Uniform Managed Care Manual, Chapter 5.3.1.76, v 2.1 (2018)
- Uniform Managed Care Manual, Chapter 5.3.1.80, v 2.1 (2018)
- Uniform Managed Care Manual, Chapter 5.3.1.82, v 2.1 (2018)
- Uniform Managed Care Manual, Chapter 5.3.1.84, v 2.0 (2018)
- Uniform Managed Care Manual, Chapter 6.1, v. 2.6 (2018) through v. 2.7 (2019)

Auditing Standards

Generally Accepted Government Auditing Standards

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

AUDIT RESULTS

Superior had controls in place to ensure its reimbursements to Envolve were (a) based on actual amounts paid to pharmacies for dispensing fees and ingredient costs and (b) accurately reported to the state on its FSRs[7] and in its encounter data.

For 2019, Superior accurately reimbursed Envolve for the cost of pharmacy benefits, including the actual amounts paid to pharmacies for dispensing fees and ingredient costs, as required. Additionally, Superior accurately reported the actual amounts paid by its claims administrator, Caremark, to pharmacies for dispensing fees and ingredient costs on its FSRs and in its encounter data. However, Superior did not report on its FSRs other payments that affect its overall reported cost of those prescriptions, as required.

Specifically, Superior did not report the fiscal year 2019 portion of $2,074,063 in discount guarantee payments it received from Envolve. As a result, Superior's expenses on its FSRs were overstated, which could result in increased pharmacy capitation payments and decreased profit-sharing through experience rebates that MCOs may pay to the state.

Superior also incorrectly classified $10,108,911 it received from Envolve. Incorrectly classifying these payments did not affect Superior's overall net cost of prescriptions, which is used in the calculation of pharmacy capitation payments and experience rebates. However, incorrectly classifying expenses on its FSRs affects HHSC's ability to understand the components of the MCOs' income and expenses.

The following sections detail the results of this audit. OIG Audit communicated other, less significant findings to Superior separately in writing.

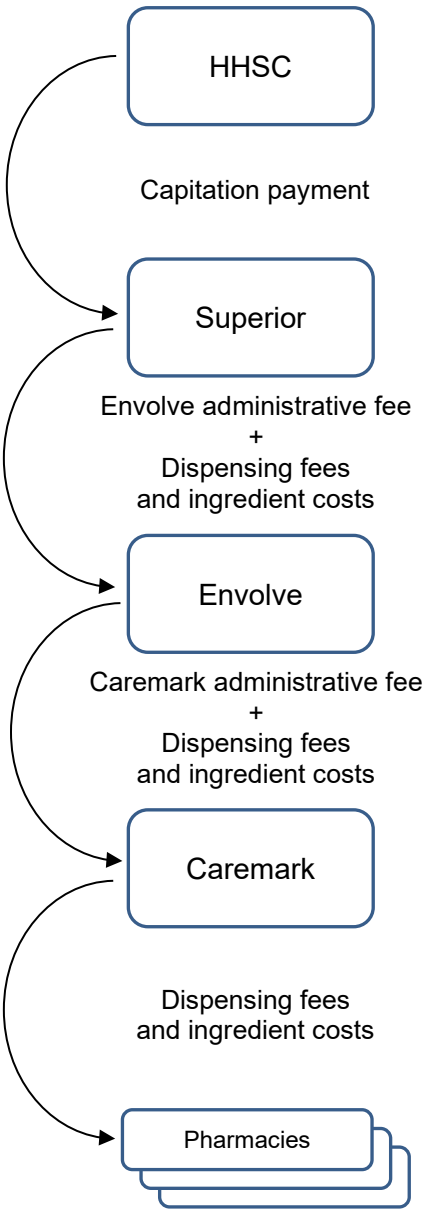
[7] For 2019, Superior reported FSRs to HHSC for all programs listed in the scope of this report and for all service delivery areas listed in Appendix A of this report. All references to Superior's 2019 FSRs in the Audit Results include these 30 reports, as well as Superior's Combined Administrative and Quality Improvement FSR.

PAYMENTS BASED ON ACTUAL AMOUNTS FOR DISPENSING FEES AND INGREDIENT COSTS

For 2019, Superior accurately reimbursed Envolve for the amounts paid to pharmacies for dispensing fees and ingredient costs.

Both Envolve and Caremark receive an administrative fee in addition to payments for the amounts paid to pharmacies for dispensing fees and ingredient costs. Figure 2 describes the contracted reimbursement processes for dispensing fees and ingredient costs from Superior to the pharmacies.

Figure 2: Superior's Pharmacy Payment Structure



Source: OIG Audit

Envolve relies on reports by third-party auditors covering controls over Caremark's claims processing system to ensure the accuracy of Caremark's reported payments to pharmacies for dispensing fees and ingredient costs. During 2019, Envolve obtained and reviewed these reports. OIG Audit tested a sample of 36 claims covering $1,257,446 in dispensing fees and ingredient costs. For the sampled claims, the amount recorded in Caremark's claims system was accurate and supported.

Envolve reimburses Caremark for the amounts paid to pharmacies for dispensing fees and ingredient costs on a periodic basis. Envolve performs a documented review of Caremark's invoices and supporting documentation for each payment, including comparing the invoiced claims to information from Caremark's claims processing system. For all 9 payments tested, or 19 percent of the 48 payments during 2019, the payments were supported, and Envolve appropriately reviewed and accurately reimbursed Caremark for the actual amounts paid to pharmacies for dispensing fees and ingredient costs for services covered by Superior, in accordance with its policies and procedures. Additionally, for each of

the payments tested, Superior accurately recorded the passed-through pharmacy-related expenses in its general ledger.

Throughout the year, Superior and Envolve, both subsidiaries of Centene, record pharmacy-related payments to Caremark on their general ledgers. Annually, Superior and Envolve settle their intercompany balance for all pharmacy-related costs. OIG Audit verified that other pharmacy-related costs on Superior's general ledger were supported and that Superior accurately reimbursed Envolve for pharmacy-related services recorded on its general ledger.

REPORTING CLAIMS COSTS

Superior accurately and completely reported both (a) its pharmacy claims for 2019 in its encounter data reported to HHSC and (b) its pharmacy encounters on its annual 334-day FSRs. Specifically:

- As of August 2020, Superior had reported $883,582,630 in pharmacy encounters with dates of service in 2019. Based on a reconciliation of Superior's claims to encounters, Superior accurately and completely reported its pharmacy claims to HHSC in its encounter data, as required by UMCC[8] and the Uniform Managed Care Manual (UMCM).[9]

- Superior reported prescription paid claims expense of $881,811,438[10] on its 334-day 2019 FSRs. Based on a reconciliation of Superior's encounters to its paid claims expense on its FSRs, Superior accurately and completely reported its pharmacy claims to the state on its FSRs, as required.[11]

[8] Uniform Managed Care Contract, Attachment B-1, § 8.1.18.1, v. 2.26 (Sept. 1, 2018) through v. 2.28 (Mar. 1, 2019).

[9] Uniform Managed Care Manual, Chapter 2.2, v. 2.8 (Nov. 1, 2016).

[10] The primary difference between the pharmacy encounter data and the prescription paid claims expense on Superior's FSRs is that claims for services directly reimbursed by HHSC are included in encounter data but not paid claims expenses, and those services are not considered in the calculation of capitation payments.

[11] Uniform Managed Care Manual, Chapters 5.3.1.60, 5.3.1.70, 5.3.1.76, 5.3.1.80, and 5.3.1.82, v. 2.1 (Dec. 15, 2018).

OTHER REQUIREMENTS RELATED TO REPORTING

While Superior accurately reported the amounts reimbursed to Envolve for prescription dispensing fees and ingredient costs on its FSRs, the UMCM requires MCOs to report other amounts affecting the cost of those prescriptions to the MCO beyond those reimbursed to pharmacies for dispensing fees and ingredient costs. Superior did not accurately or completely report other payments or credits received from Envolve that affect its reported cost of those prescriptions, as required.

Issue 1: Superior Did Not Accurately or Completely Report Payments that Affect Its Reported Cost of Prescriptions

In addition to reimbursements for prescription dispensing fees and ingredient costs on its FSRs, the UMCM requires MCOs to report receipts or reduction of expenditure-type transactions that offset or reduce expense items, such as purchase discounts, rebates, and adjustments of overpayments or erroneous charges, to the extent that these credits relate to allowable costs.[12] These credits do not affect the amounts paid to pharmacies for dispensing fees and ingredient costs or the related amounts reported on the FSRs and in the encounter data. These credits can affect HHSC's (a) ability to understand the components of the MCOs' income and expenses, (b) pharmacy capitation payments, and (c) profit-sharing through experience rebates that MCOs may pay the state. The UMCM also requires MCOs to submit FSRs based on the date of service of underlying transactions, rather than the date paid.[13] For prescription claims with dates of service in 2019, Superior received multiple types of credits offsetting the cost of those claims.

For 2019, these credits included:

- Per-claim discounts for certain claims. Superior receives a specified, per-claim reimbursement for certain categories of claims processed by Caremark.
- Recoveries from third-party insurers. Superior receives payments for claims that should have been paid through a third party, including health insurers, that were previously paid by Superior.

Superior's Receipts for Fiscal Year 2019

Per-claim credits	$9,169,313
Third-party insurers	$5,044,990
Rebates	$939,598

[12] Uniform Managed Care Manual, Chapter 6.1, v. 2.6 (May 15, 2018) and v. 2.7 (May 29, 2019).

[13] Uniform Managed Care Manual, Chapters 5.3.1.60, 5.3.1.70, 5.3.1.76, 5.3.1.80, and 5.3.1.82, v. 2.1 (Dec. 15, 2018) and Chapter 5.3.1.84, v. 2.0 (Dec. 15, 2018).

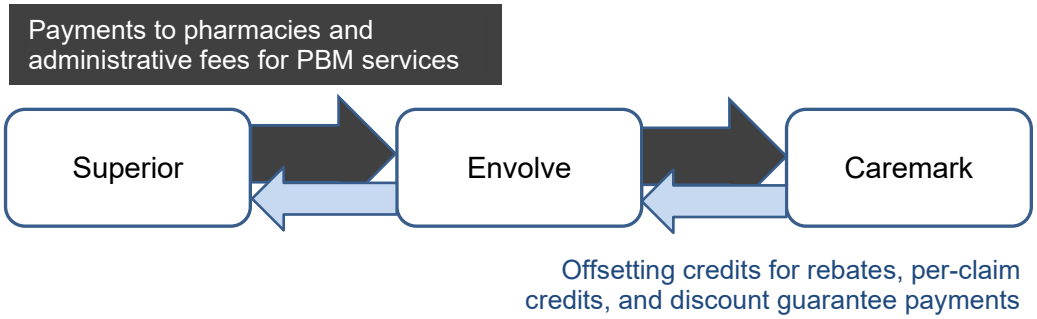
- Rebates. Superior receives manufacturer rebates related to certain home health supplies.

- Discount guarantee payments. Envolve reimburses Caremark for the actual amount paid to pharmacies for dispensing fees and ingredient costs. However, at the end of each calendar year, Envolve and Caremark calculate the average amount reimbursed for dispensing fees and ingredient costs for categories of drugs and compare that average cost to a market rate identified in their contract. If the amount reimbursed to Caremark exceeds that market rate, Caremark reimburses Envolve for the difference.

Superior's Receipts for Calendar Year 2019	
Discount guarantees	$2,074,063

Figure 3 shows transactions for per-claim credits, rebates, and discount guarantee payments in relation to payment for ingredient costs, dispensing fees, and administrative fees.[14]

Figure 3: Superior's Offsetting Through Its PBM



Source: OIG Audit

Superior Did Not Report All Receipts From Its PBM on Its FSRs

Superior did not report discount guarantee payments on its fiscal year 2019 FSRs. In June 2020, Envolve and Caremark agreed that, for calendar year 2019, Caremark owed $2,074,063 under its discount guarantee provisions and Superior recorded this amount in its general ledger; however, it did not report discount guarantee payments on its FSRs. Superior's policies and procedures do not include information about which transactions to include on the FSRs other than current claims costs and receipts from third-party insurers. Superior asserted that, after OIG Audit identified the unreported discount guarantee payments, it determined that $1,382,709 was attributable to fiscal year 2019 FSRs but not reported. Superior also asserted that it reported the remaining $691,354 of discount guarantee payments in its fiscal year 2020 FSRs. Excluding these discount guarantee

[14] Superior receives recoveries from third-party insurers through a different contracted vendor and not from Caremark.

payments from its fiscal year 2019 FSRs overstated the cost of providing pharmacy benefits. Such overstatements can affect the state's calculation of:

- Capitation payments to MCOs for pharmacy benefits
- Profit-sharing experience rebates that MCOs pay the state

Superior Incorrectly Classified Certain Receipts From Its PBM on Its FSRs

Superior incorrectly classified an additional $10,108,911 in per-claim credits and rebate payments it received through Envolve's contract with Caremark on its 2019 FSRs. As previously noted, Superior received $9,169,313 in per-claim payments for certain claims processed by Caremark. Superior also received $939,598 in manufacturer rebates for certain home health supplies. Superior correctly reported these receipts on its 2019 FSRs but reported them on the line designated in the FSR instructions for recoveries from third-party insurers.[15] Superior's policies and procedures do not include information on how to classify expenses other than current claims costs and receipts from third-party insurers. The FSRs are one of the primary financial reports used by HHSC to monitor MCO financial results. Incorrectly classifying amounts on the FSRs inhibits HHSC's ability to understand the components of Superior's income and expenses.

[15] Uniform Managed Care Manual, Chapters 5.3.1.60, 5.3.1.70, 5.3.1.76, 5.3.1.80, and 5.3.1.82, v. 2.1 (Dec. 15, 2018).

Recommendation 1

Superior should:

- Accurately report pharmacy benefit transactions on its FSRs, including discount guarantee payments, per-claim credits, and rebates, as required by UMCC[16] and the UMCM.[17]

- Determine the appropriate method of classifying pharmacy benefit transactions on its FSRs, including discount guarantee payments, per-claim credits, and rebates, in coordination with HHSC Financial Reporting and Audit Coordination (FRAC).

- Strengthen its policies and procedures for FSR reporting by incorporating procedures that prescribe the appropriate method of reporting payments that affect the reported cost of pharmacy services on its FSRs, including discount guarantee payments, per-claim credits, and rebates.

- Determine the amount of discount guarantee payments that should have been reported on the 2019 FSRs and work with FRAC on how to correct that information.

Management Response

See Appendix C for Superior's complete management response.

Action Plan

Superior will continue to work with Financial Reporting and Audit Coordination (FRAC) on guidance as to where and how to report the discount guarantee payments, per-claim credits, and rebate payments it received. Based on the updated FSR instructions provided by FRAC to the MCOs, we will adjust our Policies & Procedures.

Responsible Manager

Vice President, Finance

Target Implementation Date

August 2021

[16] Uniform Managed Care Contract, Attachment B-1, § 8.1.17.1, v. 2.26 (Sept. 1, 2018) through v. 2.28 (Mar. 1, 2019).

[17] Uniform Managed Care Manual, Chapter 6.1, v. 2.6 (May 15, 2018) and v. 2.7 (May 29, 2019).

Auditor Comment

OIG Audit appreciates the feedback provided by Superior in its management response letter, and respects Superior's position on the reported issue. OIG Audit offers the following comments regarding Superior's management response.

As stated previously in the report, the UMCM requires MCOs to report on their FSRs receipts or reduction of expenditure-type transactions that offset or reduce expense items, such as purchase discounts, rebates, and adjustments of overpayments or erroneous charges, to the extent that these credits relate to allowable costs. OIG Audit has reviewed the work supporting the report findings and stands by its conclusions.

CONCLUSION

Superior had controls in place to ensure its reimbursements to Envolve were (a) based on actual amounts paid to pharmacies for dispensing fees and ingredient costs and (b) accurately reported to the state on its FSRs and in its encounter data.

Superior accurately reimbursed Envolve for the actual amounts paid to pharmacies for dispensing fees and ingredient costs, and Superior accurately reported those reimbursements on its 2019 FSRs and in its encounter data. For 2019, Superior reported prescription paid claims expense of $881,811,438 on its 334-day FSRs. However, it did not report other payments that affect its overall reported cost of those prescriptions as required, which overstated pharmacy-related expenses on its FSRs. In addition, Superior incorrectly classified other reported expenses on its FSRs. Specifically, on its 2019 FSRs, Superior:

- Did not report the fiscal year 2019 portion of $2,074,063 in discount guarantee payments it received. Discount guarantee payments are calculated payments that offset portions of Superior's reported cost of prescriptions in excess of contractually determined market rates.

- Incorrectly classified $10,108,911 in payments for per-claim credits and rebates as recoveries from third-party insurers. These include per-claim credits that Superior receives for certain claims processed by Caremark and manufacturer rebates that Superior receives for certain home health supplies.

The FSRs are the primary statements of financial results that the MCOs submit to HHSC. The reports provide (a) the basis for calculating the amount an MCO may owe the state through profit-sharing experience rebates and (b) a key source of claims and administrative expense information used to set the amount of capitation paid to MCOs. Overstating expenses on its FSRs can affect HHSC's ability to understand the components of Superior's income and expenses and could result in increased pharmacy capitation payments and decreased profit-sharing through experience rebates that Superior may pay to the state.

OIG Audit offered recommendations to Superior, which, if implemented, will:

- Ensure that Superior reports on its FSRs all pharmacy-related payments that affect the cost of prescriptions.

- Enable Superior and HHSC to determine the overall net cost of Superior's prescription expenses for 2019.

For instances of noncompliance identified in the audit report, HHSC Medicaid and CHIP Services may consider tailored contractual remedies to compel Superior to meet contractual requirements. In addition, audit findings in the report may be subject to OIG administrative enforcement measures,[18] including administrative penalties.[19]

OIG Audit thanks management and staff at Superior for their cooperation and assistance during this audit.

[18] 1 Tex. Admin Code § 371.1603 (May 1, 2016).

[19] Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

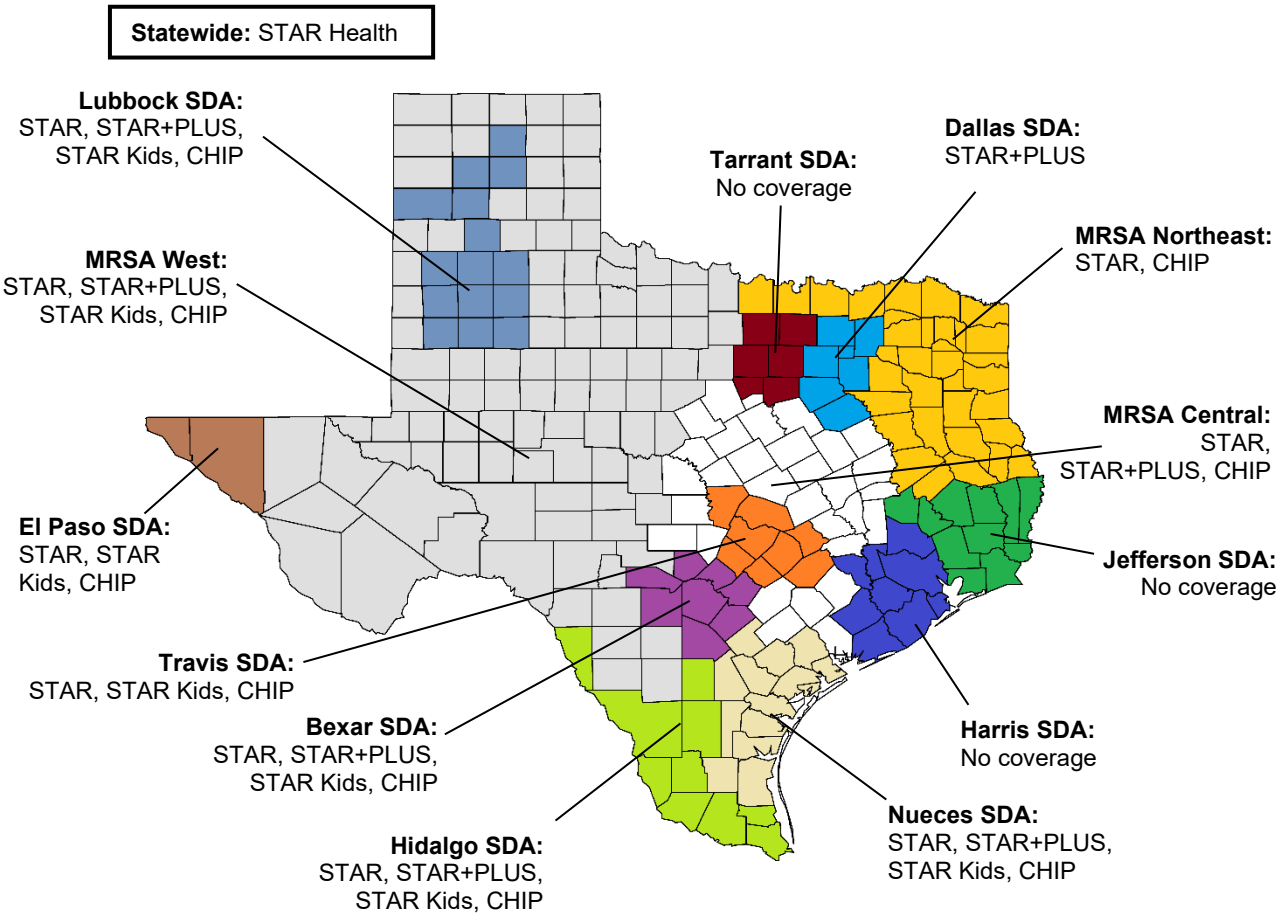
Appendix A: Superior's Organizational Structure Related to Pharmacy Services

For 2019, HHSC contracted with Superior to provide comprehensive health care services to members in Medicaid and CHIP. In those contracts, Superior comprises two entities that collectively provide services as Superior:

- Bankers Reserve Life Insurance Company, doing business as Superior HealthPlan Network
- Superior HealthPlan, Inc.

Figure 4 shows programs Superior provided under the Medicaid and CHIP programs in 2019 in Texas service delivery areas.

Figure 4: Superior's Programs and Service Delivery Areas for 2019

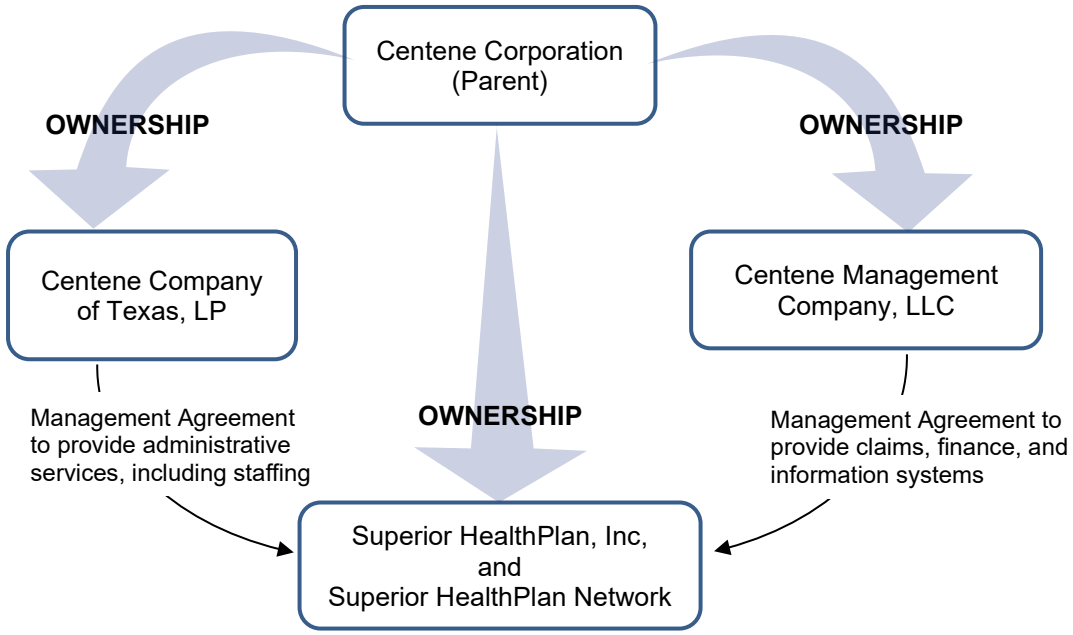


Source: HHSC's contracts with Superior

Superior, a Subsidiary of Centene

Superior is a subsidiary of Centene. Its functions are performed under a management agreement with two other subsidiaries of Centene, as illustrated in Figure 5.

Figure 5: Superior Organizational Chart



Source: OIG Audit

Superior's Contracting Relationships for Providing Pharmacy Benefit Services

Superior contracts with Envolve to provide pharmacy benefit services to Medicaid and CHIP members as Superior's PBM. Envolve is also a subsidiary of Centene. A third subsidiary of Centene, Health Net Pharmaceutical Services (Health Net), contracts with Caremark to provide pharmacy benefit services. This contract predated Centene's acquisition of Health Net. Once acquired, the Caremark contract with Health Net was amended to incorporate the relationship with Envolve, and Envolve contracted with Health Net to delegate certain pharmacy benefit management services to Health Net. Under these relationships Caremark provides services to Envolve, and Envolve provides pharmacy benefit services to Superior. Although Health Net is part of the contractual relationship between Envolve and Caremark, it is not involved in the delivery of the pharmacy benefit services discussed in this report under these relationships. As a result, it is excluded from the discussion of these services outside of this appendix. Figure 6 shows the timeline of these relationships.

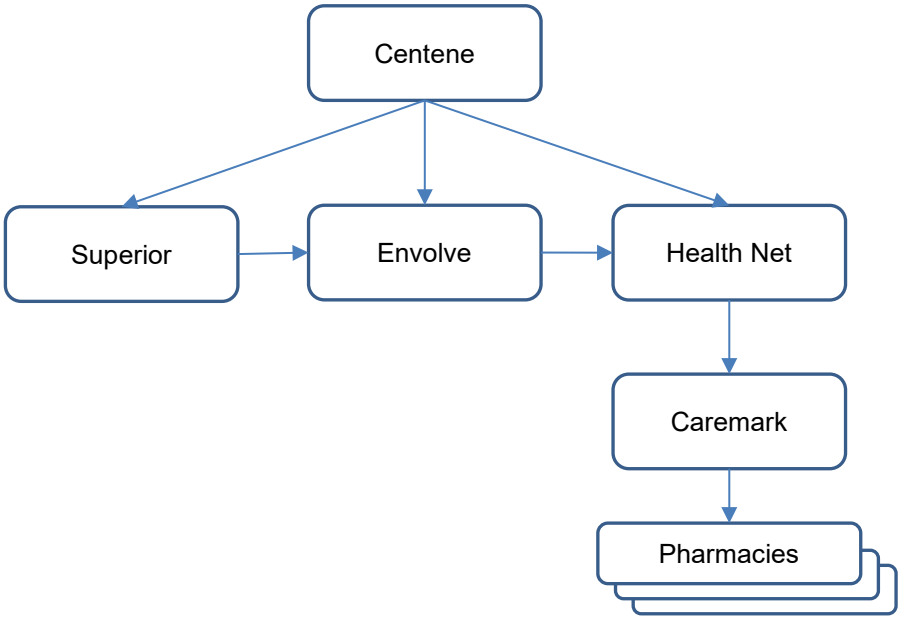
Figure 6: Timeline of Significant Relationships for Medicaid and CHIP Pharmacy Benefit Services Under Superior

January 4, 2006
• Centene acquires US Script
March 1, 2012
• Superior contracts with US Script for PBM services
December 20, 2013
• Health Net enters its second amended contract with Caremark to deliver PBM services
September 1, 2014
• Superior changes US Script's compensation model to a pass-through pricing plan
March 24, 2016
• Centene acquires Health Net
March 31, 2016
• Health Net amends its contract with Caremark to recognize the merger with Centene, as well as Caremark's new responsibilities to US Script
April 12, 2016
• Centene rebrands US Script as Envolve

Source: OIG Audit

Figure 7 shows the contract structures among Centene's subsidiary entities Superior uses to provide pharmacy services through pharmacies to Medicaid and CHIP members in Texas.

Figure 7: Contract Structures Among Centene Subsidiaries



Source: OIG Audit

Through these relationships, Envolve is Superior's PBM, and Caremark subcontracts to perform certain PBM services, including claims processing.

Appendix B: Testing Methodology

OIG Audit examined Medicaid and CHIP pharmacy benefit services provided by Superior and its subcontracted PBM for 2019 under the STAR, STAR+PLUS, STAR Kids, STAR Health, and CHIP programs (see Appendix A for description of the state's Medicaid and CHIP programs).

Data Reliability

OIG Audit assessed the reliability of the data used in the audit, including Superior's encounters and claims with dates of service in 2019, as well as information from Superior's accounting system related to its transactions with its PBM, Envolve, for 2019. Procedures used to determine the reliability of this information included, as necessary, some or all of the following procedures: observing data extracts, reviewing query parameters used to extract the data, reviewing external auditors' prior work on general and application controls, and tracing information to source documents.

Reimbursements to Envolve for Claims Costs Paid to Caremark

After an initial assessment of the reliability of Superior's accounting data, OIG Audit selected a nonstatistical, risk-based sample of 9 of 48 periodic claims cost payments to Caremark during the fiscal year to determine (a) whether payments are supported, accurate, and appropriately reviewed and (b) whether Superior accurately reimburses Envolve. These payments included $167,877,966, or 19 percent, of the $881,998,182 in claims costs recorded on Superior's general ledger. The sample was designed to obtain coverage over payments throughout the year and at different amounts, as well as other risk factors. The sample items were not necessarily representative of the population; therefore, it would not be appropriate to project the test results to the population.

Claim Accuracy

After an initial assessment of the reliability of Superior's claims data, OIG Audit selected a nonstatistical, risk-based sample of claims to determine whether they are supported and accurately reflect the amount paid to the pharmacy. The population of claims used to select the sample included $884,752,172 dispensing fees and ingredient costs. The sampled claims included $1,257,446 in dispensing fees and ingredient costs that were either paid to pharmacies ($961,613) or were dispensed directly by Caremark ($295,833). The sample was designed to obtain coverage over Superior's contracts with the state and at different drug costs, as well as other risk factors. The sample items were generally not representative of the population; therefore, it would not be appropriate to project those test results to the population.

Appendix C: Superior's Management Response

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Superior Management Response

Issue #1:

Superior Did Not Accurately or Completely Report Payments that Affect Its Reported Costs of Prescriptions

Superior HealthPlan's Response:

Superior believes that during the period covered by this audit, the FSR instructions did not specify where unreceived discount guarantee payments should be reported, nor did the FSR template accommodate such reporting.

Action Plan:

Superior will continue to work with Financial Reporting and Audit Coordination (FRAC) on guidance as to where and how to report the discount guarantee payments, per-claim credits, and rebate payments it received. Based on the updated FSR instructions provided by FRAC to the MCOs, we will adjust our Policies & Procedures.

Responsible Manager:

Dan Horn - Vice President, Finance

Target Implementation Date:

Superior will implement any revised FSR instructions produced by FRAC relating to this issue once received. Superior will continue to reach out to FRAC to follow up on this matter to ensure clarity prior to the next FSR reporting date (August 2021).

Appendix D: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Audrey O'Neill, CIA, CFE, CGAP, Chief of Audit and Inspections
- Kacy VerColen, CPA, Deputy Inspector General of Audit and Inspections
- Anton Dutchover, CPA, Audit Director
- George D. Eure, CPA, Audit Project Manager
- Karen Reed, CFE, CIGA, Senior Auditor
- Brad Etnyre, CIA, CGAP, Senior Auditor
- Bridget Hale, Staff Auditor
- Erin Powell, Quality Assurance Reviewer
- Mo Brantley, Senior Audit Operations Analyst

Report Distribution

Health and Human Services

- Cecile Erwin Young, Executive Commissioner
- Kate Hendrix, Chief of Staff
- Maurice McCreary, Jr., Chief Operating Officer
- Victoria Ford, Chief Policy and Regulatory Officer
- Karen Ray, Chief Counsel
- Michelle Alletto, Chief Program and Services Officer
- Nicole Guerrero, Director of Internal Audit
- Stephanie Stephens, State Medicaid Director, Medicaid and CHIP Services
- Michael Anaya, Associate Commissioner for Operations, Medicaid and Chip Services
- Shannon Kelley, Associate Commissioner for Managed Care, Medicaid and CHIP Services

- Katherine Scheib, Deputy Associate Commissioner, Medicaid and CHIP Services
- Jason Mendl, Director, Financial Reporting and Audit Coordination, Medicaid and CHIP Services

Superior

- Mark D. Sanders, Plan President and Chief Executive Officer
- Jared A. Wolfe, Plan Chief Performance Officer
- Sara B. Robins, Vice President of Compliance
- Dan Horn, Vice President of Finance
- Carlos E. Galvan, Compliance and Reporting Specialist

Appendix E: OIG Mission, Leadership, and Contact Information

The mission of OIG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of OIG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Inspector General
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Juliet Charron, Chief of Strategy
- Steve Johnson, Chief of Investigations and Reviews

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To Contact OIG

- Email: OIGCommunications@hhs.texas.gov
- Mail: Texas Health and Human Services
  Office of Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
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