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

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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 2016 pharmacy risk assessment in December 2016. 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* dated May 2017. Aon presented this audit's results to the state on May 11, 2017. 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, 2015-December 31, 2015.

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 2015 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, 2015 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 2015.

For the period of January 1, 2015-December 31, 2015, CVS/caremark initially reported to the state that they had slightly missed their Retail Generics discount rate, resulting in an amount due to the state of $803,155.75. They also initially reported missing the Retail Generics Dispensing Fee guarantee ($148,762.62 due State), the Retail Brands Dispensing Fee guarantee ($14,735.37 due State), and the Retail-90 Generics discount rate ($1,464,411.89 due State). CVS/caremark has already paid to the state their calculated missed discount and dispensing fee guarantees for 2015, totaling $2,431,065.63, in April 2016. Aon auditors, however, calculated different amounts in their audit. After working through the differences, both Aon and CVS/caremark have determined that an additional $1,428,949.74 is due to the State and a check for this amount has been ordered for distribution to the State.

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.* Aon presented this audit's results to the state on May 11, 2017. The pharmacy audit scope period was for pharmacy claims processed for the state account from January 1, 2015 through December 31, 2015.

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,* and presented this audit's results to the state on May 11, 2017

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 2016-April 2017.

The Department of Finance and Administration, Division of Benefits Administration's Program Integrity Group performed a review to determine whether the members for who claims were paid each month from May 2016-April 2017 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 4,445,857 pharmacy claims paid during May 2016-April 2017. 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 Pass Through Pricing Report*. Aon presented this audit's results to the state on May 11, 2017. Aon conducted a retail transparency review and an invoice reconciliation review as part of this audit.

Aon examined a sample of retail pharmacy claims paid from January 1, 2016 through December 31, 2016. 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 2016, the scope period, for a total of 2,640 samples. According to Aon's analysis, CVS/caremark has met their obligation to bill the State for brand and generic drug products under the State's Pass-Through Transparent Pricing terms. 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 the State's actual 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 audited CVS/caremark's compliance with this requirement for calendar year 2015 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 2017.

Using claims data from calendar year 2015 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 2015. 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 audited CVS/caremark's compliance with this requirement and presented their findings in a report entitled *Prescription Drug (Rx) Audit Findings* dated May 2017. Aon presented this audit's results to the state on May 11, 2017. 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, 2015-December 31, 2015.

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 2015 to:

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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 May 2017.

Auditors reviewed 4,366,592 pharmacy claims processed for State of Tennessee from January 1, 2015, through December 31, 2015 in order to validate per Rx minimum rebate amounts.

Auditors' aggregate calculated minimum rebate was 0.41% higher than the minimum rebate amount determined by CVS/caremark for claims paid during the audit scope period of January 1, 2015 through December 31, 2015. Per Aon, this variance is considered financially immaterial because the actual total formulary pass-through rebates paid to the state exceeded the calculated per Rx minimum rebates. The contract specifies that the state should receive the higher of the two amounts (formulary pass-through versus calculated per Rx minimum).

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 May 2017.

The five manufacturers selected by the Department of Finance and Administration, Division of Benefits Administration for this audit were Novo Nordisk, Gilead Sciences, Astra Zeneca, Johnson & Johnson and Valeant Pharmaceuticals. Aon auditors reviewed 122,709 claims associated with these five manufacturers. Those claims are included in the over 4,000,000 total claims processed in 2015 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 to drug manufacturers. Auditors calculated that this resulted in a shortfall of $5,281.81. Auditors identified claims that received the incorrect rebate rate during rebate invoicing. Auditors calculated that this resulted in a shortfall of $4,145.00. This affected claims for one drug for one manufacturer. CVS/caremark confirmed the auditor calculations and the final payout amount due to the State of Tennessee will be $9,426.81 for the service warranty. This will be paid to the State of Tennessee when the audit has been closed. 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 May 2017.

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 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 concluded *"…As of 8/31/2016, the State has collected 94.60% of the rebates invoiced for 2015 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.