Department of Civil Service

New York State Health Insurance Program: Payments by CVS Health for Pharmacy Services for Ineligible Members

Report 2020-S-17 | September 2021

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

Division of State Government Accountability

Audit Highlights

Objective

To determine whether CVS Health paid pharmacy claims for Empire Plan members who were not eligible. The audit covered the period January 1, 2014 through December 31, 2019.

About the Program

The New York State Health Insurance Program (NYSHIP) provides health insurance coverage to over 1.2 million active and retired State, local government, and school district employees, and their dependents. The Empire Plan is the primary health insurance plan for NYSHIP, serving about 1.1 million members. Since 2014, the Department of Civil Service (Civil Service) has contracted with CVS Health to administer the prescription drug program. From January 1, 2014 through December 31, 2019, CVS Health processed and paid over 100 million pharmacy drug claims totaling $14.9 billion.

Civil Service maintains eligibility and enrollment records for NYSHIP members in the New York Benefits Eligibility and Accounting System (NYBEAS). Typically, organizations that participate in NYSHIP (e.g., State agency, local government, and school district employers) have Health Benefits Administrators (HBA) that process eligibility transactions in NYBEAS. Civil Service sends CVS Health daily files of NYBEAS member eligibility changes, and CVS Health has access to NYBEAS to confirm eligibility information. Timely and accurate member eligibility information is crucial to ensure members are disenrolled promptly and to prevent payment of ineligible claims on their behalf.

Key Findings

For the audit period, we identified 132,051 claims, totaling $30,695,221, that were paid for pharmacy services provided during periods when members were not eligible. Further, Civil Service paid CVS Health $170,359 in administrative fees for processing these claims. We found:

- 89,654 claims, totaling $18,180,403, were improperly paid due to errors in the data sharing procedures between Civil Service and CVS Health. For the first 5 years of the contract period – when most of the ineligible payments occurred – there was no process for reconciling member eligibility data between Civil Service and CVS Health systems to identify inconsistencies and prevent improper claims from being processed. Improved controls implemented in May 2019 have significantly reduced these types of improper payments.
- 42,397 claims, totaling $12,514,818, were paid on behalf of ineligible members who were retroactively disenrolled (i.e., when a disenrollment is entered in NYBEAS after the date the change in eligibility became effective). In many cases, members were retroactively disenrolled after extended delays, taking an average of 227 days – and in one case 10 years – to cancel coverage. Civil Service relies heavily on HBAs and members to ensure their personnel records are up to date and that changes to members' eligibility status are processed timely to avoid paying claims for ineligible members. Therefore, it is important that Civil Service take steps to ensure HBAs are aware of their responsibilities for the timeliness and accuracy of updates to members' eligibility status in NYBEAS.

Key Recommendations

To Civil Service and CVS Health:

- Review the $30,695,221 in improper payments to determine the cause of the error, identify responsibility, and recover payments as warranted.
- Continue to perform periodic reconciliations, and establish or strengthen additional controls as needed, to prevent payment of ineligible claims.

To Civil Service:

- Continue to take steps to ensure HBAs are properly informed of their responsibilities (including the importance of timely and accurate coverage updates) and monitor whether HBAs are up to date on relevant training.

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

September 29, 2021

Rebecca A. Corso
Acting Commissioner
Department of Civil Service
Empire State Plaza, Building 1, 20th Floor
Albany, NY 12239

Cheryl A. Byron
Division Head, CVS/caremark
CVS Health
420 East Waterside Drive, Unit 2710
Chicago, IL 60601

Dear Acting Commissioner Corso and Ms. Byron:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government 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 New York State Health Insurance Program entitled *Payments by CVS Health for Pharmacy Services for Ineligible Members*. 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.

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
834 File	Electronic Data Interchange 834 file, a benefit enrollment and maintenance document	*Key Term*
Civil Service	Department of Civil Service	*Auditee*
Contract	Pharmacy Benefit Services Contract	*Key Term*
EGWP	Employer Group Waiver Plan for Medicare benefits	*Key Term*
Empire Plan	Primary health benefits plan for NYSHIP	*Key Term*
HBA	Health Benefits Administrator	*Key Term*
HMO	Health maintenance organization	*Key Term*
NYBEAS	New York Benefits Eligibility and Accounting System	*System*
NYSHIP	New York State Health Insurance Program	*Program*
Retroactive disenrollment	When a member's disenrollment is entered in NYBEAS after the date their coverage ended	*Key Term*
RxClaim	CVS Health's claims processing system for commercial (non-Medicare) claims	*System*

Background

The New York State Health Insurance Program (NYSHIP), administered by the Department of Civil Service (Civil Service), is one of the nation's largest public sector health insurance programs. NYSHIP covers over 1.2 million active and retired State, participating local government, and school district employees, and their dependents. The Empire Plan is the primary health insurance plan for NYSHIP, serving about 1.1 million members. The Empire Plan provides its members with four types of health insurance coverage: prescription drug, hospital, medical/surgical, and mental health and substance abuse services.

Civil Service entered into a Pharmacy Benefit Services Contract (Contract) with CVS Health to administer the Empire Plan's prescription drug program from January 1, 2014 through December 31, 2018 and subsequently a second contract, with similar terms, effective January 1, 2019 through December 31, 2023. Civil Service pays CVS Health an administrative fee per final paid claim for all services provided under the Contract. From January 1, 2014 through December 31, 2019, CVS Health processed and paid over 100 million claims totaling $14.9 billion.

Civil Service is responsible for maintaining the New York Benefits Eligibility and Accounting System (NYBEAS), which is the system of record for NYSHIP member enrollment and eligibility information. Each organization that participates in NYSHIP (e.g., State agency, local government, and school district employers) typically has at least one Health Benefits Administrator (HBA) that is responsible for processing eligibility transactions in NYBEAS. Civil Service must promptly certify to CVS Health any changes in the eligibility status of members. Civil Service provides CVS Health with a daily update file of NYBEAS changes, and CVS Health has access to NYBEAS to confirm eligibility information.

Timely and accurate member eligibility updates in NYBEAS are crucial to ensure members are disenrolled promptly to prevent payment of ineligible claims on their behalf. If a NYBEAS disenrollment is entered after the date the change in eligibility takes effect, it is considered a retroactive disenrollment. For example, if an employee who was enrolled in the Empire Plan accepts new employment and notifies their HBA to end coverage effective June 1, 2019, but the HBA does not enter the transaction into NYBEAS until December 31, 2019 (a 7-month delay), this is considered a retroactive disenrollment back to June 1, 2019.

To facilitate CVS Health's administration of pharmacy claims, Civil Service transmits eligibility and demographic information from NYBEAS to two different CVS Health claims processing systems. Civil Service uses an 834 File to transmit NYBEAS information for Empire Plan members who do not have Medicare coverage to CVS Health's RxClaim claims processing system. For Empire Plan members with Medicare coverage (referred to as Employer Group Waiver Plan or EGWP), Civil Service uses an EGWP File to transmit NYBEAS information to CVS Health's EGWP claims processing system.

The terms of the Contract require CVS Health to reimburse Civil Service for any overpayments made due to CVS Health's error and to make a reasonable effort to recover all other overpayments and remit them to Civil Service.

Audit Findings and Recommendations

To maintain the most accurate and up-to-date eligibility records, a coordinated and cooperative effort is required by Civil Service, CVS Health, HBAs, and NYSHIP members. However, Civil Service is ultimately responsible for overseeing NYSHIP and ensuring each of these groups is fulfilling its duties. We found that not enough was done to ensure eligibility information in NYBEAS is updated timely and accurately transmitted to CVS Health's claims processing systems (RxClaim system and EGWP system) to prevent claims from being paid for ineligible members. Claims paid in error increase the overall cost of the NYSHIP program, which can result in higher premiums and costs for members and employers.

For the period January 1, 2014 through December 31, 2019, we determined $30,695,221 was paid on 132,051 claims for ineligible members. Overpayments stemmed from data transfer issues between NYBEAS and CVS Health's systems (89,654 claims, or 68%) and retroactive disenrollments (42,397 claims, or 32%). Civil Service paid CVS Health $170,359 in administrative fees for these 132,051 ineligible claims.

Ineligible Claims Paid Due to Data Transfer Issues

We found 89,654 claims – accounting for $18,180,403 in payments and $118,386 in administrative fees – were improperly paid due to data transfer issues between NYBEAS and CVS Health's systems. Typically, data transfer issues occurred under the following scenarios: when changes in the NYBEAS system inadvertently caused re-enrollment of an ineligible member, when changes in the NYBEAS system were not included in the correct Civil Service eligibility file (834 File or EGWP File), or when the data contained in Civil Service's eligibility files did not successfully disenroll the member in CVS Health's claims processing systems. For example:

- A member's coverage was voluntarily canceled in NYBEAS on May 3, 2018 with an effective date of September 1, 2018. However, this member's coverage was incorrectly reactivated on June 12, 2018 when demographic update information was transmitted in the 834 File by Civil Service to CVS Health. As a result, for the period of November 2018 through May 2019, three ineligible claims totaling $33,316 were paid on behalf of this member.
- In another instance, a dependent's coverage was canceled when the policyholder switched to individual coverage (thus dropping the dependent) on May 17, 2018. The change in coverage should have taken effect on June 1, 2018 but was not included in any 834 File. As a result, for the period of June 2018 through December 2018, 10 claims totaling $1,338 were paid on behalf of this ineligible individual.
- A member's coverage in NYBEAS was changed from the Empire Plan to a health maintenance organization (HMO) on December 24, 2014 with an effective date of January 1, 2015. This information should have been transmitted to the RxClaim system via the 834 File, but was instead incorrectly transmitted to the EGWP system via an EGWP File. The EGWP system rejected the transaction because the member was not EGWP eligible, and the

member continued to receive benefits through the Empire Plan rather than the HMO from January 2015 through March 2019. For this 51-month period, CVS Health processed 28 claims totaling $227,473 on behalf of this member.

As shown in the following table, from 2014 to 2018, the incidence of overpayments due to data transfer issues had been increasing each year of the Contract. In May 2019, Civil Service and CVS Health began a monthly reconciliation process to detect inconsistencies between NYBEAS and RxClaim member eligibility data and prevent improper payments. Additionally, for the subsequent 6-month period (July–December 2019), we found improper claims and overpayments due to data transfer issues decreased significantly – by 76% – compared with the same 6-month period in 2018: from 11,486 claims totaling $2,734,066 to 2,778 claims totaling $642,936.

Year	Number of Claims	Improper Payments
2014	7,087	$1,016,874
2015	13,721	2,037,072
2016	17,237	3,193,378
2017	18,323	3,736,480
2018	22,348	5,303,966
2019	10,938	2,892,633
Totals	**89,654**	**$18,180,403**

Despite CVS Health indicating that the reconciliation process is common with its other clients, a reconciliation process was not established with Civil Service until 2019 – 5 years after the effective date of the initial Contract. Had a reconciliation process been established earlier, a substantial number of improper payments, and administrative fees, would have been avoided.

Ineligible Claims Paid Due to Retroactive Disenrollments

Empire Plan members are retroactively disenrolled when a member loses eligibility and the information is not updated in NYBEAS until after the change in eligibility takes effect. Therefore, the timeliness and accuracy of entering eligibility changes in NYBEAS are crucial to ensuring members are disenrolled promptly and avoiding claim payments on behalf of ineligible members.

For the audit period, retroactive disenrollments accounted for $12,514,818 in payments for 42,397 claims on behalf of ineligible members. We found many members were retroactively disenrolled after extended delays, taking an average of 227 days – and in one case 10 years – to cancel coverage. In addition, the administrative fees for these claims totaled $51,973.

There are various reasons why eligibility cancellations were not entered into NYBEAS timely, including those related to non-payment of premiums. Of the

$12,514,818 in retroactive disenrollments, $3,652,022 – nearly 30% – was attributable to members whose coverage was canceled for non-payment of premiums. For members who have missed coverage payments, Civil Service allows a 90-day grace period before disenrolling them. This policy allows members to catch up on payments prior to termination of coverage. Despite the 90-day policy, $2,875,190 in claim payments, of the $3,652,022 we identified, were made on behalf of ineligible members whose retroactive disenrollment for non-payment exceeded 100 days, including one case that took more than 3 years. During the audit period, Civil Service made improvements to controls relating to disenrollments for non-payment by automating some disenrollments after the 90-day grace period ends. However, some disenrollments for non-payment still require manual changes or requests by HBAs.

Civil Service relies heavily on HBAs and members to ensure their personnel records are up to date and that changes to members' eligibility status are processed timely. Civil Service provides training materials for HBAs, including videos, memos, and manuals, and offers the option for HBAs to perform reconciliations with the NYBEAS system. Civil Service is aware of the importance of ensuring that HBAs use educational and training resources to establish and maintain their NYBEAS and NYSHIP competency. Civil Service has made some progress in this area; it has begun tracking live training events and requiring HBAs to complete an attestation acknowledging that they understand their roles and responsibilities. However, Civil Service does not currently monitor on-demand training (training that is not live that users can access when convenient) and has not established formal requirements for attending training. Additionally, Civil Service needs to ensure that the training addresses the timeliness and accuracy of eligibility transactions and results in fewer ineligible claims due to retroactive disenrollments.

Recovery of Improper Payments

The terms of the Contract require CVS Health to credit Civil Service the amount of any overpayments when an ineligible claim is paid due to an error by CVS Health, regardless of any recoveries from the pharmacy and/or enrollee. If an overpayment is the result of Civil Service's error, CVS Health must still make reasonable efforts to recover the overpayment; however, reasonable efforts are not clearly defined in the Contract.

Further, we were unable to determine whether CVS Health or Civil Service was responsible for discrepancies involving certain data transfer issues. In particular, both CVS Health and Civil Service officials indicated that in instances where re-enrollment was caused by changes to member information in NYBEAS (such as an update to demographic information), the cause was the manner in which this information was being transferred by Civil Service in its eligibility files and interpreted by CVS Health's claims processing systems.

Recommendations

To Civil Service and CVS Health:

1. Review the $30,695,221 in improper payments to determine the cause of the error, identify responsibility, and recover payments as warranted.
2. Consider establishing formal guidelines with CVS Health that outline what constitutes reasonable efforts to recover overpayments that result from Civil Service errors per the Contract.
3. Continue to perform periodic reconciliations, and establish or strengthen additional controls as needed, to prevent the payment of ineligible claims.

To Civil Service:

4. Continue to take steps to ensure HBAs are properly informed of their responsibilities (including the importance of timely and accurate coverage updates) and monitor whether HBAs are up to date on relevant training.

To CVS Health:

5. Reimburse Civil Service for all claims incorrectly paid due to CVS Health's errors, and make a reasonable effort to recover the remaining overpayments.
6. Reimburse Civil Service for the portion of the $170,359 in administrative fees associated with ineligible claims paid due to CVS Health errors.

Audit Scope, Objective, and Methodology

The objective of the audit was to determine whether CVS Health paid pharmacy claims for Empire Plan members who were not eligible. The audit covered the period January 1, 2014 through December 31, 2019.

To accomplish our audit objective and assess internal controls, we reviewed NYSHIP eligibility policies and interviewed officials from Civil Service and CVS Health. We analyzed pharmacy claims for the audit period and compared the dates of service to the member's eligibility record in NYBEAS. We considered any payments for services rendered during a period when that member was not covered by the Empire Plan to be a claim paid for an ineligible member. We note that some of the improper payments we identified are offset by payments from other entities, such as subsidies from the federal government and rebates from manufacturers. In calculating the amount of the total overpayments, we did not factor in these offsets.

To select claims for review, we matched pharmacy claims data to eligibility data extracts. We then compared the date of service on the claim to the member's eligibility period. For claims that appeared to have been paid for ineligible individuals, we totaled the claims per person and selected only the claims for individuals who had at least $1,000 in what appeared to be ineligible claims; this resulted in 5,282 members being selected for further review. For the 5,282 members, we compared the date when eligibility changes were made in NYBEAS to the effective date of the eligibility changes to determine claims that were paid due to retroactive disenrollment. For the remaining claims, we judgmentally chose a sample of members based on dollar amount, number of claims, and number of NYBEAS transactions and compared NYBEAS, RxClaim, 834 Files, and EGWP Files to determine the cause of improper claim payments. Because we selected judgmental samples, the results cannot be projected to the population.

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 audit of Civil Service's oversight and administration of CVS Health's payments for pharmacy services.

Reporting Requirements

We provided a draft copy of this report to Civil Service and CVS Health officials for their review and formal comment. We considered Civil Service's and CVS Health's comments in preparing this final report and have included them in their entirety at the end of it. In their responses, Civil Service and CVS Health officials generally concurred with the audit recommendations and indicated that actions have been or will be taken to address them.

Within 180 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Civil Service 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.

Agency Comments - Department of Civil Service

ANDREW M. CUOMO
Governor

REBECCA A. CORSO
Acting Commissioner

August 16, 2021

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

Re: Draft Audit Report 2020-S-17, Issued July 16, 2021

Dear Ms. Inman:

Thank you for sharing the draft report and findings for the Office of the State Comptroller's (OSC)2020-S-17 audit titled New York State Health Insurance Program: Payments by CVS Health for Pharmacy Services for Ineligible Members and for providing the individual payment data from your findings.

The Department agrees with Recommendation 1 and will use the individual payment data in its efforts to identify and recover ineligible payments.

Thank you for noting that the $30,695,221 in total findings do not reflect the actual cost to the New York State Health Insurance Program (NYSHIP). A significant portion of that amount includes federal subsidies associated with the Medicare Part D program which have amounted to approximately 40 percent of the Empire Plan's Medicare Part D Employer Group Waiver Plan (EGWP) claims payments in recent years. Another significant portion of the total findings is reduced by manufacturer rebates, which offset approximately 26 percent of the Empire Plan's pharmacy claims in 2020.

The Department agrees with Recommendation 2 and will discuss this contract provision with CVS to establish and implement guidelines for recovering overpayments for retroactive disenrollments.

The Department agrees with Recommendation 3 and will continue to reconcile information from the New York Benefits Eligibility and Accounting System (NYBEAS) with CVS eligibility data. The Department appreciates the acknowledgement of the success of the monthly reconciliation process that was initiated in 2019.

The Department also agrees with Recommendation 4. As noted in the report, the Department is aware of the importance of reducing the number and length of retroactive disenrollments. In recent years the Department has initiated improvements that demonstrably reduced the length, number, and impact of retroactive disenrollments in the NYSHIP. These improvements include, but are not limited to, sending dependent verification letters to enrollees with family coverage, and emphasizing the importance of

timely enrollment transaction processing through health benefit administrator (HBA) trainings. The Department looks forward to providing future updates on its efforts.

Thank you again for the opportunity to provide feedback on this draft report.

Sincerely,

James DeWan
Director
Employee Benefits Division

The New York State Department of Civil Service Eligibility Audit Response Dated August 2021

Regarding:

Office of the State Comptroller
Draft Audit Report

Dated July, 2021

CVS/caremark

INTRODUCTION

Office of the State Comptroller performed an audit of The New York State Department of Civil Service (Civil Service), a client of CVS/caremark. Office of the State Comptroller's objective was to determine the financial accuracy of claims paid during the period of January 1, 2014 through December 31, 2019.

CVS/caremark has reviewed and researched the findings reported by Office of the State Comptroller to determine whether, in our view, there are outstanding financial liabilities owed to our client and/or opportunities for process improvement. Below is our response to the findings reported by Office of the State Comptroller.

FINDINGS

There were two (2) general findings within the Office of the State Comptroller report.

Office of the State Comptroller Finding 1: Ineligible Claims Paid Due to Data Transfer Issues

Auditor found 89,654 claims- accounting for $18,180,403 in payments and $118,386 in administrative fees- were improperly paid due to data transfer issues between NYBEAS and CVS Health's systems. Typically, data transfer issues occurred under the following scenarios: when changes in the NYBEAS system inadvertently caused re-enrollment of an ineligible member, when changes in the NYBEAS system were not included in the correct Civil Service eligibility file (834 File or EGWP file), or when the data contained in Civil Service's eligibility files did not successfully disenroll the member in CVS Health's claims processing systems. For example:

- A member's coverages was voluntarily canceled in NYBEAS on May 3, 2018 with an effective date of September 1, 2018. However, this member's coverage was incorrectly reactivated on June 12, 2018 when demographic update information was transmitted in the 834 File by Civil Service to CVS Health. As a result, for the period of November 2018 through May 2019, three ineligible claims totaling $33,316 were paid on behalf of this member.
- In another instance, a dependent's coverage was canceled when the policyholder switched to individual coverage (thus dropping the dependent) on May 17, 2018. The change in coverage should have taken effect on June 1, 2018 but was not included in any 834 File. As a result, for the period of June 2018 through December 2018, 10 claims totaling $1,338 were paid on behalf of this ineligible individual.
- A member's coverage in NYBEAS was changed from the Empire Plan to a health maintenance organization (HMO) on December 24, 2014 with an effective data of January, 1, 2015. This information should have been transmitted to the RxClaim system via the 834 File, but was instead incorrectly transmitted to the EGWP system via an EGWP file. The EGWP system rejected that transaction because the member was not EGWP eligible, and the member continued to receive benefits through the Empire Plan rather than the HMO from January 2015 through March 2019. For this 51-month period, CVS Health processed 28 claims totaling 227,473 on behalf of this member.

In May 2019, Civil Service and CVS Health began a monthly reconciliation process to detect inconsistencies between NYBEAS and RxClaim member eligibility data and prevent improper payments. Additionally, for the subsequent 6-month period (July-December 2019), we found improper claims and overpayments due to data transfer issues decreased significantly- by 76%- compare with the same 6-month period in 2018: from 11,486 claims totaling $2,734,066 to 2,778 claims totaling $642,936.

Despite CVS Health indicating that the reconciliation process is common with its other clients, a reconciliation process was not established with Civil Service until 2019- 5 years after the effective date of the initial Contract. Had a reconciliation process been established earlier, a substantial number of improper payment, and administrative fees, would have been avoided.

The terms of the Contract require CVS Health to credit Civil Service the amount of any overpayments when an ineligible claim is paid due to an error by CVS Health, regardless of any recoveries from the pharmacy and/or enrollee. If an overpayment is the result of Civil Service's error, CVS Health must still make reasonable efforts to recover the overpayment; however, reasonable efforts are not clearly defined in the Contract. Both CVS Health and Civil Service officials indicated that in instances where reenrollment was caused by changes to member information in NYBEAS (such as an update to demographic information), the cause was the manner in which this information was being transferred by Civil Service in their eligibility files and interpreted by CVS Health's claims processing systems.

Recommendations:

To Civil Service and CVS Health:

1. Review the $30,695,221 in improper payments to determine the cause of the error, identify responsibility, and recover payments as warranted.
2. Consider establishing formal guidelines with CVS Health that outline what constitutes reasonable efforts to recover overpayments that result from Civil Service errors per the Contract.
3. Continue to perform periodic reconciliations, and establish or strengthen additional controls as needed, to prevent payment of ineligible claims.

To CVS Health:

4. Reimburse Civil Service for all claims incorrectly paid due to CVS Health's errors, and make a reasonable effort to recover the remaining overpayments.
5. Reimburse Civil Service for the portion of the $170,359 in administrative fees associated with ineligible claims paid due to CVS Health errors.

CVS/caremark Response:

CVS/caremark reviewed the finding in relation to data transfer issues, accounting for $18,180,403 in ineligible payments, and specific examples referenced and determined the following:

- Eligibility adds, changes and reinstatements use DTP Qualifier Codes to determine effective dates and termination dates. Qualifier code 303 with date of 20180612 was submitted in the 834 file for this member, reactivating eligibility per the mapping guide.

- Specific member information with the corresponding claims identified by OSC were not provided for research.

- As the member was not correctly included in the appropriate 834 file, their coverage remained active per the enrollment process. Furthermore, the EGWP enrollment process was never completed and rejection would have been reflected in Summary Load Reports and Feedback Files; sent to the client on a regular basis and reflect statuses for each member record.

During implementation CVS/caremark did recommend to Civil Service weekly full files through the end of January 2014 with adjustment to monthly full files after January, with no agreement provided by Civil Service. After CVS/caremark identified an issue in 2019, full file process was again requested, and Civil Service then agreed.

Eligibility adds, changes, and reinstatements do not reference Maintenance Codes, but use the DTP Qualifier Codes to determine effective dates and termination dates. The information entered into these date fields on the 834 is determined by the State of New York. Every transaction that is sent to CVS/caremark requires certain fields, including effective/through dates. Without these fields, transactions will reject. Any custom coding deemed necessary for CVS/caremark to interpret the handling of maintenance vs. reinstatement records was to be discussed and approved by the State during implementation discussions, and properly documented in the approved mapping guide.

It is our view that we are in compliance with the contract, and there are no material financial discrepancies related to the finding. However, CVS/caremark is prepared to send member letters in an attempt to recover overpayments if requested by the State, pending receipt of all members and claims affected with agreement on letter parameters by Civil Service.

Office of the State Comptroller Finding 2: Ineligible Claims Paid Due to Retroactive Disenrollments

Empire Plan members are retroactively disenrolled when a member loses eligibility and the information is not updated in NYBEAS until after the change in eligibility takes effect. Therefore, the timeliness and accuracy of entering eligibility changes in NYBEAS are crucial to ensuring members are disenrolled promptly and avoiding claim payments on behalf of ineligible members.

For the audit period, retroactive disenrollments accounted for $12,514,818 in payments for 42,397 claims on behalf of ineligible members. Auditors found many members were retroactively disenrolled after extended delays, taking an average of 227 days- and in one case 10 years- to cancel coverage. In addition, the administrative fees for these claims totaled $51,973.

Civil Service relies heavily on Health Benefits Administrators (HBAs) and members to ensure their personnel records are up to date and that changes to member's eligibility statuses are processed timely. Civil Service provides training materials for HBAs, including videos, memos, and manuals, and offer the option for HBAs to perform reconciliations with the NYBEAS system. Civil Service has mad some progress in this area; it has begun tracking live training events and requiring HBAs to complete an attestation acknowledging that they understand their roles and responsibilities. However, Civil Service does not currently monitor on-demand training (training that is not live that users can access when convenient) and has not established formal requirements for attending taining. Additionally, Civil Service needs to ensure that the training addresses the timeliness and accuracy of eligibility transactions and results in fewer ineligible claims due to retractive disenrollments.

The terms of the Contract require CVS Health to credit Civil Service the amount of any overpayments when an ineligible claim is paid due to an error by CVS Health, regardless of any recoveries from the pharmacy and/or enrollee. If an overpayment is the result of Civil Service's error, CVS Health must still make reasonable efforts to recover the overpayment.

Recommendations:
To Civil Service and CVS Health:

1. Review the $30,695,221 in improper payments to determine the cause of the error, identify responsibility and recover payments as warranted.

2. Consider establishing formal guidelines with CVS Health that outline what constitutes reasonable efforts to recover overpayments that result from Civil Services per the Contract.

To Civil Service:

3. Continue to take steps to ensure HBAs are properly informed of their responsibilities (including the importance of timely and accurate coverage updates) and monitor whether HBAs are up to date on relevant training.

To CVS Health:

4. Reimburse Civil Service for all claims incorrectly paid due to CVS Health's errors, and make a reasonable effort to recover the remaining overpayments.

5. Reimburse Civil Service the portion from the $170,359 in administrative fees associated with ineligible claims paid due to CVS Health errors

CVS/caremark Response:
CVS/caremark reviewed the finding in relation to retroactive disenrollments, accounting for $12,514,818 in ineligible payments, identified by the auditor.

As stated by auditor, "the timeliness and accuracy of entering eligibility changes in NYBEAS are crucial to ensuring members are disenrolled promptly and avoiding claim payments on behalf of inelgibile members." CVS/caremark is not responsible for entering eligibility changes in

NYBEAS and should not be deemed as the cause of the error for the 42,397 claims, accounting for $12,514,818 in payments, due to retroactive disenrollments.

It is our view that we are in compliance with the contract, and there are no material financial discrepancies related to the finding. However, CVS/caremark is prepared to send member letters in an attempt to recover overpayments if requested by the State, pending receipt of all members and claims affected with agreement on letter parameters by Civil Service.

SUMMARY

Based on CVS/caremark's review of the findings, CVS/caremark is adjudicating claims in accordance with the eligibility that has been supplied. If the State chooses to request CVSC to pursue any overpayments due to incorrect eligibility that was provided by the State, reasonable efforts will be utilized to seek reimbursement to Civil Service.

It is our view that we are in compliance with the contract, and there are no material financial discrepancies related to the findings.

Upon confirmation from Civil Service that the results are accepted, and the audit can be closed, CVS/Caremark will close the audit. By closing the audit, Civil Service agrees that CVS/Caremark has no further liability with respect to claims adjudicated by CVS/Caremark, and related services, for the period from January 1, 2014 – December 31, 2019 and will not be subject to any further audits for this time period by or on behalf of Civil Services.

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