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

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 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 2017 pharmacy risk assessment in December 2017. The assessment found that material areas of risk were already 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 audited CVS/caremark's compliance with this requirement and presented their findings in a report entitled *Prescription Drug (Rx) Audit Findings-Financial Guarantees* dated May 2018. Aon presented this audit's results to the state on May 21, 2018. 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, 2016 - December 31, 2016.

Aon 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 2016 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, 2016 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 2016.

For the period of January 1, 2016-December 31, 2016, CVS/caremark initially reported to the state that they had missed their Retail Generics Dispensing Fee guarantee ($62,524.14 due to the State), and the Retail-90 Generics discount rate ($1,968,278.58 due to the State). CVS/caremark has already paid to the state their calculated missed discount and dispensing fee guarantees for 2016, totaling $2,030,802.72, in June 2017. Aon indicated in their report that their calculations totaling $2,035,533.70 were within the auditors' tolerance. Auditors calculated a Specialty Network Brand shortfall of $63,026.32 that CVS/caremark had not originally reported. CVS/caremark re-calculated the totals and arrived at a final amount of $67,712.52 that will be reimbursed to the State. Benefits Administration will track this payment to ensure receipt and accurate posting.

A separate audit conducted by Aon and addressed in section 6 of this report found that for a 4.5 month period during late 2016, CVS Caremark reimbursed CVS and Walmart stores at a different MAC rate on one drug (generic rosuvastatin) and only on those filled in a 90 day supply. The total estimated impact, per subsequent discussions with Aon, was $74,324.95. Benefits Administration has directed CVS Caremark to adjust those reimbursements using the same MAC list as other pharmacies for the same period.

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

Aon monitored CVS/caremark's compliance with this requirement in an audit entitled *Prescription Drug (Rx) Audit Findings-Financial Guarantees.* Aon presented this audit's results to the state on May 21, 2018. The pharmacy audit scope period was for pharmacy claims processed for the state account from January 1, 2016 through December 31, 2016.

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 audited CVS/caremark's compliance with this requirement in an audit entitled *Prescription Drug (Rx)Audit Findings-Financial Guarantees,* and presented this audit's results to the state on May 21, 2018.

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 (brand versus generic), basis of cost (AWP, MAC, ZBL, etc.) and other claim indicators (compounds, specialty claims, etc.). According to auditors' analysis, 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 2017-April 2018.

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 April 2017-March 2018 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 4,446,880 pharmacy claims paid during April 2017-March 2018. 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, consistent 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 audited CVS/caremark's compliance with this requirement and presented findings in a report entitled *Prescription Drug (Rx) Audit Findings Retail Transparency Assessment*. Aon presented this audit's results to the state on May 14, 2018. Aon conducted a retail transparency review as part of this audit.

Aon examined a sample of retail pharmacy claims paid from January 1, 2017 through December 31, 2017. Included in this sample were mixtures of pharmacies: national chain, second tier chain, independent, and a small number of non-traditional pharmacies. Auditors conducted a sample of 220 randomly selected claims per each month of 2017, the scope period, for a total of 2,640 samples. According to Aon's analysis, CVS has met their obligation to bill the State for brand and generic drug products under the State's Pass-Through Transparent Pricing terms. Based on an extensive review of claim samples, no discrepancies were noted between claim costs charged to the State and retail pharmacy reimbursement documentation.

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 audited CVS/caremark's compliance with this requirement for calendar year 2016 and presented findings in a report entitled *Prescription Drug (Rx) Audit Findings - Retail Pharmacy Pricing Comparison*. Aon presented this audit's results to the state in May 2018.

Using claims data from calendar year 2016 broken up into 6 month periods, Aon 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 2016. 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 determined from their comparison that the majority of the top 25 drugs in each of the four pricing categories that CVS pharmacy reimbursement was comparable or less than reimbursement to other chains and other retail providers. Most drugs had less than a 0.05 difference in relative value.

Auditors determined that for a 4.5 month period in 2016, all four strengths of rosuvastatin (generic Crestor for high cholesterol) at CVS stores and one other retailer were reimbursed at a higher MAC price. CVS/caremark researched this in detail and found that on August 18, 2016, CVS/caremark accidentally loaded into their systems retail 90 MAC list rates applicable to CVS/pharmacy and one other chain pharmacy that were less aggressive than the broader retail 90 network MAC list rates. Prior to August 18th the MAC list rates at CVS/pharmacy and the other chain pharmacy were equal to or greater than the rest of the pharmacies in the 90 day network. The timeframe for the difference is August 18, 2016 through December 31, 2016. As a result of this finding, the State has directed Aon to expand their audit of retail 90 generics from the top 25 drugs to the top 200 drugs.

For 2016 CVS/caremark under-performed in the 90 day network rates contracted with the State of Tennessee and reimbursed the State $1.9m for that underperformance as stated in the TCA 4-3-1021(c)(1) section of this report. If CVS/caremark had maintained the same MAC list rates for CVS/pharmacy and the other chain pharmacy during the period in question, CVS/caremark believes this would have resulted in CVS/caremark owing the State less than the $1.9m that was paid to the State.

The State has directed Aon to have CVS/caremark reprocess the claims and collect the additional amount from CVS and the other chain pharmacy. This will cause the state to receive a credit for these re-processed claims in a future invoice and CVS/caremark will need to recalculate the 2016 year end generic retail calculation and will seek reimbursement from the State for the increased performance in the generic retail results. The State is in agreement with this processing methodology.

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

Aon audited CVS/caremark's compliance with this requirement and presented their findings in a report entitled *Prescription Drug (Rx) Audit Findings-Financial Guarantees* dated May 2018. Aon presented this audit's results to the state on May 21, 2018. 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, 2016 - December 31, 2016.

Aon 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 2016 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, 2016 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 2016.

For the period of January 1, 2016 - December 31, 2016, CVS/caremark initially reported to the state that they had slightly missed their Retail Generics Dispensing Fee guarantee ($62,514.14 due to the State), and the Retail-90 Generics discount rate ($1,968,278.58 due to the State). CVS/caremark has already paid to the state their calculated missed discount and dispensing fee guarantees for 2016, totaling $2,030,802.72, in June 2017. Aon indicated in their report that their calculations totaling $2,035,893.70 were within the auditors' tolerance. Auditors calculated a Specialty Network Brand shortfall of $63,026.32 that CVS/caremark had not originally reported. CVS/caremark re-calculated the totals and arrived at a final amount of $67,712.52 that will be reimbursed to the State. Benefits Administration will track this payment to ensure receipt and accurate posting

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 audited CVS/caremark's compliance with this requirement in an audit entitled *Rebate Audit Findings.* Aon presented this audit's results to the state in a report dated March 2018.

Auditors reviewed 4,455,936 pharmacy claims processed for State of Tennessee from January 1, 2016, through December 31, 2016 in order to validate per Rx minimum rebate amounts. Auditors' aggregate calculated minimum rebate was 0.04% higher than the minimum rebate amount determined by CVS/caremark for claims paid during the audit scope period of January 1, 2016 through December 31, 2016. Per Aon, this variance is considered financially immaterial as the actual Formulary Pass-Through Rebates invoiced actually exceeded the Per Rx minimum rebates.

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 audited CVS/caremark's compliance with this requirement in an audit entitled *Rebate Audit Findings.* Aon presented this audit's results to the state in a report dated March 2018.

The five manufacturers selected by the Department of Finance and Administration, Division of Benefits Administration for this audit were Novo Nordisk, AbbVie Inc., Sanofi-Aventis, Merck & Co. Inc., and Allergan Pharmaceuticals. Aon auditors reviewed 146,729 claims associated with these five manufacturers. Those claims are included in the over 4,000,000 total claims processed

in 2016 to arrive at the conclusions reported pursuant to TCA §4-3-1021(c)(8) and TCA §4-3-1021(c)(10).

Auditors identified claims that were inadvertently omitted during rebate invoicing. Auditors calculated that this resulted in a shortfall of $10,786.79. This affected claims for three drugs from one drug manufacturer.

Auditors identified claims that were invoiced at an incorrect rate for the administration fee. This affected claims for one drug from one manufacturer for Q1 and Q2 only. Auditors calculated that this resulted in a shortfall of $8,787.09. CVS/caremark is working with the manufacturer and this will be re-invoiced. This amount will then flow back through the regular quarterly rebate process and be passed on to the state via the normal rebate pass-through amounts we receive.

CVS/caremark confirmed the auditor calculations and the final payout amount due to the State of Tennessee will be $10,786.79 for the service warranty. CVS/caremark has agreed to pay this amount to the State. Benefits Administration will ensure prompt payment of this amount due to the State.

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 monitored CVS/caremark's compliance with this requirement in an audit entitled *Rebate Audit Findings.* Aon presented this audit's results to the state in a report dated March 2018.

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. For the audit period, auditors confirmed the CVS/caremark reconciliation, where Formulary 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 indicated in their report to the State: *"…As of 1/3/2018, the State has collected 98.73% of the rebates invoiced for 2016 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 excluded 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.