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 2019 pharmacy risk assessment in December 2019. 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 2020. Aon presented this audit's results to the state in May 2020. The purpose of this audit was to evaluate CVS/caremark's accuracy of adjudication processes for the State's financial guarantees and to validate CVS/caremark's performance of financial guarantees for the period of January 1, 2018 - December 31, 2018.

Auditors used the following technique to test CVS/caremark's performance:

- **Financial Review** - 100% of paid claims were re-adjudicated (by complete file load and re-priced against independent data source) electronically to determine aggregate ingredient cost discounts and average dispensing fees. Specialty drug products were re-priced using drug specific discount guarantees. This process included validation of CVS/caremark's average wholesale prices (AWP) used in the financial audit.
- **Invoice Reconciliation Review—**100% of paid claim costs less member out-of-pocket costs were aggregated by auditors and compared to amounts invoiced to the State.

For the period of January 1, 2018-December 31, 2018, auditors compared the AWP used by CVS/caremark to process and reprice the State claims to an industry standard benchmark housed in a database maintained independently by the auditors, 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, and other claim indicators (compounds, specialty claims, etc.). AWP was examined for each category to identify variances for review. A small number of categories were identified for a claim level review based on minor variances noted (greater than 0.2%). Aon found that the AWP used by CVS/caremark in re-pricing the State Claims accurately reflect industry AWP data sources. Additionally, no duplicate claims were noted and all claims were processed at the lower of usual and customary as expected.

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 in May 2020. The pharmacy audit scope period was for pharmacy claims processed for the state account from January 1, 2018 through December 31, 2018.

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."* Additionally, no duplicate payments were noted, and no issues were noted with the retail pricing algorithm, where auditors confirmed that lower of Usual and Customary (U&C) applied as expected.

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 in May 2020.

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/caremark 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/caremark 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 2019-April 2020.

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 2019-March 2020 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 4,503,101 pharmacy claims paid during April 2019-March 2020. 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, 2020. Aon audited CVS/caremark's compliance with this requirement and presented their findings in a report entitled *Prescription Drug (Rx) Audit Findings Retail Transparency Assessment*. Aon presented this audit's results to the state on May 28, 2020. The audit time period included 100% of claims paid from January 1, 2019 through December 31, 2019 for the retail transparency review. The audit evaluated CVS/caremark's accuracy of adjudication processes for the State's financial guarantees related to retail transparency and the invoiced amounts billed to the State.

The Retail Transparency review was conducted using 100% of all claims (4.54M claims). From 100% of claims, there were 2,067,676 claims for testing (after removing 2.17M zero-balance liability claims, which are claims where the State insurance plans were not billed for the prescription; the member cost sharing or the adjudicated, discounted drug cost was paid entirely by the member), and after removing mail order claims (which, by definition, are not retail claims). The remaining 2.067M claims were further split between generic and brands to compare the costs invoiced to the State versus the amounts paid by the PBM to the pharmacies. 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 all non-adjusted claims, 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 2018 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 2020.

Using 100% of claims data from calendar year 2018 broken up into 6 month periods, Aon calculated the price (discounted ingredient cost) per unit for all eligible retail generic, retail 90 generics, retail brands and retail 90 brands. In previous years, the scope was limited to the top 25 drugs by plan spend; in this audit Aon was able to validate 100% of claims. Aon first notes that the negotiated pricing for retail 90 claims (greater than 83 days' supply) is discounted more in the State's advantage than for retail claims (less than or equal to 83 days) due to improved rates (i.e. better pricing, or lower cost) for retail 90 claims. Pricing for brands has been negotiated as a fixed discount from a pricing benchmark, AWP (Average Wholesale Price), while pricing for most generics is based on the PBM's proprietary pricing algorithm, called MAC (maximum acquisition cost). Aon notes that pricing based on these algorithms and benchmarks is in line with what Aon observes generally in the industry.

For purposes of the pricing comparison to validate relative economic equivalency, Aon assessed the pricing of claims segmented into the following four different subgroups:

1. Retail Brand claims (claims for brand drugs with less than or equal to 83 days' supply)
2. Retail Generic claims (claims for generic drugs with less than or equal to 83 days' supply)
3. Retail 90 Brand claims (claims for brand drugs with greater than 83 days' supply)
4. Retail 90 Generic claims (claims for generic drugs with greater than 83 days' supply)

Aon compared the ingredient cost per unit (e.g. cost per unit dose) for all eligible drugs for each of the above four drug types. These above 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 was claims incurred and paid during calendar year 2018. Brand claims without brand pricing based on an AWP discount (e.g. Usual and Customary (U&C) claims) were excluded from the analysis. Similarly, generic claims without MAC pricing were 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 performed at this level to eliminate the effects of package size in the comparison.

Aon stated that with the knowledge obtained during this pricing review, limited to the parameters of the audit, they (Aon) did not observe systemic instances where Caremark, the PBM for the State of Tennessee, paid retail network pharmacies at a rate less than the rate CVS reimbursed its own pharmacies for brand prescriptions. However, Aon did note minor issues related to generic reimbursement for six medications, and it is Aon's observation that CVS will issue a Service Warranty (SW) (refund) to adjust these issues. Aon notes it typically takes 30 days to complete SWs (timeline begins after the Client notifies CVS they agree with the suggestion to move to SW). Aon concluded that although certain drugs were not priced at the same amount across all retailers, the analysis indicates that brand drugs were priced fairly, and within reasonable variation (<.05) from CVS pricing. Aon notes that this variance was likely caused, in part, by differences in total utilization between retailers. At the same time, issues were noted in the generic categories, where Retail 90 Days' Supply issues were all captured in CVS/caremark's Service Warranty Report, however a number of drugs in the Retail Days Supply category were missed in this analysis. Per CVS/caremark, the impact period is January 18, 2018 through February 22, 2018 and their account team will work with the State to determine on how to handle this at the conclusion of the audit. The State's Division of Benefits Administration will follow through on this Service Warranty and reimbursement to the state.

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 2020. Aon presented this audit's results to the state in May 2020. 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, 2018 - December 31, 2018.

Auditors used the following technique to test CVS/caremark's performance:

- **Financial Review** - 100% of paid claims were re-adjudicated (by complete file load and re-priced against independent data source) electronically to determine aggregate ingredient cost discounts and average dispensing fees. Specialty drug products were re-priced using drug specific discount guarantees. This process included validation of CVS/caremark's average wholesale prices (AWP) used in the financial audit.
- **Invoice Reconciliation Review—**100% of paid claim costs less member out-of-pocket costs were aggregated by auditors and compared to amounts invoiced to the State.

For the period of January 1, 2018-December 31, 2018, CVS/caremark reported to the state that they had missed their Retail 30 generics and Retail 30 brand dispensing fees as well as their guaranteed discount rates for Retail 30 generics, Retail 90 generics, mail order generics, and specialty brands contracted with the State of Tennessee. CVS/caremark reimbursed the State $3,507,975.35 via check on August 8, 2019 as they are contractually required to reimburse the State Group Insurance Program dollar-for-dollar for any underperformance of their guarantees. Aon auditors calculated similar discount fee and dispensing fee misses and noted that the variances were "within auditors' tolerance (0.15%)." A comparison of gross claim costs less member-out-of-pocket amounts to invoiced amounts billed to the State confirms that CVS/caremark 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)(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 June 2020.

Auditors reviewed 4,423,383 pharmacy claims processed for the State of Tennessee from January 1, 2018, through December 31, 2018 in order to validate per Rx minimum rebate amounts. Auditors' minimum guaranteed rebates were 0.19% higher than reported by CVS (i.e. Aon calculated the minimum rebate guarantee as being higher than CVS calculated). Per Aon, this variance is considered financially immaterial because the Formulary Pass Through Rebates exceeded the per Rx Guaranteed Minimum Rebates. In other words, even if CVS were to accept Aon's higher calculations for this audit area, it would not result in a different financial result for the State of Tennessee for the time period under study, since the State receives the greater of Per Claim Rebate Guarantees (minimum guarantee) and Formulary Pass Through Rebates, and the Formulary Pass Through Rebates far exceeded the minimum guarantee. CVS/caremark complies with this requirement.

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 June 2020.

The five manufacturers selected by the Department of Finance and Administration, Division of Benefits Administration for this audit were AbbVie Inc., Amgen, Aventis, Eli Lilly & Co., and Novo Nordisk. Aon auditors reviewed 86,402 claims associated with these five manufacturers. Those claims are included in the over four million total claims processed in 2018 to arrive at the conclusions reported pursuant to TCA §4-3-1021(c)(8) and TCA §4-3-1021(c)(10).

Auditors identified claims invoiced at an incorrect rate for one (1) drug manufacturer that CVS has since re-invoiced at the correct rate, and the State of Tennessee will receive those collections totaling $45,301.65 as they become available from the manufacturer. These funds will flow through the normal rebate process.

One (1) Eli Lilly product was invoiced at the incorrect rate for CY 2018 and the State will be reimbursed $26,489.39 at the conclusion of the audit.

Claims for one (1) Eli Lilly product totaling $7,195.68 were eligible to earn rebates, but these claims were never submitted for rebates. A Service Warranty (refund) from CVS to the State of Tennessee will be issued at the conclusion of the audit.

A total of five (5) products between Eli Lilly and Novo Nordisk were invoiced incorrectly due to a system benefit design issue. A system correction was completed on May 12, 2020. The amount due to the State of Tennessee is $1,844,998.46 as confirmed by Aon. A Service Warranty (refund) from CVS to the State of Tennessee will be issued at the conclusion of the audit.

The grand total due to the State as a result of this audit is $1,878,683.53. Benefits Administration will ensure prompt payment of all amounts 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 June 2020.

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 Aon indicated in their report to the State: *"...For the audit scope of plan year 2018,*

auditors confirmed CVS's reconciliation where Formulary Pass Through rebates paid to the client during the time period exceeded the per Rx minimum rebate guarantees. As of 12/12/19, the State has collected 97.24% of the rebates invoiced for 2018 utilization. CVS indicated that these dollars can take up to four years to fully collect and reimburse 100% of the owed amount." Benefits Administration agrees with this, based on our internal rebate tracking documents. CVS/caremark complies with this requirement.

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 such things as: 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, or 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, Nuvigil, Xyrem and Sunosi* 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 prior authorization requirements in place 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.