DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF BENEFITS ADMINISTRATION

AUDIT AND MONITORING REPORT

CONTRACT COMPLIANCE FOR CVS/CAREMARK PURSUANT TO PUBLIC ACT 408 OF THE 108TH GENERAL ASSEMBLY

1900 WRS TENNESSEE TOWER
312 ROSA L. PARKS AVE
NASHVILLE, TENNESSEE
37243

AUDIT AND MONITORING REPORT

TCA §4-3-1021(a) STATUTORY REQUIREMENT

The Department of Finance and Administration, Division of Benefits Administration, has generated this report pursuant to Public Act 408 of the 108th General Assembly. Public Act 408 of the 108th General Assembly requires the Department of Finance and Administration to monitor, and cause to be audited, the state-sponsored public sector health plans' Pharmacy Benefit Manager's compliance with the Pharmacy Benefits Manager contract. This report represents the results of the state's audit and monitoring plan. For this reporting period, the state's qualified independent auditor is Aon Hewitt and the state's contracted Pharmacy Benefits Manager is CVS/caremark. Public Act 408 of the 108th General Assembly requires this report be delivered annually on or before July 1st to the Lieutenant Governor, the Speaker of the House of Representatives and the Fiscal Review Committee.

TCA §4-3-1021(b) FIRST YEAR RISK ASSESSMENT

Public Act 408 of the 108th General Assembly subsection 1(b) requires the Department of Finance and Administration to conduct a risk assessment within one year of entering into a Pharmacy Benefits Management contract. The current Pharmacy Benefits Management contract was entered into on January 1, 2015 (benefits go-live date). The Division of Benefits Administration, part of the Department of Finance & Administration, completed the pharmacy risk assessment on December 15, 2015. There were no material areas of risk not already being mitigated or monitored in the current monitoring plan. A copy of the pharmacy risk assessment was provided to the Comptroller's Office.

TCA §4-3-1021(c)(1) REPRICING OF PHARMACY CLAIMS AT THE DRUG LEVEL

Aon Hewitt audited CVS/caremark's compliance with this requirement and presented their findings in a report entitled *Prescription Drug (Rx) Audit Findings* dated June 2016. Aon Hewitt presented this audit's results to the state on June 6, 2016. The purpose of this audit was to perform a review of CVS/caremark's administration of the state's Pharmacy Benefits Management program and to validate CVS/caremark's performance of financial guarantees for the period of January 1, 2014-December 31, 2014.

Aon Hewitt auditors re-adjudicated 100% of paid claims electronically (by complete file load and re-priced against an independent data source) to confirm accurate application of ingredient cost discounts and dispensing fees. Auditors re-adjudicated 100% of paid prescription drug claims (retail, mail order and specialty) processed during calendar year 2014 to:

- Electronically re-price all pharmacy claims against an independent data source in accordance with the contractual arrangements in effect from January 1 through December 31, 2014 to examine the accuracy of the claim payments.

- Compare actual discounts and dispensing fees achieved against contract guarantees and compare CVS/caremark's year-end reconciliation report for calendar 2014.

For the period of January 1, 2014-December 31, 2014, CVS/caremark reported to the state that it had met all contractual guarantees related to ingredient costs, dispensing fees, specialty claim discounts, and claim AWP. Aon Hewitt auditors noted in their audit report that "…*CVS met all discount guarantees for CY2014, including specialty pricing…"* with regard to ingredient costs and dispensing fees. Auditors further noted that "*A review of the State's financial guarantees indicates that CVS met all contracted discount and dispensing fees with only minor, immaterial exceptions in dispensing fees.*." and with regard to claim AWP that "…*the AWP used by CVS in re-pricing the State claims accurately reflects industry AWP data sources*." Auditors also suggested future PBM contract language for the state to consider which focuses on individual discount guarantees with an overall discount guarantee for all specialty drugs. Benefits Administration notes this and will consider for future PBM procurement activities.

TCA §4-3-1021(c)(2) VALIDATION OF THE NATIONAL DRUG CODE (NDC) USAGE

Aon Hewitt monitored CVS/caremark's compliance with this requirement in an audit entitled *Prescription Drug (Rx) Audit Findings* Aon Hewitt presented this audit's results to the state on June 7, 2016. The pharmacy audit scope period was for pharmacy claims processed for the state account from January 1, 2014 through December 31, 2014.

Auditors reviewed the National Drug Codes (NDC) received and matched them with their internal data (purchased from Medispan) to ensure that CVS/caremark used valid NDCs for claims adjudication. Auditors then used the NDCs to verify that the Average Wholesale Prices (AWP) that CVS/caremark used were correct as a basis of the pricing for each claim (based on the date the claim was processed). According to the analysis performed "…*auditors did not find any issues related to the usage of the NDCs."*

TCA §4-3-1021(c)(3) APPROPRIATENESS OF THE NATIONALLY RECOGNIZED REFERENCE PRICES, OR AVERAGE WHOLESALE PRICE (AWP) IN ACCORDANCE WITH TCA §56-7-3104

TCA §56-7-3104 reads as follows:

> ***56-7-3104. Calculation of reimbursement of pharmacy benefits manager.***
>
> ***(a)*** *Reimbursement by a pharmacy benefits manager under a contract to a pharmacist or pharmacy for prescription drugs and other products and supplies that is calculated according to a formula that uses a nationally recognized reference in the pricing calculation shall use the most current nationally recognized reference price or amount in the actual or constructive possession of the pharmacy benefits manager or its agent.*

> ***(b)*** *For purposes of compliance with this section, pharmacy benefits managers shall be required to update the nationally recognized reference prices or amounts used for calculation of reimbursement for prescription drugs and other products and supplies no less than every three (3) business days.*

Aon Hewitt audited CVS/caremark's compliance with this requirement in an audit entitled *Prescription Drug (Rx)Audit Findings*, and presented this audit's results to the state on June 6, 2016.

CVS/caremark has contractual guarantees with the state to achieve prescription discounts (compounds excluded) from the AWP. The amount of the discount is dependent upon whether the prescription is brand or generic and the distribution type (retail, retail 90, mail order or specialty). The discounts are also dependent upon the calendar year, per the contract between CVS/caremark and the Insurance Committees (State, Local Education and Local Government).

Auditors compared the AWP used by CVS to process and reprice the State claims to an industry standard benchmark housed in a database maintained independently by auditors for this price, specifically MediSpan. Claims were parsed out into over 100 sub-categories based on attributes including claim channel (mail versus retail), drug type, basis of cost, and other claim indicators (compounds, specialty claims, etc.). According to auditors, the AWP used by CVS in re-pricing the State claims accurately reflects industry AWP data sources.

Therefore, the Department of Finance and Administration agrees that the AWP is appropriate in accordance with TCA §56-7-3104.

TCA §4-3-1021(c)(4) ELIGIBILITY OF BENEFICIARIES FOR PHARMACY CLAIMS PAID

The state monitored CVS/caremark's compliance with this requirement in-house in May 2015-April 2016.

The Department of Finance and Administration, Division of Benefits Administration's Program Integrity Group performed a review to determine whether the members for whom claims were paid each month from May 2015-April 2016 were in fact eligible for the benefit. The Program Integrity Group obtained an extract from CVS/caremark's data warehouse of all pharmacy claims paid during this time period. There were 4,402,688 pharmacy claims paid during May 2015-April 2016. The Program Integrity Group obtained an eligibility extract from Edison for the beginning of each month reviewed. The Program Integrity Group performed a data match against the pharmacy claims file and the state's own eligibility file. From the data match and subsequent research, the Program Integrity Group did not note any material findings. The Program Integrity Group continues to monitor pharmacy claims monthly for member eligibility.

TCA §4-3-1021(c)(5) FOR PHARMACY BENEFITS CONTRACTS ENTERED INTO OR RENEWED ON OR AFTER JULY 1, 2013, RECONCILIATION OF THE PHARMACY BENEFITS MANAGER'S PAYMENTS TO PHARMACIES WITH THE STATE'S REIMBURSEMENT TO THE PHARMACY BENEFIT MANAGER

The state's current PBM contract with CVS/caremark began January 1, 2015 and runs through December 31, 2019. Aon Hewitt audited CVS/caremark's compliance with this requirement and presented findings in a report entitled *Prescription Drug (Rx) Audit Findings*. Aon Hewitt presented this audit's results to the state on June 17, 2016. Aon Hewitt conducted a retail transparency review and an invoice reconciliation review as part of this audit.

Aon Hewitt examined a sample of claims from twenty-five (25) pharmacies paid from February 1, 2015 through December 31, 2015 (the January 2015 time period was previously audited as part of this same report delivered last year). Included in this sample were mixtures of pharmacies: national chain, second tier chain, independent, and a small number of non-traditional pharmacies. Auditors then randomly selected one brand and one generic claim per pharmacy where days supply was under 31 days. In addition, one brand and one generic claim was also selected where days supply was over 30 days (if noted in claim file). Auditors went onsite at CVS headquarters in Northbrook, Illinois to review the contracts and compare pricing observed in the claim sample to rates specified in the retail contracts. Aon Hewitt's comparison of gross claim costs less member-out-of-pocket amounts to invoiced amounts billed to the State confirms that CVS invoicing accurately reflects actual the State's utilization for the audit study period to within $0.00 (i.e. no variance was noted).

TCA §4-3-1021(c)(6) CONFIRMATION THAT THE PHARMACY BENEFITS MANAGER'S PAYMENTS TO PHARMACIES DO NOT REFLECT DISPARITY AMONG NETWORK PHARMACIES ATTRIBUTABLE TO PREFERENTIAL TREATMENT OF ONE (1) OR MORE PHARMACIES

Aon Hewitt audited CVS/caremark's compliance with this requirement for calendar year 2014 and presented findings in a report entitled *Prescription Drug Audit Findings - Retail Pharmacy Pricing Comparison*. Aon Hewitt presented this audit's results to the state in June 2016.

Using claims data from calendar year 2014 broken up into 6 month periods, Aon Hewitt calculated the price (discounted ingredient cost) per unit for the top 25 drugs for within four groups: retail generics (<= 83 days supply), retail 90 generics (> 83 d.s.), retail brands (<= 83 d.s.) and retail 90 brands (> 83 d.s.). These four drug types were separated by year, and further separated into six month reconciliation periods for a more granular view of the data. The data evaluated were incurred and paid claims in 2014. All brand claims were compared where the brand pricing was based on an AWP discount type (i.e. Usual and Customary [U&C] claims were excluded from the analysis). All generic claims were compared where the pricing type was MAC pricing only, and U&C claims were similarly excluded. Comparison for all generic claims was reported by month to more accurately portray pricing, but aggregated on a 6 month basis. Each drug has a unique identifier called NDC that is provided by the manufacturer. The 11-digit NDC is specific for that drug, strength, dosage form, package size, and manufacturer. Brands were compared at the 9-digit NDC level which is unique for drug, strength, dosage form and

manufacturer, but not package size. This was to prevent any issues with package size becoming a factor in the comparison.

Aon concluded: "……*Based on high relativity in price at the various retail pharmacy groups accessed, there does not appear to be a favorable pricing arrangement where CVS/caremark pays their own CVS pharmacies a different amount than they are paying their other big chains or independent pharmacies….With the knowledge obtained during this pricing review, Caremark, the PBM for the State of Tennessee, is fairly paying all their retail network pharmacies at relatively the same reimbursement rate."*

TCA §4-3-1021(c)(7) RECALCULATION OF DISCOUNT AND DISPENSING FEE GUARANTEES

Aon Hewitt audited CVS/caremark's compliance with this requirement for calendar year 2014 and presented findings in a report entitled *Prescription Drug (Rx) Audit Findings*. Aon Hewitt presented this audit's results to the state on June 6, 2016. The pharmacy audit scope period was for pharmacy claims processed for the state account from January 1, 2014 through December 31, 2014.

For the period of January 1, 2014-December 31, 2014, CVS/caremark reported to the state that it had met all of its discount and dispensing fee guarantees required in the contract. Aon Hewitt auditors verified that "*…a review of the State's financial guarantees indicates that CVS met all contracted discount and dispensing fee guarantees*…"

TCA §4-3-1021(c)(8) REVIEW OF THE STATE'S CLAIM UTILIZATION TO ENSURE THAT PER CLAIM REBATE GUARANTEES WERE ACCURATELY CALCULATED BY THE PHARMACY BENEFIT MANAGER

Aon Hewitt audited CVS/caremark's compliance with this requirement in an audit entitled *Rebate Audit Findings.* Aon Hewitt presented this audit's results to the state in a report dated June 2016.

Aon Hewitt's sub-contractor (Caribou Systems, Inc.) auditors (approved in advance by Benefits Administration) traveled onsite to the CVS/caremark Scottsdale, Arizona facility the week of February 1, 2016 to review the rebate related provisions of the contracts between CVS/caremark and five drug manufacturers selected by the Department of Finance and Administration, Division of Benefits Administration. Benefits Administration and Aon Hewitt selected three top drug manufacturers by rebates invoiced as well as two other small drug manufacturers from a smaller class that is not typically selected for audits. Auditors noted that the contract between the Insurance Committees (State, Local Education and Local Government) and CVS/caremark stipulates that CVS/caremark pass-through 100% of rebate and administrative fee manufacturer dollars to the state. Auditors' aggregate calculated minimum rebate is 0.22% higher than the minimum rebate amount determined by CVS for claims paid during the audit scope period of January 1, 2014 through December 31, 2014. This variance is considered financially immaterial as the Formulary Pass Through Rebates invoiced exceeded the per Rx minimum rebates. Auditors identified claims that were omitted during rebate invoicing, and calculated that this resulted in a shortfall of $60,500.65 which CVS/caremark confirmed and will issue a service warranty (payment) to the State upon the impending closeout of this rebate audit.

TCA §4-3-1021(c)(9) REVIEW OF REBATE CONTRACTS BETWEEN THE PHARMACY BENEFIT MANAGER AND FIVE (5) DRUG MANUFACTURERS, TO BE SELECTED BY THE BENEFTS ADMINISTRATION DIVISION OF THE DEPARTMENT, AND THE CONTRACTED AUDITOR TO ENSURE THAT ELIGIBLE REBATE UTILIZATION WAS ACCURATELY INVOICED ON BEHALF OF THE STATE

Aon Hewitt audited CVS/caremark's compliance with this requirement in an audit entitled *Rebate Audit Findings.* Aon Hewitt presented this audit's results to the state in June 2016.

The five manufacturers selected by the Department of Finance and Administration, Division of Benefits Administration for this audit were Novo Nordisk, Astra Zeneca, Daiichi, Merck & Co, Inc. and Boeringher Ingelheim. Aon Hewitt auditors reviewed all claims associated with these five manufacturers. Those claims are included in the over 4,000,000 total claims reviewed to arrive at the conclusions reported pursuant to TCA §4-3-1021(c)(8) and TCA §4-3-1021(c)(10).

CVS/caremark is contractually obligated to pay to the state the greater of the guaranteed minimum average rebate Per Claim or 100% of the rebates collected from manufacturers. Aon Hewitt found that CVS/caremark passed through materially 100% of rebates paid by the above referenced manufacturers for the time period audited, and because the Pass Through rebates exceeded the guaranteed minimum Per Rx rebates, the state is not owed additional monies other than a relatively minor $60,500.65 – the variance for one manufacturer (Merck) that exceeded auditors' tolerance (1%) and was reviewed in detail. As part of this review, auditors' identified claims that were omitted during rebate invoicing which auditors calculated resulted in a payment shortfall of $60,500.65 to the State. CVS/caremark was in agreement with this finding and will issue a check to the Division of Benefits Administration upon final, pending closeout of this rebate audit.

TCA §4-3-1021(c)(10) COMPARISON OF TOTAL REBATES COLLECTED BY THE PBM (PASS-THROUGH REBATES) TO THE MINIMUM REBATE GUARANTEES (PER CLAIM REBATES) TO ENSURE ANNUAL RECONCILIATION OF REBATE PAYMENTS TO THE STATE REPRESENTED THE GREATER OF THE TWO (2) AMOUNTS

Aon Hewitt monitored CVS/caremark's compliance with this requirement in an audit entitled *Rebate Audit Findings.* Aon Hewitt presented this audit's results to the state in June 2016.

For the audit period, auditors confirmed CVS/caremark reconciliation, where Pass Through rebates paid to the state during the time period exceeded the Per Rx minimum rebates guaranteed in the contract between CVS/caremark and the three Insurance Committees. Aon Hewitt concluded *"…auditors confirmed CVS' reconciliation where Formulary Pass Through rebates paid to the client during the time period exceeded the per Rx rebate minimum guarantees. As of 2/29/2016, the State has collected 98.81% of the rebates invoiced for 2014 utilization. CVS indicated that these dollars can take up to four years to fully collect and reimburse the amount."* Benefits Administration is in agreement with this, based on our internal rebate tracking documents.

TCA §4-3-1021(c)(11) MONITOR THE ACTIVITIES OF THE PHARMACY BENEFITS MANAGER TO ENSURE THAT THE CONTRACTOR IS CONDUCTING AUDITS AND OTHER REVIEWS OF PHARMACIES AS PROVIDED IN THE CONTRACTOR'S SCOPE OF SERVICES

The Pharmacy Benefits Manager contract requires CVS/caremark to conduct annual audits of network pharmacies, including a certain percentage of field audits. CVS/caremark currently delivers quarterly reports, called "Quarterly Field Audit/Daily Review Discrepant Amount Recovery," to meet the annual obligation. The state considers these contractually required reports as sufficient monitoring of CVS/caremark's obligation to conduct audits and other reviews of pharmacies as provided in their contracted scope of services. During the quarterly desk and field audits of network pharmacies, CVS/caremark staff audit for: different drugs billed or filled than what was written on the prescription, missing prescriptions, over billed quantities, early refills, insufficient directions for use, wrong patient or plan member, a denied patient or a denied prescriber. The PBM's reports to the Division of Benefits Administration detail: the number of new audits performed, the number of audits still open from the prior reporting period and the number of audits closed.

TCA §4-3-1021(c)(12) CONSIDERATION OF OTHER INDUSTRY RELATED RISKS TO REDUCE THE RISK OF FINANCIAL LOSSES DUE TO FRAUD, WASTE AND ABUSE

After consultation with the state's qualified independent actuary, the Division of Benefits Administration has identified a potential industry risk associated with individuals abusing prescription narcotics or pain medications, commonly referred to as "doctor shopping". CVS/caremark has protocols in place for flagging an individual's record for further review by one of CVS/caremark's clinical pharmacists. If the CVS/caremark clinical pharmacist suspects abuse, the individual's pharmaceutical record is referred to the Director of Clinical Services within the Division of Benefits Administration who works with the Division's Director of Pharmacy Services to determine if an individual's history warrants locking that individual into one (1) single pharmacy.. Locking the member into a single pharmacy causes all prescriptions to be filled at just one pharmacy. That single pharmacy and their associated pharmacists will see in real time if a member is trying to fill more than a normal quantity of a particular type of medication or is having multiple narcotics and/or pain medications prescribed by several different physicians.

The Division of Benefits Administration has identified a potential industry risk of abuse of certain drug classes used to treat narcolepsy. The drugs *Provigil* and *Nuvigil*, which are used for narcolepsy or to improve the wakefulness in patients diagnosed as having Shift Work Disorder, are increasingly abused nationwide. Members who wish to fill one of these medications must receive a prior authorization from the Pharmacy Benefits Manager (via their doctor providing to the Pharmacy Benefits Manager various medical records for review). Without a prior authorization, the Pharmacy Benefits Manager will not allow a fill of this type of prescription and the state plans would not pay for it. Also, the state Division of Benefits Administration has implemented prior authorization requirements for any drug compound with a cost over $300, and also has begun to exclude coverage of certain topical agents, bulk powders and creams and pain patches that are not FDA-approved due to an increase nationwide in fraudulent billing of these types of medications by some pharmacies. This is something that has affected not just the state-sponsored plans, but employer groups and health plans nationwide.