PERFORMANCE AUDIT REPORT

Kansas State Employee Health Plan: Evaluating the State's Pharmacy Benefit Management System

A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
Februrary 2015

R-15-002

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February 18, 2015

To: Members, Legislative Post Audit Committee

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Representative Tom Burroughs	Senator Anthony Hensley
Representative Peggy Mast	Senator Laura Kelly
Representative Virgil Peck, Jr.	Senator Jeff Longbine
Representative Ed Trimmer	Senator Julia Lynn

This report contains the findings, conclusions, and recommendations from our completed performance audit, *Kansas State Employee Health Plan: Evaluating the State's Pharmacy Benefits Management System*. The audit was requested by Representative Peggy Mast. We would be happy to discuss the findings, recommendations, or any other items presented in this report with any legislative committees, individual legislators, or other state officials.

Sincerely,

Scott Frank
Legislative Post Auditor

Notice to the Reader

On May 6, 2015, Legislative Post Audit revised this report to include a risk area that we discovered after the report was issued.

A "strike-and-add" version of those changes is shown in Appendix D so the reader can see how the report was changed. All legislative committee and all agency officials that received copies of the initial report were sent a copy of these changes.

This audit was conducted by Laurel Murdie, Brad Hoff, Danielle Stephen, and Kristen Rottinghaus. Chris Clarke was the audit manager. If you need any additional information about the audit's findings, please contact Laurel Murdie at the Division's offices.

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Kansas State Employee Health Plan: Evaluating the State's Pharmacy Benefits Management System

The Kansas Department of Health Environment (KDHE) is responsible for the day to day administration of the State Employee Health Plan. CaremarkPCS Health (Caremark) is currently the state's pharmacy benefit manager for the Plan. As a pharmacy benefit manager, Caremark is primarily responsible for processing and paying prescription drug claims for state employees. Pharmacy benefit managers generally are also responsible for developing and maintaining a formulary (a list that specifies particular medications that are approved to be prescribed under an existing health plan), contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers. For these types of services, the state pays Caremark a fixed administrative fee for each claim it processes.

Recent reform efforts suggest that the traditional pharmacy benefit management system creates opportunities for pharmacy benefit managers to generate additional revenues that either increase state costs or do not increase benefits to state employees. For example, depending on a pharmacy benefit manager's contract, it could negotiate to pay pharmacies in its network less for certain drugs than it charges the state.

Legislators have expressed interest in knowing whether Kansas has established sufficient controls to ensure that its current pharmacy benefit manager, Caremark, minimizes state costs and does not generate additional revenues that do not increase benefits to state employees.

This performance audit answers the following question:

1. **Does the state have sufficient controls in place to minimize state costs and enhance benefits through its pharmacy benefits manager?**

A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in ***Appendix A***.

We took several steps to answer the question. We reviewed literature to identify the risks associated with pharmacy benefit management and asked KDHE officials to identify the controls they have in place for each risk. To assess those controls' effectiveness, we reviewed a sample of claims for state employee prescriptions filled between April and June 2014. Specifically, we compared how much the state paid Caremark to how much Caremark paid selected pharmacies to determine whether those

amounts were the same as required by contract. We also identified steps KDHE takes to ensure the state received all the drug manufacturers' rebates it was entitled to. In addition, we reviewed KDHE's process for ensuring it receives funds that Caremark recoups from pharmacies for disallowed claims. To help us determine how well the state employee prescription drug formulary is managed, we asked several pharmacists to review the formulary for the state employee prescription drug plan and we also compared it to other state formularies. Finally, for a non-projectable sample of prescriptions, to determine if mail-order prescriptions cost less, we compared the cost of filling those prescriptions through mail-order to the cost of filling them at a walk-in pharmacy.

We also reviewed KDHE's internal controls, including reviewing the steps officials take to ensure that Caremark complies with contract provisions for the state employee prescription drug plan.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. As part of the audit standards, the U.S. Government Accountability Office requires us to assess the sufficiency and appropriateness of computer-processed data. To comply with this standard we performed data reliability work on all electronic prescription drug claims data we received.

We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Finally, though we do not believe that it affected our findings, conclusions, or recommendations, we do want to call the reader's attention to one issue regarding auditor independence. Generally accepted government auditing standards require that auditors and audit organizations maintain independence so that their opinions, findings, conclusions, judgments, and recommendations will be impartial (and viewed as impartial) by reasonable and informed third parties. Auditors should avoid situations that could lead reasonable and informed third parties to conclude that the auditors are not independent and thus are not capable of exercising objective and impartial judgment on all issues associated with conducting the audit and reporting on the work.

The reader should be aware that as a state agency, most employees of the Legislative Division of Post Audit receive pharmacy benefits under the State Employee Health Plan. Although any

changes in the management of those benefits could have an impact on the benefits our staff receive, we think this has not affected the impartiality of our opinions, findings, conclusions, judgments, and recommendations.

Our findings begin on page 9, following a brief overview of pharmacy benefits for state employees.

The State Employee Health Plan Provides Health Care Benefits to About 92,000 State Employees and Their Dependents

The State Employee Health Plan provides health insurance coverage for state employees, retirees, and their dependents. In total, about 92,000 state employees and their dependents are enrolled in the plan. The plan offers medical, dental, vision, and prescription drug benefits. This audit focuses only on the prescription drug plan.

The State Employee Health Plan is overseen by the Kansas State Employees Health Care Commission. Established in statute in 1984, the commission has five members. State law specifies that the Secretary of Administration and Insurance Commissioner serve on the commission and the Governor appoints the other three members. The purpose of the commission is to develop and implement the State Employee Health Plan. The commission is responsible for determining the qualifications for employees to participate in the plan, for negotiating contracts with vendors for benefit services, and submitting cost projections for the plan in coming years.

The Kansas State Employees Health Care Commission is assisted by an employee advisory committee. This 21-member committee includes current and former state employees who work with the commission to represent the interests of state employees participating in the health care plan.

The Kansas Department of Health and Environment (KDHE) administers the daily operations of the State Employee Health Plan. While the Kansas State Employees Health Care Commission is responsible for overseeing the State Employee Health Plan, KDHE is responsible for the day-to-day operations of the plan. KDHE provides oversight of vendors to determine that they meet all contractual requirements. In addition, KDHE is responsible for ensuring that vendors submit any reports or data to help the state manage the State Employee Health Plan.

In their role as program administrator, KDHE officials told us they continue to use several of the cost-controlling strategies that were in place during our 2010 audit of the state employee prescription drug plan. As part of this audit, we asked KDHE officials to report whether they are continuing to use these strategies and if they have implemented any additional strategies. ***Appendix B*** lists these cost-controlling strategies, which include reducing dispensing fees and decreasing the number of prescription drugs covered for plan members. All of the strategies listed in ***Appendix B*** are self-reported and unaudited.

The Prescription Drug Portion of the State Employee Health Plan Costs About $80 Million Each Year

For calendar year 2013, Kansas' state employee prescription drug plan had total costs of about $80 million. These costs include both state costs and member costs. Of this amount, the state paid about 80% of costs, or $65 million. Participants paid the remaining 20% or $15 million.

Figure OV-1 below compares the total costs of the prescription drug plan with the total costs of the State Employee Health Plan. As the figure shows, total costs of the prescription drug plan have remained relatively stable from 2009 to 2013. In addition, the figure shows the prescription drug plan has comprised about 14% to 17% of the State Employee Health Plan costs during that same time period.

Figure OV-1
Summary of Costs for the Prescription Drug Plan Compared to the Total State Employee Health Plan (in millions)

Calendar Year	Cost of Prescription Drugs	Total State Employee Health Plan Costs (state + member)	Percentage of Prescription Drug Costs to Total SEHP Costs
2009	$82.4	$486.7	17%
2010	$84.2	$494.0	17%
2011	$83.3	$532.0	16%
2012	$85.8	$567.4	15%
2013	$80.4	$565.7	14%
2014 (a)	$69.6	$554.4	13%

(a) Through November 2014.
Source: LPA summary of KDHE data (unaudited).

Caremark is the Pharmacy Benefit Manager for the Prescription Drug Plan

Since 2006, the Kansas State Employees Health Care Commission has contracted with CaremarkPCS Health (Caremark) to provide pharmacy benefit manager services to the state employee prescription drug plan. The current contract term is for three calendar years and expires at the end of calendar year 2016.

Caremark provides a number of prescription management services as the state's pharmacy benefit manager. In general, Caremark is responsible for providing administrative and support services for the prescription drug plan. Major services Caremark provides include:

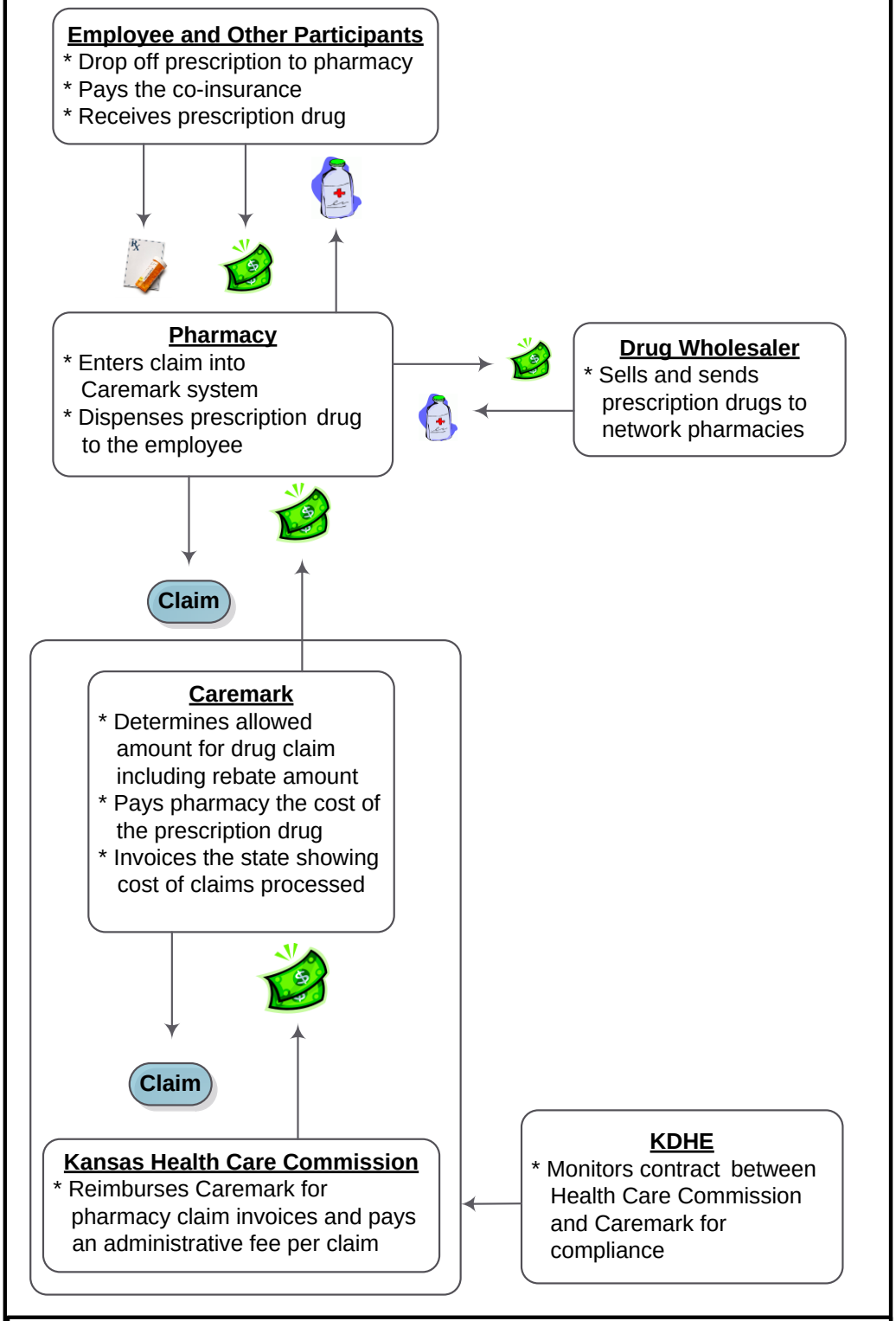
- **Caremark has established a network of pharmacies where plan members can fill their prescriptions.** Caremark is required to partner with pharmacies throughout the state and country to ensure members have access and can fill prescription drugs through both walk-in and mail-order pharmacies.

- **Caremark negotiates drug rebates on brand-name drugs and administers the plan's preferred drug list (formulary).** Rebates are discounts on prescription drug costs negotiated directly with drug manufacturers. Caremark works directly with drug manufacturers to receive these rebates and is required by contract to return 100% of these rebates to the state.

  In addition, Caremark creates and maintains a drug formulary. The formulary is a list of prescription drugs approved for use and covered by the prescription drug plan. It includes both brand-name and generic drugs. As the pharmacy benefit manager, Caremark provides KDHE with recommendations on which prescription drugs to include on the formulary to ensure cost effectiveness and availability of generic drugs.

- **Caremark pays and processes prescription drug claims.** ***Figure OV-2*** on the next page summarizes the claims payment process for the state employee prescription drug program. As ***Figure OV-2*** shows, once a claim has been approved, Caremark must promptly pay the pharmacy for filling the prescription. After paying the pharmacy, Caremark processes the claim and sends it to the state for reimbursement. As of October 2014, Caremark processed about one million claims for the 2014 plan year. In addition to paying Caremark the state portion of the prescription drug cost, Kansas pays Caremark $.90 for each claim it processes.

Figure OV-2
Summary of the Claims Payment Process
for the State Employee Prescription Drug Plan



Source: LPA summary of the state employee prescription drug plan

Question 1: Does the State Have Sufficient Controls in Place to Minimize State Costs and Enhance Employee Benefits Through its Pharmacy Benefits Manager?

Because a pharmacy benefit manager controls many aspects of the prescription drug plan, there is a risk that it may not manage the program in the state's best interest (p. 9). The Kansas State Employees Health Care Commission has negotiated strong contractual provisions to protect against those risks, but KDHE does little to verify Caremark's compliance with those terms (p. 11). Specifically, the state does not adequately check claims data for spread pricing (p. 13), does little to ensure it receives its share of drug rebates (p. 14), and does little to independently verify how the drug formulary is managed (p. 16). In addition, KDHE does not take steps to ensure it receives all claim recoupments that Caremark collected from pharmacies (p. 17). We also found that the state's contract with Caremark includes few controls related to mail-order prescriptions; however state spending for mail-order is minimal (p. 18). Finally, although specialty drugs account for 32% of total prescription drug costs for the State Employee Health Plan, we could not verify whether KDHE is proactively monitoring this area (p 18).

Because a Pharmacy Benefit Manager Controls Many Aspects of the Prescription Benefit Plan, There is a Risk That it May Not Manage the Program in the State's Best Interest

Caremark is the pharmacy benefit manager for the State Employee Health Plan. Caremark's primary role is to provide administrative services for the prescription drug portion of the plan. Some of these services include processing claims, providing a broad network of pharmacies and contracting with manufacturers for drug rebates. These services are meant to provide the best prescription coverage to members with the lowest cost to the state. However, our review of literature and recent court cases indicate that using a pharmacy benefit manager comes with certain risks. These risks are more fully explained in the following sections.

Using a pharmacy benefit manager is a convenient way for employers to ensure access to prescription drug benefits. Typically, a pharmacy benefit manager handles most aspects of administering a prescription drug plan. This includes developing and contracting with a large network of pharmacies, negotiating rebates with drug manufacturers, developing and maintaining a prescription drug formulary, and processing prescription drug claims. Having one entity handle all these services on behalf of an employer is a convenience and can also be a source of cost savings.

However, a pharmacy benefit manager is in a position to potentially manipulate the prescription drug plan in several ways to enhance its profits. While it is convenient to have one entity to administer prescription drug benefits, allowing one party to control so many aspects of a system also creates several risks. Our review of literature showed these risks include the following:

- **Spread pricing may occur if a pharmacy benefit manager charges the state more than it pays the pharmacy for a prescription drug claim.** In turn, the pharmacy benefit manager profits by keeping the difference. As discussed next, drug manufacturer rebates which are applied at the point-of-sale, can make it more difficult to determine whether a pharmacy benefit manager is using spread pricing.

- **Rebate savings may not be passed on to the state in full.** Rebates are paid by drug manufacturers directly to pharmacy benefit managers in exchange for placing drugs in a preferred place on the drug formulary. Because pharmacy benefit managers negotiate the rebates and the resulting agreements are proprietary, there is considerable risk that the pharmacy benefit manager could keep at least a portion of the rebates.

- **The formulary for prescription drugs may be managed to benefit the pharmacy benefit manager rather than the state or its employees.** Typically, the pharmacy benefit manager plays a significant role in determining which drugs will be on an insurance plan's prescription drug formulary. A pharmacy benefit manager may prefer a certain brand-name drug over other drugs or generic equivalents because of the rebates it can generate. This may result in the formulary not having the lowest cost drugs. Further, as explained in the previous bullet, there is a risk that the pharmacy benefit manager may not pass on these rebate savings to the state.

- **Payments recouped from pharmacies may not be passed on to the state.** Recoupments are claims the pharmacy benefit manager originally pays to the pharmacy and charges to the state, but later recoups from the pharmacy because the claim was not submitted properly. The risk is that the state is never reimbursed for the recouped claim.

- **Mail-order prescriptions can allow a pharmacy benefit manager an additional opportunity to increase its profits.** The risk is the pharmacy benefit manager can charge more for prescriptions filled through mail-order as compared to prescriptions filled at a walk-in pharmacy.

- **Specialty prescription drugs are used by a small percentage of insured employees and dependents, but the cost of these drugs is significant and pharmacy benefit managers often own the pharmacies that fill specialty drug prescriptions.** Specialty drugs are most often used to treat complex or chronic conditions requiring close supervision and monitoring. Because the pharmacy benefit manager often requires these drugs to be filled exclusively through its pharmacies, the risk is that the price of the drugs can be marked-

up considerably, sometimes even beyond a reasonable amount. For Kansas, KDHE officials told us the Health Care Commission has decided to have specialty drugs filled through Caremark's specialty pharmacy to save money and provide better medication management. In addition, there is also a risk the pharmacy benefit manager may keep any available manufacturer rebates from these drugs.

While the state cannot fully eliminate these risks, it can mitigate them through a combination of good contractual provisions and regular monitoring activities. Steps to mitigate the risks associated with using a pharmacy benefit manager include the following:

- **The state's contract should have provisions which require the pharmacy benefit manager to manage prescription drug benefits in a way that benefits the state and covered employees.** For example, the contract should clearly define key terms, require periodic reporting, and allow for independent verification through audits.

- **The state should also monitor whether the pharmacy benefit manager complies with contract provisions.** For example, the state should periodically take steps to independently verify prescription drug claim pricing and payments and occasionally conduct audits of drug manufacturer rebates.

The Kansas State Employees Health Care Commission is responsible for developing and implementing the State Employee Health Plan, including providing for prescription drug benefits. The commission has contracted with Caremark to provide pharmacy benefit management services. On a day to day basis, the Kansas Department of Health Environment (KDHE) is responsible for administering the State Employee Health Plan. This includes monitoring to ensure contract performance/compliance.

The Kansas State Employees Health Care Commission Has Negotiated Strong Contractual Provisions, But KDHE Does Little to Verify Caremark's Compliance with Those Terms

The Kansas State Employees Health Care Commission has included numerous contractual provisions to reduce the risks associated with using a pharmacy benefit manager. The state's contract includes multiple provisions to help decrease such risks. For example, the state's current contract with Caremark includes the following provisions:

- **To mitigate spread pricing**, the contract defines pricing terms and requires that Caremark pay pharmacies the same amount that it charges the state for prescription drug claims. Further, the contract allows for auditing prescription drug claims.

- **To help ensure the state receives all drug rebates**, the contract defines rebates and requires Caremark to provide the state with 100% of rebates received from drug manufacturers. The contract

also allows the state to hire a third-party to review rebate agreements between Caremark and drug manufacturers.

- **To help ensure the drug formulary is managed in such a way to benefit the state and its employees**, Caremark must provide the state notice of any proposed and actual changes to the formulary. Caremark's formulary recommendations are subject to the approval of KDHE as the day-to-day administrator of the State Employee Health Plan.

- **To help ensure the state receives all recouped claims payments from pharmacies**, the contract requires Caremark to pay all recouped funds to the state.

- **To help ensure that specialty drugs are provided only to insured members or their dependents that need specialty drugs,** the contract requires prior authorization.

While most of the contract provisions are strong, there is one area of weakness having to do with mail-order prescriptions. If the state wants to help ensure that mail-order prescriptions cost less than prescriptions filled at walk-in pharmacies, it would have to add such a provision to its contract with Caremark. We discuss mail-order prescriptions in more detail on page 18.

As the administrator of the contract, KDHE does not routinely take the steps needed to verify that Caremark is complying with its contractual provisions. Without regular monitoring, the state cannot ensure that Caremark is managing the state employee prescription drug plan in a way that most benefits the state and insured employees.

Here is a summary of the problems we found:

- KDHE does not adequately check claims data for spread pricing (page 13).

- Although ensuring the state receives its share of drug rebates is difficult, KDHE does little to monitor Caremark's compliance (page 14).

- KDHE does little to independently verify how the state employee prescription drug formulary is managed (page 16).

- KDHE does not take steps to help ensure it receives all claim recoupments that Caremark collects from pharmacies (page 17).

- The state's contract with Caremark includes few controls related to mail-order prescriptions, however state spending for mail-order is minimal (page 18).

- Although specialty drugs account for 32% of total prescription drug costs, we could not verify whether KDHE is proactively monitoring this area (page 18).

These are discussed more fully in the sections that follow.

FINDINGS FOR SPECIFIC RISK AREAS

KDHE Does Not Adequately Check Claims Data for Spread Pricing

Because spread pricing has the potential to affect every claim, it represents a significant risk to the state that needs to be addressed. Spread pricing occurs when a pharmacy benefit manager charges the state more than it pays the pharmacy for a prescription drug claim. Because of the number of claims processed each year, it would not take much to generate significant profits through spread pricing. For example, if the pharmacy benefit manager marks up just $1 for every prescription drug claim processed during a typical calendar year, it could generate $1.3 million in revenue. To reduce the risk of spread pricing, the state's contract does not allow Caremark to pay pharmacies less than what the state pays Caremark for prescription drugs. However, in addition to having these types of provisions in its contract, the state also needs to take steps to monitor and ensure that spread pricing is not happening.

The state only occasionally audits claims for spread pricing, and when it does, it does not independently verify Caremark's information. In addition to prohibiting spread pricing, the state's contract with Caremark allows the state to annually audit prescription drug claims data. However, the last audit of claims data was completed in 2011. In addition to being four years old, the 2011 audit relied exclusively on unverified data from Caremark regarding its payments to the pharmacies. In other words, the state used Caremark's self-reported information as evidence that Caremark had complied with the contract.

The only way for the state to truly check for spread pricing is to compare Caremark's data to the records independently maintained by individual pharmacies. KDHE would need to periodically compare the state's payments to Caremark for a sample of prescription drug claims to separate payment information obtained directly from the pharmacies. This comparison is necessary because without reviewing pharmacy data, KDHE cannot verify what Caremark paid and whether Caremark is following the contract provisions that prohibit spread pricing.

Although KDHE's monitoring for spread pricing is weak, our analysis of 259 prescription drug claims found no evidence of spread pricing. To independently test Caremark's compliance with the provisions regarding spread pricing, we obtained claims records from individual pharmacies for 259 prescription drug claims from April 2014 to June 2014. We compared what Caremark paid pharmacies to the amount that the state paid Caremark. Because the sample was not randomly drawn, our results are not statistically projectable.

- **For 224 of 259 claims (86%) Caremark charged the state <u>exactly the same</u> amount that it paid the pharmacies.** For these claims, Caremark clearly met the contract requirement that prohibits spread pricing. This is nearly consistent with the findings in our 2004 audit of the state employee prescription drug plan, in which we did not find any instances of spread pricing.

- **For the remaining claims (35 of 259) Caremark appeared to charge the state <u>less</u> than it paid the pharmacies, though this may be due to inadequate information regarding drug rebates.** For example, the records for one claim showed the state paid Caremark $54 to fill a prescription for Dexilant, while Caremark paid the pharmacy $159. This would indicate that Caremark actually lost $105 on the transaction. However, officials from both Caremark and KDHE told us the $105 difference was likely covered by a rebate from the drug manufacturer. Because Caremark's specific rebate agreements with the drug manufacturers are proprietary, we were unable to confirm whether rebates were the reason such claims looked like overpayments to pharmacies.

Although Ensuring the State Receives its Share of Drug <u>Rebates</u> is Difficult, KDHE does Little to Monitor Caremark's Compliance

Rebates are paid by drug manufacturers in exchange for placing drugs in a preferred place on the formulary. A drug formulary is simply a list of medicines that are covered by a prescription drug plan. Rebates act essentially like a coupon toward the cost of brand-name drugs and help lower the price paid by the insured member and the state. Our audit work included identifying any steps the state takes to ensure it receives all drug rebates it is entitled to.

Monitoring drug manufacturer rebates is important because rebates often total in the millions of dollars, and it can be easy for pharmacy benefit managers to keep them. Rebates are paid directly to pharmacy benefit managers in exchange for placing drugs in a preferred place on a drug formulary. However, because pharmacy benefit managers directly negotiate the rebates and the resulting agreements are considered proprietary, there is considerable risk that the pharmacy benefit manager could keep at least a portion of the rebates. This is why it is important for the state to monitor to help ensure it receives <u>all</u> rebates.

However, monitoring drug rebates is difficult because drug manufacturers consider rebate information proprietary. The total amount of drug rebates the state is entitled to is primarily determined by Caremark's contracts with the various drug manufacturers. Getting that information is difficult. First, those agreements likely affect many of Caremark's clients, not just the Kansas State Employee Health Plan. Second, because rebate agreements are considered proprietary neither we, nor KDHE can easily determine whether the state received all drug manufacturer rebates as required by contract.

The exact total in drug rebates that Kansas received from Caremark is also considered proprietary. While we cannot report the exact amount, we can generally report that the state received significantly more than the minimum total drug rebate guaranteed by contract in each of the past three calendar years. However, that does not mean Kansas received the maximum amount possible (all rebates).

Even so, KDHE has not taken proactive steps to verify rebate amounts. To mitigate the risk that Caremark may not pass all rebate savings back to the state, the term "rebate" is defined in contract, and Caremark is required to pass all rebates savings on to the state. In addition, the contract allows the state to hire a third-party to audit drug manufacturers' agreements with Caremark. Despite those provisions, the state relies solely on an annual rebate reconciliation report prepared by Caremark to determine whether it has received all the drug rebates it should. The report shows the minimum rebate amounts guaranteed to the state at the point-of-sale (at the pharmacy) and the rebate amounts Caremark returned to the state. The report does not include details about how much in total rebates Caremark received directly from drug manufacturers. KDHE officials told us that because the state received at least the minimum guaranteed by contract, they did not take any steps to verify rebate amounts provided by Caremark.

KDHE officials told us they plan to audit drug rebates during calendar year 2015. To date, KDHE has not audited the amount of rebates applied at the point-of-sale nor audited rebates amounts provided directly to Caremark. KDHE officials said the audit planned for calendar year 2015 will include the top five (by volume and cost) drug manufacturer arrangements with Caremark, and will include reviewing point-of-sale rebates guaranteed and paid by Caremark.

The State Does Little to Independently Verify How the State Employee Prescription Drug Formulary is Managed

Scrutiny of proposed formulary changes is important because a pharmacy benefit manager could manage the formulary in such a way to benefit itself more than the state. The drug formulary is simply a list of medicines that are covered by a prescription drug plan. As the pharmacy benefit manager, Caremark is responsible for providing KDHE with recommendations on how to best manage the formulary. Specifically, the state's contract requires Caremark to provide an evidence-based drug access plan, which includes suggesting when to add new cost-effective prescription drugs and ensuring that all available generics are included.

Having a pharmacy benefit manager make formulary recommendations is not a problem if the state receives all rebates that result from those formulary recommendations. However, because the pharmacy benefit manager directly negotiates rebates with drug manufacturers and the resulting agreements are considered proprietary, it is easily in the position to benefit from any formulary changes it suggests.

Despite the contract giving KDHE the final say on any formulary changes, Kansas relies primarily on Caremark's recommendations. On a quarterly basis, Caremark provides written recommendations to KDHE with suggestions for managing the formulary. In turn, KDHE officials decide whether to approve or reject the recommended changes. However, officials conceded that nearly all formulary recommendations made by Caremark are approved. Further, although KDHE has contracted with Aon Consulting (Aon), a third-party consultant, whose primary role is helping KDHE manage the state employee prescription drug formulary, KDHE has not asked for Aon's help in reviewing the formulary as much as we would have expected. KDHE officials estimated that in the past three years, they have only asked Aon to review such changes two or three times in total.

Finally, our review showed that KDHE has not always taken steps to verify Caremark's assertion that certain brand-name drugs should be on Kansas' formulary because they are more cost effective than other brand-name drugs. For example, Kansas' formulary includes the insulin products Novalog and Novolin, but not Humalog. KDHE officials told us that Caremark recommended the Novalog and Novolin brands because those brands were more cost effective than Humalog. KDHE acknowledged they did not ask Caremark to produce details to verify that assertion.

The State Does Not Take Steps to Ensure it Receives all Claim Recoupments that Caremark Collected from Pharmacies

As part of the contract with the state, Caremark is responsible for performing claim recoupment audits at pharmacies. Each time a prescription drug is purchased, the claim is processed electronically at the pharmacy. Caremark later goes back and checks a sample of claims for accuracy. If any claims are determined to be inaccurate, Caremark can recoup the payment it made to the pharmacy. The following is a summary of our findings related to claim recoupments:

- **There is a risk that payments recouped from pharmacies may not be passed to the state.** The purpose of recoupment audits is to determine whether the pharmacy had a valid physician order for the prescription and to ensure it was properly dispensed. If not, Caremark recoups the claims payment from the pharmacy. The state's contract requires Caremark to return all recouped funds to the state. When we started the audit, several pharmacists we spoke with mentioned this as a big area of concern.

- **The state does not verify whether Caremark has provided all the funds it has recouped from pharmacies.** During our work, we saw evidence that Caremark was conducting recoupments audits. Some resulted in funds being recouped, while others did not. For calendar years 2013 and 2014, Caremark provided the state with a total of $4,300 and $13,000 respectively, in claims payments recouped from pharmacies. However, up until now KDHE officials have not taken steps to verify whether Caremark had provided the state with all the recouped funds that it should.

- **Total claims recouped from pharmacies likely does not merit the state spending significant resources to ensure that state receives all that it should.** We were unable to find an industry standard that would help us estimate about how much the state should expect to receive in claim recoupments. However, if Caremark only audits about 1 to 2% of claims costs each year and if only 5% of those claims were recouped, the potential amount recouped would be only about $65,000. KDHE has the ability to request detailed reports regarding the recoupments. KDHE could use this information to help verify whether the recoupments received from Caremark match the amounts shown in reports. This is not an ideal way to determine if Caremark provided the state with all recoupments, but it also does not require much effort.

The State's Contract with Caremark Includes Few Controls Related to Mail-Order Prescriptions, However, State Spending for Mail-Order is Minimal

State employees and family members enrolled in the state's prescription drug plan have the option to use a mail service when filling prescriptions. Generally, mail-order pharmacies offer prescriptions at lower costs and can be a convenient way to fill prescriptions. The following is a summary of our findings related to mail-order prescriptions:

- **There is a risk that the pharmacy benefit manager will charge more for mail-order prescriptions.** Our review of literature showed the risk is that a pharmacy benefit manager can charge more for prescriptions filled through mail-order as compared to prescriptions filled at a walk-in pharmacy.

- **The state does not have controls related to mail-order prescriptions.** As mentioned earlier, there are no provisions in the state's contract with Caremark that require mail-order prescriptions to cost less than prescriptions filled at walk-in pharmacies. In addition, KDHE officials do not monitor whether mail-order prescriptions actually cost less.

- **The lack of controls is not a significant issue because mail-order prescriptions comprise a very small portion of total prescription drug costs.** Mail-order prescriptions account for only about $800,000 of total annual state employee prescription drug costs (1%). In addition, we reviewed 1,029 mail-order claims for some of the most expensive drug prescriptions filled from April 2014 through June 2014. On average, mail-order prescriptions were less expensive than the same prescription filled at a walk-in pharmacy.

- **Because mail-order prescriptions are a small portion of total costs, there is little reason to dedicate additional state resources at this time.** However, it will be important for KDHE to occasionally monitor the total cost of mail-order prescriptions. If the costs become a significant portion of total costs, the state will want to consider whether it should do more to ensure that mail-order prescriptions cost less than when filled at walk-in pharmacies.

Although Specialty Drugs Account for 32% of Total Prescription Drug Costs for the State Employee Health Plan, We Could Not Verify Whether KDHE is Proactively Monitoring This Area

Specialty drugs are used by a small percentage of enrollees in the state's prescription drug plan. The drugs are most often used to treat complex or chronic conditions that require expensive prescription drug treatments and close supervision from a medical professional. With a few exceptions, most specialty drugs must be purchased from the Caremark's specialty pharmacy. The following is a summary of our findings related to specialty prescription drugs.

Monitoring and controlling how much the state spends on specialty drugs is important because they are a significant portion of the total costs and are increasing rapidly. For calendar year 2014, the state spent $27.3 million on specialty prescription drugs. This accounted for nearly 32% of total costs. In addition, since 2010, state spending for specialty prescription drugs has increased by 140%. KDHE officials told us that controlling future specialty drug costs will continue to be a challenge because generally, only one drug manufacturer produces each type of specialty drug and few generic alternatives exist.

KDHE officials told us they monitor the total costs of specialty drugs and check specialty drug pricing for accuracy, but we could not verify these actions. Because specialty drugs are not clearly labeled, KDHE officials cannot easily identify them in the claims data. Instead, staff told us they rely on quarterly reports from Caremark that summarize all claims information, including specialty drug claims. Those reports provide a wealth of information, however, in regard to specialty drugs, the information is somewhat limited. The reports only compare specialty drug claims for the current quarter to the same quarter for the prior year, and do not show year-to-date costs or compare annual spending. KDHE provides the Health Care Commission with information about prescription drugs costs, but that information did not show that specialty drug costs had nearly doubled from calendar year 2012 to 2014 ($14.9 million to $27.3 million).

In addition to monitoring the quarterly reports from Caremark, KDHE officials told us their 2011 audit of claims data included work to check specialty drug pricing for accuracy. However, because KDHE officials were unable to provide us a copy of that audit report, we could not verify that it included an assessment of specialty drug pricing.

KDHE plans to more closely monitor specialty drug costs and take steps to ensure the state receives all drug manufacturer rebates for specialty drugs. KDHE officials told us they plan to rely on its third-party consultant, Aon Consulting, to advise them of any cost control strategies that can be used to contain the growth of specialty drug costs. Also, KDHE officials stated that they are working to correct the claims data to ensure that specialty drugs are labeled as such. Finally, KDHE officials also told us they plan to include specialty drugs in the drug rebate audit planned for calendar year 2015.

Conclusion

Like so many employers, it is convenient for the state to contract with a pharmacy benefit manager to administer its state employee prescription drug insurance plan. Pharmacy benefit managers provide a wide range of services, including negotiating drug prices and rebates with drug manufacturers, processing prescription drug claims for insured employees, establishing a contracted network of pharmacies, and managing the prescription drug formulary. However, because pharmacy benefit managers control so many aspects of the prescription drug process, they are also in the position to manage prescription drug plans in ways that financially benefit them and not the state or its employees. Without meaningful oversight that includes verifying compliance with contractual provisions, there are many opportunities for a pharmacy benefit manager to financially benefit at the state's expense.

While it is very encouraging that we found no evidence that Caremark has violated any contract requirements related to the state employee prescription drug plan, it is still concerning that the Kansas State Employees Health Care Commission and KDHE do little to monitor Caremark's compliance with the contract. The state has handed over most of the key components of the prescription drug plan to Caremark and is simply trusting that Caremark will honor all the terms of its contract and act in the state's best interest.

Recommendations for Executive Action

1. To address the issues with the state's monitoring of spread pricing, the Kansas State Employees Health Care Commission and KDHE should include terms in its contract with the pharmacy benefit manager that would allow KDHE to periodically request data directly from pharmacies and test for spread pricing (pages 13-14).

2. To address the issues with the state's monitoring of drug manufacturer rebates, the Kansas State Employees Health Care Commission and KDHE should (pages 14-15):

    a. Develop benchmarks to assess whether the total rebate amount received from its pharmacy benefit manager is generally reasonable.

    b. Develop a process to verify whether the claims figures used by the pharmacy benefit manager to calculate the state's point-of-sale rebates is correct.

c. Contract with a third-party to periodically audit rebate amounts that the pharmacy benefit manager receives from drug manufacturers to ensure that the state receives the total amount of drug rebates to which it is entitled.

3. To address the issues regarding the state employee prescription drug formulary, the Kansas State Employees Health Care Commission and KDHE should regularly have a third-party conduct independent reviews of the pharmacy benefit manager's formulary recommendations to determine whether they are cost effective and in the best interest of the state and its employees (page 16).

4. To address the issues regarding mail-order prescriptions, the Kansas State Employees Health Care Commission and KDHE should monitor the number of mail-order prescription drug claims. If the share of these claims increases significantly, they should consider auditing the cost of mail-order prescription drug claims to ensure they cost less than prescriptions filled at walk-in pharmacies (page 18).

5. To address the issues regarding specialty drugs, the Kansas State Employees Health Care Commission and KDHE should (page 18-19):

   a. Periodically monitor how much the state spends on specialty drugs.

   b. Include specialty prescription drugs in the drug rebate audit planned for calendar year 2015.

   c. Periodically take steps to monitor and ensure that pricing is accurate for specialty drug claims.

APPENDIX A
Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee for this audit on April 29, 2014. The audit was requested by Representative Peggy Mast.

Kansas State Employee Health Plan: Evaluating the State's Pharmacy Benefits Management System

CVS Caremark is currently the state's pharmacy benefit manager (PBM) for the State Employee Health Plan. As a PBM, CVS Caremark is primarily responsible for processing and paying prescription drug claims for state employees. PBM's are generally also responsible for developing and maintaining a formulary (a list that specifies particular medications that are approved to be prescribed under an existing health plan), contracting with pharmacies, and negotiating discounts and rebates with drug manufacturers. For these types of services, the state pays CVS Caremark a fixed administrative fee for each claim it processes.

Recent reform efforts suggest that the traditional pharmacy benefit management system creates opportunities for PBMs to generate additional revenues that ether increase state costs or do not increase benefits to state employees. For example, depending on a PBM's contract, a PBM could negotiate to pay pharmacies in its network less for certain drugs than it charges the state. Similarly, some PBM's maintain their own mail-order pharmacies which could create a conflict of interest.

Legislators have expressed interest in knowing whether Kansas has established sufficient controls to ensure that its current PBM, CVS Caremark, minimizes state costs and does not generate additional revenues that do not increase benefits to state employees.

A performance audit in this area would address the following question:

1. **Does the state have sufficient controls in place to minimize state costs and enhance employee benefits through its pharmacy benefits manager?** To answer this question, we would review PBM reform literature to identify ways in which the traditional PBM system can create inefficiencies or reduce employee benefits. We would also interview officials from the Health Care Commission and the Department of Health and Environment to determine whether they thought these potential risks were relevant in Kansas. Based on that information, we would work with State Employee Health Plan staff to determine what controls currently exist to mitigate these potential issues. Specifically, we would evaluate the state's PBM procurement process, its current contract with CVS Caremark, and any oversight mechanisms established to ensure the contract was being followed as designed. We would perform additional work in this area as necessary.

Estimated Resources: 3 LPA staff
Estimated Time: 3 months

(a) From the audit start date to our best estimate of when it would be ready for the committee.

APPENDIX B
Cost-Controlling Strategies
State Employee Prescription Drug Plan (Unaudited)

This appendix contains a listing of cost-controlling strategies that KDHE officials reported they have implemented for the state employee prescription drug plan.

Appendix B Cost-Controlling Strategies KDHE Officials Report Having Implemented for the State Employee Prescription Drug Program (Unaudited)
Increase the Maximum Day Supply of Maintenance Drugs: Increase the maximum supply of maintenance drugs from 30 days to either 60 or 90 days to reduce the overall dispensing fees paid. On Plan A, the maximum day supply remains 60 days, while Plan C has a maximum of 90 days. Maintenance drugs are any medication taken over an extended period of time to treat a chronic disease or condition. Despite the larger day supplies available, the overall day supply purchased remains on average in the 28 day range.
Check Claims Data Accuracy: Routinely check accuracy of claims processing (paying correct amount, paying for covered prescriptions, etc.), and ensure staff have the training and tools needed to conduct these checks. If necessary, collect any penalties due from the vendor if claims are paid to ineligible individuals.
Check Beneficiary Eligibility: Along with Caremark, cross-check eligibility accuracy, ensure complete updates are made on a timely basis, and check whether claims were paid for ineligible people.
Collect Penalties for Not Meeting Performance Guarantees: Collect payment and penalties from Caremark for not meeting certain performance guarantees that are included in the contract.
Reduce Drugs Covered: Reduce the number of drugs covered under the State Employee Health Plan.
Reduce Dispensing Fees: Reduce fees paid to pharmacies for every prescription dispensed. The current dispensing fee is $.70 cents, which is a reduction from the previous contract.
Implement a Wellness Program: Discuss health issues with beneficiaries through a monthly newsletter and administer wellness activities.
Implement Step Therapy Programs: Require beneficiaries to try a less expensive prescription drug option before a more expensive alternative.
Monitor Members' Drug Usage and Provide After-the-Fact Training to Physicians: The State Employee Health Program continues to have a drug utilization review program in place through Caremark to address drug usage and to provide providers with coaching.
Allow Mail Order Prescription Drugs: Allow beneficiaries the option of receiving prescription drugs via mail at a lower cost.
Use Prior Authorizations: Require a physician override before a patient can receive a more expensive non-generic drug if a less expensive alternative is available.
Privatize the Prescription Drug Plan: Contract with a third-party, Caremark, to process claims and negotiate prices to reduce the state's overhead costs.
Provide Counseling for Chronic Illness or Conditions: Require beneficiaries with chronic illnesses or conditions to work with a case manager to determine the most appropriate treatment options.
Specialty Drug Mail-Order Program: Beginning in 2010, all specialty drugs must be purchased through Caremark's mail order specialty pharmacy. By moving to a sole source arrangement, KDHE was able to negotiate with Caremark better pricing on these medications then what it would have been if using retail pharmacies.
Specialty Guidelines Management: This requires all new prescriptions for specialty products be reviewed by Caremark against national standards and protocols for the specialty drug use before the drug is dispensed.
Pharmacogenomics Program: For some of the new generation of prescription drugs, a member's individual genetic makeup will determine whether or not the medication will be effective for that member. Caremark, using its broad basis of covered members, is able to negotiate discount fees for this specialized testing and the State Employee Health Plan benefits from the discounted fees and by ensuring that medications purchased under the plan will be effective for the member.
Source: Kansas Department of Health and Environment officials (unaudited)

APPENDIX C
Agency Response

On January 30th, we provided copies of the draft audit report to the Kansas Department of Health and Environment. Its response is included as this Appendix. Following the agency's written response is a table listing the department's specific implementation plan for each recommendation.

In its response, the agency stated that it found the report's findings helpful and that it planned to immediately implement additional controls.

After we released the report, we discovered that we omitted a risk area associated with pharmacy benefit management and the state employee health plan. The risk area that we omitted was specialty drugs. Claims for specialty drugs were in the data provided to us, but were not clearly labeled as such. Instead they were marked as retail claims. For calendar year 2014, specialty drug accounted for 32% of total prescription drug costs for the State Employee Health Plan. Therefore, we amended report pages 9-13 and 18-21 to include a discussion of specialty drugs.

On March 25, 2015 and April 15, 2015, we provided copies of the amended report to the Kansas Department of Health and Environment. Its response to the amended report is also included in this Appendix. In its response, the agency stated it will begin to implement the additional controls.

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Kansas

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Susan Mosier, MD, Acting Secretary | Department of Health & Environment | Sam Brownback, Governor

Mr. Scott Frank
Legislative Division of Post Audit
800 SW Jackson, Suite 1200
Topeka, KS. 66612

Dear Mr. Frank:

Thank you for the opportunity to respond to your performance audit, *Kansas State Employee Health Plan: Evaluating the State's Pharmacy Benefits Management System:*

Your auditors appear to have conducted a thorough review of the structure and functionality of the State's Pharmacy Benefits Management (PBM) contract. The report indicates that the State Employee Health Plan should take additional steps to what is already occurring to maintain that the PBM is providing the State of Kansas with the most cost efficient services.

The information obtained in this performance audit will be helpful as additional controls are implemented for the daily operation of the PBM contract.

It is very encouraging that you found no evidence that the current PBM has violated any contract requirements related to the prescription drug plan.

We appreciate the audit findings and will begin immediately to implement the additional controls.

Susan K. Mosier

Susan Mosier, MD
Acting Secretary and State Health Officer
Kansas Department of Health and Environment

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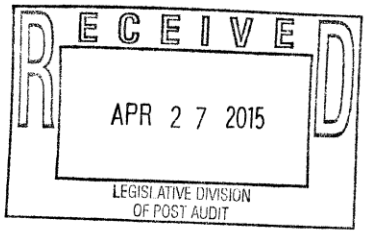
Susan Mosier, MD, Secretary

Sam Brownback, Governor

April 23, 2015



Mr. Scott Frank
Legislative Division of Post Audit
800 SW Jackson St., Suite 1200
Topeka, KS. 66612

Dear Mr. Frank:

Thank you for the opportunity to respond to your amended portion of the performance audit, *Kansas State Employee Health Plan: Evaluating the State's Pharmacy Benefits Management System:*

The amended report to include the specialty drugs indicates that the State Employee Health Plan should take additional steps to what is already occurring to maintain that the PBM is providing the State of Kansas with the most cost efficient services for the specialty drugs.

The information obtained in this performance audit will be helpful as additional controls are implemented for the daily operation of the PBM contract. In addition to what staff currently monitors regarding the drug spend staff will continue to implement additional processes working with the pharmacy consultant, Rx Savings Solution and recommendations from the independent audit firm that will audit the pharmacy program in 2015.

We appreciate the amended audit findings and will begin to implement the additional controls.

Sincerely,

Susan Mosier

Susan Mosier, MD, MBA, FACS
Secretary and State Health Officer

Itemized Response to LPA Recommendations

Kansas Department of Health and Environment - Kansas State Employee Health Plan: Evaluating the State's Pharmacy Benefits Management System

LPA Recommendation	Agency Action Plan
Question 1	
1. To address the issues with the state's monitoring of spread pricing, the Kansas State Employees Health Care Commission and KDHE should include terms in its contract with the pharmacy benefit manager that would allow KDHE to periodically request data directly from pharmacies and test for spread pricing.	We do not feel this is an audit the SEHP can legally undertake itself due to patient privacy issues. We will work with the SEHP audit firm to determine a process that can be implemented to review claims payments to pharmacies. The auditors may encounter some difficulty as participation by pharmacies would be voluntary and they may not elect to provide this data to an outside third party out of respect for their patient's privacy. The SEHP will include language in the contract to allow for a third party audit firm to obtain this information during a pharmacy audit.
2. To address the issues with the state's monitoring of drug manufacturer rebates, the Kansas State Employees Health Care Commission and KDHE should:	
a. Develop benchmarks to assess whether the total rebate amount received from its pharmacy benefit manager is generally reasonable.	The current contract has the amount of rebate that is guaranteed to be paid to the SEHP. The SEHP will work with their pharmacy consultant to develop appropriate benchmarks.
b. Develop a process to verify whether the claims figures used by the pharmacy benefit manager to calculate the state's point-of-sale rebates is correct.	The rebate applied at the point of sale are drug specific to each strength and quantity dispensed. As such the POS rebate is dependent on the rebate agreement and the drug purchased. The contract provides for annual true ups of any differences between the amount applied at the POS and the actual rebate received by the PBM. The SEHP will work with their audit firm to determine the appropriate process to verify the POS rebates are correct.
c. Contract with a third-party to periodically audit rebate amounts that the pharmacy benefit manager receives from drug manufacturers to ensure that the state receives the total amount of drug rebates to which it is entitled.	A contract has already been approved by the HCC at the December 2014 meeting. This will be part of the ongoing audit process
3. To address the issues regarding the state employee prescription drug formulary, the Kansas State Employees Health Care Commission and KDHE should regularly have a third-party conduct independent reviews of the pharmacy benefit manager's formulary recommendations to determine whether they are cost effective and in the best interest of the state and its employees.	The SEHP currently utilizes their pharmacy consultant on some of the formulary changes that are not considered routine additions or deletions due to new to the market drugs and new generic options. The SEHP will be sending all formulary changes to the pharmacy consultant which began with the fourth quarter 2014 changes.
4. To address the issues regarding mail-order prescriptions, the Kansas State Employees Health Care Commission and KDHE should monitor the number of mail-order prescription drug claims. If the share of these claims increase significantly, they should consider auditing the cost of mail-order prescription drug claims to ensure they cost less than prescriptions filled at walk-in pharmacies.	The SEHP will work with their pharmacy consultant to add provisions to the contract to strengthen the mail-order provisions. The mail-order prescriptions claims will be part of the audit process.

LPA Recommendation	Agency Action Plan
Question 1 (recommendations continued)	
5. To address the issues regarding specialty drugs, the Kansas State Employees Health Care Commission and KDHE should:	
a. Periodically monitor how much the state spends on specialty drugs.	In addition to what staff is currently doing to monitor the speciality drug spend staff will continue to work with the pharmacy consultant, Rx Savings Solution and implement any recommendations from the independent audit firm that will be auditing the pharmacy program in 2015.
b. Include specialty prescription drugs in the drug rebate audit planned for calendar year 2015.	This has been included as part of the pharmacy audit approved by the Health Care Commission which is scheduled for 2015.
c. Periodically take steps to monitor and ensure that pricing is accurate for specialty drug claims.	Staff periodically reviews the prescription drug pricing and this will be included in the pharmacy audit scheduled for 2015 to verify the pricing is accurate.

APPENDIX D
Changes Made to the Audit Report on May 6, 2015

On May 6, 2015, we revised pages 9-13 and 18-21 of the original audit report to include a risk area that we omitted. The risk area omitted was specialty drugs. Claims for these drugs were in our claims data and were included in our originally reported claims totals. However, they were not marked as being specialty drug claims. For calendar year 2014, specialty drug accounted for 32% of total prescription drug costs for the State Employee Health Plan. Therefore, we amended the report to include a discussion of specialty drugs. The amendments are shown in this Appendix. A "strike-and-add" version of the changes to the report is presented below so the reader can see how the report was changed. New text is shown in italics; deleted text has been crossed out. All legislative committees and agency officials that received copies of the original report were sent a copy of these changes.

- A change to the last sentence and a new last sentence in the answer paragraph on page 9:

~~Finally~~, W~~we~~ also found that the state's contract with Caremark includes few controls related to mail-order prescriptions; however state spending for mail-order is minimal (p. 17). *Finally, although specialty drugs account for 32% of total prescription drug costs for the State Employee Health Plan, we could not verify whether KDHE is proactively monitoring this area (p 18).*

- New text at the bottom of page 10 and top of page 11:

Specialty prescription drugs are used by a small percentage of insured employees and dependents, but the cost of these drugs is significant and pharmacy benefit managers often own the pharmacies that fill specialty drug prescriptions. *Specialty drugs are most often used to treat complex or chronic conditions requiring close supervision and monitoring. Because the pharmacy benefit manager often requires these drugs to be filled exclusively through its pharmacies, the risk is that the price of the drugs can be marked-up considerably, sometimes even beyond a reasonable amount. For Kansas, KDHE officials told us the Health Care Commission has decided to have specialty drugs filled through Caremark's specialty pharmacy to save money and provide better medication management. In addition, there is also a risk the pharmacy benefit manager may keep any available manufacturer rebates from these drugs.*

- A new bullet (the third bullet) at the top of page 12:

To help ensure that specialty drugs are provided only to insured members or their dependents that need specialty drugs, *the contract requires prior authorization.*

- A new bullet (the first and only bullet) at the top of page 13:

Although specialty drugs account for 32% of total prescription drug costs, we could not verify whether KDHE is proactively monitoring this area (page 18).

- A new sidehead and text section starting on page 18 and ending on page 19:

Although Specialty Drugs Account for 32% of Total Prescription Drug Costs for the State Employee Health Plan, We Could Not Verify Whether KDHE is Proactively Monitoring This Area

Specialty drugs are used by a small percentage of enrollees in the state's prescription drug plan. The drugs are most often used to treat complex or chronic conditions that require expensive prescription drug treatments and close supervision from a medical professional. With a few exceptions, most specialty drugs must be purchased from the Caremark's specialty pharmacy. The following is a summary of our findings related to specialty prescription drugs.

Monitoring and controlling how much the state spends on specialty drugs is important because they are a significant portion of the total costs and are increasing rapidly. *For calendar year 2014, the state spent $27.3 million on specialty prescription drugs. This accounted for nearly 32% of total costs. In addition, since 2010, state spending for specialty prescription drugs has increased by 140%. KDHE officials told us that controlling future specialty drug costs will continue to be a challenge because generally, only one drug manufacturer produces each type of specialty drug and few generic alternatives exist.*

KDHE officials told us they monitor the total costs of specialty drugs and check specialty drug pricing for accuracy, but we could not verify these actions. *Because specialty drugs are not clearly labeled, KDHE officials cannot easily identify them in the claims data. Instead, staff told us they rely on quarterly reports from Caremark that summarize all claims information, including specialty drug claims. Those reports provide a wealth of information, however, in regard to specialty drugs, the information is somewhat limited. The reports only compare specialty drug claims for the current quarter to the same quarter for the prior year, and do not show year-to-date costs or compare annual spending. KDHE provides the Health Care Commission with information about prescription drugs costs, but that information did not show that specialty drug costs had nearly doubled from calendar year 2012 to 2014 ($14.9 million to $27.3 million).*

In addition to monitoring the quarterly reports from Caremark, KDHE officials told us their 2011 audit of claims data included work to check specialty drug pricing for accuracy. However, because KDHE officials were unable to provide us a copy of that audit report, we could not verify that it included an assessment of specialty drug pricing.

KDHE plans to more closely monitor specialty drug costs and take steps to ensure the state receives all drug manufacturer rebates for specialty drugs. *KDHE officials told us they plan to rely on its third-party consultant, Aon Consulting, to advise them of any cost control strategies that can be used to contain the growth of specialty drug costs. Also, KDHE officials stated that they are working to correct the claims data to ensure that specialty drugs are labeled as such. Finally, KDHE officials also told us they plan to include specialty drugs in the drug rebate audit planned for calendar year 2015.*

- A new recommendation at the bottom of page 21:

5. To address the issues regarding specialty drugs, the Kansas State Employees Health Care Commission and KDHE should (page 18):

a. Periodically monitor how much the state spends on specialty drugs.

b. Include specialty prescription drugs in the drug rebate audit planned for calendar year 2015.

c. *Periodically take steps to monitor and ensure that pricing is accurate for specialty drug claims*.