



STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE

REPORT ON AUDIT
OF
CAREMARK, L.L.C., CAREMARK PHC, L.L.C., AND CAREMARKPCS
HEALTH, L.L.C. ("CAREMARK")
SCOTTSDALE, AZ

FOR THE YEAR ENDED
DECEMBER 31, 2024

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SCOTTSDALE, AZ
January 22, 2026

Honorable Carter Lawrence
Commissioner
Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, Tennessee 37243

Dear Commissioner:

In accordance with your instructions and pursuant to Tennessee Code Annotated (“Tenn. Code Ann.”) § 56-7-3101 and the Tennessee Compilation of Rules and Regulations (“Tenn. Comp. R. & Regs.”) § 0780-01-95-.11, a statutory audit, as of December 31, 2024, has been made of the condition and affairs of:

Caremark, L.L.C., Caremark PhC, L.L.C., and CaremarkPCS Health, L.L.C.
 (“Caremark”)
9501 E. Shea Blvd.
MC024 (Llano)
SCOTTSDALE AZ 85260

Hereinafter referred to as (“Caremark”) or (the “Company”) and a report thereon is submitted as follows:

INTRODUCTION

This audit was arranged by the Tennessee Department of Commerce and Insurance (“TDCI” or “Department”) and was conducted by duly authorized representatives of the Department.

SCOPE OF AUDIT

This is the first audit of the Company. This audit covered the period of January 1, 2024, through December 31, 2024, and included any material transactions and/or events occurring subsequent to the audit date, which were noted during the course of the audit.

The audit was conducted in accordance with rules and procedures as prescribed by the statutes of the State of Tennessee, and in accordance with the *NAIC Market Regulation Handbook* (“Handbook”), as deemed appropriate. The audit was planned and performed to evaluate the Company’s compliance with Tennessee statutes and regulations, as of December 31, 2024.

COMPANY HISTORIES

CaremarkPCS Health, L.L.C. was originally formed as ADVP Operations, L.P., a Delaware limited partnership, on May 31, 2000. It underwent several name changes:

- Renamed AdvancePCS, L.P. in March 2001
- Renamed AdvancePCS Health, L.P. in June 2001
- Renamed CaremarkPCS Health, L.P. in September 2005

In March 2007, CVS Health Corporation (“CVS Health”) acquired the parent company of CaremarkPCS Health, L.P. In January 2009, the entity was converted to a Delaware limited liability company and became CaremarkPCS Health, L.L.C.

Caremark, L.L.C. was originally formed as Home Health Care of America, Inc., a California corporation, on June 12, 1979. It underwent the following changes:

- Renamed Caremark Homecare Inc. on September 25, 1987
- Merged with Caremark, Inc. (Delaware) and Caremark Nursing Services Inc. on March 31, 1989, becoming Caremark Inc., a California corporation
- Its parent company was acquired by CVS Health in March 2007
- Converted to a California limited liability company on April 30, 2007, and became Caremark, L.L.C.

Caremark PhC, L.L.C. was originally formed as PharmaCare Management Services, Inc., a Delaware corporation, in June 1994. It underwent the following changes:

- Converted to a Delaware limited liability company in April 2007
- Renamed Caremark PhC, L.L.C. in March 2010.

In 2018, CVS Health and a merger subsidiary acquired Aetna, a leading health care benefits provider offering a wide range of insurance products and related services including medical, pharmacy, dental, vision, behavioral health plans, medical management capabilities, and Medicare Advantage and Medicare Supplement plans. This acquisition positioned CVS Health as a major vertically integrated healthcare company.

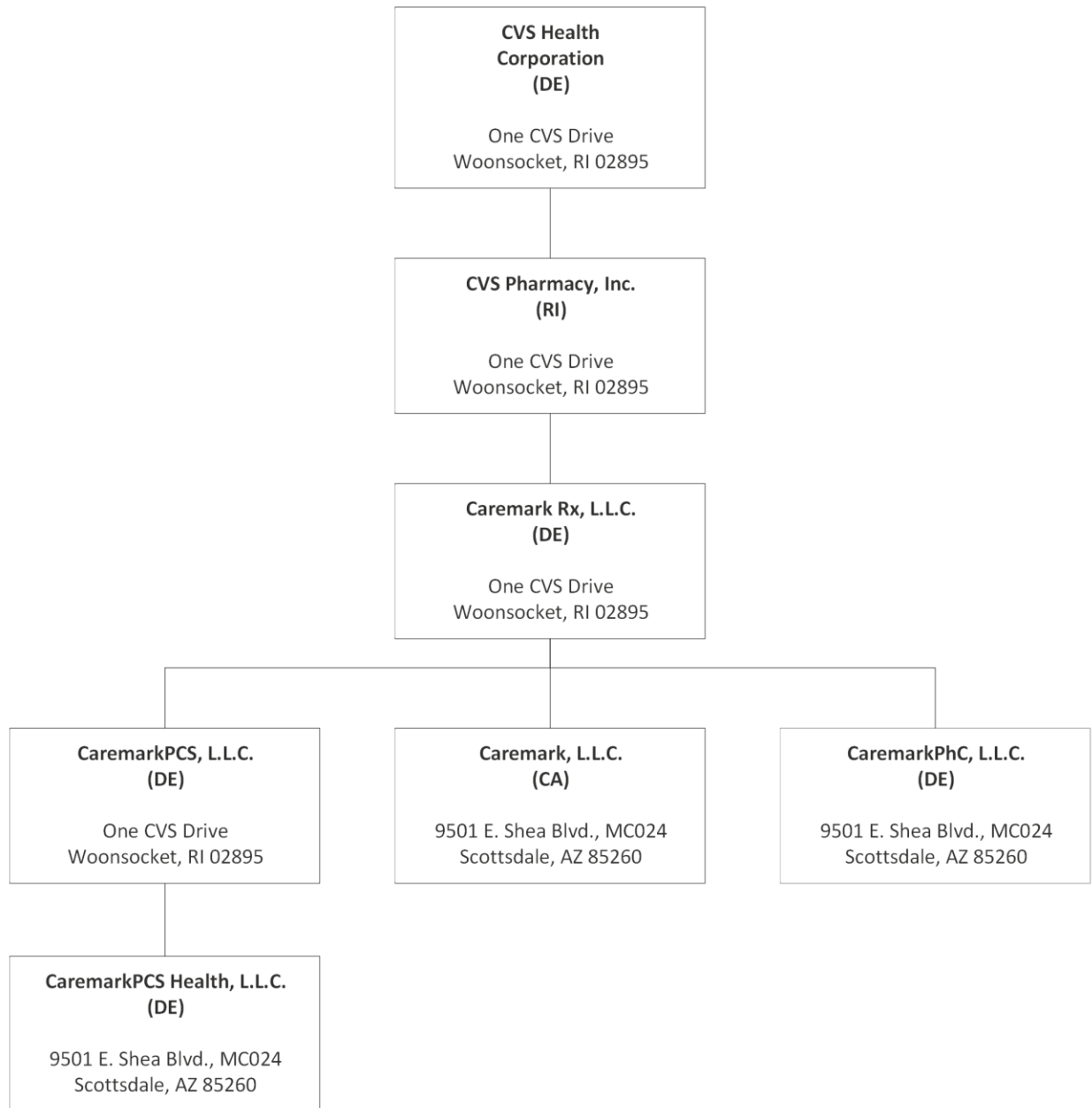
In addition to its CVS Caremark pharmacy benefit management operations, CVS Health owns a wide range of health care-related businesses including:

- **CVS Pharmacies:** A nationwide retail pharmacy chain integrated with MinuteClinic, offering in-store health services.
- **CVS Specialty Pharmacies:** Provides mail-order specialty pharmacy services for patients with complex and chronic conditions.
- **Signify Health:** Provides in-home health risk assessments, value-based care and provider enablement services.

- Oak Street Health: Operates value-based primary care centers serving Medicare eligible patients.
- Coram: Specializes in infusion therapy and home-based specialty care.
- Cordavis: A drug co-manufacturer focused on biosimilars, providing cost-effective alternatives to branded biologics.

Organizational Chart

A simplified organizational chart is presented below. All subsidiaries listed are 100% owned.



PBM OPERATIONS AND FINDINGS

A statutory audit was conducted of the Company as of December 31, 2024, addressing the following areas:

Dispensing Fee

Tenn. Comp. R. & Regs. 0780-01-95-.10 requires that a PBM pay an enhanced dispensing fee to pharmacies that submit a certification to the PBM that it qualifies as a low-volume pharmacy as defined by Tenn. Code Ann. § 56-7-3206(f).

Testwork was completed to determine whether qualifying low-volume pharmacies were timely paid an enhanced dispensing fee as set forth in Tenn. Code Ann. § 56-7-3206(f) and Tenn. Comp. R. & Regs. 0780-01-95-.10. Auditors reviewed a sample of claims from pharmacies designated by the PBM as low-volume, where the dispensing fee paid was below the required enhanced rate.

PBM policies and procedures related to low-volume pharmacy claim reimbursements were reviewed to determine compliance with Tenn. Code Ann. § 56-7-3206(f) and Tenn. Comp. R. & Regs. 0780-01-95-.10.

The auditors are aware that the Company failed to provide all self-insured commercial claims for the audit period. Note that any testwork and findings related to low volume pharmacy enhanced dispensing fees did not include all claims within scope.

Finding #1

In 4 of 115 low-volume pharmacy paid claims tested (3.5%), the Company failed to apply the correct enhanced professional dispensing fee rate, resulting in underpayments to pharmacies for services provided and non-compliance with Tenn. Code Ann. § 56-7-3206(f).

PBMs are required to reimburse low-volume pharmacies a professional dispensing fee that is no less than the amount paid by the TennCare program to low-volume pharmacies. For prescriptions filled on or after November 1, 2023, the applicable rate was raised by the Division of TennCare from \$11.98 to \$13.16.

- 2 claims were processed through a specialty network, which inadvertently applied the outdated low-volume dispensing fee rate of \$11.98 instead of the updated \$13.16 rate effective November 1, 2023.
- 2 claims were paid incorrectly due to claim processing overrides that prevented the correct enhanced dispensing fee from being applied.

Recommendation: It is recommended that the Company adopt and develop procedures to ensure that it fully complies with Tenn. Code Ann. § 56-7-3206(f).

Finding #2

In 25 of 115 low-volume pharmacy paid claims tested (21.7%), the Company failed to pay the applicable enhanced professional dispensing fee or any dispensing fee resulting in non-payment for services provided and non-compliance with Tenn. Code Ann. § 56-7-3206(f).

According to information provided by the Company, the applicable claims were submitted to Caremark and subsequently forwarded to and processed through the Cost Saver program, a discount card program. Because the claim was processed through the discount card program, the Company claimed that it was not required to reimburse the pharmacy for an enhanced dispensing fee for these claims.

Tenn. Code Ann. Title 56, Chapter 7, Parts 31 and 32, apply to certain transactions when a PBM utilizes a discount plan as part of its processing of a claim for a pharmacy benefit under an insurance plan. Because the transaction constitutes the administration of pharmacy benefits on behalf of a Covered Entity, as defined by Tenn. Code Ann. § 56-7-3102(1), the transaction is subject to the requirements under Tenn. Code Ann. Title 56, Chapter 7, Parts 31 and 32 regarding claims adjudicated by PBMs. Therefore, the Company is subject to Tenn. Code Ann. § 56-7-3206(f) and is required to pay an enhanced professional dispensing fee to qualifying low-volume pharmacies for these transactions.

Recommendation: It is recommended that the Company update its policies and procedures to ensure the low-volume pharmacies are paid a proper dispensing fee for claims when a PBM utilizes a discount plan as part of its processing of the claim for a pharmacy benefit under an insurance plan, and that it fully complies with Tenn. Code Ann. § 56-7-3206(f).

Finding #3

In 56 of the 115 low-volume pharmacy paid claims tested (48.7%), the Company failed to apply the enhanced professional dispensing fee within 7 business days of the receipt of a completed certification from a pharmacy indicating that it qualifies for the enhanced professional dispensing fee. This resulted in underpayment for services provided during the interim period and non-compliance with Tenn. Comp. R. & Regs. 0780-01-95-.10(3).

Per Tenn. Comp. R. & Regs. 0780-01-95-.10(3), when a pharmacy with an existing business relationship with a PBM submits a delayed certification for low-volume pharmacy status, the PBM must begin paying the enhanced professional dispensing fee for prescriptions dispensed on or after the seventh business day following receipt of the complete certification.

The Company's delay in applying the correct dispensing fee was due to the internal processes and procedures requiring pharmacies to perform additional steps beyond the submission of the information required for low-volume pharmacy certification found in Tenn. Comp. R. & Regs. 0780-01-95-.10(2)(b).

Recommendation: It is recommended that the Company update its policies and procedures to ensure that low-volume pharmacies are paid a proper dispensing fee within seven business days after the PBM receives a complete certification containing the elements required by Tenn. Comp. R. & Regs. 0780-01-95-.10(1) and (2).

Fair Reimbursement

Testwork was performed to determine whether the Company engaged in a pattern or practice of reimbursing pharmacies or pharmacists in this state less than the amount that the Company reimburses a PBM affiliate for providing the same drug or dispensed product or service as set forth in Tenn. Code Ann. § 56-7-3118(d).

The auditors are aware that the Company failed to provide all self-insured commercial claims for the audit period. Note that any testwork and findings related to fair reimbursement did not include all claims within scope.

Finding #4

The Company did not comply with Tenn. Code Ann. § 56-7-3118(d) when engaging in a practice of reimbursing non-affiliated pharmacies in the State of Tennessee less than the amount that the pharmacy benefit manager reimburses its affiliate pharmacies for the same drug or dispensed product. The Company used reimbursement practices that led to higher payments for prescription medications dispensed at the PBM-affiliated retail, mail order, and specialty pharmacies than payments made to the non-affiliated Tennessee pharmacies.

The auditor used price per unit (“PPU”) when assessing the Company’s payment and/or reimbursement for each drug and dosage to specific pharmacies. Auditors identified 3,646 unique dosages of different medications and/or products filled by both the affiliated and non-affiliated pharmacies in Tennessee within Quarter 1 of 2024. For 661 (18%) of those medications and/or products, the maximum reimbursement rate paid to affiliate pharmacies during the quarter exceeded the maximum reimbursement rate paid to non-affiliate pharmacies.

The table below highlights instances where several medications and/or products were filled by both affiliate and non-affiliate pharmacies within a short timeframe during Quarter 1 and often on the same day to reflect comparable market conditions. The claims noted in the table show that the Company reimbursed its affiliate pharmacies at higher rates than non-affiliates for the same drugs. While not exhaustive, the table demonstrates the Company engaged in a prohibited practice of reimbursing its affiliates more for a prescription drug or dispensed product than non-affiliates.

Medication	Date Filled by Affiliate	Date Filled by Non-Affiliate	% Difference Per Unit
Abiraterone 500mg	2/6/2024	2/5/2024	209.00%
Amlodipine/ Atorvastatin 5-40mg	3/15/2024	3/15/2024	24.33%
Aripiprazole 30mg	3/11/2024	3/10/2024	40.62%
Azelastine Sol Op 0.05%	2/8/2024	2/8/2024	224.28%
Cinacalcet 60mg	1/22/2024	1/18/2024	16510.24%
Dexmethylphenidate ER 40mg	2/27/2024	2/27/2024	420.12%
Enoxaparin 40mg/0.4ml	2/10/2024	2/10/2024	128.48%
Erleada 60mg	3/1/2024	3/1/2024	10.49%
Erythromycin 250mg	2/19/2024	2/19/2024	97.56%
Everolimus 5mg	3/15/2024	3/19/2024	50.52%
Fenofibric Acid DR 45mg	2/20/2024	2/20/2024	66.52%
Glatiramer Inj.40mg/ml	3/22/2024	3/23/2024	52.00%
Glucagon Kit 1mg	1/22/2024	1/23/2024	18.87%
Imatinib 100mg	3/10/2024	3/12/2024	74.95%
Lamotrigine ER 250mg	2/1/2024	2/1/2024	126.63%
Losartan/Hct 100-25mg	3/27/2024	3/26/2024	89.54%
Minocycline 50mg	3/28/2024	3/28/2024	134.64%
Mycophenolate 250mg	2/22/2024	2/19/2024	513.81%
Olmesartan 20mg	3/11/2024	3/11/2024	24.51%
Oseltamivir 30mg	2/29/2024	2/29/2024	191.81%
Pioglitazone/ Metformin 15-500mg	3/4/2024	3/1/2024	78.06%
Promethazine Sup 25mg	3/23/2024	3/25/2024	176.72%
Quetiapine 300mg	2/1/2024	2/1/2024	570.07%
Ropinirole 0.25mg	2/23/2024	2/22/2024	71.43%
Ropinirole ER 12mg	3/13/2024	3/15/2024	540.01%
Sirolimus 2mg	2/15/2024	2/15/2024	31.86%
Sumatriptan Vial 6mg/0.56mg	1/26/2024	1/25/2024	26.32%
Tadalafil 20mg	3/28/2024	3/28/2024	9927.39%
Testosterone Gel 1%	2/19/2024	2/19/2024	116.11%
Tizanidine 6mg	3/28/2024	3/28/2024	122.18%
Tolterodine ER 2mg	3/5/2024	3/4/2024	26.86%
Tramadol ER 300mg	2/5/2024	2/1/2024	139.58%
Venlafaxine ER 37.5mg	1/14/2024	1/17/2024	181.83%
Yuvafem Vaginal 10mcg	2/2/2024	2/2/2024	114.09%

Recommendation: It is recommended that the Company review its contracted rates and reimbursements with affiliate and non-affiliate pharmacies to develop a reimbursement model and methodology that establishes compliance with Tenn. Code Ann. § 56-7-3118.

Spread Pricing

Testwork was performed to determine whether the Company charged a covered entity — defined by Tenn. Code Ann. § 56-7-3102(1)—an amount greater than the reimbursement paid by the Company to a contracted pharmacy for prescription drugs or devices as prohibited by Tenn. Code Ann. § 56-7-3206(b). The auditors analyzed claims where the PBM, in response to a claims data request, indicated that the amount charged to the plan sponsor by the PBM for the cost of the drug or device was greater than amount paid by the PBM.

The auditors are aware that the Company failed to provide all self-insured commercial claims for the audit period. Note that any testwork and findings related to spread pricing did not include all claims within scope.

Finding #5

The Company utilized a spread pricing model, charging certain covered entities more than the reimbursement paid to contracted pharmacies for prescription drugs or devices. This practice resulted in covered entities paying above the actual cost of medications provided to their members and non-compliance with Tenn. Code Ann. § 56-7-3206(b).

Tenn. Code Ann. § 56-7-3206(b), which became effective July 1, 2021, following the enactment of Public Chapter 569, prohibits PBMs from engaging in spread pricing. It was determined that the Company had contracts and agreements that were entered into, amended, or renewed to take effect on or after July 1, 2021, that administered a spread pricing model to covered entities.

The Company did not comply with Tenn. Code Ann. § 56-7-3206(b) when charging a covered entity an amount greater than the reimbursement paid by a pharmacy benefits manager (“PBM”) to a contracted pharmacy for the prescription drug or service.

Recommendation: It is recommended that the Company adopt and develop procedures to ensure that it fully complies with Tenn. Code Ann. § 56-7-3206(b).

Initial Appeals

Testwork was performed to determine whether the Company timely and properly adjudicated initial appeals; whether, when an appeal was resolved in favor of the appealing pharmacy, the Company adjusted the reimbursement rate for the item that was the subject of the appeal and allowed the pharmacy to reverse and rebill the claim; and whether, when applicable, the Company applied the findings from the appeal as to the rate of reimbursement and actual cost of the particular drug, medical product, or device to other similarly situated pharmacies; as required by Tenn. Code Ann. § 56-7-3206 and

Tenn. Comp. R. & Regs. 0780-01-95-.03 through -.05. Auditors reviewed samples of denied and approved initial appeals submitted by Tennessee pharmacies during the audit period.

Finding #6

In 31 of 111 denied pharmacy initial appeal files tested (27.9%), the Company failed to accept an incomplete initial appeal and hold it open to allow pharmacies to submit missing information.

Pursuant to Tenn. Comp. R. & Regs. 0780-01-95-.05(3), when a PBM receives an initial appeal that lacks required information, it must still accept the appeal, notify the pharmacy within five business days about what's missing, and allow the pharmacy five business days to respond before denying the appeal.

In each of the 31 instances, the Company denied the appeal solely because the required information was not received, without allowing the full response window. As a result, the Company was not in compliance with Tenn. Comp. R. & Regs. 0780-01-95-.05(3).

Recommendation: It is recommended that the Company adopt and develop procedures to ensure that it fully complies with Tenn. Comp. R. & Regs. 0780-01-95-.05(3).

Finding #7

In 10 of 65 applicable approved pharmacy initial appeal files tested (15.4%) that were received after June 26, 2024, the Company failed to make payment(s) within 15 business days of receiving notice of the initial appeal when the appealing pharmacy failed to reverse and rebill its claim.

Effective June 26, 2024, Tenn. Comp. R. & Regs. 0780-01-95-.04(7)(b) requires that if a pharmacy does not reverse and rebill a claim after a successful appeal, the PBM must still adjust the reimbursement rate and issue payment within fifteen business days of receiving notice of the initial appeal.

By failing to make payments within the required timeframe, the Company was not in compliance with Tenn. Comp. R. & Regs. 0780-01-95-.04(7)(b).

Recommendation: It is recommended that the Company adopt and develop procedures to ensure that it fully complies with Tenn. Comp. R. & Regs. 0780-01-95-.04(7)(b).

Finding #8

In 29 of 111 denied pharmacy initial appeal files reviewed (26.1%), the Company failed to properly adjudicate initial appeals in which pharmacies alleged they were not reimbursed at least their actual cost for the prescription drug or device.

Tenn. Code Ann. § 56-7-3206(c)(2)(A) requires that PBMs establish a process for a pharmacy to appeal a reimbursement for failing to pay at least the actual cost to the pharmacy for the prescription drug or device.

- In 24 instances, the Company's appeal outcome statement indicated that the invoice documentation provided by the pharmacy was insufficient or was not an official copy of the wholesaler invoice. However, each pharmacy supplied all required information sufficient to allow the PBM to conduct a complete analysis of the initial appeal, including drug wholesaler invoices in the supporting documentation of the appeal requests.

Under Tenn. Comp. R. & Regs. 0780-01-95-.05(2), a PBM is considered to have received all necessary information to conduct a full review of a pharmacy's initial appeal once it has received two things: (1) a completed appeal form either the Commissioner's standard form or the PBM's approved version and (2) a certification from the pharmacy that it has submitted all relevant invoices or records showing the actual cost of the drug or product, including any discounts, rebates, or price reductions available at the time of the appeal.

- In 5 instances, the Company's appeal outcome statement indicated that the pharmacy must submit appeal questions directly to the dedicated GoodRx Caremark Program support line. According to information provided by the Company, the applicable claims were submitted to Caremark and subsequently forwarded to and processed through the Cost Saver program, a discount card program operated by the Company. Because the claim was processed through the discount card program, the Company claimed that the claims were not subject to Tenn. Code Ann. § 56-7-3206(c)(1).

TDCI Bulletin 24-01 dated June 18, 2024, provides additional guidance that Tenn. Code Ann. Title 56, Chapter 7, Parts 31 and 32, apply to certain transactions when a PBM utilizes a discount plan as part of its processing of a claim for a pharmacy benefit under an insurance plan. Because the transaction constitutes the administration of pharmacy benefits on behalf of a covered entity, as defined by Tenn. Code Ann. § 56-7-3102(1), the transaction is subject to the requirements under Tenn. Code Ann. Title 56, Chapter 7, Parts 31 and 32 regarding claims adjudicated by PBMs.

By failing to reimburse a contracted pharmacy at least the actual cost of a prescription drug following an initial appeal, the Company was not in compliance with Tenn. Code Ann. § 56-7-3206(c)(2)(A).

Recommendation: It is recommended that the Company develop and adopt procedures to ensure that it fully complies with Tenn. Code Ann. § 56-7-3206(c)(1).

Finding #9

In 61 of 115 approved pharmacy initial appeal files reviewed (53.0%), the Company failed to provide detailed instructions on how to reverse and rebill the claim for which the initial appeal was approved.

Under Tenn. Comp. R. & Regs. 0780-01-95-.04(3)(c), when a pharmacy prevails in an initial appeal, the PBM is required to provide written instructions to the pharmacy explaining how to reverse and rebill the claim that was the subject of the appeal.

By failing to provide detailed instructions on how to reverse and rebill the claim on which the initial appeal is based, pharmacies were prevented from taking the necessary steps to quickly receive proper reimbursement and resulted in the Company's non-compliance with Tenn. Comp. R. & Regs. 0780-01-95-.04(3)(c).

Recommendation: It is recommended that the Company adopt and develop procedures to ensure that it fully complies with Tenn. Comp. R. & Regs. 0780-01-95-.04(3)(c).

External Appeals

Testwork was performed to ensure the Company was in compliance with the established requirements for the external appeals process. Tenn. Code Ann. § 56-7-3206(g)(2) requires the Department to institute an external appeals process for any initial appeal denied by a PBM. Tenn. Comp. R. & Regs. 0780-01-95-.06 establishes the requirements for the external appeals process to be followed by the Department, appealing pharmacies, and PBMs. Auditors reviewed all approved external appeals submitted by Tennessee pharmacies during the audit period.

Finding #10

In 8 of 54 pharmacy external appeal files reviewed (14.8%), the Company did not reimburse the pharmacy at least its actual cost for the prescription drug within seven business days of receipt of the Commissioner's written notice.

Pursuant to Tenn. Comp. R. & Regs. 0780-01-95-.06(9), when a PBM is required to pay a pharmacy additional funds following the resolution of an external appeal,

it must issue the payment within seven business days of receiving the Commissioner's written notice of the appeal decision.

In the 8 instances, the Company did not reimburse the pharmacy at least its actual cost for the prescription drug within seven business days of receipt of the Commissioner's written notice.

According to information provided by the Company, the related claims were submitted to Caremark and subsequently forwarded to and processed through the Cost Saver program, a discount card program by the Company. Because the claim was processed through the discount card program, the Company claimed that the appeals were not subject to Tenn. Comp. R. & Regs. 0780-01-95-.06(9).

TDCI Bulletin 24-01 dated June 18, 2024, provides additional guidance that Tenn. Code Ann. Title 56, Chapter 7, Parts 31 and 32, apply to certain transactions when a PBM utilizes a discount plan as part of its processing of a claim for a pharmacy benefit under an insurance plan. Because the transaction constitutes the administration of pharmacy benefits on behalf of a covered entity, as defined by Tenn. Code Ann. § 56-7-3102(1), the transaction is subject to the requirements under Tenn. Code Ann. Title 56, Chapter 7, Parts 31 and 32 regarding claims adjudicated by PBMs.

By failing to reimburse the pharmacy at least its actual cost for the prescription drug within seven business days of receipt of the Commissioner's written notice, the Company was not in compliance with Tenn. Comp. R. & Regs. 0780-01-95-.06(9).

Recommendation: The Company should review and update its internal policies and procedures for providing timely payment for external reviews to ensure compliance with Tenn. Comp. R. & Regs. 0780-01-95-.06(9).

Finding #11

In 2 of 54 pharmacy external appeal files reviewed (3.7%), the Company failed to provide proof of payment of at least the actual cost owed to the pharmacy within seven business days of issuing the payment to the pharmacy.

Pursuant to Tenn. Comp. R. & Regs. 0780-01-95-.06(9), when a PBM is required to pay a pharmacy additional funds following the resolution of an external appeal, it must issue the payment within seven business days of receiving the Commissioner's written notice of the appeal decision. Additionally, the PBM must provide the Department with proof that it reimbursed the pharmacy at least its actual cost for the drug or medical product. This proof must include a statement of

the additional amount paid and must be submitted within seven business days of issuing the payment to the pharmacy.

By failing to provide the Department with proof that it reimbursed the pharmacy at least its actual cost for the drug or medical product within seven business days of issuing the payment to the pharmacy, the Company was not in compliance with Tenn. Comp. R. & Regs. 0780-01-95-.06(9).

Recommendation: The Company should review and update its internal policies and procedures for providing proof of timely payment for external reviews to ensure compliance with Tenn. Comp. R. & Regs. 0780-01-95-.06(9).

Audits of Pharmacies

Testwork was performed to determine if the Company complied with standards for timing and notice concerning pharmacy audits, standards for the conduct of the audits, and the proper determination of and handling of recoupments as a result of a pharmacy audit found in Tenn. Code Ann. § 56-7-3103 and Tenn. Comp. R. & Regs. 0780-01-95-.09. Auditors reviewed a sample of audits of Tennessee pharmacies conducted by the PBM during the audit period.

No instances of noncompliance by the Company with Tenn. Code Ann. § 56-7-3103 and Tenn. Comp. R. & Regs. 0780-01-95-.09 were noted.

OBSERVATIONS

The following list presents a summary of comments noted by the auditors:

Observation #1

On multiple occasions, the Company was unable to provide information within the timeframes requested by the Department.

At the outset of the audit, the Department requested several documents necessary to initiate the audit, with a due date of April 1, 2025. Extensions were granted for most items through April 4, 2025, and for pharmacy claims data through April 10, 2025. Despite these extensions, the Company's submission of these items was not complete until May 23, 2025. The Company's failure to provide timely and complete information contributed to significant delays in the audit process, prompting consent orders which were executed on September 23, 2025.

Additionally, the Company submitted late responses for 20 of 49 information requests issued during the course of the audit (41%).

Observation #2

In 2024, the Company received 11,402 total initial appeals from pharmacies challenging the amount reimbursed for a drug or product. The Company denied a total of 1,710 of the 11,402 initial appeals (15%) from pharmacies seeking higher reimbursement.

Pharmacies requested external appeal reviews on 259 of the 11,402 initial appeal determinations made by the Company (2.3%). The external appeal process conducted by the State of Tennessee ruled in favor of the appealing pharmacies in 54 of the 259 external appeals (21%).

Observation #3

After reviewing approved initial appeal files for 2024, it was determined that 135 appeals were submitted by the same pharmacies for the same prescription number for consecutive months. The appeals appeared to be consistent with dispensing future fills for the same prescription drug or device. It was noted that in 86 of the 135 appeals (64%), the Company adjusted the reimbursement of the prescription drug or device back to a reimbursement that was less than the newly approved rate.

Observation #4

After reviewing the approved initial appeals for 2024, it was determined that the Company increased the final reimbursement to the appealing pharmacy on average by \$35.28 or 119% and a median change of \$14.45 or 55% higher than the original claim reimbursement amount.

Observation #5

The Company does not maintain a transparent process for handling the reimbursement to similarly situated pharmacies for approved maximum allowable cost ("MAC") appeals. When reviewing documents provided, the auditors noticed there is no website that communicates claim level detail submission of wholesaler information for MAC appeals. The only website that communicates claim level detail submission of wholesaler information is for non-MAC appeals. The Company provided a Tennessee Addendum to the Caremark Provider Agreement that states:

"In addition to the above-listed required information, the PBM is required to request that the Provider submit wholesaler information associated with each reimbursement claim to the PBM each time a pharmacy files a claim for reimbursement. Tenn. Comp. R. Regs. 0780-01-95-.03(2) Provider may submit wholesaler information using the following website:

cvscaremark.tfaforms.net/f/TN_Wholesaler_Submission. Additional instructions and information are provided on this website.”

Although the Company has this process in place, it only appears to be applicable to non-MAC pricing appeals. The addendum does not communicate to pharmacies that this is applicable to MAC appeals. Additionally, it appears that only four pharmacies utilized this process, submitting wholesaler information for 237 claims, during the audit period. The information provided to pharmacies does not effectively communicate the process of submitting claim level wholesaler information to receive additional reimbursement when applicable for similarly situated pharmacies.

CONCLUSION

Rules and procedures as prescribed by the statutes of the State of Tennessee and guidance from the NAIC Market Regulation Handbook, as deemed appropriate, have been followed in connection with the audit of Caremark.

Respectfully submitted,



Elizabeth Harvey, CIE
Auditor-in-Charge
INS Regulatory Insurance Services, Inc.
Representing the State of Tennessee



[Rhonda Bowling-Black \(Feb 2, 2026 10:06:44 CST\)](#)

Rhonda Bowling-Black, CFE, ARe, MCM
Department Designee
State of Tennessee

CERTIFICATION

The undersigned certifies and says that they have duly executed the attached audit report of Caremark located in Scottsdale, AZ, dated January 22, 2026, and made as of December 31, 2024, on behalf of the Tennessee Department of Commerce and Insurance. The undersigned further says they are familiar with such instrument and the contents thereof, and the facts therein set forth are true to the best of their knowledge, information, and belief.



Elizabeth Harvey, CIE
Auditor-in-Charge
INS Regulatory Insurance Services, Inc.
Representing the State of Tennessee

CERTIFICATION

The undersigned certifies and says that they have duly executed the attached audit report of Caremark located in Scottsdale, AZ, dated January 22, 2026, and made as of December 31, 2024, on behalf of the Tennessee Department of Commerce and Insurance. The undersigned further says they are familiar with such instrument and the contents thereof, and the facts therein set forth are true to the best of their knowledge, information, and belief.



[Rhonda Bowling-Black \(Feb 2, 2026 10:06:44 CST\)](#)

Rhonda Bowling-Black, CFE, ARe, MCM
Department Designee
State of Tennessee