Greater Tompkins County Municipal Health Insurance Consortium

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

Claims and Appeals Committee
Meeting Agenda
September 14, 2021 – 2:00 PM

Remote by Zoom

(Contact consortium@tompkins-co.org for link)

1. Call to Order — Bud Shattuck
2. Changes to the Agenda
3. Approval of Minutes – July 20, 2021
4. Executive Director Report — Elin Dowd
5. Discussion on the following topics: — Elin Dowd
   a) Appeal Process Flow Charts
   b) PBM Audit Update
6. Set Next Meeting Date
   a) Proposed: _______________
7. Future agenda topics
8. Adjourn

Confidentiality: Committee membership will adhere to the Consortium's Conflict of Interest and Code of Ethics Policy when discussing any information specific to a subscriber.

Minutes – DRAFT
Claims and Appeals Committee
July 20, 2021 – 3:30 p.m.
Zoom

Present: Bud Shattuck, Don Fischer, Tanya DiGennaro, Tom Brown, Donna Dawson (arrived at 2:14 p.m.)
Staff/Guests: Elin Dowd, Executive Director; Michelle Cocco, Clerk of the Board; Kylie Rodrigues, Benefits Specialist; Steve Locey, Rob Spenard, Locey & Cahill

Call to Order

Mr. Shattuck, Chair, called the meeting to order at 2:06 p.m.

Changes to the Agenda

There were no changes to the agenda.

Approval of Minutes of May 24, 2021

It was MOVED by Mr. Fischer, seconded by Ms. DiGennaro, and unanimously adopted by voice vote by members present to approve the minutes of May 24, 2021 as submitted. MINTUES APPROVED.

Executive Director Report

Ms. Dowd introduced Kylie Rodrigues, Benefits Specialist for the Consortium. She said the Consortium is frequently contacted by members with what they initially believe is an appeal; however, these are primarily communications to confirm and clarifiy benefits. Anything that turns into an official appeal will be presented to the Committee.

Ms. Dowd reported the Consortium will be doing strategic planning this Fall that will begin at the Executive Committee level. She is in the process of interviewing facilitators who will help with that process. The Board of Directors will hold a remote educational session in August and a formal Board meeting in September. Information presented in August is based on the results of the survey conducted of Directors and will focus on benefit plans, Article 47 information, and the 2022 Budget. The September meeting will be in-person at the Tompkins County Public Library. Ms. Dowd said there are efforts underway to petition the State Legislature to amend the New York State Open Meetings Law to allow the Zoom link to be a location; however, nothing has been approved to date.

Ms. Dowd reported she received feedback from the Department of Financial Services on the Consortium's request for a new Certificate of Authority to operate in nine additional counties. She was informed the approval has moved to the Department's General Counsel; she expects a final response soon. There are three municipalities outside the Consortium's current region that have expressed in joining in 2022; there are few within the current region that have inquired about membership.

Ms. Dawson arrived at this time.

Medical Claims Audit Update

Ms. Dowd reported the audit is coming to a close and asked Mr. Locey to provide an overview of the status. Mr. Locey said there were 27 items left over from the audit that had

outstanding questions related to adjudication. Following discussions with Excellus and BMI and a review of each of the claims by Locey and Cahill, most of those claims have been resolved. There are a couple of cases where the plan document has to match the way that Excellus is adjudicating claims; that is being taken care of by Locey and Cahill through a refiling of plan documents with the Department of Financial Services. At this time there is no additional work by the Consortium needed and Locey and Cahill recommends acceptance of the final report from BMI noting there are a couple of items that need to be cleaned up.

Ms. Dowd commented that the 2018 audit resulted in some claims that were paid in error in favor of a member. In anticipation of possible questions from members as to why the same coverage for those claims will not be in place going forward, members will be contacted and will be informed that they had a claim that was paid in error and they are not responsible; however, the benefit will be paid correctly going forward. Also, some of the wording that needs to be clarified in the plan document is not a change in benefit but a clarification or how Excellus is to adjudicate the claim.

Mr. Shattuck said he feels the audit went smoothly this year due to both the Consortium's staffing resources as well as Locey & Cahill.

It was MOVED by Mr. Fischer, seconded by Ms. DiGennaro, and unanimously adopted by voice vote by members present, to approve the following resolution and submit to the Executive Committee:

RESOLUTION NO. - 2021 – ACCEPTANCE OF 2018 AND 2019 MEDICAL CLAIMS AUDIT REPORT

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. 008 of 2020 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 on 2018 and 2019 Medical Claims.

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Appeal Process

Ms. Dowd explained at the last meeting the Committee reviewed an appeals process flow chart that was developed based on a narrative that was in place. When the flow chart was presented for review by Excellus they sent their flow chart that included an additional piece of information relating to filing a complaint related to service or care. She agreed with Mr. Shattuck that having more information on a public-facing document is better. Mr. Shattuck spoke in favor of a flow chart including a direct phone number to both Excellus and ProAct. Ms. Dowd said the two documents will be combined into one document.

Ms. Dowd informed the committee that ProAct states that a majority of Prior Authorization and Step Therapy approvals happen without most knowing. The Consortium finds out when it doesn't happen well; the prior approval appeal process happens with the physician or pharmacy going back to ProAct and not the individual member. ProAct would like the Consortium to do more education on members not leaving the pharmacy if they are told something is denied; they should be asking for more information and asking them to contact the physician and ProAct while still in the pharmacy to try to get the process moving along. Mr. Brown encouraged the Consortium to post as much of this information as possible on its website. Mr. Shattuck asked that the Committee also receive a final copy of the flow chart at its next meeting.

Prescription Benefit Management (PBM) Audit

Ms. Dowd said a decision has not yet been made on whether the Consortium will be making a change in its provider of prescription benefit management services. At this time the years 2019 and 2020 need to be audited before proceeding with a new contract; she recommended moving forward with this audit and if a change is made the 2021 audit can be added to the contract. She has contacted BMI which has done prior audits and received a quotation for the same price as the last contract ($33,000) and asked for direction from the Committee in allowing this audit to proceed. She also noted the Operations Committee is looking at when the Consortium should issue an RFP (Request for Proposals) for all contracts; therefore, this service may be put out to bid for the next audit.

Ms. Dowd reported there were eight responses to the RFP for Prescription Benefit Management Services; the Subcommittee selected four companies to do pricing based on the current list of drugs and has narrowed the list to three that will be interviewed tomorrow.

RESOLUTION NO. ____ - 2021 - AUTHORIZING CONTRACT FOR PRESCRIPTION DRUG CLAIMS AUDIT WITH BMI– 2019 AND 2020 CLAIMS

It was MOVED by Ms. DiGennaro, seconded by Mr. Fischer, and unanimously adopted by voice vote by members present, to approve the following resolution and submit to the Executive Committee:

WHEREAS, the Consortium has determined there is value in conducting periodic medical and prescription drug claims audits, and

WHEREAS, the Consortium's has developed a pattern of conducting these claims audits on alternate years for medical one year and then pharmaceutical claims the next and

WHEREAS, the Consortium is now prepared to undertake a prescription drug claims audit as part of its fiduciary responsibility to ensure claims paid by ProAct are in accordance with the benefit plan documents, Federal and State Laws, Rules, and Regulations, and industry standard practices for the years 2019 and 2020 and

WHEREAS, in anticipation of initiating a prescription drug claims audit the Executive Director has obtained a contract proposal from BMI Audit Services, now therefore be it

RESOLVED, on recommendation of the Claims and Appeals Committee, That the Executive Committee, on behalf of the Board of Directors, hereby authorizes the Consortium to engage the firm of BMI to perform an audit of the Consortium's prescription drug claims for an amount not to exceed $35,000.

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Next Meeting

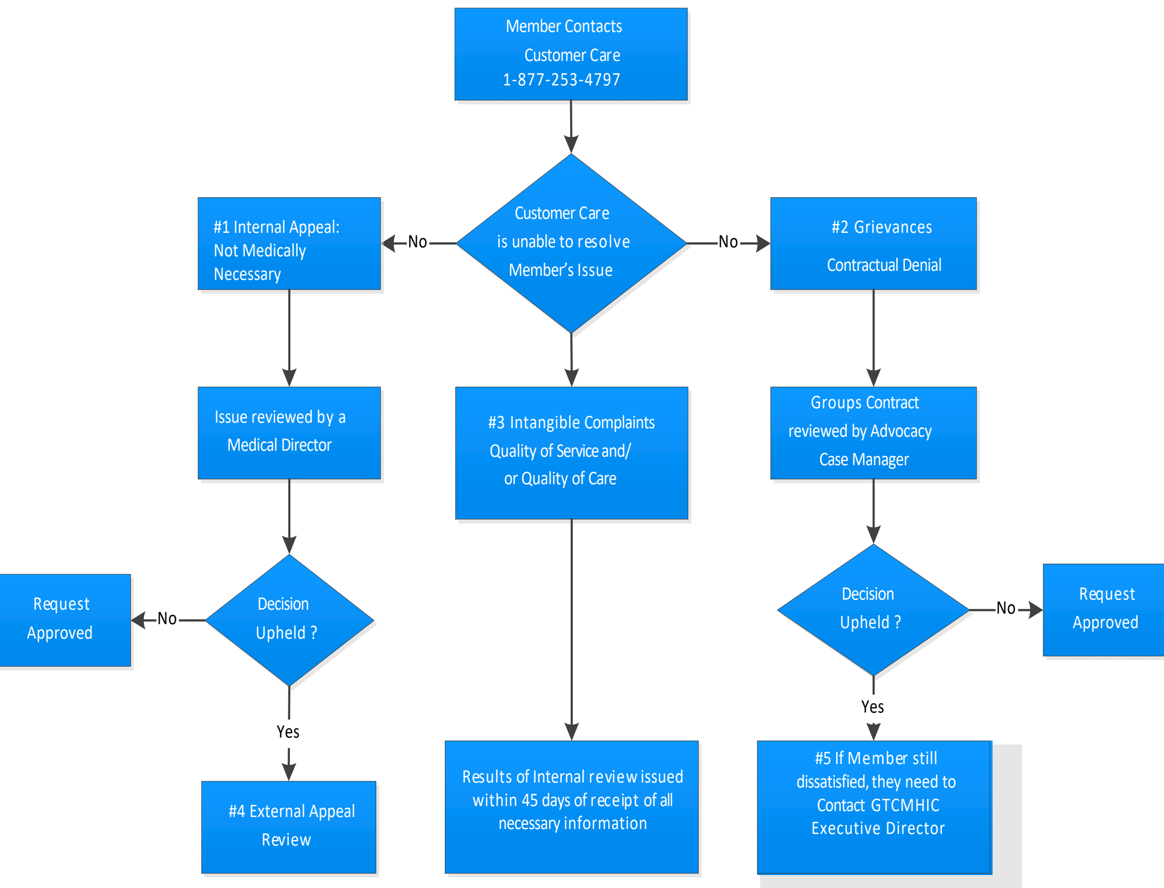
The Committee scheduled the next meeting for September 14th at 1 p.m. At that time the Committee will review the updated flow charts and will receive an update on the prescription drug claims audit.

Adjournment

The meeting adjourned at 2:46 p.m.

Greater Tompkins County Municipal Health Insurance Consortium
Internal Appeals / Grievance Process

Excellus



Excellus Contact Information:
Dedicated Customer Service Line: 1-877-253-4797

Appeal Mailing Address:
Excellus BCBS
Customer Advocate Unit
PO BOX 4717
Syracuse, NY 13221

1) Internal Appeal: Not Medically Necessary

- Member, or an authorized representative, has 180 days following receipt of the notification to file an Appeal regarding the decision.
- Excellus has 15 days to acknowledge receipt of the appeal and has either a) 30 days for pre-service appeals, b) 30 days from receipt of all necessary information for post-service appeals, not to exceed 60 days or c) for urgent cases it is the lessor of 72 hours or 2 business days to respond. If upheld, Excellus will issue a Final Adverse Determination.
- Excellus BCBS, Customer Advocate Unit, PO BOX 4717, Syracuse, NY 13221

2) Grievance: Contractual Benefit Denial

- Member, or authorized representative, has 180 days following receipt of notification to file a grievance regarding the decision.
- Excellus has 15 days to acknowledge receipt of the grievance and 30 days to respond for both pre-service and post-service grievances. If upheld, Excellus will issue a notice of determination.

3) Complaint: Dissatisfaction with Services or Quality of Care Issue

- Member, or authorized representative can file a complaint.
- Excellus has 15 days to acknowledge receipt, request input and / or medical records from provider. Results of review will be issued within 45 days of receipt of all necessary information to conduct review.

4) External Appeal:

- Member, or an authorized representative, has 4 months from the Final Adverse Determination to file an External Appeal with NYS Department of Financial Service. Notice of decision will be issued directly from NYS.
- DFS- Department of Financial Service- 1-800-342-3736

5) Appeal to GTCMHIC- Greater Tompkins County Municipal Health Insurance Consortium:

- If member, or an authorized representative remains dissatisfied with the plan's decision, they can file an appeal directly with the employer group.
- GTCMHIC, Att: Executive Director, PO BOX 7, Ithaca, NY 14851, Phone: (607) 274-5590, Email: consortium@tompkins-co.org

EBSA: Employee Benefits Security Administration

- For questions about your rights, this notice for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

PRO ACT PHARMACY BENEFIT MANAGEMENT

Your Fully Integrated Pharmacy Benefit Manager
Customer Service: 1-877-635-9545

What you should know about the PRIOR AUTHORIZATION AND APPEALS PROCESS

Submitted prior authorization (PA) requests are subject to validation against both member-specific prescription drug coverage and clinical criteria guidelines which evaluate both clinical effectiveness and alternative therapy costs. Approval/denial and lack of information notifications are faxed or mailed to appropriate parties–keeping the healthcare team and patient informed of the PA outcome. If ProAct does not receive enough information to make a determination, ProAct will reach out to the prescriber at least two times to attempt to obtain the additional information, if that information is not received from the prescriber, ProAct will dismiss the request and notify the member and the prescriber.

STANDARD PRIOR AUTHORIZATION

Prescriber visits ProAct's PromptPA portal, attaches *clinical notes* and answers any pertinent clinical criteria questions.
www.proactrx.promptpa.com

REQUEST IS **DENIED**

INTERNAL APPEAL

Prescriber visits ProAct's PromptPA portal, attaches *letter of appeal or medical necessity* and answers any pertinent clinical criteria questions.

REQUEST IS **DENIED**

EXTERNAL APPEAL

Prescriber visits ProAct's PromptPA portal, attaches *request for external appeal* and answers any pertinent clinical criteria questions. *ProAct submits request to external review agency.*

REQUEST IS **DENIED**
Original appeal decision stands

Appeals

INTERNAL: Appeals of a PA denial must be made in writing and submitted along with a copy of the original denial letter. Appeals are reviewed by a licensed doctor of pharmacy. The deadline for submission of an appeal is 180 days from the date of the original denial of the claim. Requests for urgent appeals will be acted on within 1 business day of receipt. Requests for standard appeals will be acted on within 3 business days of receipt.

EXTERNAL: Requests for an external review will be performed by a group not associated with ProAct, or ProAct's internal review board. If this group decides to overturn ProAct's denial decision, ProAct will provide coverage for the medication. Requests for an external review must be submitted in writing within 4 months after receiving the initial appeal denial notice. The external review organization is required under Federal Law to complete the review no later than 45 calendar days following the request being submitted. An urgent request for review is required to be completed within 72 hours.