

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**AUDIT OF MEDICARE PART D  
PHARMACY FEES: GROUP HEALTH  
COOPERATIVE, INC.**

*Notice: Information in this report has been redacted because it contains commercial, financial, or confidential information pertaining to the auditee.*

*Inquiries about this report may be addressed to the Office of Public Affairs at  
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**Amy J. Frontz**  
Deputy Inspector General  
for Audit Services

July 2021  
A-03-19-00002

# *Office of Inspector General*

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## Report in Brief

Date: July 2021

Report No. A-03-19-00002

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



### Why OIG Did This Audit

Medicare Part D is an optional program to help Medicare beneficiaries pay for prescription drugs. For drugs dispensed to Part D beneficiaries, Part D prescription drug plan sponsors may receive direct and indirect remuneration (DIR), which consists of rebates, subsidies, or other price concessions that decrease the costs that a sponsor incurs for a Part D drug. Part D sponsors or their pharmacy benefit managers (PBMs) may negotiate with pharmacies to charge various fees, and these fees are included as DIR. Part D sponsors are required to report their DIR to the Centers for Medicare & Medicaid Services (CMS) each year.

Our objective was to determine whether Group Health Cooperative, Inc. (GHC), complied with Federal requirements for reporting pharmacy fees in its Summary DIR Reports.

### How OIG Did This Audit

We reviewed GHC's Summary DIR reports for contract years (CYs) 2014 through 2017 to determine whether GHC complied with Federal requirements for reporting pharmacy fees. We reviewed GHC's contracts with its PBMs as well as contracts its PBMs had with pharmacies. We reviewed point-of-sale fees totaling \$212,638 collected by its PBMs for CYs 2014, 2015, 2016 and 2017.

## Audit of Medicare Part D Pharmacy Fees: Group Health Cooperative, Inc.

### What OIG Found

For CYs 2014 and 2015, GHC did not have adequate support for the point-of-sale fees that its PBM charged to pharmacies. For CYs 2014 and 2015, its PBM reported it received at least \$52,076 and \$36,346 respectively in point-of-sale fees. GHC refiled its DIR reports twice, and the refiled amounts were not supported by other documentation that its PBM provided. As a result, we could not validate whether the amounts GHC reported to CMS were accurate.

For CY 2016, GHC's PBM did not charge pharmacy fees, and, for CY 2017, we determined that GHC correctly reported the pharmacy fees collected by its PBM.

### What OIG Recommends and Kaiser Permanente Comments

We recommend that Kaiser Permanente, which acquired GHC in 2017: (1) validate the point-of-sale fee amounts that disclosed for CYs 2014 and 2015 and refile the CY 2014 and 2015 DIR reports if appropriate, and (2) develop written policies and procedures to validate the amounts its PBM discloses before submitting the DIR reports to CMS.

Kaiser Permanente concurred with our recommendations to validate the point-of sale fee amounts disclosed for CYs 2014 and 2015, refile the DIR reports if appropriate, and develop written policies and procedures to validate the amounts its PBM discloses before submitting the DIR reports to CMS. Kaiser Permanente stated that it had worked with its PBM to validate the point-of-sale pharmacy fees that were collected during CYs 2014 and 2015. Kaiser Permanente identified a discrepancy in the amount reported in its 2019 refiling of the CY 2014 DIR. Kaiser Permanente intends to resubmit its CY 2014 DIR. However, it validated the CY 2015 DIR.

Kaiser Permanente also stated that it had revised and updated its written policies and procedures to include procedures that it will use to validate data its PBMs disclosed before submitting the DIR reports to CMS.

The full report can be found at <https://oig.hhs.gov/oas/reports/region3/31900002.asp>.

*This report contains information exempt from disclosure under the Freedom of Information Act, 5 U.S.C. § 552, or other Federal statute or regulation. All such information has been redacted from the final report posted on the Internet.*

*Notice: Information in this report has been redacted because it contains commercial, financial, or confidential information pertaining to the auditee.*

**TABLE OF CONTENTS**

INTRODUCTION..... 1

    Why We Did This Audit..... 1

    Objective ..... 1

    Background ..... 1

        The Medicare Part D Program ..... 1

        Direct and Indirect Remuneration ..... 2

        Pharmacy Payment Arrangements ..... 2

        Reconciliation ..... 2

        Group Health Cooperative..... 2

    How We Conducted This Audit..... 3

FINDING ..... 4

    Group Health Cooperative Did Not Always Have Adequate Support for Its  
    Reported Pharmacy Fees ..... 4

        Federal Regulations and Reporting Requirements ..... 4

        Contract Year 2014 and 2015 Pharmacy Fees Were Not Adequately Supported .. 5

RECOMMENDATIONS..... 6

KAISER PERMANENTE COMMENTS ..... 6

APPENDICES

    A: Audit Scope and Methodology ..... 7

    B: Auditee Comments ..... 9

## INTRODUCTION

### WHY WE DID THIS AUDIT

Medicare Part D is an optional program to help Medicare beneficiaries pay for prescription drugs. For drugs dispensed to Part D beneficiaries, Part D prescription drug plan sponsors may receive direct and indirect remuneration (DIR), which consists of rebates, subsidies, or other price concessions that decrease the costs that a sponsor incurs for a Part D drug (42 CFR § 423.308). Part D sponsors or their pharmacy benefit managers (PBMs) may negotiate with pharmacies to charge various fees, and these fees are included as DIR. Part D sponsors are required to report their DIR to the Centers for Medicare & Medicaid Services (CMS) each year.

As part of its oversight activities, the Office of Inspector General is conducting a series of audits to determine whether Medicare Part D sponsors correctly reported pharmacy fees.

### OBJECTIVE

Our objective was to determine whether Group Health Cooperative, Inc., (GHC) complied with Federal requirements for reporting pharmacy fees in its Summary DIR reports (DIR reports).

### BACKGROUND

#### The Medicare Part D Program

Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) amended Title XVIII of the Social Security Act (the Act) by establishing the Medicare Part D prescription drug program. Under Part D, which began January 1, 2006, individuals entitled to benefits under Part A or enrolled in Part B may obtain drug coverage.

To provide prescription drug benefits under Part D, CMS contracts with private entities called sponsors that act as payers and insurers. Sponsors provide a minimum set of prescription benefits, referred to as the basic benefit. For an additional premium, they may also offer supplemental benefits through enhanced alternative coverage. Sponsors may offer drug benefits through a stand-alone prescription drug plan or as part of a managed care plan known as a Medicare Advantage prescription drug plan.

CMS pays sponsors for Part D basic benefits through subsidy payments and a final payment reconciliation (the Act §§ 1860D-14 and -15).<sup>1</sup> CMS pays the subsidies prospectively throughout the plan year based in part on information in the sponsors' annual bid. The bid estimates the plan's allowable costs for providing drug benefits and includes the sponsor's anticipated drug costs, taking into consideration negotiated price concessions such as rebates.

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<sup>1</sup> Final payment determination is CMS's final plan payment based on the costs actually incurred by the Part D sponsor.

Under Part D, sponsors may contract with PBMs to manage or administer the drug benefit on a sponsor's behalf. Sponsors or their PBMs establish a pharmacy network and negotiate pharmacy reimbursement rates.

### **Direct and Indirect Remuneration**

DIR consists of any rebates, subsidies, or other price concessions, from any source, that decrease the costs that a sponsor incurs under the Part D plan (42 CFR § 423.308). DIR results from payment arrangements negotiated independent of CMS between Part D sponsors, PBMs, network pharmacies, drug manufacturers, and other parties involved in the administration of the Part D benefit. Manufacturer rebates comprise a significant share of all DIR reported to CMS. Other examples of DIR include incentive payments and risk-sharing arrangements with various parties (including PBMs), and concessions (such as pharmacy fees). Sponsors report DIR to CMS using the Summary DIR Report and Detailed DIR Report. Sponsors must submit a DIR report each contract year for each plan that they offer and must report DIR in accordance with CMS's annual DIR Reporting Requirements.

### **Pharmacy Payment Arrangements**

Pharmacy payment arrangements may include price concessions in the form of pharmacy fees. Pharmacy fees occur when the sponsor or its PBM receives amounts from pharmacies or makes incentive payments to pharmacies. For example, a PBM may charge a pharmacy fee for being part of the PBM's preferred networks or for not meeting certain performance metrics such as generic dispensing rates. The contracts between a pharmacy and a sponsor or its PBM dictate the terms and timing of the concessions.

### **Reconciliation**

After the close of the plan year, CMS is responsible for calculating the final payment amount for each Part D sponsor by reconciling the prospective payments made to the sponsor to the sponsor's actual allowable costs (42 CFR § 423.343). Total prospective payments include certain CMS subsidy payments and beneficiary premiums minus administrative costs. Actual allowable costs are generally the payments that the sponsor makes for covered drugs less reported DIR.

### **Group Health Cooperative**

GHC, a health maintenance organization founded in 1945, was a nonprofit corporation based in Seattle, Washington, that provided Medicare Part D coverage to beneficiaries in Washington State. In February 2017, Kaiser Permanente acquired GHC.

For contract years (CYs) 2014 through 2016, GHC used [REDACTED] as its PBM. [REDACTED] provided a claims adjudication process and an online claims processing service. [REDACTED] charged network pharmacies a standard point-of-sale fee for CYs 2014 and 2015. The fee amount varied by contract, and pharmacies were charged

per transaction for [REDACTED] to process the claim. [REDACTED] withheld the fees from future pharmacy payments rather than at the point of sale and retained these fees from pharmacies. For CY 2016, [REDACTED] did not charge pharmacy fees.

For CY 2017, GHC used [REDACTED] as its PBM. [REDACTED] provided claim adjudication, benefit administration and maintenance, and pharmacy network administration services. [REDACTED] charged network pharmacies a flat transaction fee to process the pharmacy claim. According to [REDACTED] the amount of the fee varied by contract. [REDACTED] withheld the fees from future pharmacy payments rather than at the point of sale and retained these fees but disclosed them to GHC.

## HOW WE CONDUCTED THIS AUDIT

We reviewed GHC's DIR reports for CYs 2014 through 2017 (the audit period) to determine whether GHC complied with Federal requirements for reporting pharmacy fees. We reviewed GHC's contracts with [REDACTED] as well as contracts [REDACTED] had with pharmacies. We reviewed pharmacy fees totaling \$86,237 and \$36,346 reported collected by [REDACTED] for CYs 2014 and 2015 respectively and \$90,054 reported collected by [REDACTED] for CY 2017. For CY 2016, [REDACTED] did not collect pharmacy fees for GHC claims.

To determine whether GHC reported pharmacy fees in accordance with Federal requirements, we reviewed GHC's DIR reports submitted through the CMS Health Plan Management System (HPMS) for CYs 2014, 2015, 2016, and 2017. We also requested the DIR reports from GHC and reconciled them with GHC's DIR reports submitted to HPMS. We reviewed prescription drug event (PDE)<sup>2</sup> data records by service plan type, prescription count, and sum of ingredient cost plus dispensing fees. We selected a judgmental sample of 15 pharmacies [REDACTED] contracted with and 23 pharmacies [REDACTED] contracted with to determine whether they defined terms for payments to or from pharmacies.

We requested a sample explanation of benefits, which detailed the health care claim payment and advice details, for the 15 pharmacies sampled from [REDACTED] for CYs 2014 through 2016. We also reviewed pharmacy fees associated with the 23 pharmacies sampled from [REDACTED] for CY 2017. We followed up with [REDACTED] and requested supporting documentation for the fees that were reported as DIR for CY 2017.

We also requested a sample of the explanations of benefits for paid claims and analyzed them for payments to or from pharmacies. We followed up with GHC regarding contracts that had point-of-sale fees per transaction.

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

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<sup>2</sup> Every time a beneficiary fills a prescription covered under Part D, plans must submit to CMS a summary record called the PDE record. The PDE record contains information about the drug, the dispensing pharmacy, and cost and payment data; this information enables CMS to make payments to plans and otherwise administer the Part D benefit.



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 A contains the details of our audit scope and methodology.

## FINDING

For CYs 2014 and 2015, GHC did not have adequate support for the point-of-sale fees that ██████████ charged to pharmacies. For CYs 2014 and 2015, ██████████ reported it received at least \$52,076 and \$36,346 respectively in point-of-sale fees. GHC refiled its DIR reports twice, and the refiled amounts were not supported by other documentation that ██████████ provided. As a result, we could not validate whether the amounts GHC reported to CMS were accurate.

For CY 2016, ██████████ did not charge pharmacy fees, and, for CY 2017, we determined that GHC correctly reported the pharmacy fees collected by ██████████.

### **GROUP HEALTH COOPERATIVE DID NOT ALWAYS HAVE ADEQUATE SUPPORT FOR ITS REPORTED PHARMACY FEES**

#### **Federal Regulations and Reporting Requirements**

Section 1860D-15(f)(1)(A) of the Act requires Part D sponsors to fully disclose to CMS any information necessary for carrying out Part D's payment provisions, including reinsurance and risk-sharing calculations. Each Part D sponsor is required to report to CMS its drug costs and DIR associated with the Medicare prescription drug benefit, and CMS uses these data to calculate its payments to each Part D sponsor.

Following the end of each contract year, CMS issues the final Part D DIR reporting requirements for the previous year. While the requirements are generally consistent from year to year, CMS may expand or change the reporting requirements. The DIR Summary Report is divided into multiple columns for reporting various types of DIR, and the columns sponsors used for reporting pharmacy fees changed between CY 2014 and CY 2015 and again between CY 2015 and CY 2016.<sup>3</sup>

For CY 2014, CMS required sponsors to report post point-of-sale administrative fees in column 5, "Price Concessions for Administrative Services." Sponsors were required to use this column to report "Applicable price concessions for administrative services that are not associated with a specific drug . . . with no portion allocated for non-Part D covered drugs." The requirements for the column also specified that "This DIR must fully accrue to the government

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<sup>3</sup> Although the columns changed from year to year, the requirements remained the same for 2014, 2015, and 2016.

and beneficiaries and cannot be kept by the Part D sponsor. This column must also include post point-of-sale per claim administrative fees.”

For CY 2015, CMS required sponsors to report pharmacy fees in column 9, “Other Pharmacy Incentive Payments and Adjustments.” Sponsors were required to use this column to report “any sum received from or paid to a pharmacy *after* the point-of-sale based on factors other than generic dispensing.”

For CYs 2016 and 2017, CMS required sponsors to report pharmacy fees in column 8, “Amounts Received from Pharmacies.” Sponsors were required to use this column to report “any sum *received* by a PBM or Part D sponsor (directly or indirectly through the PBM) from a pharmacy *after* the [point of sale] that is not otherwise required to be included in the negotiated price.” Sponsors were specifically required to include “any amounts received and retained by PBMs” and “per-claim administrative fees collected, not paid, by a Part D sponsor or PBM from pharmacies *after* the [point of sale] that are not included in the negotiated price.”

### **Contract Year 2014 and 2015 Pharmacy Fees Were Not Adequately Supported**

Although ██████████ provided some support for the pharmacy fee amounts it reported to GHC for CYs 2014 and 2015, these amounts were not supported by other documentation that ██████████ provided. For example, for some pharmacies, either the pharmacy fee rate in the contract was different than the rate used, or the contract did not contain any information about point-of-sale fees to be charged to or taken back from the pharmacy. As a result, we could not validate whether the amounts GHC reported to CMS were accurate.

In its original filed DIR reports, GHC reported pharmacy fees of \$86,237 and \$36,346 for CYs 2014 and 2015 respectively. In 2016, ██████████ provided GHC with information to refile its 2014 and 2015 DIR reports. GHC misunderstood ██████████ instructions and reduced the pharmacy fee amount to \$0 for both CYs. After the start of our audit, Kaiser Permanente refilled GHC’s 2014 and 2015 DIR reports. In September 2019, the 2014 DIR reports were adjusted to report \$52,076 for pharmacy fees. In July 2020, the 2015 DIR reports were adjusted to report \$36,346 for pharmacy fees. We were unable to determine whether this amount is correct because the terms of ██████████ contracts with pharmacies did not always support the pharmacy fees.

At the time it originally filed its CY 2014 and 2015 DIR reports, GHC did not have adequate policies and procedures to verify whether the amounts its PBM submitted to prepare its DIR reports were correct. After Kaiser Permanente bought GHC in February 2017, it instituted various tests to assure itself of the accuracy of the information its PBM provided. However, these tests were not formally documented.

The MMA requires that CMS calculate the difference between the prospective payments received by a sponsor and the actual allowable costs incurred. The allowable costs are generally payments that the sponsor makes for covered drugs less reported DIR. CMS uses the amounts reported in the DIR reports to make final payment determinations. In this case, CMS

will use the refiled DIR amounts for reconciliation to determine final payments. If the current amounts reported on the CY 2014 and 2015 DIR reports are incorrect, this would cause final payment determinations for later years to be incorrect.

### RECOMMENDATIONS

We recommend that Kaiser Permanente:<sup>4</sup>

validate the point-of-sale fee amounts that [REDACTED] disclosed for CYs 2014 and 2015 and refile the CY 2014 and 2015 DIR reports if appropriate, and

develop written policies and procedures to validate the amounts its PBM discloses before submitting the DIR reports to CMS.

### KAISER PERMANENTE COMMENTS

Kaiser Permanente concurred with our recommendations to validate the point-of-sale fee amounts disclosed for CYs 2014 and 2015, refile the DIR reports if appropriate, and develop written policies and procedures to validate the amounts its PBM discloses before submitting the DIR reports to CMS. Kaiser Permanente stated that it had worked with its PBM to validate the point-of-sale pharmacy fees that were collected during CYs 2014 and 2015. Kaiser Permanente identified a discrepancy in the amount reported in its 2019 refiling of the CY 2014 DIR. Kaiser Permanente intends to resubmit its CY 2014 DIR. However, it validated the CY 2015 DIR.

Kaiser Permanente also stated that it had revised and updated its written policies and procedures to include procedures that it will use to validate data its PBMs disclose before submitting the DIR reports to CMS.

Kaiser Permanente's comments are included in their entirety as Appendix B.

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<sup>4</sup> We are addressing our recommendations to Kaiser Permanente because it acquired GHC in February 2017.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

We reviewed GHC's DIR reports for CYs 2014 through 2017 to determine whether GHC complied with Federal requirements for reporting pharmacy fees. We selected a judgmental sample of 15 pharmacies [REDACTED] contracted with and 23 pharmacies [REDACTED] contracted with and reviewed the contracts that the pharmacies had with [REDACTED]. We reviewed reported pharmacy fees totaling \$86,237 and \$36,346 that were collected by [REDACTED] for CYs 2014 and 2015, respectively. For CY 2017, we covered pharmacy fees totaling \$90,054 that were collected by [REDACTED]. For 2016, [REDACTED] did not collect pharmacy fees for GHC claims. We also requested a sample of remittance advices and other source documentation from the 15 pharmacies [REDACTED] contracted with to determine whether GHC reported pharmacy fees in accordance with Federal requirements.

We did not audit the overall internal control structure of GHC or its PBMs. Rather we audited only those internal controls related to our objective. We limited our audit to determining whether GHC complied with Federal requirements for reporting pharmacy fees in its DIR reports.

We conducted our audit, which included fieldwork at [REDACTED] from September 2019 to April 2020.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance pertaining to reporting DIR payments to and from pharmacies;

- reviewed GHC's policies and procedures for DIR reporting;

- met with GHC to gain an understanding of its DIR process;

- met with [REDACTED] to gain an understanding of their claims and DIR processes;

- obtained and reviewed PDE records;

- obtained GHC's DIR reports from CMS's HPMS;

- obtained and reviewed DIR reports provided by GHC;

- reviewed the contracts between GHC and [REDACTED] and between GHC and [REDACTED]

selected a judgmental sample of contracts [REDACTED] had with pharmacies; and

reviewed pharmacies' explanations of benefits.

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: KAISER PERMANENTE COMMENTS



Kaiser Foundation Health Plan  
Program Offices

April 26, 2021

### VIA USPS MAIL AND ELECTRONIC MAIL

Attn: Ms. Nicole Freda, Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Inspector General ("OIG")  
Office of Audit Services, Region III  
Strawbridge Building  
801 Market St., Suite 8500  
Philadelphia, PA 19107

**RE: Report Number: A-03-19-00002 – Audit of Medicare Part D Pharmacy Fees: Group Health Cooperative, Inc. ("GHC")**

Dear Ms. Freda:

Kaiser Permanente ("Kaiser") appreciates the opportunity to provide a written response with respect to the OIG's draft report A-03-19-0002: Audit of Medicare Part D Pharmacy Fees: Group Health Cooperative, Inc. (the "Report"). As discussed further below, the OIG provided two recommendations for Kaiser in the Report. Kaiser concurs with both of the OIG's recommendations.

#### First OIG Recommendation

The OIG recommends that Kaiser "validate the point-of-sale fee amounts that [GHC's PBM] disclosed for CYs 2014 and 2015 and refile the CY 2014 and 2015 DIR reports if appropriate." In the Report, the OIG found that for contract years ("CY") 2014 and 2015, OIG could not validate whether the amounts GHC reported to the Center for Medicare and Medicaid Services ("CMS") through its Direct and Indirect Remuneration ("DIR") reports were accurate with respect to the point-of-sale fees that GHC's PBM charged to pharmacies and retained.

Kaiser acquired GHC in February 2017<sup>1</sup> and discovered at the start of the OIG's audit that the DIR fees for CY 2014 and 2015 reported by GHC to CMS before Kaiser's acquisition were incorrect as a result of certain miscommunications between GHC and its PBM as noted in the Report. Consequently, Kaiser refiled the DIR reports in 2019 for CY 2014 and 2020 for CY 2015 to CMS with what it believed to be the appropriate DIR amounts for point-of-sale pharmacy fees collected by the PBM as reported to Kaiser by the PBM.

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<sup>1</sup> Following Kaiser's acquisition in 2017, GHC discontinued using its contracted PBM and shifted to Kaiser's contracted PBM.

Kaiser concurs with the OIG's first recommendation. Since Kaiser's Exit Conference with the OIG in November 2020, Kaiser has worked with the PBM to validate the point-of-sale pharmacy fees that the PBM collected during CY 2014 and 2015. Kaiser and the PBM identified a discrepancy in the DIR amount that was previously reported by Kaiser in its 2019 refiling for CY 2014. Accordingly, Kaiser intends to request a reopening from CMS to open the portal for resubmission of DIR for CY 2014 so Kaiser may update the amount previously reported by Kaiser in 2019. With respect to CY 2015, Kaiser and the PBM have validated that the DIR refiling by Kaiser in 2020 was accurate. Consequently, Kaiser has determined that no DIR resubmission is necessary for CY 2015.

Second OIG Recommendation

The OIG also recommends that Kaiser "develop written policies and procedures to validate the amounts its PBM discloses before submitting the DIR reports to CMS." In the Report, the OIG found "that at the time [GHC] originally filed its CY 2014 and 2015 DIR reports, GHC did not have adequate policies and procedures to verify whether the amounts its PBM submitted to prepare its DIR reports were correct." The Report further states that "[a]fter Kaiser bought GHC in February 2017, it instituted various tests to assure itself of the accuracy of the information its PBM provided. However, these tests were not formally documented by Kaiser."

Kaiser also concurs with the OIG's second recommendation. At the conclusion of the OIG's audit testing phase in October 2020, Kaiser's internal written policies and procedures were formally revised and updated to specify the procedures Kaiser uses to validate the data disclosed to Kaiser by the PBM before Kaiser submits its DIR report to CMS. This data validation process is performed in conjunction with periodic audits of the PBM to support reporting accuracy. Finally, we note that as of 2018, Kaiser's PBM does not collect any point-of-sale pharmacy fees on Medicare Part D claims, further mitigating any future DIR reporting issues with respect to pharmacy fees.

We thank the OIG audit staff who conducted the review for their professionalism and responsiveness throughout the audit.

Sincerely,



Agnes Strandberg  
Senior Vice President, Medicare