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, 2021 (benefits go-live date). The Division of Benefits Administration, part of the Department of Finance & Administration, however, completes a PBM risk assessment each calendar year and the 2020 pharmacy risk assessment was completed in March 2021. 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 2021. Aon presented this audit's results to the state in May 2021. 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, 2019 - December 31, 2019.

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 financial reconciliation.

- **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, 2019-December 31, 2019, CVS Caremark reported to the state that they had missed their dispensing fees on Retail 30 brands and Retail 30 generics as well as their guaranteed discount rates for Retail 30 generics and Retail 30 brands, and specialty brands contracted with the State of Tennessee. CVS Caremark reimbursed the State $2,373,071.32 via check on April 6, 2020 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." Regarding the Invoice Reconciliation Review, 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)(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 2021. The pharmacy audit scope period was for pharmacy claims processed for the state account from January 1, 2019 through December 31, 2019.

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 2021.

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 2020-April 2021.

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 2020-April 2021were 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 4,358,421 pharmacy claims paid during May 2020-April 2021. 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 previous PBM contract with CVS Caremark began January 1, 2015 and ran 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 21, 2021. The audit time period included 100% of claims paid from January 1, 2020 through December 31, 2020 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 (4.47M claims). From 100% of claims, there were 4,363,301 claims eligible for testing (non-adjusted retail claims). These eligible 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 2019 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 2021.

Using 100% of claims data from calendar year 2019 broken up into 6-month periods, Aon calculated the price (discounted ingredient cost) per unit for all eligible retail 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 were claims incurred and paid during calendar year 2019. 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, paid retail network pharmacies at a rate less than the rate CVS reimbursed its own pharmacies.

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 2021. Aon presented this audit's results to the state in May 2021. 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, 2019 - December 31, 2019.

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 reconciliation.
- **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, 2019-December 31, 2019, CVS Caremark reported to the state that they had missed their dispensing fees on Retail 30 brands and Retail 30 generics as well as their guaranteed discount rates for Retail 30 generics and Retail 30 brands, and specialty brands contracted with the State of Tennessee. CVS Caremark reimbursed the State $2,373,071.32 via check on April 6, 2020 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." Regarding the Invoice Reconciliation Review, 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 April 2021.

Auditors reviewed 4,475,308 pharmacy claims processed for the State of Tennessee from January 1, 2019 through December 31, 2019 in order to validate per Rx minimum rebate amounts. Auditors' minimum guaranteed rebates were 0.26% 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 actual pass through rebates paid to the state 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 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 April 2021.

The ten manufacturers selected by the Department of Finance and Administration, Division of Benefits Administration for this audit were AbbVie Inc., Allergan, Amgen, AstraZeneca, Aventis, Boehringer Ingelheim, Eli Lilly & Co., Johnson & Johnson, Novo Nordisk, and Takeda. Aon auditors reviewed 223,824 claims associated with these ten manufacturers. Those claims are included in the over four million total claims processed in 2019 to arrive at the conclusions reported pursuant to TCA §4-3-1021(c)(8) and TCA §4-3-1021(c)(10).

Auditors identified a copay setup issue for 7 drugs for three manufacturers and this is part of a separate "tier issue impact analysis" – a separate project currently underway by CVS Caremark and being reviewed by Aon, Aon found an additional $11,578.39 that represented "new" issues discovered during the audit process. In addition, auditors found that supplemental rebates for three drugs from three manufacturers totaling $97,051.67 were not invoiced. CVS Caremark is in agreement that these rebates should be paid to the state. There will not be a separate service

warranty for this amount; rather, they will flow through the normal rebate invoicing process for payment to the state.

A service warranty payment of $11,578.39 will be made to the State from CVS Caremark as a result of this audit, at the conclusion of this audit. 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 April 2021.

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 2019, 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 9/30/2020, the State has collected 92.81% of the rebates invoiced for 2019 utilization. CVS indicated that these dollars can take up to four years to fully collect and reimburse the 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

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. In 2019 and 2020, a total of six members in the state group insurance program were locked into a single pharmacy for suspected doctor shopping and/or pharmacy shopping.

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.