

# Department of Health and Human Services

## OFFICE OF INSPECTOR GENERAL

**THE DISTRICT OF COLUMBIA HAS  
TAKEN SIGNIFICANT STEPS TO ENSURE  
ACCOUNTABILITY OVER AMOUNTS  
MANAGED CARE ORGANIZATIONS PAID  
TO PHARMACY BENEFIT MANAGERS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Amy J. Frontz  
Deputy Inspector General  
for Audit Services

March 2023  
A-03-20-00200

# ***Office of Inspector General***

<https://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## ***Office of Audit Services***

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## ***Office of Evaluation and Inspections***

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## ***Office of Investigations***

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## ***Office of Counsel to the Inspector General***

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

## **THIS REPORT IS AVAILABLE TO THE PUBLIC**

at <https://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## Report in Brief

Date: March 2023

Report No. A-03-20-00200

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

Spread pricing occurs when a managed care organization (MCO) contracts with a pharmacy benefit manager (PBM) to manage its prescription drug benefits, and the PBM keeps a portion of the amount the MCO paid to it for prescription drugs instead of passing the full payment on to the pharmacy. Several States have conducted audits of PBM spread pricing practices due to concerns about the transparency and appropriateness of spread pricing in the Medicaid program. Other States, including New York, Texas, and Virginia, have enacted or drafted legislation to increase transparency and change the contracting process with PBMs.

Our objective was to determine whether the District of Columbia provided oversight of its MCOs to ensure adequate accountability over amounts paid to PBMs for prescription benefits.

### How OIG Did This Audit

We reviewed the contracts between the District and its five MCOs and the seven contracts between those MCOs and PBMs from October 1, 2016, through September 30, 2019 (audit period). We also reviewed the five MCOs' claims for prescription drugs dispensed during the audit period and obtained the amounts the PBMs reimbursed pharmacies for the prescription drugs dispensed during the audit period.

### The District of Columbia Has Taken Significant Steps To Ensure Accountability Over Amounts Managed Care Organizations Paid to Pharmacy Benefit Managers

#### What OIG Found

The District provided some oversight of its MCOs with the intent of ensuring adequate accountability over amounts paid for prescription benefits to its PBMs. This oversight consisted of guidance requiring MCOs to report spread pricing. However, the amounts reported were aggregated with other amounts and as a result did not provide transparency over the amount of the funds that was attributable to spread pricing. We found that PBMs kept \$23.3 million in spread pricing during our audit period. Spread pricing may increase the cost of Medicaid prescriptions for both the MCO and the Medicaid program and, if not correctly accounted for, inflate the cost of the drugs. Limiting spread pricing may decrease Federal and State spending through lower payments to MCOs.

#### What OIG Recommends and District Comments

We recommend that the District develop policies and procedures for validating MCO, PBM, and pharmacy transactions on a periodic basis to ensure transparency of costs associated with the prescription drug program.

In written comments on our draft report, the District concurred with our recommendation and asked for clarification and guidance regarding the amounts or percentages that are deemed appropriate for PBMs to retain under the practice of spread pricing. The District also asked for clarification regarding whether it should require its contracted MCOs to make a separate payment to its PBMs for administrative costs and fees.

We appreciate the District's desire to improve its PBM oversight, an important topic receiving much congressional interest. After receiving its comments, we met with the District to discuss some observations that we noted during the audit and encouraged the District to contact the Centers for Medicare & Medicaid Services for clarification and guidance and work with other State agencies and its counsel to determine best practices. In addition, while we did not specifically recommend that the District disaggregate information in the medical loss ratio report, we look forward to the steps the District takes to ensure transparency of costs associated with the prescription drug program.

## TABLE OF CONTENTS

|  |    |
|--|----|
| INTRODUCTION .....   | 1  |
| Why We Did This Audit .....  | 1  |
| Objective .....  | 1  |
| Background .....   | 1  |
| Medicaid Program.....  | 1  |
| Department of Health Care Finance .....  | 2  |
| How We Conducted This Audit.....   | 2  |
| FINDING.....   | 2  |
| Federal Requirements.....  | 3  |
| The State Agency's Oversight Did Not Provide Transparency Over Spread Pricing .....  | 5  |
| Spread Pricing Amounts Were Aggregated With Other Amounts .....  | 5  |
| The State Agency Has Taken Steps To Increase Accountability Over<br>Spread Pricing but Could Take Additional Steps To Improve Oversight..... | 6  |
| RECOMMENDATION .....   | 7  |
| STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE .....   | 7  |
| APPENDICES   |    |
| A: Audit Scope and Methodology .....   | 8  |
| B: State Agency Comments.....  | 10 |

## INTRODUCTION

### WHY WE DID THIS AUDIT

Spread pricing occurs when a managed care organization (MCO) contracts with a pharmacy benefit manager (PBM) to manage its prescription drug benefits, and the PBM keeps a portion of the amount the MCO paid to it for the prescription drugs instead of passing the full payment on to the pharmacy. Several States, including Ohio, Kentucky, Maryland, and Pennsylvania, have conducted audits of PBM spread pricing practices due to concerns about the transparency and appropriateness of spread pricing in the Medicaid program. Other States, including New York, Texas, and Virginia, have enacted or drafted legislation to increase transparency and change the contracting process with PBMs.

### OBJECTIVE

Our objective was to determine whether the District of Columbia's (the District's) Department of Health Care Finance (State agency) provided oversight of its MCOs to ensure adequate accountability over amounts paid to PBMs for prescription benefits.

### BACKGROUND

#### Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

MCOs contract with State Medicaid agencies to ensure that beneficiaries receive covered Medicaid services. Under these contracts, MCOs arrange for a network of providers to deliver to enrolled beneficiaries certain benefits and services, including prescription drugs, specified by the State. In exchange, the State Medicaid agency generally pays MCOs a capitation payment, which is a fixed amount per member per month, for each enrolled beneficiary. The capitation payment represents a payment amount that is adequate to allow the MCO to efficiently deliver covered services to beneficiaries in a manner compliant with contractual requirements.<sup>1</sup>

MCOs may contract with PBMs to manage or administer drug benefits on the MCO's behalf. PBMs offer a variety of services such as establishing retail, mail-order, and specialty pharmacy networks; negotiating pharmacy reimbursement rates; adjudicating pharmacy claims; and negotiating supplemental rebates with pharmaceutical manufacturers.

---

<sup>1</sup> 42 CFR § 438.3(c).

The practice of spread pricing, which occurs when a PBM keeps a portion of the amount the MCO paid to it for prescription drugs instead of passing the full payment on to the pharmacy, is currently permissible according to Federal law. However, because contracts between PBMs and pharmacies are proprietary, State Medicaid agencies often cannot verify the amount of spread pricing. If spread pricing is not appropriately monitored and accounted for, MCOs may not be aware of the spread amount included in pharmacy costs and may negotiate separate administrative payments to PBMs without knowing how much PBM profit is already built into the pharmacy costs as spread pricing. The State Medicaid agency may use these inflated pharmacy costs in setting capitation rates. If the State Medicaid agency increases its capitated payments to MCOs based on a rate setting influenced by inflated pharmacy costs, it increases the cost of the Medicaid program.

### **Department of Health Care Finance**

The State agency's mission is to improve health outcomes by providing access to comprehensive, cost-effective, quality health care services for District residents. For State fiscal years (FYs) 2017 through 2019, the State agency's contracted MCOs paid PBMs over \$364.4 million for pharmacy claims.

### **HOW WE CONDUCTED THIS AUDIT**

We reviewed the contracts between the State agency and its five MCOs and the seven contracts between those MCOs and PBMs from October 1, 2016, through September 30, 2019 (audit period). Specifically, we reviewed the contracts the State agency had with the five MCOs to determine the payment terms and guidance for spread pricing contained in the contracts.<sup>2</sup> We also reviewed the five MCOs' claims for prescription drugs dispensed during our audit period and obtained the amounts the PBMs reimbursed pharmacies for the prescription drugs dispensed during our audit period. For the claims, we calculated the difference between the amounts the MCOs paid to the PBMs and the amounts the PBMs paid to the pharmacies.

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.

The Appendix contains the details of our audit scope and methodology.

### **FINDING**

The District provided some oversight of its MCOs with the intent of ensuring adequate accountability over amounts paid for prescription benefits to its PBMs. This oversight consisted

---

<sup>2</sup> During our audit period, the contracts between the State agency and its MCOs did not contain language prohibiting spread pricing.

of guidance requiring MCOs to report spread pricing. However, the amounts reported were aggregated with other amounts and as a result did not provide transparency over the amount of the funds that was attributable to spread pricing. We found that PBMs kept \$23.3 million in spread pricing during our audit period. Spread pricing may increase the cost of Medicaid prescriptions for both the MCO and the Medicaid program and, if not correctly accounted for, inflate the cost of the drugs. Limiting spread pricing may decrease Federal and State spending through lower payments to MCOs.

## **FEDERAL REQUIREMENTS**

Federal requirements at 42 CFR section 438.230 state that States must ensure, through their contracts, that each MCO is ultimately responsible for adhering to and complying with all terms and conditions of its contract with the State, notwithstanding any relationship that the MCO may have with any subcontractor. Similarly, 42 CFR section 438.230 requires subcontractors to comply with the standards that govern the managed care plan's performance as stated in the managed care plan's contract.<sup>3</sup>

For Medicaid managed care contracts that started on or after July 1, 2017, States are to include requirements for managed care plans to calculate and report a medical loss ratio (MLR), including related underlying data as described in 42 CFR section 438.8. In addition, under 42 CFR section 438.8(k)(3), managed care plans must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the managed care plan to calculate and validate the accuracy of MLR reporting.

As provided by 42 CFR sections 438.8(d) through (f), the MLR experienced for each managed care plan in an MLR reporting year is expressed as a ratio in which the numerator is the sum of the managed care plan's incurred claims, expenditures for activities that improve health care quality, and fraud prevention activities. The denominator is the adjusted premium revenue, which is the managed care plan's premium revenue minus Federal, State, and local taxes and licensing and regulatory fees. The premium revenue is aggregated for all Medicaid eligibility groups covered under the contract with the State unless the State requires separate reporting and a separate MLR calculation for specific populations.

Under 42 CFR section 438.8(e)(2)(v)(A), the incurred claims used in the numerator must exclude non-claims costs, which include: (1) amounts paid to third-party vendors for secondary network savings; (2) amounts paid to third-party vendors for network development, administrative fees, claims processing, and utilization management; (3) amounts, including those amounts paid to a provider, that are paid for professional or administrative services that do not represent compensation or reimbursement for State Plan services or services meeting the definition of in-lieu-of services in 42 CFR section 438.3(e) and provided to an enrollee; and (4) fines and penalties assessed by regulatory authorities. As stated in 42 CFR section 438.8(e)(2)(ii)(B),

---

<sup>3</sup> Managed care plans provide for the delivery of Medicaid health benefits and additional services through contracted arrangements between State Medicaid agencies and MCOs.

prescription drug rebates received and accrued must also be deducted from the incurred claims.

Federal regulations at 42 CFR section 438.74(a) specify that the State must submit to CMS on an annual basis a summary description of the report or reports received from its contracted MCOs according to section 438.8(k). The summary description must include, at a minimum, the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed by each MCO for that MLR reporting year.

In a May 15, 2019, Informational Bulletin, CMS highlighted and clarified that its interpretation of 42 CFR section 438.8(e)(2)(ii)(B) requires that prescription drug rebates received and accrued must be deducted from incurred claims.<sup>4</sup> CMS interprets this regulation to require that any time a managed care plan receives something of value for the provision of a Medicaid covered outpatient drug (e.g., manufacturer rebates, incentive payments, direct or indirect remuneration, goods in kind), the value must be deducted from the amount of incurred claims used for calculating and reporting the MLR. Spread pricing would be considered something of value and should be deducted from the number of incurred claims in the MLR.<sup>5</sup> In the press release accompanying the Informational Bulletin, CMS added:

In today's guidance CMS is making clear that, for purposes of the MLR regulation, "prescription drug rebates" means any price concession or discount received by the managed care plan or by its PBM, regardless of who pays the rebate or discount. Some possible examples include payments from pharmaceutical manufacturers, wholesalers, and retail pharmacies. Therefore, the amount retained by a PBM under spread pricing would have to be excluded from the amount of claims costs used for calculating the managed care plan's MLR. The policy underpinning this guidance is that spread pricing should not be used to artificially inflate a Medicaid or [Children's Health Insurance Program] managed care plan's MLR.

Further, according to the Informational Bulletin, the requirement to deduct spread pricing from incurred claims applies regardless of whether value is received by the managed care plan or by a subcontractor administering the covered outpatient drug benefit on behalf of the managed care plan.

---

<sup>4</sup> CMS, "CMCS Informational Bulletin: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors." Available at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf>. Accessed on August 18, 2022.

<sup>5</sup> CMS Press Release, "CMS Issues New Guidance Addressing Spread Pricing in Medicaid, Ensures Pharmacy Benefit Managers are not Up-Charging Taxpayers." Available at <https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not>. Accessed on August 18, 2022.

## THE STATE AGENCY'S OVERSIGHT DID NOT PROVIDE TRANSPARENCY OVER SPREAD PRICING

### Spread Pricing Amounts Were Aggregated With Other Amounts

During our audit period, the State agency provided some oversight, through its instructions and guidance for MCOs to report spread pricing, with the intent of ensuring adequate accountability over amounts paid for prescription benefits. Specifically, during our audit period, the State agency instructed its MCOs to submit MLR reports and provided its MCOs with explicit instructions related to reporting spread pricing. However, the State agency only instructed MCOs to report spread pricing in aggregate with other amounts, and thus the spread pricing amounts were not transparent.

The State agency's "Instructions for MLR Report" specified that MCOs were to report pharmacy expenditures and the gross total of rebates, excluding any spread pricing. In addition, the guidance instructed MCOs to total the PBM spread pricing amount and the amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management and report the combined total of these amounts as one line item on each MCO's MLR Report. Upon receipt of the MLR reports, the State agency did not perform validation steps such as reviewing transactions between the MCO and PBM and the PBM and pharmacy because it had no policies or procedures to require such steps.

Because the spread pricing and third-party payment amounts were aggregated, the State agency could not validate the amount of spread pricing in the MLR reports, and the spread pricing amounts were not transparent to the State agency.

During our audit period, the MCOs paid PBMs over \$364.4 million for prescription claims, and the PBMs paid pharmacies over \$341.1 million for those prescription claims. The remaining \$23.3 million is the spread pricing that was kept by the PBMs. (See the table on the following page.) This \$23.3 million is in addition to the other fees the MCOs paid the PBMs. During our audit period, the PBMs received a total of \$12.4 million from these other fees.<sup>6</sup>

---

<sup>6</sup> PBMs provide a variety of services such as establishing retail, mail-order, and specialty pharmacy networks; negotiating pharmacy reimbursement rates; adjudicating pharmacy claims; and negotiating supplemental rebates with pharmaceutical manufacturers. The specific services the PBM provided varied depending on the MCO-PBM contract.

**Table: Amounts MCOs Paid to PBMs and Amounts PBMs Paid to Pharmacies**

| MCO           | PBM   | Amount MCO Paid to PBM | Amount PBM Paid to Pharmacies | Spread Amount Kept by PBM | Other Fees Paid to PBM |
|---------------|-------|------------------------|-------------------------------|---------------------------|------------------------|
| MCO A         | PBM 1 | \$6,971,821            | \$5,626,543                   | \$1,345,278               | \$142,560              |
|               | PBM 2 | 24,795,253             | 18,585,338                    | 6,209,915                 |                        |
| MCO B         | PBM 3 | 199,347,433            | 199,347,433                   | 0                         | 10,017,531             |
| MCO C         | PBM 4 | 50,773,859             | 41,253,331                    | 9,520,528                 | 0                      |
| MCO D         | PBM 5 | 5,885,651              | 5,870,732                     | 14,920*                   | 2,121,590              |
|               | PBM 6 | 30,547,136             | 29,751,791                    | 795,345                   |                        |
| MCO E         | PBM 4 | 46,141,875             | 40,724,475                    | 5,417,400                 | 145,782                |
| <b>Totals</b> |       | <b>\$364,463,028</b>   | <b>\$341,159,643</b>          | <b>\$23,303,386</b>       | <b>\$12,427,463</b>    |

\*Amounts do not calculate exactly due to rounding.

The State agency could not account for this \$23.3 million in spread pricing kept by PBMs during our audit period. Although spread pricing is currently federally permissible, the State agency was unaware of the exact amount of spread pricing.

Spread pricing may increase the cost of Medicaid prescriptions to both MCOs and the Medicaid program. Spread pricing occurs when the PBM keeps a portion of the amount the MCO paid for prescription drugs instead of passing the full payment on to pharmacies. If spread pricing is not appropriately monitored and accounted for, MCOs may not be aware of the spread amount included in the pharmacy costs and may negotiate separate administrative payments to PBMs without knowing how much PBM profit is already built into the pharmacy costs as spread pricing. The State agency may use these inflated pharmacy costs in setting capitation rates. If the State agency increases its capitated payments to MCOs based on a rate setting influenced by spread pricing, it thereby increases the cost of the Medicaid program.

#### **The State Agency Has Taken Steps To Increase Accountability Over Spread Pricing but Could Take Additional Steps To Improve Oversight**

During our audit but after our audit period, the State agency took steps to improve its oversight of MCOs and accountability over PBM spread pricing. In October 2020, the State agency modified its contracts with MCOs to include specific language to, among other things, eliminate spread pricing in contracts between MCOs and PBMs. It also added a requirement for MCOs to provide the State agency with information on contract terms with PBMs, including estimates of PBM profits and payment streams. However, the State agency currently does not confirm the individual amounts reported on the MLR report. Formally establishing policies and procedures to validate the amounts (MCO, PBM, and pharmacy transactions) on the MLR report on a periodic basis will help to ensure transparency of costs associated with the prescription drug program.

## **RECOMMENDATION**

We recommend that the District of Columbia Department of Health Care Finance develop policies and procedures for validating MCO, PBM, and pharmacy transactions on a periodic basis to ensure transparency of costs associated with the prescription drug program.

## **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency concurred with our recommendation and asked for clarification and guidance regarding the amounts or percentages that are deemed appropriate for PBMs to retain under the practice of spread pricing. The State agency also asked for clarification regarding whether it should require its contracted MCOs to make a separate payment to its PBMs for administrative costs and fees.

We appreciate the State agency's desire to improve its PBM oversight, an important topic receiving much congressional interest. After receiving its comments, we met with the State agency to discuss some observations that we noted during the audit and encouraged the State agency to contact CMS for clarification and guidance and work with other State agencies and its counsel to determine best practices.

In addition, while we did not specifically recommend that the State agency disaggregate information in the MLR report, we look forward to the steps the State agency takes to ensure transparency of costs associated with the prescription drug program.

The State agency's comments are included in their entirety as Appendix B.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered 6,198,833 prescription drug claims totaling \$341,159,643 reimbursed to pharmacies during State FYs 2017 through 2019. MCOs paid \$364,463,028 to the PBMs for these claims.

We did not review the State agency's overall internal control structure. We limited our review of internal controls to those applicable to our objective. Specifically, we reviewed the State agency's internal controls related to contracting with MCOs. To assess the State agency's control activities, we interviewed contracting officials and reviewed copies of the State agency's policies and procedures to obtain an understanding of the State agency's contracting policies and procedures as they involve spread pricing.

We performed our audit work from November 2019 through September 2022.

### METHODOLOGY

To accomplish the objective, we:

- reviewed applicable Federal laws, regulations, and other requirements;
- met with CMS program officials to discuss the Federal requirements regarding spread pricing that the State agency and MCOs must follow;
- interviewed State agency officials to obtain an understanding of the State agency's policies, procedures, and guidance for MCOs;
- interviewed State agency officials to obtain an understanding of the State agency's processes for contracting with MCOs;
- obtained and reviewed contracts between the State agency and the MCOs;
- obtained the MCOs' quarterly and annual MLR reports submitted to the State agency;
- obtained Medicaid claims for prescription drugs from the PBMs for State FYs 2017 through 2019;
- calculated the difference between what the MCOs paid to PBMs and what the PBMs paid to pharmacies;
- obtained and reviewed contracts between MCOs and their PBMs; and
- met with State agency officials to discuss the results of our audit.

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.

## APPENDIX B: STATE AGENCY COMMENTS

### GOVERNMENT OF THE DISTRICT OF COLUMBIA

#### Department of Health Care Finance

Office of the Senior Deputy Director and  
Medicaid Director



January 19, 2023

Nicole Freda  
Regional Inspector General for Audit Services  
Office Of Audit Services, Region III  
801 Market Street, Suite 8500  
Philadelphia, PA 19107-3134

Sent by electronic mail to [Nicole.Freda@oig.hhs.gov](mailto:Nicole.Freda@oig.hhs.gov)

RE: Report Number A-03-20-00200

Dear Ms. Freda:

The D.C. Department of Health Care Finance (DHCF) is in receipt of the HHS OIG Draft Report *The District of Columbia Has Taken Significant Steps to Ensure Accountability Over Amounts to Managed Care Organizations Paid to Pharmacy Benefit Managers*. In this letter, please find DHCF's written comments to the recommendations contained in this Draft Report, including a statement of concurrence or nonconcurrence with the recommendation.

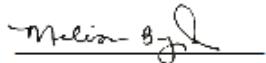
In the Draft Report, the OIG recommended that DHCF develop policies and procedures for validating MCO, PBM, and pharmacy transactions on a periodic basis to ensure transparency of costs associated with the prescription drug program. The OIG also recommends that DHCF disaggregate the report in order to obtain more accurate spread-pricing information. DHCF does not object to this recommendation and concurs to the extent that additional clarification is needed. Specifically, in order to implement meaningful policies and procedures, DHCF requests clarification or guidance regarding amounts or percentages that are deemed appropriate for PBMs to retain under the otherwise permissible practice of spread-pricing. This guidance will provide assistance to DHCF in both developing policies and procedures and enforcing accountability regarding spread-pricing. Additionally, DHCF requests clarification regarding whether it should require its contracted MCOs to make a separate payment to its PBMs for administrative costs and fees.

---

441 4<sup>th</sup> Street NW, Suite 900 South, Washington, D.C. 20001 (202) 442-5988 Fax (202) 442-4790

If you have any questions or require any further information from DHCF, please feel free to contact Lisa Truitt, Director of the DHCF Health Care Delivery Management Administration at [lisa.truitt@dc.gov](mailto:lisa.truitt@dc.gov).

Sincerely,



Melisa Byrd  
Senior Deputy Director and Medicaid Director  
D.C. Department of Health Care Finance

---

441 4<sup>th</sup> Street NW, Suite 900 South, Washington, D.C. 20001 (202) 442-5988 Fax (202) 442-4790