Greater Tompkins County Municipal Health Insurance Consortium

408 East Upland Road, Suite 2 • Ithaca, New York 14850 • (607) 274-5590

healthconsortium.net • consortium@tompkins-co.org

"Individually and collectively, we invest in realizing high quality, affordable, dependable health insurance."

Claims and Appeals Committee
Meeting Agenda
July 1, 2024 –2:30PM
Remote/Zoom Meeting

1. **Call to Order** — B. Shattuck
2. **Approval of Minutes – October 30, 2023 & April 2, 2024**
3. **Executive Director Update** — E. Dowd
4. **BMI RX Audit Review** — K. Rodrigues, G. Wilcox
5. **Acceptance of Prescription Drugs/RX Claims Audit Report**
6. **Next Meeting/Future Agenda Topics**
7. **Adjourn**

Next Meeting: TBD – To Be Held as Necessary

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Minutes – DRAFT
Claims and Appeals Committee
October 30, 2023 – 3:00 p.m.
Remote/Zoom Meeting

Present: Bud Shattuck, Chair, Donna Dawson, Tanya DiGennaro, Carol Sosnowski; Don Fischer; Tom Brown; Judy Drake (assigned as temporary member by Committee Chair - Rordan Hart)
Excused:
Staff/Guests: Elin Dowd, Executive Director; Lynne Sheldon, Clerk of the Board; Kylie Rodrigues, Benefits Specialist; Rob Spenard, Paul Pelton, Locey & Cahill

Call to Order

Mr. Shattuck, Chair, called the meeting to order at 3:04 p.m. – (To ensure quorum, Board Chair, Rordan Hart, assigned Judy Drake as temporary member for this meeting only, or until another committee member arrived)

Changes to the Agenda

There were no changes to the agenda.

Approval of Minutes of December 22, 2022 and August 11, 2023

It was MOVED by Ms. DiGennaro, seconded by Mr. Brown, and unanimously adopted by voice vote by members present via remotely, to approve the minutes of December 22, 2022 and August 11, 2023. MINUTES APPROVED.

Executive Director Update

Ms. Dowd said the Consortium staff has been busy as it is currently in the open enrollment period. She also reported that the Department of Financial Services (DFS) is still conducting their audit and she expects a status update to come from them soon.

BMI Medical and RX Claims Audit

Ms. Dowd said BMI is currently conducting two audits for the Consortium. She said the medical audit has been very timely. Currently, BMI has given their medical claims audit findings to Excellus. Excellus may now review those findings, and a meeting between the two groups will be set up to discuss any discrepancies. Ms. Dowd said BMI is also starting to request information from ProAct pharmacy to get the RX Claims audit started.

Ms. Dowd reported that the pharmacy RX provider transition from ProAct to Excellus will begin soon and communications have started with members to explain the transition, which will take place effective January 1, 2024.

Other Updates

Ms. Dowd did not have any other updates to report.

Appeal 2023-001

Ms. Dowd explained that the Consortium, since inception, has only had a few appeals. She believes this would be the third appeal, and unique to the Consortium. She said today's Claim and Appeals meeting was called to discuss an appeal, but due to HIPAA, diagnosis, and patient information will not be provided at the meeting. Ms. Dowd explained that this appeal that was received by the Consortium approximately one week ago, refers to a subscriber's dependent. Ms. Dowd said the Consortium has been in constant communication with the subscriber.

Ms. Dowd said Excellus is administering the plan of 45 days per year of Physical Therapy in a year for the dependent. A request from the patient's Physical Therapist was sent to Excellus to have an extension of the 45 days of therapy extended. She said Excellus has declined this extension. Ms. Dowd said typically when Excellus denies an appeal, the appeal is then forwarded to the Department of Financial Services (DFS). Ms. Dowd explained that would be unnecessary for the appeal to be forwarded to DFS due to the nature of this denial. Excellus denied this due to the member meeting the maximum days per year only. Ms. Dowd said the Consortium was asked for an exception to this unique case as additional therapy would provide a better outcome for the total health of this dependent. Ms. Dowd said the Consortium does not change policy on a case-by-case basis, which means a total change to the benefits must come from the Consortium, not the administrators of the plan. Ms. Dowd also explained that the current coverage is a maximum of 45 days of Physical Therapy/Occupational Therapy/Speech Therapy which will max out for this dependent this November.

Ms. Dowd wanted to make the committee aware that Excellus has already planned for the 2024 year to increase from 45 days to 60 days per year on their metal level plans these services on January 1, 2024. This benefit change increase would affect today's current date until the end of the 2023 year. Ms. Dowd said Consortium researched how many individuals within the Consortium could potentially need additional therapy days. The individual count was three, however, those three individuals have not reached the 45 days as of today.

Mr. Shattuck expressed concern that when policies are changed, it may set a precedent, however, also says that therapy is important to continue if it is helping the total health of a patient and realizes stopping and starting a new therapy program isn't always in the best interest of a patient. Mr. Shattuck also questioned the cost of a change in benefit mid-year for the Consortium.

Mr. Locey said that they reviewed and discussed. Benefit change during the year is a slippery slope as others may come back with similar requests. He said competitively the benefits are comparable to many other plans. Mr. Locey said that they questioned Excellus the rationale of why they are moving to the 60 days at the beginning of the new year, and their response said that it was complaint driven requesting additional visits. Mr. Locey said there are also no changes to the actuarial value if this change in plan was made.

Mr. Shattuck asked the course of the approval process headed to other committees and ultimately to the Executive Committee in the month of December. Ms. Dowd said that Consortium asked for claims to be resubmitted. Ms. Rodrigues said that a similar billing situation happened last year with hearing aids and Excellus did pull those claims and resubmitted those on behalf of the individuals.

MOTION NO. 004-2023– MOTION TO MOVE APPEAL 2023-001 TO THE JOINT COMMITTEE AND EXECUTIVE COMMITTEE ON BEHALF OF THE BOARD OF DIRECTORS FOR GTCMHIC FOR REVIEW AND POTENTIAL APPROVAL

It was MOVED by Ms. DiGennaro, seconded by Mr. Brown, and unanimously adopted by voice vote by members present by video or in person, to approve the motion "To Move Appeal 2023-001 to the Joint Committee and Executive Committee on behalf of the Board of Directors for GTCMHIC for review and potential approval. MOTION CARRIED.

Other Potential Appeals

Future Agenda Topics

BMI Claims Audit

Adjournment

The meeting was adjourned at 3:37 p.m.

Respectfully submitted by Lynne Sheldon, Clerk of the Board

Minutes – DRAFT
Claims and Appeals Committee
April 2, 2024 – 2:30p.m.
Remote/Zoom Meeting

Present: Bud Shattuck, Chair*, Don Fischer*, Tanya DiGennaro*, Krissie Brown, Tom Brown*
Excused:
Absent: Donna Dawson; Mike Murphy
Staff/Guests: Elin Dowd*, Executive Director; Lynne Sheldon, Clerk of the Board; Kylie Rodrigues, Benefits Specialist; Teri Apalovich, Finance Manager

**The meeting was held remotely*

Call to Order

Mr. Shattuck, Chair, called the meeting to order at 2:31 p.m.

Changes to the Agenda

There were no changes to the agenda.

Approval of Minutes of August 11, 2023

It was MOVED by Mr. Brown, seconded by Ms. Dawson, and unanimously adopted by voice vote by members present, to approve the minutes of August 11, 2023, as submitted. MINTUES APPROVED.

Executive Director Report

Ms. Dowd reported that the Consortium is still awaiting a final exit letter from the Department of Financial Services (DFS) audit. She said the Consortium met with DFS at the end of 2023, where DFS explained the audit was completed, but did not have a final approval. DFS also informed the Consortium they would be sending out an exit letter, which allows the Consortium to respond and discuss. Ms. Dowd said once the audit is finalized and approved by the Audit Committee, the Consortium can file the Jurat and then will receive the final invoice from DFS.

Ms. Dowd explained that the Consortium is also currently involved in their internal audit. Ms. Dowd stated the audit shows the Consortium was over budget and had to utilize reserves in the amount of four million dollars. She reported, the first couple months of this year's claims have been slightly over budget, but not as significant as the Consortium had at the end of last year.

Ms. Dowd said that the Consortium is working on strategic initiatives. One item is the research and exploration of the Consortium offering a 4-Tier premium program.

Other items Ms. Dowd discussed were meeting governance, including how meetings will happen in the future regarding the NYS Open Meeting Laws, and how/if the Consortium will offer Medicare Advantage Plan.

BMI Medical Claims Audit

Ms. Dowd reported that the Consortium held a Request for Proposal (RFP) and decided to stay with BMI. She said BMI audited medical claims for the years 2020 and 2021, and it was a very long process that took approximately 300 days. Ms. Dowd also indicated that there was a very large disconnect with the Summary Plan Descriptions (SPDs). She said that New York State has mandates and riders that had been added into the Consortium plans in the last 5 years that are not in the last SPDs approved by the DFS as it takes an extended period to approve these documents. Therefore, the auditors were auditing off the previously approved SPDs. Ms. Dowd indicated that there was quite a bit of disconnect between BMI and Excellus, which included, but not limited to, issues with the exchange of SPDs, lack of communication, leading to the audit taking longer than the process generally performed.

Ms. Dowd said ultimately, the post audit meetings between BMI and Excellus were positive meetings, with feedback, and post audit amendments. (Click on document below)

BMI Post Audit Amendment

Ms. Dowd discussed each category within the document, and announced duplicate items that also came up on the DFS audit. Items discussed included, but not limited to:

> Claims paid during COVID period – Rules and regulations were changing daily along with coding, which may not have been paid properly, however Excellus did review, and ultimately paid those claims correctly.
>
> Infusion Drugs as home therapy: Excellus encourages home infusion rather than at facility for certain diagnosis, due to cost effectiveness. There were claims that BMI felt were more expensive, or issues with prior authorizations.
>
> Claims paid after termination, potentially due to benefit clerks not terminating members on a timely basis. (Ms. Dowd said that the Consortium is putting policies and procedures in place to help correct this which includes the Consortium will no longer refund premiums paid after 4 months).

Coordination of durable medical equipment with a diabetes diagnosis. Some supplies were paid for under a prescription drug program, and some insulin was paid for in various other ways.

Cayuga Medical Center (CMC) continues to have issues with double billing. CMC has been encouraged to change this process; however, Excellus has been auditing CMS claims on a monthly basis to ensure this is not happening.

Ms. Dowd suggested that members review pages 31 and 32 of the audit documents, to review recommendations.

BMI Post Audit Amendment

Mr. Brown asked how often the Consortium has these audits. Ms. Dowd said that this topic came up in the first audit that DFS conducted. She said it was recommended that a plan be developed to ensure our third-party administrations were adjudicating benefits according to the plan. She said in 2014, it was agreed that the Consortium was to hold periodic audits and their recommendation was to develop a plan to make sure third-party administrators were adjudicating benefits according to plan. Ms. Dowd said periodic audit were in 2016 and 2019 and then a resolution was developed that the Consortium would alternate years. (One year would audit 2 years of medical claims, and following year would be 2 years of RX claims). Ms. Dowd also indicated this practice is not mandated by Article 47, however determined in 2019 that the Consortium would continue with this practice. Ms. Dowd also said that due to the cost of audits and Excellus now being the administrator of Medical and RX, the audit may be combined and conducted every three years.

Resolution: Acceptance of Medical Claims Audit Report

Mr. Shattock presented a resolution to approve the audit for discussion and potential vote.

RESOLUTION NO. XXX- 2024 – ACCEPTANCE OF MEDICAL CLAIMS AUDIT REPORT

MOVED by Ms. DiGennaro, seconded by Mr. Fischer. The resolution was unanimously adopted by voice vote of members present, and visibly seen members via remote locations to approve the following resolution.

WHEREAS, The Greater Tompkins County Municipal Health Insurance Consortium (“Consortium”) is a self-insured municipal cooperative health benefits plan operating pursuant to a Certificate of Authority issued in accordance with Article 47 of the New York State Health Insurance Law, and

WHEREAS, the New York State Department of Financial Services during its initial audit recommended that the Consortium conduct periodic medical claims audits, and

WHEREAS, by Resolution No. 002 of 2023 the Board of Directors authorized a contract with BMI Audit Services to perform a medical claims audit to ensure medical

claims are paid by Excellus are in accordance with benefit plan documents, Federal and State Laws, Rules, and Regulations, and industry standard practices, and

WHEREAS, BMI has completed the medical claims audit and presented the final report to the Claims and Appeals Committee, now therefore be it

RESOLVED, on recommendation of the Claims and Appeals Committee, That the Executive Committee on behalf of the Board of Directors, accepts the final audit report presented by BMI of 2020 and 2021 Medical Claims.

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RX Claims and Rebate Audit Review

Ms. Rodrigues reported that BMI has selected the claims that they would like to sample from ProAct. The estimated completion date of the RX audit is the end of June.

RFP Update

Ms. Dowd reported that there were many responses to the RFP. There was one vendor with an extremely high price that would be dropped unless they countered with their pricing. Ms. Dowd said the RFP would be discussed again after the RX audit has been completed near the end of June.

Benefit Change Update

Ms. Dowd said at the last Claims and Appeals meeting held, members looked at an appeal. This appeal brought forward the recommendation to move physical therapy occupational therapy to 60 days from 46 days. She reported as of January 1, 2024, the Consortium has changed all those benefit levels and is in process of updating documents to reflect that.

Mr. Shattuck asked the process of how all members know of these benefit changes. Ms. Rodrigues reported once the Consortium updates benefit summaries, she emails out a resource page, website posts, all the updated benefit summaries to benefit clerks. Ms. Rodrigues also said discussions are made to clerks at open enrollment trainings in the fall and at the upcoming spring training as well.

Future Agenda Topics

BMI RX Claims Audit

Adjournment

The meeting was adjourned at 3:11 p.m.

Respectfully submitted by Lynne Sheldon, Clerk of the Board

BMI Audit Services

Prescription Claims Audit Report

Prepared for:	Greater Tompkins County Municipal Health Insurance Consortium
Administrator:	ProAct, Inc.
Audit Period:	1/1/2021 - 9/30/2023
Delivered:	June 5, 2024

100 E. Wayne Street, Suite 400
South Bend, IN 46601

(800) 826-7041
info@bmiaudit.com

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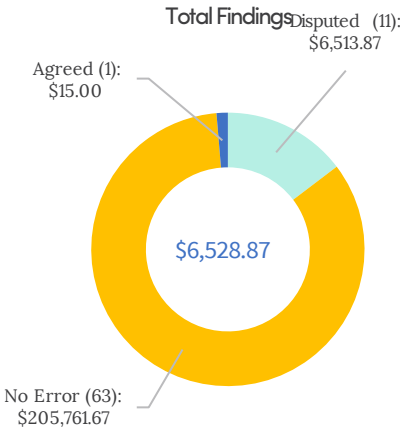
BMI Audit Services

$26.12M
Total payments audited.

202,546
Total # of claims audited.

$212,290.54
Total payments sampled.

75
Total # of claims sampled.



1/1/2021 - 9/30/2023
Timeframe of claims audited.

Background Details

BMI Audit Services was contracted to assess the accuracy of claims administration of the prescription drug benefits plan sponsored by Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC). Using electronic claims and eligibility data provided to us, various administrative service groupings were tested. These groups include eligibility, cost control, fraud/waste/abuse, member liability and plan design. Based on the assessment results, a sample of claims was selected for further review. This report presents the key findings of this comprehensive audit.

The opinions expressed within this report relate narrowly and specifically to the overall efficiency of the claims administrator's management policies, procedures, and controls, as well as to the accuracy and validation of paid claims. BMI is not a certified public accounting firm and the results of this audit are not designed to support the accuracy of financial statements.

Summary

Based on the procedures that were performed, it is BMI's opinion that there are claims errors and other administrative issues identified that expose GTCMHIC to financial risk. Some of the administrative issues we identified during our manual review have been confirmed by both BMI and ProAct to be processing errors made by the claims administrator. However, there are additional findings with which the claims administrator does not agree. BMI recommends that these findings be reviewed, and steps taken to ensure that ProAct's systems, training, investigative techniques, and documentation practices are consistent with the intent of the health plan going forward.

The Results

AUDiT iQ

Based on reports created during the forensic analysis of this audit, the below summarizes the performance of processed claims during the audit period.

ELIGIBILITY

- ✓ Ineligible Members
- ✓ Paid After Termination

FRAUD, WASTE, & ABUSE

- ✓ Drug Class: Abuse and Addictive Agents
- ✓ Drug Class: Anabolic Steroids
- ✓ Duplicate
- ✓ Refill Too Soon
- ✓ Timely Dispensing

MEMBER LIABILITY

- △ Copay / Coinsurance
- ✓ Deductibles

PLAN DESIGN

- ✓ Annual Maximum Benefit
- △ Days Supply
- ✓ Drug Class: Amphetamines
- ✓ Drug Class: Acne Products
- ✓ Drug Class: Anorexiants / Anti-Obesity
- ✓ Drug Class: Antianxiety Agents
- ✓ Drug Class: Antidepressants
- ✓ Drug Class: Antipsychotics
- ✓ Drug Class: Biologicals
- ✓ Drug Class: Blood Components
- ✓ Drug Class: CNS Stimulants (ADHD)
- ✓ Drug Class: Contraceptives - Emergency
- ✓ Drug Class: Contraceptives - Non-Oral Systemic
- ✓ Drug Class: Contraceptives - Oral
- ✓ Drug Class: Contraceptives - Other
- ✓ Drug Class: Cosmetic
- ✓ Drug Class: Diabetic Supplies
- ✓ Drug Class: Diagnostic Agents
- ✓ Drug Class: Fertility
- ✓ Drug Class: Fluoride Products
- ✓ Drug Class: Fungal Medications
- ✓ Drug Class: Growth Hormones
- ✓ Drug Class: HIV - AIDS Drugs
- ✓ Drug Class: Hypnotics / Sedatives
- ✓ Drug Class: Immunizing Agents
- ✓ Drug Class: Impotence Agents
- ✓ Drug Class: Insulin
- ✓ Drug Class: Irrigation Solutions
- ✓ Drug Class: Medical Devices / Ostomy
- ✓ Drug Class: Multiple Sclerosis Agents
- △ Drug Class: Over-the-Counter
- ✓ Drug Class: Serums
- ✓ Drug Class: Smoking Deterrents
- ✓ Drug Class: Toxoids
- ✓ Drug Class: Vaccines
- ✓ Drug Class: Vitamins
- ✓ Prior Authorization
- ✓ Quantity Limits
- ✓ Specialty Drugs
- △ Step Therapy

✓ = meets expectations
△ = further review needed
△ = suspected systemic errors
▲ = confirmed systemic errors

BMI

Audit Services

The findings of this audit are presented as a result of expert review. BMI's proprietary software, AUDiT iQ, was used to examine 100% of claims processed during the requested timeframe. This review flagged claims that appear to have been paid against the Summary Plan Description (SPD) and/or generally accepted billing procedures. Auditors then used their experience, expertise, and judgment to select samples across a comprehensive base of benefit and administrative categories for further examination.

If, during the manual review, the sample claim was questioned by our auditor as to appropriateness of benefits paid or administrative practices used by the claims administrator, we noted the finding in a worksheet along with any potential financial consequence(s) related to the claim in question. These details were shared with the claims administrator so that supportive facts regarding the adjudication could be provided. Please note that these verbatim annotations are provided to you as an exhibit of this report. After consideration of these comments, an outcome was applied to the finding that indicates whether both parties agree or disagree that the claim was processed in error or if it was processed correctly.

A summary of these findings organized by group is displayed on this page.

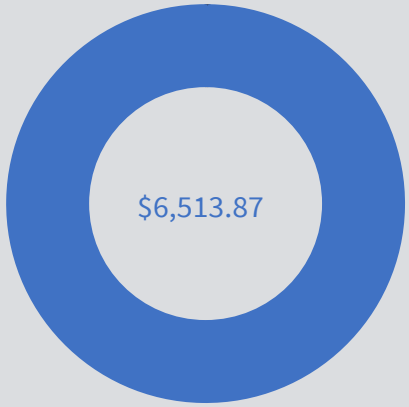
The Results

Sampled Findings by Group

$6,528.87

Agreed

Disputed



Additional Impact

$9,062.43

*dollars shown are absolute sums of the financial findings

Detailed Findings

MEMBER LIABILITY

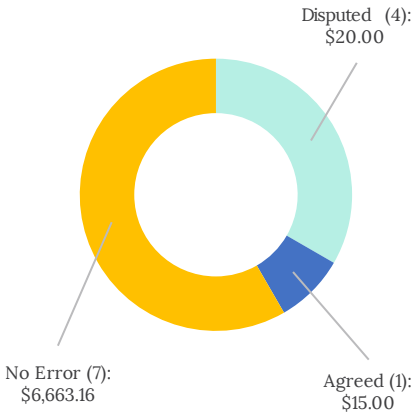
Checks to ensure that calculations for portions of coverage that plan participants are responsible are being calculated correctly. This includes annual deductible requirements, copays, coinsurance and out-of-pocket maximum calculations.

$6,698.16
Total payments sampled.

12
Total # of claims sampled.

Copay / Coinsurance: $35.00

Group Findings



Key Findings & Recommendations

Copay/Coinsurance. Sample claims #1, 3-5, and 7 were reviewed for appropriate application of a copayment for various medications. Per plan documentation provided for use during the audit, samples #1 and 3-4 should have applied a $10 Copay/Coinsurance. ProAct applied a $5 copayment in error. ProAct disagrees with the errors noting: *Copay for a Generic Tier 1 medication is $5. ProAct does not agree with disputed finding.*

For sample #5, per plan documentation, a copayment of $15 was expected. ProAct applied a $10 copayment in error. ProAct disagrees stating: *Copay structure is $10 for brand and non-preferred claims. ProAct does not agree with disputed findings.*

The audit found for sample #7, per the plan documentation, this claim should have applied a $35 copay. ProAct applied a $20 copay in error. ProAct agreed with sample #7 and advised: *Claim processed with $20 copay when it is a Tier 3 medication. Claims on 04/27/2022 & 06/18/2022 processed for $35. Claim on 05/24/2022 processed for $20 with no override. ProAct agrees to $15 agreed finding.* See Exhibit for further details on these claims.

-GTCMHIC should review the findings on samples #1 and 3-5 and clarify plan intent with ProAct and/or update plan documentation accordingly.

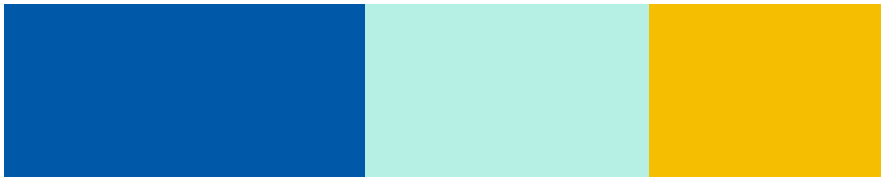
-GTCMHIC should follow-up with ProAct regarding reimbursement to the plan on sample #7. ProAct should advise GTCMHIC as to the root cause of the error. If the error is found to be systemic, an impact analysis should be conducted.

PLAN DESIGN

BMI tests claims that could be misrepresenting a service, gaining a financial benefit or expending resources carelessly. These incorrect payments result in an unnecessary cost to health programs, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards.

$172,756.88
Total payments sampled.

41
Total # of claims sampled.

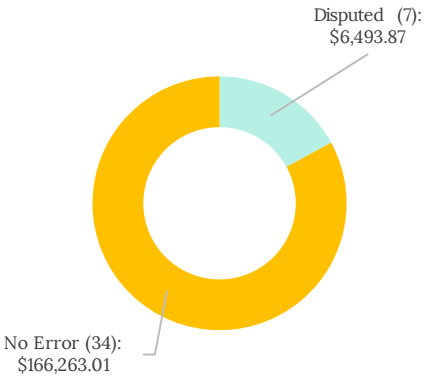


Days Supply : $6,341.60

Drug Class: OTC: $83.70

Step Therapy: $68.57

Group Findings



Key Findings & Recommendations

Drug Class: OTC. Sample claims #22-24 are under review for an over-the-counter medication. The medication billed on these claims, IBUPROFEN SUSP 100 MG/5ML, is available over the counter. Per pages 68 and 69 of the SPD, this medication has been processed in error. ProAct disagrees and noted: *NDC on the formulary has an OTC indicator of no therefore the claim would not reject for OTC not covered. ProAct does not agree with disputed findings.* BMI maintains, per pages 68 & 69 of the SPD, "We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.". This sample is for IBUPROFEN SUSP 100 MG/5ML, which is available over the counter and has the same name and chemical entity. BMI notes that preventive over-the-counter (OTC) products are covered, however this product is not a preventive OTC and was allowed in error.

-GTCMHIC should review this finding and clarify plan intent with ProAct and/or update plan documentation accordingly. If GTMCHIC agrees that these claims paid against plan documentation, an impact analysis should be requested.

PLAN DESIGN *continued*

Key Findings & Recommendations

Days' Supply. Samples #13, 15, and 17 were reviewed to ensure the appropriate days' supply limits were being adhered to for various medications. Per page 62 of the SPD, only a 90-day supply can be filled at the retail level.

Samples #13 and 15 appear to have filled a 180-day supply in error. ProAct disagrees with the errors and advised for sample #13: *Claim on 08/18/2022 processed for a 90ds. Prior claim was filled on 04/21/2022 for a 90ds. The claim on 08/18/2022 processed for a 90-day supply which does not exceed the 90-day supply limit. We show a billed amount of $1,405.69, not $2,901.38. ProAct does not agree with disputed finding.*

ProAct advised for sample #15: *Prior claim processed on 11/15/2022 for a 90ds (Qty: 90). Claim processed on 02/13/2023 for a 90ds (Qty: 90). Member paid $30 for both fills as it is a Tier 3 medication. We show a billed amount of $743.07, not $1,546.14. ProAct does not agree with disputed findings.*

Sample #17 appears to have filled a 180-day supply for a controlled substance for a claim charge of $2074.08. Per the plan documentation, only 30 days can be filled at the retail level for a controlled medication. It appears this claim exceeded the 30-day supply limit in error. ProAct advised: *There are times when a 90-day supply can be filled at retail. Speaking to our Clinical department, it would depend on how the prescriber wrote the prescription. Prior claim processed on 06/13/2023 for a 30ds (Qty: 30). Claim processed on 07/12/2023 for a 90ds (Qty: 90). Benefit allows a 90ds at retail, and controlled substances are not exempt from this as long as the prescription has appropriate codes to dispense a 90ds. ProAct does not agree with disputed findings.*

BMI maintains the errors on each of these claims. In addition to the above, page 66 of the SPD states. "Maintenance Drugs: We will pay for up to a 90-day supply of a drug purchased at a RETAIL pharmacy. You are responsible for one (1) Cost-Sharing amount for a 90-day supply at a retail pharmacy. Benefits will be provided for Prescription Drugs dispensed by a MAIL ORDER pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a MAXIMUM OF TWO (2) Cost Sharing amounts for a 90-day supply.". The data line provided for the audit indicates an "Rx Count" value of 2 and has a "Maintenance Indicator" present. Which would explain the doubled amounts in comparison to the numbers that were provided in the admin response (i.e. 180 days vs 90 days-supply). However, BMI notes that the ingredient cost in the original claims data, which is submitted by the pharmacy is also double the amounts indicated in the admin's response. Furthermore, the NPI, 1275640450, is identified as a Community/Retail Pharmacy, not a mail order pharmacy. Based on this information, it appears that the (2) two-cost sharing maximum provision was being applied to a maintenance drug, however this occurred at a retail pharmacy, instead of a mail order pharmacy. The admin did provide a partial data line in excel, however did not provide any screenshots of the data adjudications, which would support their response and their partial data line. It is BMI's position that this claim processed in error exceeding the day supply and cost sharing limit of one (1) at retail and is therefore an error. BMI also notes that samples 13, 15 & 17 all have the same dispensing pharmacy, matched by NPI.

-ProAct should provide supporting documentation via screenshots of the claims to show what payments were made on these claims. Additionally, BMI recommends that the client check their accounting to see if they were billed for the amounts identified by the admin in their response or the amounts identified in the original data provided in order to verify accuracy of the amount actually paid under the plan as there are two different possible data sources (the original data file provided for the audit and the admin response to the findings).

PLAN DESIGN *continued*

Key Findings & Recommendations

Step Therapy. The sample claim #74 is under review for Step Therapy. The medication billed on the claim was CRESTOR TABS 10 MG, which has a Step Therapy requirement. The audit found this requirement was not met and therefore the claim paid in error. ProAct originally agreed with the error, but now disagrees stating: *Member was taking Crestor since 2021 therefore member would not need to satisfy step therapy requirement. ProAct does not agree with disputed findings.* BMI maintains per the documentation provided for the audit; this medication requires step therapy. As it was not conducted, claim was paid in error.

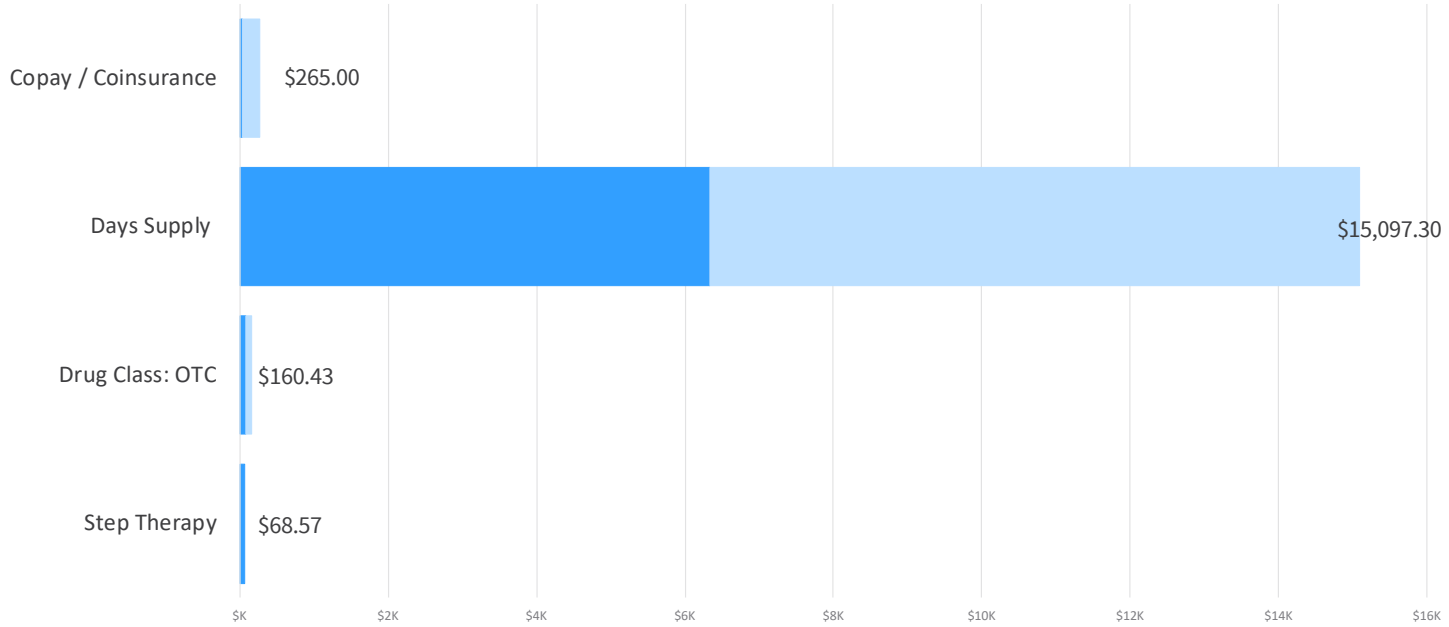
-GTCMHIC should review this finding and clarify plan intent with ProAct and/or update plan documentation accordingly.

POTENTIAL OVERALL FINANCIAL IMPACT

The below information organizes errors identified during the audit by the individual finding, as assessed by BMI. Some errors that are systemic in nature may have greater financial impact on the plan as they can be repetitive across benefits and/or plan members. For such errors, BMI recommends requesting ProAct to produce impact studies that will reveal the overall financial effect on the plan.

Using claims data provided for the audit, BMI has estimated the amounts shown below for each of the identified errors that are systemic in nature (see Out-of-Sample Claims).

$15,591.30 + pending impact study results
Potential Overall Financial Impact.



Impact studies produced by ProAct may reveal different results as they have access to additional administrative details (e.g. documentation of exceptions requested by the plan, member appeals, plan design clarification, special circumstances) that can affect final approval of the claims payments. It is important to discuss these differences with ProAct.

FINANCIAL GUARANTEE

Executive Summary

BMI assessed all AWP discount and dispensing fee pricing guarantees as contained and applicable in the Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC) contract with ProAct, Inc. (PROACT). This assessment covered the audit period of 1/1/2022 through 12/31/2022.

Details of this review and assessment can be found in the **Financial Guarantees Exhibit**.

Methodology

Using BMI's proprietary technology, and industry-accepted AWP pricing, BMI assessed and calculated all AWP discount and dispensing fee guarantees pursuant to the contract between GTCMHIC and PROACT.

With respect to the contract, BMI identified the following *claim exclusions* not subject to the financial guarantees:

Exclusions – AWP Discount and Dispensing Fees

- *Compound Drugs* – Compound drugs are excluded from the contract.
- *Direct Member Reimbursement Claims*
- *Coordination of Benefit (COB) Claims*
- *Limited Distribution Drug (LDD) Claims*
- *340B/Federal Pharmacy Claims*
- *OTC Claims* – Over-the-counter claims are excluded.
- *Long Term Care Pharmacy Claims*
- *Indian Health Service Claims*
- *Vaccine Claims* – All vaccine claims are excluded from the contract.

On a claim-by-claim basis, BMI analyzed each exclusion for applicability and appropriateness per the contract and verified all claims belonging to each exclusion group – these claims were excluded from BMI's calculations.

FINANCIAL GUARANTEE

Summary of Findings

Contract Type	Result	BMI Notes
1/2022 thru 12/2022 AWP Discounts Brand (Retail & Mail-Order)	✓	While differences exist between BMI's calculations and PROACT's calculations, they fall within an acceptable range of variance.
1/2022 thru 12/2022 AWP Discounts Generic (Retail & Mail-Order)	✓	While differences exist between BMI's calculations and PROACT's calculations, they fall within an acceptable range of variance.
1/2022 thru 12/2022 AWP Discounts Specialty	✓	While differences exist between BMI's calculations and PROACT's calculations, they fall within an acceptable range of variance.
1/2022 thru 12/2022 Dispensing Fees (All Types)	✓	While differences exist between BMI's calculations and PROACT's calculations, they fall within an acceptable range of variance.

FINANCIAL GUARANTEE

Audit Findings and Conclusion

AWP Discounts and Dispensing Fees

With respect to the AWP discount and dispensing fee guarantees, **PROACT** calculated the following net performance:

AWP Discounts	**$122,008.91**	**Overperformance**
Dispensing Fees	**$24,342.90**	**Overperformance**

With respect to the same AWP discount and dispensing fee guarantees, **BMI** calculated the following net performance:

AWP Discounts	**$117,263.71**	**Overperformance**
Dispensing Fees	**$24,068.30**	**Overperformance**

Net Performance and Conclusion

PROACT's calculated net **Overperformance:**	**$146,351.81**
BMI's calculated net **Overperformance:**	**$141,332.01**

While BMI notes differences in its respective calculations to PROACT's calculations, across many of the guarantee tranches, both PROACT and BMI have calculated a significant net overperformance overall.

As a result, BMI agrees that PROACT has met the contractual guarantees pursuant to the AWP discount and dispensing fee guarantees, and that a **$0 net payout** is due to GTCMHIC.

Next Steps

SHORT TERM SOLUTIONS

Clarify plan intent.

The below list includes benefits that are being paid in conflict with your plan language. Start a dialog with your health plan administrator to clarify plan intent and come to an agreed upon approach for claims moving forward.

- Copay/Coinsurance = #1, 3-5
- Step Therapy- #74
- Drug Class: OTC- #22-24

If you are satisfied with the administrator's current processing approach, update plan documentation accordingly.

Options for financial adjustments.

Audit findings with financial errors offer an opportunity for claims adjustments. BMI recommends working closely with the claims administrator to ensure that these adjustments are made in an efficient manner and to GTCMHIC's satisfaction.

$15.00 Total agreed overpayments.	$0.00 Total agreed underpayments.
$15,576.30 Total disputed overpayments.	$0.00 Total disputed underpayments.

Requests for administrator.

- Confirm once reimbursement to the plan is complete on sample #7.
- Provide GTCMHIC with the root cause of the error on sample #7. If found to be systemic, impact analysis should be complete.
- Provide documentation via screenshots of the claims to support claim payment for samples #13, 15, 17.

LONG TERM SOLUTIONS

Follow-up audit.

BMI recommends a one year follow up audit. This gives you the opportunity to confirm that the requested corrective actions have been implemented and there are no new concerns that have occurred since the prior audit was conducted.

Dependent audit.

On average, 4-10% of dependents covered on any given health plan are ineligible for coverage. This presents a plan with ERISA compliancy risks as well as exposure to unnecessary expenses. A dependent eligibility audit reduces exposure and assists with ERISA compliancy.

Exhibits

Audit Worksheet

Overall Findings:	$15.00	$0.00	$6,513.87	$9,062.43

Sample #	Finding Category	Plan	Agreed to Finding (Claim Sample)	Agreed to Finding (Related Claims)	Disputed Finding (Claim Sample)	Disputed Finding (Related Claims)	BMI Audit Findings	Administrator Response (Verbatim)	BMI Comments
1	Copay / Coinsurance	2022/2023 BET, BEV, BFX, BGG, BG			$5.00		Sample claim is under review for application of copay. Medication billed on the sample claim is ATORVASTATIN TAB 80MG. The out of pocket does not appear to be met. Claim should have applied a $10 Copay/Coinsurance. 1.) Please explain the how this claim has met all conditions to be paid in full. Provide documentation of the individual and family out of pocket accumulators for the time of the clam.	This claim processed under a previous vendor and we can no longer see this claim. POST DRAFT RESPONSE: Copay for a Generic Tier 1 medication is $5. ProAct does not agree with disputed finding.	The sample claim was submitted in the data from ProAct and is within the scope of the audit. Please review BMI's original comments and advise. Additionally, please explain what ProAct means when they state: "This claim processed under a previous vendor" 1.) Who is the previous vendor? POST DRAFT RESPONSE: Admin stated they were unable to see this claim, then provided a response regarding the claim. ProAct advised copay is $5. Per the plan documentation provided for use during the audit copay is $10. No additional plan documentation was provided that indicated a $5 copay should be applied. BMI's position remains that this claim is an error. Client should review and clarify plan intent. If determined to be outside of plan intent, client should request impact analysis be completed by admins to ensure all correctable dollars are accounted and recovered if possible.
3	Copay / Coinsurance	2022/2023 BET, BEV, BFX, BGG, BG			$5.00		Sample claim is under review for application of copay. Medication billed on the sample claim is PAROXETINE TAB 20MG. The out of pocket does not appear to be met. Claim should have applied a $10 Copay/Coinsurance. 1.) Please explain the how this claim has met all conditions to be paid in full. Provide documentation of the individual and family out of pocket accumulators for the time of the clam	This claim processed under a previous vendor and we can no longer see this claim. POST DRAFT RESPONSE: ProAct was able to coordinate access with our previous adjudication vendor. Copay for a Generic Tier 1 medication is $5. ProAct does not agree with disputed findings.	The sample claim was submitted in the data from ProAct and is within the scope of the audit. Please review BMI's original comments and advise. Additionally, please explain what ProAct means when they state: "This claim processed under a previous vendor" 1.) Who is the previous vendor? POST DRAFT RESPONSE: Admin stated they were unable to see this claim, then provided a response regarding the claim. ProAct advised copay is $5. Per the plan documentation provided for use during the audit copay is $10. No additional plan documentation was provided that indicated a $5 copay should be applied. BMI's position remains that this claim is an error. Client should review and clarify plan intent. If determined to be outside of plan intent, client should request impact analysis be completed by admins to ensure all correctable dollars are accounted and recovered if possible.
4	Copay / Coinsurance	2022/2023 BET, BEV, BFX, BGG, BG			$5.00	$10.00	Sample claim is under review for application of copay. Medication billed on the sample claim is ROSUVASTATIN TAB 10MG. The out of pocket does not appear to be met. Claim should have applied a $10 Copay/Coinsurance. 1.) Please explain the how this claim has met all conditions to be paid in full. Provide documentation of the individual and family out of pocket accumulators for the time of the clam.	This claim processed under a previous vendor and we can no longer see this claim. POST DRAFT RESPONSE: ProAct was able to coordinate access with our previous adjudication vendor. Copay for a Generic Tier 1 medication is $5. ProAct does not agree with disputed findings.	The sample claim was submitted in the data from ProAct and is within the scope of the audit. Please review BMI's original comments and advise. Additionally, please explain what ProAct means when they state: "This claim processed under a previous vendor" 1.) Who is the previous vendor? POST DRAFT RESPONSE: Admin stated they were unable to see this claim, then provided a response regarding the claim. ProAct advised copay is $5. Per the plan documentation provided for use during the audit copay is $10. No additional plan documentation was provided that indicated a $5 copay should be applied. BMI's position remains that this claim is an error. Client should review and clarify plan intent. If determined to be outside of plan intent, client should request impact analysis be completed by admins to ensure all correctable dollars are accounted and recovered if possible.

Audit Worksheet

Overall Findings:	$15.00	$0.00	$6,513.87	$9,062.43

Sample #	Finding Category	Plan	Agreed to Finding (Claim Sample)	Agreed to Finding (Related Claims)	Disputed Finding (Claim Sample)	Disputed Finding (Related Claims)	BMI Audit Findings	Administrator Response (Verbatim)	BMI Comments
5	Copay / Coinsurance	2022/2023 BGJ1, BGJ2 3T6			$5.00	$10.00	Sample claim is under review for application of copay. Medication billed on the sample claim is BAQSIMI ONE PACK POWD 3 MGDOSE. The out of pocket does not appear to be met. Claim should have applied a $15 Copay/Coinsurance. 1.) Please explain the how this claim has met all conditions to be paid in full. Provide documentation of the individual and family out of pocket accumulators for the time of the clam.	The standard copay for the benefit this member was in, was $10. This processed correctly. POST DRAFT RESPONSE: . Copay structure is $10 for brand and non-preferred claims. Accumulators were at $0 at the time of the claim. ProAct does not agree with disputed findings.	The sample claim was submitted in the data from ProAct and is within the scope of the audit. Please review BMI's original comments and advise. Additionally, please explain what ProAct means when they state: "This claim processed under a previous vendor" 1.) Who is the previous vendor? POST DRAFT RESPONSE: Admin stated they were unable to see this claim, then provided a response regarding the claim. ProAct advised copay is $10. Per the plan documentation provided for use during the audit copay is $15. No additional plan documentation was provided that indicated a $10 copay should be applied. BMI's position remains that this claim is an error. Client should review and clarify plan intent. If determined to be outside of plan intent, client should request impact analysis be completed by admins to ensure all correctable dollars are accounted and recovered if possible.
7	Copay / Coinsurance	2022/2023 BET, BEV, BFX, BGG, BG	$15.00			$210.00	Sample claim is under review for application of copay. Medication billed on the sample claim is VIVELLE-DOT PTTW 0.0375 MG24HR. The out of pocket does not appear to be met. Claim should have applied a $35 Copay/Coinsurance. 1.) Please explain the how this claim has met all conditions to be paid in full. Provide documentation of the individual and family out of pocket accumulators for the time of the clam.	This should have paid at a tier 3 copay as it's a non-preferred brand. Copay should have been $35 POST DRAFT RESPONSE: Claim processed with $20 copay when it is a Tier 3 medication. Claims on 04/27/2022 & 06/18/2022 processed for $35. Claim on 05/24/2022 processed for $20 with no override. ProAct agrees to $15 agreed finding. ProAct does not agree to $210.00 disputed finding.	POST DRAFT RESPONSE: Agreed Finding. Client should request impact analysis be completed by all administrators to ensure all correctable dollars are accounted for and recovered if possible.

Audit Worksheet

Overall Findings:	$15.00	$0.00	$6,513.87	$9,062.43

Sample #	Finding Category	Plan	Agreed to Finding (Claim Sample)	Agreed to Finding (Related Claims)	Disputed Finding (Claim Sample)	Disputed Finding (Related Claims)	BMI Audit Findings	Administrator Response (Verbatim)	BMI Comments
13	Days Supply	2022/2023 BGJ1, BGJ2 3T6			$2,811.38	$2,811.38	Sample claim is under review for the days supply limit. Medication on the sample is XARELTO TABS 20 MG. Only 90 days can be filled at the retail level per SPD Page 62. It appears this claim exceeded the 90 day supply limit. 2.) Please provide documentation for why the refill was allowed to be filled earlier. Also include documentation showing the "sig directions" adjudicated by the pharmacy for both the sample fill and the previous fill, in order to determine if there was a therapy change between fills that needs to be considered. 3.) Sample claim is under review for application of copay. The member is only paying for a 90 days supply when getting a 180 days supply. Should have paid $180. 4.) Filled at Kinney Drugs NPI #1275640450	This was not refilled early. The last fill date was 4/21/22. Claim number 379906608 for a 90 day supply. Both claims were for a 90 day supply. There is no copay for $180 within the copay structure. We show a billed amount of $1,405.69, not $2,901.38. POST DRAFT RESPONSE: Claim on 08/18/2022 processed for a 90ds. Prior claim was filled on 04/21/2022 for a 90ds. The claim on 08/18/2022 processed for a 90 day supply which does not exceed the 90 day supply limit. Please reference excel spreadsheet tab labeled Sample #13. ProAct does not agree with disputed finding.	The data provided for the audit has 180 tabs filled for 180 day supply for a claim charge of $2901.38. This exceeds the days supply limit of 90 per page 62 of the SPD. Please explain the discrepancy and provide documentation the claim processed correctly. POST DRAFT RESPONSE: Page 66 of the SPD states. "Maintenance Drugs We will pay for up to a 90-day supply of a drug purchased at a RETAIL pharmacy. You are responsible for one (1) Cost-Sharing amount for a 90-day supply at a retail pharmacy. Benefits will be provided for Prescription Drugs dispensed by a MAIL ORDER pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a MAXIMUM OF TWO (2) Cost Sharing amounts for a 90-day supply.". The data line provided for the audit indicates an "Rx Count" value of 2 and has a "Maintenance Indicator" present. Which would explain the doubled amounts in comparison to the numbers that were provided in the admin response. However, BMI notes that the ingredient cost in the original claims data, which is submitted by the pharmacy is also double the amounts indicated in the admin's response. Furthermore, the NPI, 1275640450, is identified as a Community/retail Pharmacy, not a mail order pharmacy. Based on this information, it appears that the (2) two-cost sharing maximum provision was being applied to a maintenance drug, however this occurred at a retail pharmacy, instead of a mail order pharmacy. The admin did provide a partial data line in excel, however did not provide any screenshots of the data adjudications, which would support their response and their partial data line. It is BMI's position that this claim processed in error exceeding the day supply and cost sharing limit of one (1) at retail and is therefore an error. BMI also notes that sample 13, 15 & 17 all have the same dispensing pharmacy, matched by NPI. BMI recommends that the client check their accountings to see if they were billed for the amounts identified by the admin in their response or the amounts identified in the original data provided in order to verify accuracy of the amount actually paid under the plan as there are two different possible data sources now (the original and the admin response).

Audit Worksheet

Overall Findings:	$15.00	$0.00	$6,513.87	$9,062.43

Sample #	Finding Category	Plan	Agreed to Finding (Claim Sample)	Agreed to Finding (Related Claims)	Disputed Finding (Claim Sample)	Disputed Finding (Related Claims)	BMI Audit Findings	Administrator Response (Verbatim)	BMI Comments
15	Days Supply	2022/2023 BGJ1, BGJ2 3T5a			$1,486.14	$5,944.32	Sample claim is under review for the days supply limit. Medication on the sample is NEXIUM CPDR 40 MG. Only 90 days can be filled at the retail level per SPD Page 62. It appears this claim exceeded the 90 day supply limit. 2.) Please provide documentation for why the refill was allowed to be filled earlier. Also include documentation showing the "sig directions" adjudicated by the pharmacy for both the sample fill and the previous fill, in order to determine if there was a therapy change between fills that needs to be considered. 3.) Sample claim is under review for application of copay. The member is only paying for a 90 days supply when getting a 180 days supply. Should have paid $120. 4. Filled at Kinney Drugs NPI #1275640450	This was not filled early as the last fill was on 11/15/22, claim number 467496071. This claim only processed for a 90 day supply and was charging the correct copay. A copay of $120 was not in this benefits copay structure. We show a billed amount of $743.07, not $1,546.14. POST DRAFT RESPONSE: Prior claim processed on 11/15/2022 for a 90ds (Qty: 90). Claim processed on 02/13/2023 for a 90ds (Qty: 90). Member paid $30 for both fills as it is a Tier 3 medication. Please reference excel spreadsheet tab labeled Sample #15. ProAct does not agree with disputed findings.	The data provided for the audit has 180 caps filled for 180 day supply for a claim charge of $1546.14. This exceeds the days supply limit of 90 per page 62 of the SPD. Please explain the discrepancy and provide documentation the claim processed correctly. POST DRAFT RESPONSE: Page 66 of the SPD states. "Maintenance Drugs We will pay for up to a 90-day supply of a drug purchased at a RETAIL pharmacy. You are responsible for one (1) Cost-Sharing amount for a 90-day supply at a retail pharmacy. Benefits will be provided for Prescription Drugs dispensed by a MAIL ORDER pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a MAXIMUM OF TWO (2) Cost Sharing amounts for a 90-day supply.". The data line provided for the audit indicates an "Rx Count" value of 2 and has a "Maintenance Indicator" present. Which would explain the doubled amounts in comparison to the numbers that were provided in the admin response. However, BMI notes that the ingredient cost in the original claims data, which is submitted by the pharmacy is also double the amounts indicated in the admin's response. Furthermore, the NPI, 1275640450, is identified as a Community/retail Pharmacy, not a mail order pharmacy. Based on this information, it appears that the (2) two-cost sharing maximum provision was being applied to a maintenance drug, however this occurred at a retail pharmacy, instead of a mail order pharmacy. The admin did provide a partial data line in excel, however did not provide any screenshots of the data adjudications, which would support their response and their partial data line. It is BMI's position that this claim processed in error exceeding the day supply and cost sharing limit of one (1) at retail and is therefore an error. BMI also notes that sample 13, 15 & 17 all have the same dispensing pharmacy, matched by NPI. BMI recommends that the client check their accountings to see if they were billed for the amounts identified by the admin in their response or the amounts identified in the original data provided in order to verify accuracy of the amount actually paid under the plan as there are two different possible data sources now (the original and the admin response).

Audit Worksheet

Overall Findings:	$15.00	$0.00	$6,513.87	$9,062.43

Sample #	Finding Category	Plan	Agreed to Finding (Claim Sample)	Agreed to Finding (Related Claims)	Disputed Finding (Claim Sample)	Disputed Finding (Related Claims)	BMI Audit Findings	Administrator Response (Verbatim)	BMI Comments
17	Days Supply	2022/2023 BGJ1, BGJ2 3T5a			$2,044.08		Sample claim is under review for the days supply limit. Medication on the sample is VYVANSE CAPS 30 MG. Only 30 days can be filled at the retail level for a controlled medication. It appears this claim exceeded the 30 day supply limit. 2.) Sample claim is under review for application of copay. The member is only paying for a 90 days supply when getting a 180 days supply. Should have paid $60. 4. Filled at Kinney Drugs NPI #1275640450	There are times when a 90 day supply can be filled at retail. Speaking to our Clinical department, it would depend on how the prescriber wrote the prescription. POST DRAFT RESPONSE: Prior claim processed on 06/13/2023 for a 30ds (Qty: 30). Claim processed on 07/12/2023 for a 90ds (Qty: 90). Benefit allows a 90ds at retail, and controlled substances are not exempt from this as long as the prescription has appropriate codes to dispense a 90ds. Please reference excel spreadsheet tab labeled Sample #17. ProAct does not agree with disputed findings.	The data provided for the audit has 180 caps filled for 180 day supply for a claim charge of $2074.08. This exceeds the days supply limit of 90 per page 62 of the SPD. Please explain the discrepancy and provide documentation the claim processed correctly. POST DRAFT RESPONSE: Page 66 of the SPD states. "Maintenance Drugs We will pay for up to a 90-day supply of a drug purchased at a RETAIL pharmacy. You are responsible for one (1) Cost-Sharing amount for a 90-day supply at a retail pharmacy. Benefits will be provided for Prescription Drugs dispensed by a MAIL ORDER pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a MAXIMUM OF TWO (2) Cost Sharing amounts for a 90-day supply.". The data line provided for the audit indicates an "Rx Count" value of 2 and has a "Maintenance Indicator" present. Which would explain the doubled amounts in comparison to the numbers that were provided in the admin response. However, BMI notes that the ingredient cost in the original claims data, which is submitted by the pharmacy is also double the amounts indicated in the admin's response. Furthermore, the NPI, 1275640450, is identified as a Community/retail Pharmacy, not a mail order pharmacy. Based on this information, it appears that the (2) two-cost sharing maximum provision was being applied to a maintenance drug, however this occurred at a retail pharmacy, instead of a mail order pharmacy. The admin did provide a partial data line in excel, however did not provide any screenshots of the data adjudications, which would support their response and their partial data line. It is BMI's position that this claim processed in error exceeding the day supply and cost sharing limit of one (1) at retail and is therefore an error. BMI also notes that sample 13, 15 & 17 all have the same dispensing pharmacy, matched by NPI. BMI recommends that the client check their accountings to see if they were billed for the amounts identified by the admin in their response or the amounts identified in the original data provided in order to verify accuracy of the amount actually paid under the plan as there are two different possible data sources now (the original and the admin response).
22	Drug Class: OTC	2022/2023 DAA ACA-P			$18.10		Sample claim is under review for a over the counter medication. The medication billed on the claim IBUPROFEN SUSP 100 MG5ML is available over the counter. Per page 68 of the SPD this medication has been processed in error. Please Explain how this medication fits within these parameters	POST DRAFT RESPONSE: NDC on the formulary has an OTC indicator of no therefore the claim would not reject for OTC not covered. ProAct does not agree with disputed findings.	POST DRAFT RESPONSE: The administrator did not provide a response for this sample on the first pass, therefore the assumption was that the admin was in agreement with the error. However admin did provide a response in the post draft response. Per page 68 & 69 of the SPD, "We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.". This sample is for IBUPROFEN SUSP 100 MG/5ML, which is available over the counter and has the same name and chemical entity. BMI notes that preventive otc products are covered, however this product is not a preventive otc and was covered in error. Impact analysis should be completed on all products that have an over the counter equivalent available, as the otc indicator in the PBMs plan setup is not reflective of all otc equivalent products, which is evident by this sample claim error.

Audit Worksheet

Overall Findings:	$15.00	$0.00	$6,513.87	$9,062.43

Sample #	Finding Category	Plan	Agreed to Finding (Claim Sample)	Agreed to Finding (Related Claims)	Disputed Finding (Claim Sample)	Disputed Finding (Related Claims)	BMI Audit Findings	Administrator Response (Verbatim)	BMI Comments
23	Drug Class: OTC	2022/2023 BGP,BGS,BGU 3T9			$24.76	$35.89	Sample claim is under review for a over the counter medication. The medication billed on the claim IBUPROFEN SUSP 100 MG5ML is available over the counter. Per page 68 of the SPD this medication has been processed in error. Please Explain how this medication fits within these parameters	POST DRAFT RESPONSE: NDC on the formulary has an OTC indicator of no therefore the claim would not reject for OTC not covered. ProAct does not agree with disputed findings.	POST DRAFT RESPONSE: The administrator did not provide a response for this sample on the first pass, therefore the assumption was that the admin was in agreement with the error. However admin did provide a response in the post draft response. Per page 68 & 69 of the SPD, "We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.". This sample is for IBUPROFEN SUSP 100 MG/5ML, which is available over the counter and has the same name and chemical entity. BMI notes that preventive otc products are covered, however this product is not a preventive otc and was covered in error. Impact analysis should be completed on all products that have an over the counter equivalent available, as the otc indicator in the PBMs plan setup is not reflective of all otc equivalent products, which is evident by this sample claim error.
24	Drug Class: OTC	2022/2023 BGN,BFI 3T3			$40.84	$40.84	Sample claim is under review for a over the counter medication. The medication billed on the claim IBUPROFEN SUSP 100 MG5ML is available over the counter. Per page 68 of the SPD this medication has been processed in error. Please Explain how this medication fits within these parameters	POST DRAFT RESPONSE: NDC on the formulary has an OTC indicator of no therefore the claim would not reject for OTC not covered. ProAct does not agree with disputed findings.	POST DRAFT RESPONSE: The administrator did not provide a response for this sample on the first pass, therefore the assumption was that the admin was in agreement with the error. However admin did provide a response in the post draft response. Per page 68 & 69 of the SPD, "We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.". This sample is for IBUPROFEN SUSP 100 MG/5ML, which is available over the counter and has the same name and chemical entity. BMI notes that preventive otc products are covered, however this product is not a preventive otc and was covered in error. Impact analysis should be completed on all products that have an over the counter equivalent available, as the otc indicator in the PBMs plan setup is not reflective of all otc equivalent products, which is evident by this sample claim error.
74	Step Therapy	2022/2023 BGP,BGS,BGU 3T9			$68.57		The sample claim is under review for Step Therapy. The medication billed on the claim CRESTOR TABS 10 MG has a Step Therapy requirement. 1.)Please provide documentation of how the Step Therapy requirement was satisfied including the pre-requisite drug names and dates they were filled.	Agree POST DRAFT RESPONSE: Member was taking Crestor since 2021 therefore member would not need to satisfy step therapy requirement. ProAct does not agree with disputed findings.	POST DRAFT RESPONSE: ProAct originally agreed with the error, but now disagrees with the error . BMI maintains per the documentation provided for the audit, this medication requires step therapy. As it was not completed, claim was paid in error.

Audit Period	Performance Type	Contractual Guarantee	Adminsitrator Findings Actual / Calculated	Adminsitrator Findings Overperformance / Shortfall (-) $ Calculated	BMI Audit Findings Actual / Calculated	BMI Audit Findings Overperformance / Shortfall (-) $ Calculated	BMI Audit Comments
1/1/2022 thru 12/31/2022	AWP Discount Pricing Guarantee	AWP - 25.50% "Aggregate" Mail-Order, Brand	25.31%	($3,159.44)	25.28%	($3,390.21)	BMI recommends no further action.
1/1/2022 thru 12/31/2022	AWP Discount Pricing Guarantee	AWP - 84.50% "Aggregate" Mail-Order, Generic	84.61%	$3,343.63	84.62%	$3,459.88	BMI recommends no further action.
1/1/2022 thru 12/31/2022	AWP Discount Pricing Guarantee	AWP - 18.50% "Aggregate" Retail 30, Brand (1 - 89 Days)	18.78%	$14,817.22	18.76%	$14,034.15	BMI recommends no further action.
1/1/2022 thru 12/31/2022	AWP Discount Pricing Guarantee	AWP - 83.50% "Aggregate" Retail 30, Generic (1 - 89 Days)	83.27%	($20,598.13)	83.25%	($21,369.00)	BMI recommends no further action.
1/1/2022 thru 12/31/2022	AWP Discount Pricing Guarantee	AWP - 21.00% "Aggregate" Retail 90, Brand (90 and Greater Days)	21.80%	$8,149.16	21.82%	$8,825.66	BMI recommends no further action.
1/1/2022 thru 12/31/2022	AWP Discount Pricing Guarantee	AWP - 85.00% "Aggregate" Retail 90, Generic (90 and Greater Days)	84.97%	($1,042.98)	84.96%	($1,390.11)	BMI recommends no further action.
1/1/2022 thru 12/31/2022	AWP Discount Pricing Guarantee	AWP - 19.00% "Aggregate" Specialty	21.10%	$120,499.45	-20.56%	$117,093.34	BMI recommends no further action.
1/1/2022 thru 12/31/2022	Dispensing Fee Guarantee	$.00 Mail-Order, Brand	0.00%	($0.65)	0.00%	$0.00	BMI recommends no further action.
1/1/2022 thru 12/31/2022	Dispensing Fee Guarantee	$.00 Mail-Order, Generic	0.00%	$0.00	0.00%	$0.00	BMI recommends no further action.
1/1/2022 thru 12/31/2022	Dispensing Fee Guarantee	$.80 Retail, Brand 30	60.00%	$1,603.80	62.00%	$1,523.60	BMI recommends no further action.
1/1/2022 thru 12/31/2022	Dispensing Fee Guarantee	$.80 Retail, Generic 30	59.00%	$15,237.75	60.00%	$15,082.40	BMI recommends no further action.
1/1/2022 thru 12/31/2022	Dispensing Fee Guarantee	$.80 Retail, Brand 90	2.00%	$534.10	2.00%	$534.10	BMI recommends no further action.

Audit Period	Performance Type	Contractual Guarantee	Adminsitrator Findings Actual / Calculated	Adminsitrator Findings Overperformance / Shortfall (-) $ Calculated	BMI Audit Findings Actual / Calculated	BMI Audit Findings Overperformance / Shortfall (-) $ Calculated	BMI Audit Comments
1/1/2022 thru 12/31/2022	Dispensing Fee Guarantee	$.80 Retail, Generic 90	2.00%	$7,076.50	3.00%	$6,928.20	BMI recommends no further action.
1/1/2022 thru 12/31/2022	Dispensing Fee Guarantee	$.00 Specialty	12.00%	($108.60)	0.00%	$0.00	BMI recommends no further action.
TOTAL AWP Discount & Dispensing Fee Guarantees				**$146,351.81**		**$141,332.01**	

Greater Tompkins County Municipal Health Insurance Consortium

408 East Upland Road, Suite 2 • Ithaca, New York 14850 • (607) 274-5590
healthconsortium.net • consortium@tompkins-co.org

"Individually and collectively, we invest in realizing high quality, affordable, dependable health insurance."

RESOLUTION NO. XXX-2024 – ACCEPTANCE OF PRESCRIPTION DRUG/RX CLAIMS AUDIT REPORT

WHEREAS, The Greater Tompkins County Municipal Health Insurance Consortium ("Consortium") is a self-insured municipal cooperative health benefits plan operating pursuant to a Certificate of Authority issued in accordance with Article 47 of the New York State Health Insurance Law, and

WHEREAS, the New York State Department of Financial Services during its initial audit recommended that the Consortium conduct periodic prescription drug/RX claims audits, and

WHEREAS, by Resolution No. 015 of 2023 the Board of Directors authorized a contract with BMI Audit Services to perform a prescription drug/RX claims audit to ensure prescription drug/RX claims paid by ProAct are in accordance with benefit plan documents, Federal and State Laws, Rules, and Regulations, and industry standard practices, and

WHEREAS, BMI Audit Services has completed the prescription drug/RX claims audit and presented the final report to the Claims and Appeals Committee, now therefore be it

RESOLVED, on recommendation of the Claims and Appeals Committee, That the Executive Committee on behalf of the Board of Directors, accepts the final prescription drug/RX claims audit report presented by BMI Audit Services of 2021, 2022, and YTD 2023 (through 9/30/23).

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