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 2023 risk assessment was completed in March 2024. 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 *2022 Prescription Drug (Rx) Final Audit Findings-2022 Financial Guarantees* dated May 2024. Aon presented this audit's results to the state in May 2024. 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, 2022 - December 31, 2022.

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. 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.

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 *2022 Prescription Drug (Rx) Final Audit Findings-2022 Financial Guarantees* dated May 2024. Aon presented this audit's results to the state in May 2024. The pharmacy audit scope period was for pharmacy claims processed for the state account from January 1, 2022 through December 31, 2022.

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 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 *2022 Prescription Drug (Rx) Final Audit Findings- 2022 Financial Guarantees* and presented this audit's results to the state in May 2024.

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 reflects 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 2023-April 2024.

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 2023-April 2024 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 4,621,175 pharmacy claims paid during May 2023-April 2024. 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 runs 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 *2023 Prescription Drug (Rx) Final Audit Findings Pharmacy Retail Transparency Review*. Aon presented this audit's results to the state on May 17, 2024. The audit time period included 100% of claims paid from January 1, 2023 through December 31, 2023 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 4,612,968 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 2022 and presented findings in a report entitled *2022 Prescription Drug (Rx) Final Audit Findings - Retail Pharmacy Pricing Comparison*. Aon presented this audit's results to the state in May 2024.

Using 100% of claims data from calendar year 2022 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 2022. 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 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*."

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 *2022 Prescription Drug (Rx) Final Audit Findings- 2022 Financial Guarantees* dated May 2024. Aon presented this audit's results to the state in May 2024. 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, 2022 - December 31, 2022.

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. 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, 2022-December 31, 2022, CVS Caremark reported to the state that they had missed their mail order generics and brand drug discount guarantees, retail pharmacy 30-day generics and brand drug discount guarantees, retail 90-day 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 $8,722,961.32 via a check received on August 22, 2023 as they are contractually required to reimburse the State Group Insurance Program dollar-for-dollar for any underperformance of their guarantees. Additionally, Aon auditors found three pricing errors:

Pricing Confirmed Error #1 – In May 2022, the PBM provided performance reports to the State indicating that CVS Caremark owed the state $7,585,344.76 for Retail and Mail shortfalls and $1,137,616.56 for Specialty shortfalls. However, in the performance reports provided for the audit, the amount due to the State increased to $14,494,016.72 for Retail and Mail shortfalls, and the Specialty shortfalls remained at $1,137,616.56 (an increase of **$6,908,671.96** owed to the State). When questioned about the variance between the May 2022 performance report and the December 2023 performance report, the PBM replied, "*The updated reported provided by Client Audit took into account correction of reconciling Specialty Generic with Retail Generics (issue addressed during 2021 audit). At the close of the audit, any additional payment as a result of the updated reporting will be submitted to Client.*"

Pricing Confirmed Error #2 - Auditors identified that CVS Caremark included 54,576 Retail 90 Brand claims in the Retail Brand discount guarantee. CVS Caremark included all claims with a Network ID of STTNRX, the same network reconciled as Retail 90 for the Generic guarantees. In response, CVS Caremark agreed that claims with a Network ID of STTNRX should be categorized within the Retail 90 Brand guarantee. As a result, additional funds are owed to the State. The 54,576 claims all had an AWP discount greater than the Retail Brand target discount rate of 19.50%. These claims contributed a surplus of $6,742,701.13 towards the Retail Brand discount guarantee. Removing these claims eliminates the PBM reported surplus of $6,065,540.62 and creates a shortfall of $677,160.51 in the Retail Brand category ($6,065,540.62 - $6,742,701.13 = -$677,160.51). These claims also reduced the Retail Brand dispensing fee shortfall by $8,186.40 and understated the Retail 90 Brand discount shortfall by $110,539.12.

Hence, **$795,886.03** in additional funds are owed to the State consisting of the following:

* Retail Brand Discount Shortfall: $677,160.51
* Retail Brand Dispensing Fee Shortfall: $8,186.40
* Retail 90 Brand Discount Shortfall: $110,539.12

It should be noted that the dollar amounts provided are approximations based on Auditor findings, and the PBM may calculate a different amount during the reprocessing of their reconciliation reports.

Pricing Confirmed Error #3 - CVS Caremark included 24,769 COVID-19 Test Kits into the Retail Brand discount and dispensing fee guarantees, where the Ingredient Cost is lower than the Full AWP. However, COVID-19-related products with an Ingredient Cost higher than the Full AWP are being excluded.

As per an email regarding the State's position on COVID-19 vaccines, antivirals, and at-home test kits in relation to rebate audits and financial audits, the State has agreed to exclude the following from the 2021 and 2022 audits:

* All COVID-19 vaccines
* COVID-19 antivirals (Paxlovid and Lagevrio)
* COVID-19 at-home test kits that have been required to be covered for plan members since 1/15/2022 by the federal government

Taking into account the inclusion of COVID-19 claims where the Ingredient Cost is less than the Full AWP, the PBM's reported Retail Brand discount surplus is understated by ($128,819.23), while the Retail Brand dispensing fee shortfall is inflated by ($45,373.07). This discrepancy totals **$174,192.30**.

This error may be discovered when CVS Caremark regenerates the financial performance reports after the close of the audit. If this error is corrected, it will reduce the amount of shortfall due to the client that is noted in Confirmed Error # 2.

In total, these three errors net out to **$7,530,365.69** ($6,908,671.96 + $795,886.03 – $174,192.30).

CVS Caremark's summary response to the audit findings, dated April 29, 2024 stated: "*At the close of the audit, State of Tennessee will be reimbursed seven million, five hundred sixty-two thousand, eight-hundred four dollars and seventy-two cents (**$7,562,804.72**) as payment for the additional shortfall owed as a result of the updated performance guarantee measurement. Upon confirmation from State of Tennessee that the results are accepted, the audit will be closed for the audit findings pursuant to claims reviewed by Aon and Caribou covering dates of service from January 1, 2022 through December 31, 2022*."

Aon auditors' final response to CVS Caremark's comments in the final audit report were as follows: "*Regarding all financial audit findings, auditors had estimated that $7,530,365.69 in additional monies were owed to the State. While CVS calculated a final impact amount of **$7,562,804.72** in additional monies due to the State. There is a slight difference of $32,439.03 or 5% of total net shortfall for calendar year 2022 (between the auditors and CVS' calculations) which is favorable to the State; however, the difference is attributable to data set variances*."

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 *2022 Rx Rebate Audit.* Aon presented this audit's results to the state in a report dated May 21, 2024.

Auditors reviewed 4,351,080 pharmacy claims processed for the State of Tennessee from January 1, 2022 through December 31, 2022 to validate Per Rx Minimum Rebate Amounts. Auditors'

aggregate calculated minimum rebate was 0.06% higher than the minimum rebate amount determined by CVS Caremark for claims paid during the audit scope period of January 1, 2022 through December 31, 2022. In other words, Aon calculated $122,701.50 more in minimum rebates than CVS Caremark**.** This variance is within auditors' tolerance of 2%. However, this is considered by auditors as financially immaterial for the time period under scope as the pass-through rebates provided to the state from CVS Caremark significantly 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 *2022 Rx Rebate Audit.* Aon presented this audit's results to the state in a report dated May 21, 2024.

The ten manufacturers selected by the Department of Finance and Administration, Division of Benefits Administration for this audit were AbbVie Inc., Allergan, Amgen, AstraZeneca, Boehringer Ingelheim, Eli Lilly & Co., Johnson & Johnson, Merck & Co., Inc., Novo Nordisk, and Takeda. Aon auditors reviewed 330,482 claims associated with these ten manufacturers. Those claims are included in the over four million total claims processed in 2022 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 0.22% of CVS Caremark's calculations for the in-scope manufacturers and quarters.

- Auditors identified findings totaling $979,465.67 (consisting of $409,026.32 confirmed findings, $63,017.40 unconfirmed findings, and $507,421.95 inform client observation) as detailed below:
  - Confirmed findings totaling $409,026.32 are as follows-
    - **$68,568.80**: will be issued to state via service warranty.
    - $340,457.42: payment will be pass through to the State upon collections received by CVS Caremark.
  - Unconfirmed findings totaling $63,017.40 are as follows-
    - $27,546.22: CVS Caremark asserts that these claims are ineligible for rebates. Auditors disagree, arguing that these claims should qualify for rebates.
    - $35,471.18: CVS Caremark asserts that these claims are ineligible for rebates due to not meeting specific conditions. However, auditors disagree and argue that these claims should qualify for rebates
  - Inform Client Observation totaling $507,421.95 are as follows-
    - The State is eligible for an Incremental Annual Rebate for the estimated amount of $507,421.95. Once CVS Caremark receives payment from the manufacturer, payment will be distributed.

- Additional findings related to rebate adjustments (not included in the variance noted above) amounted to $121,518.50 (consisting of $9,887.24 confirmed finding, $33,770.26 unconfirmed finding, and $77,861.00 inform client observation) as detailed below:

  o Confirmed Finding: Auditors identified additional Rebate Adjustments owed to the State totaling $9,887.24. CVS Caremark will issue a service warranty of **$9,549.84**. Auditors successfully reconciled $337.47 as CVS Caremark provided evidence of the correct invoiced amount.

  - Unconfirmed Finding: Auditors identified additional Rebate Adjustments due to the State in the amount of $33,770.26. While CVS Caremark acknowledges that these claims were subsequently invoiced for the correct amounts, auditors were unable to validate this.
  - Inform Client Observation: As of 11/30/2023, auditors observed that $77,861.00 is still owed to the State. CVS Caremark acknowledges that invoiced amounts could take up to four years to fully collect and passed through to the State.

- 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 *2022 Rx Rebate Audit.* Aon presented this audit's results to the state in a report dated May 21, 2024.

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 2022, auditors confirmed CVS's reconciliation where Manufacturer Formulary Pass-Through rebates collected exceeded the Per Claim Minimum Rebate Guarantees. As of 3/12/2024, the State has collected 94.36%, or $273,102,770.19, of the rebates invoiced for 2022 utilization. (CVS indicated that these dollars could take up to four years to fully collect. Auditors noted that this is within range PBM generally cite for the rebate collection cycle."* 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 2022 and 2023, a total of five 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. The state Division of Benefits Administration has a prior authorization requirement in place for any compound drug 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 other employer groups and health plans nationwide. Benefits Administration has implemented these and other responsible utilization management programs with our pharmacy benefits manager in order to be a responsible steward of taxpayer and other employer groups' dollars.