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 audited 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 completes a PBM risk assessment each calendar year and the 2024 risk assessment was completed in March 2025. 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 *2023 Prescription Drug (Rx) Final Audit Findings-2023 Financial Guarantees* dated May 2025. Aon presented this audit's results to the state in May 2025. 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, 2023 - December 31, 2023.

Auditors used the following techniques 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. Additionally, the calculation of the Generic Drug Dispensing Rate (GDR) involved

analyzing prescription claims data to determine the percentage of generic drug claims dispensed versus total prescriptions.

- **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.

Auditors compared the AWP used by CVS Caremark to an external industry source for AWP costs, MediSpan, with the following results:

- 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). The auditors did not find any issues related to the usage of the NDCs, and no material issues were noted in the auditors' review of AWP.

In addition, the auditors found:

- No duplicate payments were noted.
- No issues were noted with compounds or paper claims.
- No issues were noted with the retail pricing algorithm, where auditors confirmed that lower of Usual and Customary (U&C) applied as expected.
- Regarding invoice reconciliation, a comparison of gross claim costs less member-out-of-pocket amounts to invoiced amounts billed to the State confirmed that CVS invoicing accurately reflects the actual State's utilization for the audit study period to within 0.0000%.

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 *2023 Prescription Drug (Rx) Final Audit Findings-2023 Financial Guarantees* dated May 2025. Aon presented this audit's results to the state in May 2025. The pharmacy audit scope period was for pharmacy claims processed for the state account from January 1, 2023, through December 31, 2023.

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*, *and no material issues were noted in the auditors' review of Average Wholesale Price (AWP)*." No duplicate payments were noted, no issues were noted with compounds or paper claims, 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 *2023 Prescription Drug (Rx) Final Audit Findings- 2023 Financial Guarantees* and presented this audit's results to the state in May 2025.

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 Medi-Span. 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 reflect industry AWP data sources.

The Department of Finance and Administration, Division of Benefits 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 2024-April 2025.

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 2024-April 2025 were in fact eligible for the benefit. The Data Integrity Team obtained an extract from CVS Caremark's data warehouse of all pharmacy claims paid during this time period. There were 4,724,051 pharmacy claims paid during May 2024-April 2025. The Data Integrity Team obtained an eligibility extract from Edison for the beginning of each month reviewed. The Data Integrity Team performed a data match against the pharmacy claims file and the state's own eligibility file. From the data match and subsequent research, the Data Integrity Team did not note any material, consistent findings. The Data Integrity Team 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 PBM contract with CVS Caremark had service delivery dates from January 1, 2021, through December 31, 2024 (with a six-month runout for claims runout). Aon audited CVS Caremark's compliance with this requirement and presented their findings in a report entitled *2024 Prescription Drug (Rx) Final Audit Findings Retail Pharmacy Transparency Pricing Review*. Aon presented this audit's results to the state in March of 2025. The audit time period included 100% of claims paid from January 1, 2024 through December 31, 2024 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. From 100% of claims, there were 4,481,358 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 Caremark 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 2023 and presented findings in a report entitled *2023 Prescription Drug (Rx) Final Audit Findings - Retail Pharmacy Pricing Comparison*. Aon presented this audit's results to the state in May 2025.

Using 100% of claims data from calendar year 2023 broken up into 6-month periods, Aon calculated the price (discounted ingredient cost) per unit for all eligible retail claims. In this audit, Aon validated 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 were claims incurred and paid during calendar year 2023. 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.

As documented in their report, limited to the parameters of the audit, Aon did not observe broad instances where CVS Caremark, the PBM for the State, paid retail network pharmacies at a rate less than the rate CVS Caremark reimbursed its own pharmacies. Based on the claims review, Aon determined that "*Caremark paid CVS stores, other chains, and independent pharmacies equally at retail. In aggregate, it does not appear that Caremark is paying CVS stores a higher amount*."

Aon audited CVS Caremark's compliance with this requirement for calendar year 2023 and presented findings in a report entitled 2023 Prescription Drug (Rx) Final Audit Findings – Mail Order & Specialty Pharmacy Pricing Comparison. Aon presented this audit's results to the state in June 2025.

Using 100% of claims data from calendar year 2023 broken up into monthly periods, Aon calculated the price (unit cost of each NDC by channel when applied to Specialty and Mail Order utilization) per unit for all eligible generics and brands. In this audit, Aon validated 100% of claims.

For purposes of the pricing comparison to validate relative economic equivalency, Aon assessed the pricing of claims segmented into the following six different subgroups:
1. CVS Specialty vs Non-CVS Specialty Brand Claims
2. CVS Specialty vs Non-CVS Specialty Generic Claims
3. CVS Mail Order vs All Others Brand Claims filled in the Standard Network

4. CVS Mail Order vs All Others Brand Claims filled in the Retail 90 Network
5. CVS Mail Order vs All Others Generic Claims filled in the Standard Network
6. CVS Mail Order vs All Others Generic Claims filled in the Retail 90 Network

Aon compared the ingredient cost per unit (e.g., cost per unit dose) for all eligible drugs for each of the above six different subgroups. Unit costs are calculated as the sum of the Ingredient Cost plus the Dispensing fee divided by the metric quantity for the channel represented. The above six different subgroups were separated into quarterly reconciliation periods for a more granular view of the data. Where applicable, Aon summarized data by National Drug Code (NDC), quarter, and days supply range. Days supply range is defined as Retail 30 (R30) 1 through 83-days supply, and Retail 90 (R90) days supply above 83. Each drug has a unique identifier called National Drug Code (NDC) that is provided by the manufacturer. The 11-digit NDC is specific for that drug, strength, dosage form, package size and manufacturer. Within the CVS Mail Order analysis, brands were compared at the 9-digit NDC level, which is unique for drug, strength, and dosage form, but not package size. Within the CVS Specialty analysis, brands were compared at the 11-digit NDC level, which is unique for drug, strength, dosage form and manufacturer and package size. This is because the variability in specialty drug products does not exist like it does for non-specialty drugs, where purchasing in small bottle sizes of 30 tablets versus larger sizes of 1000 is not generally an option for specialty drugs, Generic Code Number (GCN) is a drug classification published by First Data Bank, where all drugs with a specific strength and dosage form (e.g., Simvastatin 10mg tablets) are comparable, irrespective of the manufacturer. GCN was used for comparison of generics. This allowed for all generics for a particular drug, strength and dosage form to be aggregated at the appropriate pricing level for comparison.

Aon stated that "*Based on the claims review, Aon determined that CVS Specialty and CVS Mail Order are competitively priced as compared to other retailers; this includes the vast majority of drugs utilized by the State of Tennessee in 2023 that were priced at Usual and Customary (U&C).*"

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 *2023 Prescription Drug (Rx) Final Audit Findings- 2023 Financial Guarantees* dated June 2025. Aon presented this audit's results to the state in June 2025. 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, 2023 - December 31, 2023.

Auditors used the following techniques 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. Additionally, the calculation of the Generic Drug Dispensing Rate (GDR) involved analyzing prescription claims data to determine the percentage of generic drug claims dispensed versus total prescriptions.

- **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, 2023-December 31, 2023, CVS Caremark reported to the state that they had missed their retail pharmacy 30-day generics and brand dispensing fee guarantees, their retail pharmacy 30-day generics and brand drug discount guarantees, retail brand specialty drug discount guarantees, and specialty affiliate brand drug discount guarantees contracted with the State of Tennessee. CVS Caremark reimbursed the State $1,770,319.35 via ACH payment on March 10, 2025, and $10,488,214.71 via ACH payment received on April 14, 2025, as they are contractually required to reimburse the State Group Insurance Program dollar-for-dollar for any underperformance of their guarantees.

Aon auditors found two financial confirmed errors and three inform client observations:

Financial Confirmed Error # 1 – Auditors identified that CVS included vaccine claims in their reconciliation. However, the State of TN, Benefits Administration had sent an email to CVS that stated it was to exclude vaccine claims from calculation of the discount guarantees. Including the vaccines favored the State of TN, as the vaccine claims increased the PBM's self-reported Retail Brand pricing discount shortfall by $21,445.97 and the Retail Brand dispensing fee shortfall by $13,524.90. Excluding the claims would reduce the amount due to the client by $34,970.87.

Aon estimates that monies are owed back to the PBM totaling **($34,970.87)** due to the expected reduced shortfall.

Financial Confirmed Error # 2 – Auditors identified a difference in the Claims Sequence Number and Network ID between the claims file and the reconciliation file supplied for claims identified as National Average Drug Acquisition Cost (NADAC) in the performance financial guarantee report. Auditors were not able to accurately identify the claims included in the Retail National Average Drug Acquisition Cost (NADAC) guarantees using indicators on the claims file. Auditors used the reconciliation file to identify claims to include in the Retail National Average Drug Acquisition Cost (NADAC) guarantees.

Per the Letter of Agreement (LOA) entered on July 12, 2024, the State requested that CVS Caremark reverse and reprocess all claims for Low-Volume Pharmacies from January 1, 2023, pay the professional dispensing fee equal to the TennCare Dispensing Fee, and apply the National Average Drug Acquisition Cost (NADAC) drug reimbursement where available.

Auditors requested that CVS provide criteria to be used to identify the claims eligible for exclusion under the 7/12/24-effective Letter of Agreement between CVS and the State of TN. CVS provided a list of low-volume pharmacies. However, auditors were not able to recreate CVS' claim exclusions using the pharmacy list provided. Using the pharmacy list provided by CVS, auditors estimated that an additional 9,815 Retail Brand and 8,795 Retail Generic claims should have been excluded. Including these claims reduced the PBM's self-reported Retail Brand shortfall by $16,466.53 and increased the PBM's self-reported Retail Generic shortfall by $13,695.28. Claims have been sent to the PBM to explain why they were included in the Retail Brand/Generic Discount guarantees instead of the Retail Brand/Generic NADAC guarantees.

Aon estimates that the additional shortfall would be owed to the state, totaling **$2,771.25**.

Financial Inform Client Observation # 1 – During the audit, CVS responded to the auditors' inquiry and confirmed that payment had not yet been issued to the State for their self-reported CY2023 financial guarantee shortfalls totaling $12,354,506.51.
– Amount owed for Retail & Mail financial guarantee shortfalls: $10,584,187.16
– Amount owed for Specialty Network financial guarantees shortfalls: $1,770,319.35

Per the contract, "The Contractor shall measure guaranteed discounts and Dispensing Fees within ninety (90) days following the end of each quarter and reconcile with the State annually during the first quarter of the following calendar year. The Contractor shall reimburse the State the difference between actual discounts and fees and the contracted overall effective discounts (i.e., discount guarantees and dispensing fee guarantees) by cash or check only. Credits to the Plan are not acceptable unless otherwise approved by the State in Writing. The Contractor will pay one hundred percent (100%) of any guarantee shortfalls to the State within forty-five (45) days of the close of each annual reconciliation period, with the State retaining one hundred percent (100%) of any savings above the guarantees."

CVS Caremark responded that "*No reconciliation reporting was issued 150 days post year end for 2023 due to a large amount of claims needing to be reprocessed per a bulletin requiring reprocessing related to the State of Tennessee's Public Chapter 1070 (PC1070). A letter of agreement (LOA) was finalized with the client in July 2024. Service Warranty adjustments could not occur until the LOA was final. Reconciliation reporting was not able to start until after all complex service warranties were completed. Preliminary 2023 reconciliation reporting was provided to the client in January 2025. A revised report was given to the client in mid-February 2025. An inquiry was made to the client asking if payment should be held until audit review confirmed any amount due or if they preferred the funds to be paid now. On 2/11/25, Client asked CVS to process payment now and the audit vendor would review for accuracy of the self-reported reconciliation. Payment takes time to release due to obtaining adequate operational approvals. Nothing was released in February due to not being able to use the vendor ID as rebates were being paid in that month. The 2023 reconciliation shortfalls are expected to be paid in mid-March 2025."* As mentioned previously, the State received a reimbursement of $1,770,319.35 via ACH payment on March 10, 2025, and a reimbursement of $10,488,214.71 via ACH payment received on April 14, 2025, as they are contractually required to reimburse the State Group Insurance Program dollar-for-dollar for any underperformance of their guarantees.
Auditors have reviewed CVS' response to the draft report and determined there is a misalignment with the amount owed to the State. CVS has issued payment since release of the draft audit report; however, the payments were $95,972.45 less than expected. CVS Caremark responded that "t*he performance guarantee reporting provided during the audit was the most current reporting. However, the shortfall payment total of $10,488,214.71 was incorrectly paid from earlier reporting that was processed prior to the completion of NADAC pricing updates. As such, CVS Caremark agrees that the initial total shortfall payment that should have been made was 10,584,187.16 as per the performance guarantee reporting provided during the audit. However, as CVS has also agreed that a pricing guarantee rerun is necessary due to agreed upon findings, it will be necessary to process the rerun first in order to determine final financial impact. And before a pricing guarantee rerun can be reprocessed, the service warranty for the claims that need to be reprocessed under NADAC pricing will need to be completed. At the closure of the audit, once the service warranty is completed and the Validation Report approved, a pricing rerun will be requested and provided for approval.*"

Financial Inform Client Observation # 2 – Auditors observed that CVS excluded 6,906 claims and 1,041 COVID-19 claims due to Ingredient Costs being greater than the Full Average Wholesale Price (AWP).

In response to the claim sample, CVS stated, "Per Item 3 of the Letter of Agreement (LOA) (effective 7/12/2024), the State requested that CVS Caremark reverse and reprocess all claims for Low Volume Pharmacies from January 1, 2023, to pay the professional dispensing fee equal to the TennCare Dispensing Fee."

Auditors agree that CVS is allowed to make these exclusions; however, they received the Letter of Agreement (LOA) from CVS after the audit was completed. Thus, auditors have included this observation to explain the variance between the auditors' calculated results and CVS' self-reported shortfall.
– Excluding these claims reduced the PBM's self-reported Retail Brand shortfall by $259,175.00.
– Excluding these claims increased the PBM's self-reported Retail Generic shortfall by $48,268.03.
– Provided for informational purposes only.

Financial Inform Client Observation # 3 – Auditors observed that CVS did not achieve a Generic Discount Rate of 85% on Mail claims. Overall, the PBM did achieve the Generic Dispensing Rate (GDR) of 85% on all claims (retail and mail combined) as contractually required.

No additional monies are owed to the client due to failing to achieve the Generic Discount Rate of 85% on Mail claims.

– Provided for informational purposes only.

CVS Caremark's summary response to the audit findings, dated June 2, 2025, stated: "*CVS Caremark agrees with the following findings:*
▪ *Aon Financial Confirmed Error #1 (as originally categorized in the draft report and Unconfirmed Finding # 1)*
− *Claims for some low volume pharmacies with retroactive effective dates need to be reprocessed with NADAC pricing.*
▪ *Aon Financial Confirmed Error #2 (as originally categorized in the draft report as Unconfirmed Finding # 2)*
− *Vaccine claims should have been excluded from the pricing reconciliations per agreement between CVS and the State of Tennessee as reflected in email communications.*

Any amounts due for the above findings will be reimbursed at the conclusion of the audit. The payments represent a remittance for the previously stated findings pursuant to claims reviewed by Aon covering dates of service from January 1, 2023 through December 31, 2023. After the service warranty and pricing rerun have been completed, it is our view that we are in compliance with the plan design and there are no additional material financial discrepancies related to these findings."

Aon auditors' final response to CVS Caremark's comments in the final audit report were as follows: "*Regarding all financial audit findings and observations, auditors estimated that $63,772.83 in additional monies are due to the State. While CVS calculated an estimated amount of ($32,199.62) in monies that are owed back to CVS. At the close of the audit, CVS plans to provide a revised financial performance report to resolve the two confirmed findings. CVS will also provide support that ties to the payments for their self-reported aggregate guarantee shortfalls (since their payments do not match the original financial performance report that was provided for the audit).*"

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 *2023 Rx Rebate Audit.* Aon presented this audit's results to the state in a report dated May 12, 2025.

Auditors reviewed 4,702,208 pharmacy claims processed for the State of Tennessee from January 1, 2023 through December 31, 2023 to validate Per Rx Minimum Rebate Amounts. Auditors' aggregate calculated minimum rebate was 0.31% higher than the minimum rebate amount determined by CVS Caremark for claims paid during the audit scope period of January 1, 2023 through December 31, 2023. However, this variance is within auditors' tolerance of 2% and is financially immaterial, or not payable, for the in-scope time period as pass-through rebates exceeded the minimum guarantees. 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 *2023 Rx Rebate Audit.* Aon presented this audit's results to the state in a report dated May 12, 2025.

The ten manufacturers selected by the Department of Finance and Administration, Division of Benefits Administration for this audit were AbbVie Inc., Amgen, AstraZeneca, Boehringer Ingelheim, Dexcom, Eli Lilly & Co., Glaxo SmithKline, Johnson & Johnson, Merck & Co., Inc., and Novo Nordisk. Aon auditors reviewed 394,000 claims associated with these ten manufacturers. Those claims are included in the over four million total claims processed in 2023 to arrive at the conclusions reported pursuant to TCA §4-3-1021(c)(8) and TCA §4-3-1021(c)(10).

Auditors' aggregate base rebates were within 0.03% (or $102,860.98) higher than CVS' calculations for the in-scope manufacturers and quarters.

- Auditors identified findings totaling $920,294.99 (consisting of a $102,860.98 confirmed finding and $817,434.01 in inform client observations) as detailed below:
  - Confirmed finding totaling $102,860.98 as follows:
    - $102,860.98: Issued via Service Warranty
  - Inform Client Observations totaling $817,434.01 are as follows:
    - The State is eligible for an Incremental Annual Rebate for the estimated amount of $798,695.25. Once CVS receives payment from the manufacturer, payment will be distributed.

▪ The State is eligible for Value Based Arrangement (VBA) rebates for the estimated amount of $18,738.76. Once CVS receives payment from the manufacturer, payment will be distributed.

- During a review of Rebate Adjustments, auditors verified that all applicable payments were accurately calculated and applied in accordance with the State's contract with the PBM, confirming that the correct fees were applied for the in-scope manufacturers with no discrepancies identified.

- Aon expects CVS Caremark to reimburse the State for all findings, through a combination of Service Warranties (one-off reports and payments), and future invoicing (i.e., collected and paid based on regular course-of-business re-invoicing to manufacturers).

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 audited CVS Caremark's compliance with this requirement in an audit entitled *2023 Rx Rebate Audit.* Aon presented this audit's results to the state in a report dated May 12, 2025.

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 period of plan year 2023, auditors verified CVS' reconciliation, confirming that Manufacturer Formulary Pass-Through rebates collected exceeded the Per Claim Minimum Rebate Guarantees. As of 11/25/2024, 91.60% or $370,527,054.43 of the rebates invoiced for 2023 utilization have been collected. CVS indicated that invoiced dollars could take up to four years to fully collect, which auditors note is consistent with typical PBM rebate collection cycles."* Benefits Administration agrees with this based on our internal rebate tracking documents, and auditors note that this is within the range PBMs generally cite for the rebate collection cycle. 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 2023 and 2024, a total of three 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 significant and emerging industry risk associated with GLP-1 medications, such as semaglutide and liraglutide, which are commonly prescribed for type 2 diabetes and increasingly for weight management. These medications have seen a surge in demand, leading to heightened scrutiny around their use, distribution, and reimbursement. Due to their high cost and popularity, GLP-1 medications are particularly vulnerable to fraud, waste, and abuse (FWA). Key risks include the infiltration of counterfeit or diverted products into the supply chain, inappropriate off-label prescribing, and fraudulent billing practices such as phantom prescriptions or inflated claims. These activities not only threaten the financial integrity of healthcare programs but also pose serious safety risks to patients. To address these concerns, the Division of Benefits Administration is actively evaluating and implementing mitigation strategies. These include stricter prior authorization and quantity limitation protocols, real-time claims monitoring, and member education initiatives. Additionally, collaboration with regulatory agencies and industry partners is being strengthened to ensure compliance with federal and state laws, including the Drug Supply Chain Security Act (DSCSA). The Division of Benefits Administration remains committed to protecting the integrity of its benefits programs and ensuring that members receive safe, effective, and appropriately prescribed medications. Continued vigilance and proactive risk management will be essential in minimizing financial losses and maintaining public trust.

The Division of Benefits Administration recognizes that the rising cost and complexity of specialty medications present a significant industry risk, particularly as these treatments become more prevalent in managing chronic and rare conditions. With many specialty drugs requiring special handling, administration, or monitoring, there is growing concern around affordability, adherence, and equitable access for members. This risk is compounded by market exclusivity, limited competition, and opaque pricing structures, which can strain plan sustainability. The Division of Benefits Administration must remain vigilant in evaluating these trends to ensure continued access to high-value therapies while balancing fiscal responsibility and member outcomes.

The Division of Benefits Administration acknowledges that while manufacturer coupons can ease financial burdens for members in the short term, they present a potential industry risk by undermining formulary strategy and inflating long-term plan costs. These coupons often incentivize the use of higher-cost brand-name drugs when lower-cost, clinically equivalent alternatives are available. By bypassing member cost-sharing structures, they erode the intended steering mechanisms of tiered benefits, making it harder to manage pharmaceutical spending and ensure equitable cost distribution. Additionally, once coupons expire, members may struggle with the full out-of-pocket costs, affecting adherence and continuity of care. This dynamic creates challenges in promoting value-based care and sustaining fiscally responsible benefit designs. In addition to the direct financial implications for health plans, manufacturer coupons introduce other concerns such as data visibility challenges. Pharmacy claims systems often can't detect when a coupon has been applied, making it difficult for payers to track true patient cost exposure or evaluate utilization trends.