Department of Health

Medicaid Program: Recovering Managed Care Overpayments for Pharmacy Services on Behalf of Recipients With Third-Party Health Insurance

Report 2020-S-39 | July 2022

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller

Division of State Government Accountability

Audit Highlights

Objective

To determine whether Medicaid overpayments for pharmacy services on behalf of managed care recipients who had third-party health insurance were appropriately recovered. The audit covered the period from October 2015 through May 2020.

About the Program

The Department of Health (Department) administers New York's Medicaid program. Many of the State's Medicaid recipients receive their services through managed care, where the Department pays managed care organizations (MCOs) a monthly premium for each enrolled recipient, and in turn, the MCOs are required to pay for the Medicaid services their recipients require, which includes pharmacy services. Many recipients have other third-party health insurance (TPHI) in addition to Medicaid (e.g., employer-based coverage or Medicare Part D). Medicaid is considered the payer of last resort, and as such, MCOs are required to coordinate benefits with the recipient's TPHI prior to paying for Medicaid services. The Office of the Medicaid Inspector General (OMIG) contracts with Health Management Systems, Inc. (HMS) to identify and recover payments made for services that should have been paid for by a recipient's TPHI. During the audit period, HMS' third-party liability recoveries on MCO pharmacy payments totaled about $118 million.

Key Findings

We found that the Department and OMIG lacked adequate oversight of the third-party liability recovery process to ensure that all available recoveries are made. During our audit scope:

- HMS did not bill TPHI carriers for the recovery of about $292 million in pharmacy claims that MCOs paid as the primary insurance for recipients who had TPHI drug coverage. We found improvements could be made in HMS' processes for recovering claims.
- Third-party insurers often denied claims HMS submitted for recovery for reasons that could be rectified, but follow-up actions by HMS to get payment on those claims were limited, and many payments, potentially tens of millions of dollars, were never recouped.
- Neither the Department nor OMIG performed reviews, reconciliations, or other monitoring of HMS' recoveries by comparing claims MCOs paid on behalf of recipients with TPHI drug coverage to claims reviewed and recovered by HMS. Furthermore, OMIG and HMS were unable to determine why payments for specific pharmacy services we provided for review were not recovered.

Key Recommendations

- Review the $292 million in MCO payments for pharmacy services we identified and ensure appropriate recoveries are made.
- Implement ongoing monitoring of the TPHI recovery process for pharmacy services on behalf of managed care members to ensure all appropriate recoveries are made.

Office of the New York State Comptroller
Division of State Government Accountability

July 13, 2022

Mary T. Bassett, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Bassett:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Recovering Managed Care Overpayments for Pharmacy Services on Behalf of Recipients With Third-Party Health Insurance*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

Contents

Glossary of Terms

Term	Description	Identifier
Department	Department of Health	*Auditee*
eMedNY	Department's Medicaid claims processing and payment system, which also contains information on recipients' TPHI	*System*
FFS	Fee-for-service	*Key Term*
HMS	Health Management Systems, Inc.	*Key Term*
MCO	Managed care organization	*Key Term*
NYSOH	New York State of Health	*System*
OMIG	Office of the Medicaid Inspector General	*Agency*
PBM	Pharmacy benefit manager	*Key Term*
TPHI	Third-party health insurance	*Key Term*
TPL	Third-party liability	*Key Term*
WMS	Welfare Management System	*System*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the Department of Health (Department). For the State fiscal year ended March 31, 2021, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $68.1 billion. The federal government funded about 56.5% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.5%.

The Department uses two methods to pay for Medicaid services, including pharmacy services: fee-for-service (FFS) and managed care. Under the FFS method, the Department, through its Medicaid claims processing and payment system (eMedNY), pays Medicaid-enrolled pharmacy providers directly for each drug dispensed to a Medicaid recipient. Under the managed care method, the Department pays managed care organizations (MCOs) a monthly premium for each enrolled Medicaid recipient and the MCOs arrange for the provision of health care services, including pharmacy benefits, and reimburse providers for those services. MCOs then submit claims (referred to as encounter claims) to the Department's Encounter Intake System to inform the Department of each service provided to their enrollees. In addition, MCOs report their medical costs and administrative costs annually to the Department on Medicaid Managed Care Operating Reports. The Department uses this information to establish MCOs' managed care premium payment amounts.

Many Medicaid recipients have other sources of health care coverage in addition to Medicaid, such as Medicare and commercial health insurance (hereafter referred to as third-party health insurance, or TPHI). Some TPHI carriers, as well as some MCOs, utilize pharmacy benefit managers (PBMs) to manage their pharmacy benefits. Per federal law and State regulations, Medicaid is always the payer of last resort. If a Medicaid recipient has TPHI coverage, Medicaid providers and MCOs are required to coordinate benefits in order to exhaust the benefits of the TPHI coverage before billing the Medicaid program. While the Department maintains information on recipients' TPHI in eMedNY, in many instances, this information isn't available in time to prevent Medicaid from being identified as the primary payer.

The Department utilizes post-payment reviews to identify instances where a TPHI carrier may be liable for the services provided to a Medicaid recipient. The Office of the Medicaid Inspector General (OMIG) contracts with Health Management Systems, Inc. (HMS) to perform these reviews and to pursue recoveries from TPHI carriers. Under State and federal laws, the Department – or HMS, as its third-party liability (TPL) contractor – must initiate the process of recovering payments from TPHI carriers within 3 years of the claim date of service and then the Department (or HMS) has up to 6 years from the submission of the claim to enforce its right to recover any amount for which the TPHI carrier is liable.[1]

1 Social Services Law § 367-a; Insurance Law § 3212; Social Security Act § 1902 (42 U.S.C. § 1396a).

Audit Findings and Recommendations

Comprehensive and well-monitored processes for TPHI-related post-payment reviews and recoveries are critical to ensure Medicaid is the payer of last resort and to ensure all appropriate recoveries are pursued and collected. However, we determined that neither the Department nor OMIG provided adequate oversight of HMS' activities to ensure that all MCO pharmacy payments on behalf of Medicaid recipients who also had TPHI drug coverage were identified and pursued for recovery.

Although HMS reports claim recoveries to OMIG, the Department and OMIG do not perform any reviews, reconciliations, or monitoring to verify that all appropriate TPL recoveries are made. For example, no analysis is done comparing the pharmacy claims MCOs paid on behalf of recipients with TPHI drug coverage against those claims reviewed and recovered by HMS. Without this means of oversight, the Department and OMIG do not know which encounter claims HMS did not bill to TPHI carriers (and whether they were properly excluded from TPHI carrier billings) or which encounter claims were not recovered (and the reasons why not).

We determined that, for the period October 2015 through May 2020, MCOs paid about $292 million as the primary insurance on pharmacy encounter claims where the recipient also had TPHI drug coverage, and for which HMS had not billed the claims to TPHI carriers for recovery. We provided OMIG and HMS a sample of pharmacy services to review, and officials were unable to determine why many of the claims were not recovered. Furthermore, although the TPL recovery process is ongoing, a significant portion of the $292 million may be unrecoverable because they exceed New York State's 3-year statute of limitations period for TPHI recoveries. According to information provided by OMIG in December 2020, HMS' TPL recoveries of pharmacy encounter payments totaled about $118 million during the same time period (October 2015 through May 2020).

We found HMS' recovery processes are guided by business rules that remove claims HMS believes are unlikely to have a successful recovery outcome. However, its business rules may have incorrectly excluded recoverable claims. We also found that TPHI carriers often denied HMS' claims for reasons that could be rectified, but follow-up actions by HMS to get payment on those denied claims were limited, and many payments, potentially tens of millions of dollars, were never recouped.

According to Department and OMIG officials, TPHI coordination of benefits is a complex process, and there are numerous impediments to successful TPL recoveries, such as erroneous policy information, incomplete billing information, frequent changes in TPHI coverage, and inadequate responses or denials by TPHI carriers. Officials contend that HMS ran all appropriate pharmacy encounter claims through its internal processes during our audit period, and any pharmacy encounter claims not billed to TPHI carriers or otherwise not recovered were appropriately excluded. While we agree TPHI coordination of benefits and TPL recoveries are complex processes, weaknesses in the Department and OMIG's oversight of these processes likely contributed to significant waste and lost opportunity for recovery of improper payments.

We also determined the Department does not have processes in place to transmit all relevant pharmacy-related TPHI policy information in eMedNY to MCOs, which could help them to better coordinate TPHI benefits for pharmacy services and mitigate the risk that Medicaid is identified as the primary payer.

Weaknesses in TPL Recovery Efforts

Claims Not Billed to TPHI Carriers for Recovery

For the period October 2015 through May 2020, we determined MCOs paid about $292 million for pharmacy claims as the primary insurance on behalf of recipients who, according to eMedNY, had TPHI drug coverage, and for which HMS had not billed the claims to TPHI carriers for recovery.[2] Approximately $243.5 million (3.75 million encounter claims) was related to commercial (non-Medicare) TPHI and the remaining $48.3 million (776,231 encounter claims) was paid on behalf of recipients with Medicare Part D (see the table below).

Year	Commercial Insurance		Medicare Part D	
	Payment Amount	Number of Encounter Claims	Payment Amount	Number of Encounter Claims
2015*	$12,843,279	180,491	$3,404,752	43,008
2016	61,615,967	813,691	19,151,028	185,934
2017	51,107,974	773,518	7,219,419	109,374
2018	47,467,549	844,284	5,842,667	156,195
2019	47,377,961	818,114	6,749,926	193,872
2020**	23,083,204	321,556	5,979,675	87,848
Totals	**$243,495,934**	**3,751,654**	**$48,347,467**	**776,231**

*Data for 2015 only includes October 1, 2015 through December 31, 2015.
**Data for 2020 only includes January 1, 2020 through May 31, 2020.

Of the $48.3 million related to Medicare Part D coverage, we found $39.1 million was associated with either on-formulary drugs and in-network providers or with Medicare's Limited Income Newly Eligible Transition program, which covers all Part D drugs with no network restrictions. About $7.7 million (of the $48.3 million) was paid for a non-formulary drug and/or to an out-of-network pharmacy (Medicare Part D plans may pay for a non-formulary drug or when the provider is out-of-network in certain instances). For the remaining $1.5 million (of the $48.3 million), we did not determine if the provider was in-network or if the drug was on-formulary.[3] Commercial TPHI provider networks and drug formularies can vary among the

2 Based on files of TPHI carrier billings (current as of June 7, 2021) and recovered encounter claims (current as of December 4, 2020) obtained from OMIG and HMS for service dates from October 2015 through May 2020.

3 We did not review Medicare drug formulary or provider network information for service dates in 2015 and for certain Medicare drug plans which did not report this information to the Centers for Medicare & Medicaid Services.

many different carriers and policies, and historical information was generally not accessible; therefore, this information was not used in our audit.

We reviewed information provided by HMS regarding its recovery processes, which included a summary of the business rules it uses to guide its decisions on encounter claim recoveries. We note that HMS did not provide all business rules but rather a list of the most common rules it applies. These business rules are intended to remove claims from further review if HMS believes they are unlikely to have a successful recovery outcome. Neither the Department nor OMIG received reports from HMS to monitor encounter claims that were removed from further review based on HMS business rules and therefore not billed to TPHI carriers for recovery.

Using data obtained from OMIG and HMS, we identified over 4.5 million encounter claims totaling about $292 million for which HMS did not bill claims to TPHI carriers for recovery. We selected a judgmental sample of 50 pharmacy encounter claims and provided them to OMIG and HMS for their review to determine why they were not billed to the TPHI carrier and did not result in a recovery. According to HMS, three of the 50 encounter claims in our sample had been billed to or recovered from the TPHI carrier after the date we received the files of TPHI carrier billings and recovered encounter claims. We note that HMS' recovery process is ongoing, and our analysis is based on carrier billings and recoveries at the point in time these files were provided during the audit.

HMS was unable to determine why 38 of the remaining 47 encounter claims were not recovered. According to HMS officials, internal processes are not set up to track exclusions of individual encounter claims. However, without this tracking, as well as the lack of any reconciliation of encounter claims by the Department and OMIG, there is no assurance that all appropriate recoveries are being made.

HMS officials stated that eight of the 47 encounter claims were excluded from further review because the recipient did not have a stand-alone commercial PBM TPHI policy (i.e., a separate policy for drug coverage) on file in eMedNY. According to HMS, if a recipient has commercial TPHI, it only pursues recovery of pharmacy claims if a stand-alone PBM policy is listed in eMedNY. HMS officials explained that they believe billing TPHI carriers that are not PBMs will result in unadjudicated or denied claims and that this practice was implemented at the direction of the Department and OMIG. However, this practice should be re-assessed because (1) Department officials acknowledged certain TPHI with drug coverage is entered into eMedNY without a stand-alone PBM policy; and (2) it contradicts FFS controls put in place for cost avoidance purposes in eMedNY. The eMedNY system edits for FFS claims processing identify all TPHI policies with pharmacy coverage, not just those with stand-alone PBM coverage, and deny claims where the TPHI hasn't been billed as the primary payer before Medicaid. Approximately $53.2 million (of the $243.5 million) in pharmacy payments were on behalf of recipients with drug coverage not under a stand-alone PBM policy in eMedNY.

HMS excluded the one remaining encounter claim in our sample from further review because it contained a generic billing provider identification number (i.e., the actual

billing provider was not identified). We note that encounter claims for pharmacy services are required to contain another field, the biller's National Provider Identifier, which can be readily used to identify the exact pharmacy where the recipient received services. As a result of this HMS business rule, certain encounter claims may have been incorrectly excluded from TPHI carrier billings. Approximately $24.4 million (of the $292 million) in payments we identified may have been excluded from the TPL recovery process due to containing a generic billing provider identification number even though the National Provider Identifier was available.

In response to our audit, HMS officials stated they have been working on obtaining additional data fields to improve the TPL recovery process. In addition, Department and OMIG officials indicated they will obtain more details of TPL recovery efforts from HMS, such as claim disposition reporting on claims that are not selected to be billed to TPHI carriers.

Follow-Up of Carrier-Denied Claims

At the time of our audit, neither the Department nor OMIG received reports from HMS regarding TPHI carrier denials, particularly follow-up actions taken by HMS on those carrier denials. Department and OMIG officials do not perform any reviews or monitoring in this area.

We obtained files from HMS for encounter claims billed to, but subsequently denied by, TPHI carriers during our audit period. We identified pharmacy encounter claims totaling $120.9 million that were denied by TPHI carriers for either administrative reasons or other reason codes that may be rectifiable. Federal and State laws prohibit liable third parties from denying Medicaid TPL claims for administrative or procedural reasons. Administrative reasons such as prior authorization issues and timely filing restrictions accounted for about $26.5 million of the $120.9 million. For the remaining $94.4 million, the claims were denied for other potentially rectifiable reasons such as "Billing Provider Not Eligible to Bill This Claim Type," "Missing or Invalid Quantity Dispensed," "Missing or Invalid Birth Date," and "Missing or Invalid Diagnosis Code." These denial reason codes and others could ultimately be recoverable if appropriate follow-up actions are taken, such as correcting deficiencies in the data used for carrier billings. Furthermore, although the State should have 6 years from the submission of a claim to enforce its right to recover, HMS often ceased follow-up activity after 3 years from the date of service.

HMS did not have comprehensive reports of its follow-up activities available upon our request, and therefore could not provide information pertaining to: how often it took follow-up actions, what those actions were, and whether those actions were successful for these types of denials. Upon request for such reports, HMS provided one report of follow-up activities. The report covered the year 2020 and contained about $11 million in recoveries (of which about $350,000 was for pharmacy encounter claims), but we could not confirm that the pharmacy services were initially denied by TPHI carriers.

We also determined HMS billed a significant amount of pharmacy encounter claims to TPHI carriers and the claims remained unadjudicated beyond the 3-year statutory period for initiating recoveries. OMIG and the Department should monitor HMS' follow-up efforts in this area and determine if any additional recoveries can be made up through the 6-year period for enforcing recoveries.

According to HMS officials, it performs ongoing reviews to ensure encounter claims are corrected and rebilled to TPHI carriers when possible, including for the reason codes previously mentioned. Their assertions notwithstanding, our audit noted a significant amount of pharmacy claims that were not recovered after being denied by TPHI carriers with potentially rectifiable denial reason codes. OMIG and the Department should routinely review HMS' efforts in this area and determine if any improvements can be made to resolve more carrier denials and successfully obtain more recoveries from TPHI carriers. In response to our audit, Department and OMIG officials indicated they will obtain more details of TPL recovery efforts from HMS, such as monthly or quarterly reporting on TPHI carrier billing efforts.

Recommendations

1. Review the $292 million in Medicaid payments for pharmacy services on behalf of recipients with TPHI drug coverage we identified and ensure overpayments are appropriately recovered, prioritizing encounter claims that are approaching the 3-year window for recovery.

2. Assess the recoverability of pharmacy encounter claims that were billed to TPHI carriers but did not result in a recovery (due to carrier denial or non-response) and ensure all necessary follow-up actions are taken to obtain appropriate recoveries.

3. Assess the TPL recovery process for managed care pharmacy services to identify all factors that led to exclusions from TPHI carrier billings, and ensure corrective actions are taken where appropriate.

4. Implement ongoing monitoring of the entire TPHI recovery process for managed care pharmacy services to ensure all appropriate recoveries are made within the required time frames, including monitoring of pharmacy encounter claims that are not billed to TPHI carriers and pharmacy encounter claims that are billed to TPHI carriers but do not result in a recovery.

MCO Third-Party Health Insurance Information

The Department maintains a record of recipients' TPHI information in eMedNY and has processes in place to communicate TPHI policies to MCOs to assist them in coordinating proper billing of third-party payers. However, we found that certain pharmacy TPHI information was not sent to MCOs.

Medicaid recipients can be enrolled in Medicaid through two systems: the Welfare Management System (WMS) or the New York State of Health (NYSOH) system. The

system under which a recipient is enrolled in Medicaid ultimately impacts which TPHI information is sent to MCOs.

Generally, NYSOH-enrolled recipients who have a comprehensive TPHI policy that covers a broad range of medical services (e.g., physician visits, hospital services, durable medical equipment) in addition to pharmacy services are automatically disenrolled from their Medicaid MCO via NYSOH system processes. For the remaining NYSOH-enrolled managed care recipients, the TPHI policies are only sent to MCOs if a recipient provided the TPHI details at the time of their Medicaid eligibility determination. Otherwise, MCOs must use other means to identify TPHI and coordinate benefits. During our audit period, when a recipient was enrolled through WMS, the primary method of sending TPHI data was monthly reports sent to MCOs. However, these reports only included information on recipients' Medicare Part D coverage if the coverage was from a Medicare managed care plan; therefore, Part D information was not provided to MCOs if recipients had a stand-alone Medicare Part D drug plan.

In January 2021, after our audit period, the Department began a new process for sending TPHI information to MCOs for WMS-enrolled recipients. According to Department officials, the process now includes all Medicare Part D information (i.e., stand-alone Part D plans and Medicare managed care plans that include drug coverage). However, for recipients enrolled through NYSOH, not all TPHI listed in eMedNY is sent to MCOs. If MCOs do not have all TPHI information timely, it can lead to ineffective coordination of benefits.

Recommendation

5. Ensure MCOs are made aware of all eMedNY TPHI policies with drug coverage, and take corrective actions where appropriate.

TPL Recovery Time Frame

Currently, New York State Social Services Law sets the period for Medicaid to initiate TPL recoveries at 3 years from the date of service – the minimum period required by the Social Security Act; the Centers for Medicare & Medicaid Services has advised that states are allowed to establish longer time frames. We identified a significant amount of pharmacy service payments where recoveries were not initiated within the 3-year recovery window and can no longer be recovered. Given the complexity of the TPL recovery process, a longer recovery time frame could be beneficial to the Medicaid program.

Recommendation

6. Engage other stakeholders to assess the feasibility and benefits of increasing the recovery window for initiating Medicaid TPL recoveries beyond the current statutory maximum of 3 years.

Audit Scope, Objective, and Methodology

The objective of this audit was to determine whether Medicaid overpayments for pharmacy services on behalf of managed care recipients who had TPHI were appropriately recovered. The audit covered the period from October 2015 through May 2020.

To accomplish our objective and assess related internal controls, we interviewed officials and obtained data from the Department, OMIG, HMS, and MCOs. We reviewed applicable State and federal guidance and regulations and examined the Department's relevant Medicaid policies and procedures. Our review focused on Medicaid managed care pharmacy services provided through mainstream managed care, health and recovery plans, and special needs plans.

We reviewed pharmacy encounter data and TPHI policy data from the Medicaid Data Warehouse and eMedNY, and determined the data was sufficiently reliable for the purpose of this audit. We identified pharmacy encounter claims where the recipient had TPHI with drug coverage on the date of service and the encounter record showed no third-party payments toward the services provided. We also reviewed data available from the Centers for Medicare & Medicaid Services to determine the Medicare drug formulary and provider network statuses relating to pharmacy encounter claims for recipients who had drug coverage under Medicare Part D. Further, we accounted for both pharmacy encounter claims recovered[4] as part of the TPL recovery process and pharmacy encounter claims billed to TPHI carriers[5] by HMS, according to data provided by OMIG and HMS during the audit. To determine why the TPL recovery process did not result in billings to TPHI carriers or recoveries of payments on the pharmacy encounter claims identified, we selected a judgmental sample of 50 pharmacy encounter claims and provided it to OMIG and HMS for review. The sampled encounter claims included a variety of high-cost drugs paid on behalf of recipients with various commercial TPHI carriers as well as other recipients with Medicare Part D coverage. Because the sample was judgmentally selected, the results cannot be projected to the population as a whole.

We shared our methodology and findings with officials from the Department and OMIG during the audit for their review.

4 Auditors received a data file of encounter claims recovered due to a third-party liability for our audit period on December 4, 2020.

5 Auditors received a data file of encounter claims billed to TPHI carriers and subsequently denied during our audit period on June 7, 2021.

Statutory Requirements

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

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

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of the Department's oversight and administration of Medicaid payments for pharmacy services made by managed care organizations on behalf of recipients with third-party health insurance.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of the report. In their response, Department officials concurred with many of the audit recommendations, and indicated that certain actions have been and will be taken to address them. We addressed certain of their remarks in our State Comptroller's Comments, which are embedded within the Department's response.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

June 13, 2022

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2020-S-39 entitled, "Medicaid Program: Recovering Managed Care Overpayments for Pharmacy Services on Behalf of Recipients with Third-Party Health Insurance".

Thank you for the opportunity to comment.

Sincerely,

Kristin M. Proud

Kristin M. Proud
Acting Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
Frank Walsh
Amir Bassiri
Geza Hrazdina
Daniel Duffy
James Dematteo
James Cataldo
Brian Kiernan
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Amber Rohan
Michael Atwood
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Department of Health Comments to Draft Audit Report 2020-S-39 entitled, "Medicaid Program: Recovering Managed Care Overpayments for Pharmacy Services on Behalf of Recipients With Third-Party Health Insurance" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report 2020-S-39 entitled, Medicaid Program: Recovering Managed Care Overpayments for Pharmacy Services on Behalf of Recipients With Third-Party Health Insurance" by the Office of the State Comptroller (OSC).

General Comments:

Audit Findings and Recommendations (page 6):

- *We determined that, for the period October 2015 through May 2020, managed care organizations (MCOs) paid about $292 million as the primary insurance on pharmacy encounter claims where the recipient also had third party health insurance (TPHI) drug coverage, and for which Health Management Systems, Inc. (HMS) had not billed the claims to TPHI carriers for recovery. We provided the Office of the Medicaid Inspector General (OMIG) and HMS a sample of pharmacy services to review, and officials were unable to determine why many of the claims were not recovered.*

The finding that the State did not bill the claims to TPHI carriers is misleading and is not substantiated by the examples provided in the audit report. The examples detailed from OSC do not provide evidence that a recovery should have been made or that a recovery would have ever occurred. For example, absence of a denial reason or the existence of billed claims that were not adjudicated by the carrier does not substantiate that a recovery was warranted or that a recovery would have ever occurred, as they may be appropriate Medicaid claims. The OSC assumption that any claim without a recovery represents an error or is evidence of inaction to the detriment of the State is patently false.

The existence of overlapping TPHI, in and of itself, does not mean that a Medicaid claim is recoverable. HMS processes and reviews all of the paid claims through their system, including encounters that are included as part of their review period. Where TPHI is discovered, edits within HMS' system are employed to eliminate billings that likely would not result in recovery, but systematically prevent overpayment. The data provided to OSC demonstrates that even when claims pass through all applicable edits in the system and are billed, valid carrier denials are often the result. Stating that $292 million were recoverable, with no evidence that the claims are even billable or recoverable, and that HMS had not billed the claims to TPHI carriers is a gross generalization that is inaccurate, misleading and does not take into consideration the complex processes that are designed to bill only those claims to carriers that are appropriate for reimbursement.

State Comptroller's Comment 1 – The Department's response, that "the OSC assumption that any claim without a recovery represents an error or is evidence of inaction to the detriment of the State is patently false," is incorrect. The response also reflects OMIG's and the Department's

attitude and hands-off approach toward their oversight of HMS' recovery process. The response is ill-conceived and, given the significance of money at stake, is irresponsible to the taxpayers funding Medicaid. OMIG and the Department should not be dismissive but should thoughtfully review the audit's findings and implement the recommendations.

The audit does not make any assumptions regarding the recoverability of the $292 million in encounter claims that we determined were not billed to TPHI carriers. Further, OMIG and the Department make their inflammatory statement, but when provided with a sample of claims, neither OMIG nor HMS could provide an explanation as to why 38 of 47 claims (81%) were not billed to TPHI carriers for potential recovery. Moreover, in some cases when a reason was given (9 of 47 claims, or 19%), we found the reasons were not justified. For example, when claims were excluded from the TPL recovery process due to containing a generic billing provider identification number, we found that an alternate field, the National Provider Identifier (NPI), was available for use in billing TPHI carriers (see pages 8–9 of the report).

The audit concluded that OMIG and the Department provided inadequate oversight over HMS' TPL recovery processes and, as a result, HMS excluded certain categories of pharmacy encounter claims from TPHI carrier billings, which should be re-evaluated, such as: $53.2 million related to recipients whose drug coverage was not under a stand-alone PBM policy in eMedNY (this exclusion is contradictory to how FFS claims are processed); $39.1 million paid on behalf of Medicaid recipients with Medicare Part D for on-formulary drugs at in-network providers (we also add that the Department makes monthly clawback payments to the federal government for many individuals with this coverage instead of paying individual claims); and $24.4 million in encounter claims containing a generic billing provider identification number (when an alternate field, the NPI, was available for use in billing TPHI carriers).

Follow-Up of Carrier-Denied Claims (page 9):

- *For the remaining $94.4 million, the claims were denied for other potentially rectifiable reasons such as "Billing Provider Not Eligible to Bill This Claim Type," "Missing or Invalid Quantity Dispensed," "Missing or Invalid Birth Date," and "Missing or Invalid Diagnosis Code." These denial reason codes and others could ultimately be recoverable if appropriate follow-up actions are taken, such as correcting deficiencies in the data used for carrier billings. Furthermore, although the State should have 6 years from the submission of a claim to enforce its right to recover, HMS often ceased follow-up activity after 3 years from the date of service.*

HMS specifically reviews each of the reason codes listed above as part of their denial follow-up efforts. For example, for reason code "Missing or Invalid Quantity Dispensed", HMS has conducted a multi-pronged recovery effort aimed explicitly at this denial, including multiple system enhancements, as well as ongoing sweeps of the data to ensure that any claims where the required level of detail is present are corrected and re-billed to commercial payers. As previously noted, the continued presence of a denial code does not indicate that follow up activity was not performed; carriers may re-deny claims or stand by their original adjudication decision.

State Comptroller's Comment 2 – OMIG and the Department have provided little oversight of HMS' recovery process, including HMS follow-up activity in cases where TPHI carriers denied claims. Therefore, it is unclear how OMIG and Department officials know whether HMS' follow-

up activities related to TPHI carrier denials were appropriate to ensure all available recoveries were made.

Recommendation #1:

Review the $292 million in Medicaid payments for pharmacy services on behalf of recipients with TPHI drug coverage we identified and ensure overpayments are appropriately recovered, prioritizing encounter claims that are approaching the 3-year window for recovery.

Response #1:

OMIG and HMS fundamentally disagree with the underlying assertions of this recommendation.

State Comptroller's Comment 3 – Given the examples provided in State Comptroller's Comment 1, and the circumstances whereby neither OMIG nor the Department review, monitor, or reconcile TPHI recoveries to ensure that all appropriate recoveries are pursued and collected, we strongly encourage OMIG and the Department to implement this recommendation.

As stated above, the existence of TPHI, in and of itself, does not mean that a Medicaid claim is recoverable. Medicaid benefits may, and often do, exceed commercial insurance benefits, contributing to instances where the existence of TPHI does not change Medicaid's liability. Another example is when a claim includes multiple services and only some of the services are covered by TPHI. In this example, Medicaid would be appropriately billed to cover the remaining services.

State Comptroller's Comment 4 – These are general statements that may not be relevant to the audit findings. For example, pharmacy encounter claims are only related to one service, drug, or item and, therefore, the claims identified in our audit do not include claims with multiple services. No evidence of OMIG, Department, or HMS reviews was provided to relate these statements to the audit findings.

A lack of a billing does not mean an attempt to recover did not occur. Rather, OMIG and HMS consider complimentary processes, including the act of passing claims through the HMS systems edits, as an attempt for recovery. HMS' TPHI edits are thoughtfully developed and rigorously tested to identify claims for recovery, but also eliminate claims that were billed appropriately to Medicaid. Therefore, it is important to recognize that submission of a bill by HMS to a TPHI carrier is not the only evidence of an attempt for recovery. Absent existing system edits to capture these claims, inappropriate billings may be provided to carriers leading to carrier abrasion. For example, edits may remove claims properly submitted by the provider to the TPHI carrier prior to the Medicaid claim being submitted for payment. Confidential claims related to abortion, pregnancy, sexual abuse, etc. are appropriately removed from recovery attempts due to their sensitive nature and to protect the privacy of the members.

Valid TPHI carrier denials do occur as evidenced in the data provided to OSC as part of this audit. When claims pass through all applicable edits in the HMS system, there may still be denials taken by the TPHI carrier that are appropriate.

OSC's examples provided during the audit do not substantiate that a recovery was warranted or that a recovery would have ever occurred. As stated in the general comments above, absence of a denial reason or the existence of billed claims that were not adjudicated by the carrier does

not prove that recovery should have or would have occurred, as they may be appropriate Medicaid claims. The OSC assumption that any claim without a recovery represents an error or is evidence of inaction to the detriment of the State is flawed.

State Comptroller's Comment 5 – See State Comptroller's Comment 1. Additionally, officials consider the act of passing claims through HMS system edits that eliminate billings HMS believes would likely not result in recovery as an attempt for recovery. However, the audit demonstrated the current TPL recovery process systematically excluded certain categories of pharmacy encounter claims from TPHI carrier billings based on flawed and incomplete rationales.

The contract between HMS and OMIG is structured to provide robust TPHI identification and recovery procedures. The State's and HMS' interests are aligned to maximize recoveries of inappropriate payments for the Medicaid program.

State Comptroller's Comment 6 – From October 2015 through May 2020, HMS' third-party liability recoveries on MCO pharmacy payments totaled about $118 million. During this same period, we found HMS did not bill TPHI carriers for the recovery of about $292 million in pharmacy claims. We found significant improvements could be made in HMS' processes for recovering claims. We encourage OMIG and the Department to implement our recommendations to maximize these recoveries.

Recommendation #2:

Assess the recoverability of pharmacy encounter claims that were billed to TPHI carriers but did not result in a recovery (due to carrier denial or nonresponse) and ensure all necessary follow-up actions are taken to obtain appropriate recoveries.

Response #2:

OMIG and HMS perform vigorous follow-up activities and reject OSC's assertion that follow-up actions on denied claims by HMS has been "limited" in scope and likely contributed to "significant waste and lost opportunity for recovery of improper payments." This is simply incorrect. HMS specifically reviews administrative denials such as prior authorization issues or timely filing restrictions as part of denial follow-up efforts. Moreover, HMS routinely conducts follow-up efforts for denial reasons which may be rectifiable such as "Billing Provider Not Eligible to Bill This Claim Type" and "Missing or Invalid Quantity Dispensed." This multi-faceted recovery effort is specifically aimed at these denials and includes multiple system enhancements, as well as ongoing sweeps of the data to ensure that any claims where the required level of detail is not present are corrected and re-billed to commercial payers, rather than being paid by Medicaid. The continued presence of a denial code does not indicate that follow-up activity was not performed; rather, carriers may re-deny claims or stand by their original adjudication decision. When appropriate, HMS pursues actionable denials.

State Comptroller's Comment 7 – It is unclear what rigorous follow-up activities are performed by OMIG and HMS. As stated throughout the report, OMIG and the Department have provided little oversight of HMS' recovery process, including follow-up activity when TPHI carriers deny claims. Additionally, HMS did not have sufficient reports of its follow-up activities available upon request and could not provide information pertaining to: how often it took follow-up actions, what those actions were, and whether those actions were successful. As a result, it is unclear how

officials know whether HMS' follow-up activities on carrier denials were appropriate to ensure all available recoveries were made. Therefore, we encourage OMIG and the Department to implement this recommendation.

HMS must operate within the confines of the current three-year recovery lookback period. Without enforceable and exercised compliance penalties, it is difficult for HMS and OMIG to compel payment from TPHI carriers. Some states have adopted various penalties ranging from monetary, to licensure revocation and even application of unfair and deceptive trade practices which would support this and other recommendations in the audit. However, it is important to note that even if the lookback period was elongated and carriers were compelled to respond (e.g., penalties), there would still be a significant population, albeit smaller, of unrecoverable claims due to faulty carrier information, non-covered services, etc.

Recommendation #3:

Assess the third-party liability (TPL) recovery process for managed care pharmacy services to identify all factors that led to exclusions from TPHI carrier billings, and ensure corrective actions are taken where appropriate.

Response #3:

OMIG and HMS agree that TPL recovery processes, including edits and business rules, should be regularly reviewed. HMS and OMIG understand that some claim types are inherently excluded due to confidentiality as well as heightened patient privacy associated with services related to abortions, sexual assault/abuse, and substance abuse treatment. HMS has a long-standing, effective process in place to regularly review edits and business rules and update as appropriate. HMS continues to confer with OMIG on updates to claim types necessitating exclusion or to business rules that may require further update and/or modification.

HMS has already taken steps to further enhance the TPL recovery process in New York for managed care pharmacy services by proactively instituting systems changes needed to have visibility into which claims were excluded and the rationale for exclusion. OMIG in collaboration with HMS is exploring additional systems enhancements to provide greater clarity and detail on TPHI carrier billing follow up activities.

State Comptroller's Comment 8 – We are pleased HMS is taking steps to ensure visibility into which claims were excluded and the rationale for exclusion. We encourage the Department and the OMIG to fully implement this recommendation by identifying and assessing all factors that led to exclusions.

Recommendation #4:

Implement ongoing monitoring of the entire TPHI recovery process for managed care pharmacy services to ensure all appropriate recoveries are made within the required time frames, including monitoring of pharmacy encounter claims that are not billed to TPHI carriers and pharmacy encounter claims that are billed to TPHI carriers but do not result in a recovery.

Response #4:

OMIG and HMS are implementing additional enhancements into all aspects of the process.

Specifically, HMS and OMIG are developing additional reporting to give OMIG greater insight into the entire TPHI recovery process, including, but not limited to, claim disposition reporting.

HMS has also implemented enhancements to its billing processes to allow more granularity into the end-to-end recovery process, including, but not limited to, the ability to report on edits triggered from HMS' billing process. This enhancement allows the identification of specific reasons claims were removed from recovery attempts as well as provides detail for follow-up research to further maximize billings.

State Comptroller's Comment 9 – We are pleased OMIG and HMS are implementing enhancements to the TPL recovery process that will allow for proper monitoring of claims excluded from TPHI carrier billings and TPHI carrier denial follow-up activities.

Recommendation #5:

Ensure MCOs are made aware of all eMedNY TPHI policies with drug coverage, and take corrective actions where appropriate.

Response #5:

Requirements for MCOs regarding enrollees in receipt of comprehensive TPHI and requirements to coordinate benefits are already included in the Model Contract under Sections 3.7 and 10.1(e). To reinforce these requirements, the Department is reminding MCOs of these requirements through routine meetings with plans and Medicaid guidance articles.

State Comptroller's Comment 10 – The Department's response is not relevant to the intent of this recommendation. Our audit determined the Department does not have processes in place to transmit all pharmacy-related TPHI policy information from eMedNY to MCOs. As stated on page 9 of the report, not all TPHI information listed in eMedNY is sent to MCOs on behalf of recipients enrolled through NYSOH. If the MCOs do not have this information timely, it can lead to ineffective coordination of benefits.

Recommendation #6:

Engage other stakeholders to assess the feasibility and benefits of increasing the recovery window for initiating Medicaid TPL recoveries beyond the current statutory maximum of 3 years.

Response #6:

OMIG is collaborating with the Department and other agency stakeholders to determine the appropriateness and feasibility of this recommendation.

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