Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicaid Recovery of Pharmacy Payments from Liable Third Parties

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EXECUTIVE SUMMARY

PURPOSE

This report (1) quantifies the Medicaid dollars at risk of being lost when Medicaid pays pharmacy claims for beneficiaries who have other insurance, and (2) describes States' experiences with third-party payment of claims.

BACKGROUND

Millions of Medicaid beneficiaries have other pharmacy coverage through private health plans, employers, non-custodial parents, State programs such as workers' compensation, or Federal programs such as Medicare. Because Medicaid is usually considered the payer of last resort, other insurance sources may be liable for claims providers send to Medicaid. In this report, other insurance sources are referred to as "third parties." Since many third parties contract with pharmacy benefit management companies to provide a host of services including pharmacy-claims processing, we also use the term third parties for these companies.

When claims have a liable third party, State Medicaid agencies either use a cost-avoidance system in which the claim is returned to the pharmacy to bill the third party, or they "pay and chase," i.e., pay the claim and try to recover the payment from the third party. States are mandated to pay and chase claims under certain circumstances, but in general, payment for claims with third-party liability must be avoided unless the State has a Federal cost-avoidance waiver. The Centers for Medicare and Medicaid Services (CMS) may grant a cost-avoidance waiver for pharmacy claims if the State demonstrates that paying and chasing is cost effective.

FINDINGS

Thirty-two States are at risk of losing over 80 percent ($367 million) of the Medicaid pharmacy payments they tried to recover from third parties through the pay-and-chase approach

Thirty-two States identified $440 million in potential recoveries, of which they recovered $73 million (17 percent). The remaining 18 States reported they could not identify the amount they paid and chased.

However, the cost-avoidance approach prevented $185 million from being at risk in 17 States

States that use cost avoidance say it is successful once a system is in place. States that do not use cost avoidance have concerns about it burdening pharmacies and beneficiaries.

Almost three-quarters of States report third parties refuse to process or pay Medicaid pharmacy claims

States said when they try to recover payments they are faced with the following problems: denials due to incompatible claim formats, unreasonable filing time limits, unprocessed claims with no explanation, vague denials, and the inability to identify the liable payer or claims processing entity.

More States had problems with pharmacy benefit management companies than with all other types of third parties combined

Thirty-two States experienced problems with pharmacy benefit management companies. In addition to having all the same problems with these companies as with other types of third parties, 14 States said pharmacy benefit management companies will not process Medicaid claims because their clients have not authorized them to do so.

While States have difficulty recovering payments, methods such as sharing information with third parties, using effective billing practices, and taking legal action have been successful for some States

State recommendations for solving recovery problems include universal claim formats, eligibility data matches, and new rules for pharmacy benefit management companies and insurers

RECOMMENDATIONS

To reduce the dollars at risk of being lost, we offer the following recommendations for CMS:

Waivers. Review States' cost-avoidance waivers for pharmacy claims to determine if they are meeting the cost-effectiveness criterion. Our findings indicate that, overall, pay and chase is not a cost-effective policy. The CMS should also review State policies to determine if some States are paying and chasing pharmacy claims without a waiver.

Best Practices. Continue working together with States to identify, develop, and disseminate the most successful methods in both avoiding and recovering Medicaid pharmacy payments that are the responsibility of liable third parties.

Tracking. Require States to track the dollar amounts they pay and chase and the amounts they recover on pharmacy claims if they have cost-avoidance waivers. This information is necessary to determine whether a State's paying and chasing is cost effective. Furthermore, unless States know how much money third parties owe, they cannot use their collection resources to the best advantage.

Claim format. Clarify for States whether claim standardization requirements under the Health Insurance Portability and Accountability Act will be applied to pharmacy services in a third party environment. Since implementation of these requirements is at least 1.5 years away, CMS should continue to assist States in seeking immediate remedies to get their claims processed. The types of roles CMS might play in this regard could be fact finder, technical advisor, or coordinator.

Education. Develop strategies, on a national level, to educate third parties about Medicaid and third-party pharmacy issues. In addition, CMS should collaborate with the Department of Labor to develop education targeted specifically to self-insured health plans regulated under the Employee Retirement Income Security Act (ERISA).

Legislation. Determine whether legislation is needed to:

- explicitly include pharmacy benefit management companies in the Medicaid program's definition of a third party,
- require third parties to match their eligibility files with Medicaid's eligibility files, and
- allow Medicaid up to 3 years to recover payments from liable third parties.

If legislation is determined to be needed, CMS should consider coordinating with the Department of Labor to discuss requiring similar items from ERISA-governed health plans.

AGENCY COMMENTS

The CMS concurred with our recommendations and stated they are committed to resolving issues that stand in the way of full recovery of Federal and State dollars. They plan to re-examine States' cost avoidance waivers and will emphasize cost avoidance at the August 2001 National Third Party Liability Conference. In addition, they have worked with States and third parties to develop a claim format that Medicaid agencies can use for submitting electronic claims to third parties; they are helping to educate PBM's clients about Medicaid reimbursement issues; and they will review issues to determine if legislation is needed. While concurring with the premise of our recommendation to require tracking of dollar amounts paid and chased and dollar amounts recovered on pharmacy claims, CMS stated that tracking all pharmacy claims may not be the only method to substantiate cost-effectiveness of a waiver. We recognize that this data may not be the sole factor in determining the cost-effectiveness of a waiver. However, we still believe that upon receiving a waiver, a State should be required to track this information.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

This report (1) quantifies the Medicaid dollars at risk of being lost when Medicaid pays pharmacy claims for beneficiaries who have other insurance, and (2) describes States' experiences with third-party payment of claims.

BACKGROUND

Medicaid Expenditures for Pharmacy Claims

Medicaid is a program, created under Title XIX of the Social Security Act, that pays for medical and health-related assistance for certain vulnerable and needy individuals and families. It is administered by States but financed with State and Federal funds. The Federal Government provides 50 to 83 percent of the funding depending on the State's per capita income.

The annual Federal-State Medicaid expenditure for pharmacy claims is in the billions of dollars. In 1997 it was $11.9 billion, and in 1999 it was $16.4 billion. In 1999, over 32 million beneficiaries were served under the pharmacy benefit.

Medicaid Beneficiaries with Other Insurance

Millions of Medicaid beneficiaries have other health insurance. Pharmacy coverage may be through private health insurance, employment-related health insurance, medical support from non-custodial parents, automobile insurance, State programs such as workers' compensation, or Federal programs such as Medicare. In accordance with Federal regulations, Medicaid beneficiaries "assign to the Medicaid agency their rights to medical support and to payment for medical care from any third party. [However,] the assignment of rights ... is effective only for services that are reimbursed by Medicaid (42CFR433.145)." In other words, if Medicaid paid for a service that is covered by another source of insurance, Medicaid has a legal right to payment from that source.

Most other insurance sources are considered primary payers in relation to Medicaid and may, therefore, be financially liable for claims. Medicaid is a payer of last resort with a few exceptions which are noted in the State Medicaid Manual, Section 3904.4A-B. Medicaid refers to other insurers as third parties and refers to claims for beneficiaries who have other insurance as third party claims. These and other technical terms are defined in Appendix A.

Cost Avoidance

The term cost avoidance is used to describe Medicaid's avoidance of paying claims when beneficiaries have other insurance. Under cost avoidance, if a State Medicaid agency receives a claim, the agency must deny the claim and return it to the provider. The provider can then bill the third party for payment. Medicaid agencies also avoid paying claims by preventing them from being billed to them in the first place. Instead, the agencies alert pharmacies about the existence of the liable third party through their computer systems at the time of purchase.

In order for Medicaid agencies to use cost avoidance effectively, they must take reasonable measures to determine the legal liability of third parties. At a minimum, the agencies must collect insurance information from prospective Medicaid beneficiaries during the initial eligibility interview and the redetermination process. State Medicaid agencies must also conduct data exchanges with Social Security Administration wage and earnings files; and the files of State agencies that keep information on wages, child support, welfare, motor vehicle accidents, and workers' compensation. Any of these files might indicate the existence of other health insurance.

Medicaid agencies are required to notify the Centers for Medicare and Medicaid Services (CMS) of the total amount they avoided paying for all services for beneficiaries who have other insurance. This notification is part of the State's quarterly report of expenditures for their Medicaid program. The notification does not, however, distinguish the amount avoided for pharmacy services from the total amount avoided for all services.

Waivers to Pay and Chase Pharmacy Claims

The CMS grants cost-avoidance waivers for various services including pharmacy. Medicaid agencies with a cost-avoidance waiver for pharmacy services may reimburse pharmacies that serve beneficiaries who have other insurance. After paying the pharmacy, the agency seeks payment recovery from the third party. This process is known as pay and chase. Federal waivers from cost avoidance are granted if the State Medicaid agency can demonstrate that paying and chasing is cost effective.

There are circumstances under which Medicaid agencies pay and chase even when they do not have a waiver. Federal law requires States to pay and chase claims when (1) coverage is through a parent whose obligation to pay support is enforced by the State's child support enforcement agency, (2) the service is prenatal care for pregnant women, and (3) the service is preventive pediatric care. In addition, if a State learns of the existence of third-party insurance after the claim has been paid, the State will chase for payment recovery.

When States submit their quarterly report of Medicaid expenditures to CMS, they include the total amount they recovered from pay and chase activity. The States are not required to notify CMS of the total amount they attempted to recover. Nor are the States required to report the amounts recovered on pharmacy services alone.

Pharmacy Benefit Management Companies

Payers of insurance benefits either process claims in-house or contract the processing to another entity. In the case of pharmacy benefits, many payers have contracts with pharmacy benefit management companies (PBMs). These companies provide numerous client-tailored services for health plans. The PBMs may be responsible for the entire management of the health plan's pharmacy benefit, or they may provide one or more of the following services: process pharmacy claims, provide mail-order prescription services, maintain pharmacy networks, conduct drug utilization reviews, and develop drug formularies. Organizations that contract with these companies include, but are not limited to, insurers, employers, and managed care organizations.

It has been estimated that PBMs handle 70 percent of all prescription orders dispensed for ambulatory care, and that 10 PBMs account for the bulk of covered individuals. What this means for Medicaid is that many payments made on pharmacy claims have to be recovered from PBMs. For the purposes of this report we include PBMs in the term third party.

Problems Recovering Pharmacy Payments from Third Parties

In 1996, the Pharmacy Claims Reimbursement Team, made up of CMS and State Medicaid agency representatives, collaborated on a study called "Medicaid Encounters Barriers to Recovering Payment for Pharmacy Claims from Third Parties." The study found that "58 percent of the States recover less than 40 percent of the money they pursue..." and that a small number of PBMs and TRICARE (health plan for military personnel) stood out as creating the greatest obstacles for payment recovery. One PBM in particular was far and above the most uncooperative entity among third parties. The PBMs were not processing Medicaid claims and were not willing to identify the insurers and employers with whom they contract.

Efforts to Overcome Payment-Recovery Barriers

The Pharmacy Claims Reimbursement Team has been steadily gathering facts and working toward overcoming payment-recovery barriers. One effort of the team has been to identify third parties that contract with the PBM named in their 1996 study as the most uncooperative. Another major step was building a partnership between CMS and States so that information could be shared. A network of State pharmacy representatives was developed and information can now be disseminated to all States.

The team has also been laboring to understand claim formatting problems which prevent the recovery of some pharmacy payments. To this end they have worked with a major PBM, the National Council for Prescription Drug Programs, and with Medicaid claims-processing contractors to find solutions. They are currently trying to help all States move to a commonly-used electronic format for their pharmacy claims.

Request for Assistance

Our inspection was requested by CMS staff. We were asked for assistance in resolving problems identified in the Pharmacy Claims Reimbursement Team's 1996 study. A particular concern was that PBMs would not disclose information about third parties that might be liable for Medicaid claims.

METHODOLOGY

We collected information from CMS, Medicaid agencies, insurers, and employers from December 1999 through March 2001.

CMS Data

We gathered information from CMS's Central Office concerning the Pharmacy Claims Reimbursement Team's 1996 study, and we received periodic updates regarding the team's continuing work.

State Medicaid Agency Data

We gathered information from representatives of Medicaid agencies in 49 States and the District of Columbia. These representatives had expertise in pharmacy, third-party liability, and operational issues. Data was not collected from the State of Tennessee because their representative informed us their entire Medicaid population is in managed care. In Tennessee, the State's managed care contractors are responsible for determining third-party liability and for recovering payments. For the sake of brevity, we use the word "State" as a synonym for "State Medicaid agency" and "State Medicaid agency representative" throughout the findings section of this report. We refer to the District of Columbia as a State for the same reason.

We collected a variety of data regarding outpatient pharmacy claims. The data we requested included total expenditures for pharmacy benefits; and total number of beneficiaries with third-party insurance, and the percentage of these beneficiaries with pharmacy coverage. The data on pharmacy claims with third-party liability included total dollars avoided; total dollars paid and chased; and total dollars recovered from pay and chase activity. We also requested information about agencies' policies and procedures, and their experiences with third parties.

While we collected data for calendar years 1998, 1999, and first quarter of 2000, the findings in this report are based on 1999 data. Some States did not have figures available for some of the items and time periods we asked about. Because 1999 was the most recent full year prior to our study, and because States had more data for 1999 than for 1998 or 2000, our findings are for 1999 unless we specify otherwise.

The financial data States provided had caveats. First, pharmacy payment amounts were not always limited to outpatient prescription drugs, or for the calendar year, as we requested. Some States provided data that included inpatient drugs, syringes, diabetes test strips, over-the-counter drugs, or small amounts of other health services. Some States provided fiscal year instead of calendar year data, and some provided estimated instead of actual figures. Finally, States said that the claims they paid and chased could have included claims that were not the liability of third parties if a Medicaid beneficiary's coverage changed, or if the third party's health plan did not cover a particular service. See Appendix B for the 1999 pharmacy data provided by each State.

Insurer and Employer Data

We requested information from a purposive sample of 170 insurers and 114 employers about their policies and practices regarding reimbursement of Medicaid pharmacy claims. The insurers included 149 members of the Health Insurance Association of America who were listed on the Internet and 21 insurers identified by CMS. The 114 employers were identified by CMS and States.

We received information, anonymously, from 41 insurers and 47 employers who provided pharmacy benefits. Forty-four of the 47 employers were partially or fully self-insured (i.e., employers who bear some of the risk for their employees' health claims). In this report, we use the term self-insured plans to describe private employer health plans which are regulated by the U.S. Department of Labor under the Employee Retirement Income Security Act.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Thirty-two States are at risk of losing over 80 percent ($367 million) of the Medicaid pharmacy payments they tried to recover from third parties through the pay-and-chase approach

Thirty-two States were able to provide data quantifying the dollars at risk. These 32 States identified $440 million in potential recoveries from third parties in 1999, of which they recovered $73 million (17 percent). The total pharmacy expenditures for these 32 States was over $12 billion.

The 32 individual States paid and chased amounts ranging from $1,000 to $70 million. See Appendix C for dollars at risk in each of these 32 States. While the percentage of dollars at risk for these States ranged from 0 to 99 percent, only 5 States recovered more than half of the outstanding amounts.

The other 18 States reported that they could not identify the amount they paid and chased for pharmacy claims. Thirteen of the 18 States could not identify the amount they recovered for pharmacy claims. The most common reason why the States could not provide financial data was that their systems do not isolate pharmacy claims from claims for other services. The total pharmacy expenditures for these 18 States was $4.2 billion in 1999.

Regardless of whether a State used mainly cost avoidance or pay and chase, the overall recovery rate for pay and chase was low

In 1999, 35 States used the pay-and-chase method for the majority of their pharmacy claims, and 15 States used the cost-avoidance method for the majority of their pharmacy claims. However, of the 32 States that were able to quantify dollars at risk, 24 used pay and chase and 8 used cost avoidance. As shown in Table 1 on the next page, regardless of which of these two methods States used for the majority of their claims, when they paid and chased, the overall recoveries from third parties were less than 20 percent. Whether a State pays and chases a large or small amount of claims, the results are the same—a significant percentage of dollars are at risk of not being recovered from third parties.

Table 1. PERCENTAGE OF DOLLARS AT RISK BY MAIN CLAIMS PROCESSING METHOD - 1999

State's Method for Processing the Majority of Pharmacy Claims	Number of States that Provided Data	Amount Paid and Chased	Amount Recovered	Percentage of Dollars At Risk
Pay and Chase	24	$404,286,020.39	$67,840,490.81	83%
Cost Avoidance	8*	$35,870,979.91	$5,333,374.97	85%
Totals	**32**	**$440,157,000.30**	**$73,173,865.78**	**83%**

* One of these States only cost avoided claims that were over $50

Source: State Medicaid agency data provided to OIG

Three States paid and chased the majority of pharmacy claims without a waiver

Three States paid and chased the majority of their claims without a cost-avoidance waiver. Two of the three States provided data on both the amounts they paid and chased and recovered. One of these States paid and chased $21 million and recovered $2.2 million (11 percent). The other State paid and chased $800,000 and recovered $60,000 (7 percent). The State which could not provide pay and chase and recovery amounts had the second highest total pharmacy expenditures among States ($1.8 billion).

However, the cost-avoidance approach prevented $185 million from being at risk in 17 States

Seventeen States were able to provide financial cost-avoidance data for pharmacy claims. These States avoided paying $185 million in 1999. The data comes from both the States that avoid payment and those that pay and chase the majority of their third party claims. However, only 9 of 15 States that avoided the majority of their claims could provide us with data. These nine States reported avoiding $80 million.

The premise of cost avoidance is that it prevents the payment of claims that are the liability of third parties. Many of the claim dollars that are avoided cannot be tracked by States because the responsible third party has been billed first instead of Medicaid. Therefore, the total actual amount avoided is greater than the amount States are able to track.

States that use cost avoidance say it is successful once a system is in place

States that use cost avoidance believe that doing so is not difficult once a system is in place. But they said two things are key to making cost avoidance successful: (1) working with pharmacies or pharmacy associations prior to implementing the cost-avoidance system, and (2) maintaining accurate information on beneficiaries' third-party coverage. They also said States should implement a system override that allows pharmacies to bill Medicaid when there is a discrepancy in a beneficiary's coverage. Six States cited cost

avoidance as the most successful way to circumvent problems associated with paying and chasing. One State called it a "silver bullet."

States that do not use cost avoidance have concerns about it burdening pharmacies and beneficiaries

Nineteen States that pay and chase a majority or all of their pharmacy claims believe cost avoidance places a financial burden on pharmacies. For example, States reported that some pharmacies have billing systems which prohibit them from billing two payers at the same time (i.e., billing the third party for the claim and Medicaid for the copayment). States also said (1) some third parties pay the policyholder and not the pharmacy; and (2) if coverage information is not accurate the claim could be denied by both Medicaid and the third party, which leaves the pharmacy without reimbursement.

Eight States that pay and chase all of their pharmacy claims also said cost avoidance can negatively impact beneficiary access. They are concerned that pharmacies that are unable to bill two payers at the same time may refuse to serve Medicaid beneficiaries who have third-party insurance. Other State concerns are for beneficiaries in nursing homes who cannot use the third party's network pharmacy as required by the health plan, and for beneficiaries who cannot afford the copayment required by mail order programs that many health plans use.

Despite these concerns, when we collected our data 12 States reported they were switching to cost avoidance, or were considering switching in the future because of all the problems associated with paying and chasing.

Almost three-quarters of States report that third parties refuse to process or pay Medicaid claims

Thirty-six States said that when they try to recover payments, they are faced with the following problems: denials due to incompatible claim formats, unreasonable filing time limits, unprocessed claims with no explanation, vague claim denials, and the inability to identify the liable payer or claims processing entity.

Incompatible claim formats often lead to the denial of Medicaid claims

Twenty-nine States indicated that the lack of universal formatting and data elements on pharmacy claims leads to the denial of Medicaid claims. States said they usually do not have various pieces of information that are required by some third parties. For example, they may not have diagnosis codes, patient's signature, patient's relationship to the policyholder, or physician's Drug Enforcement Agency number. Third parties have different requirements which makes it even harder for States to submit "correctly" formatted claims. Data that we collected from insurers and employers indicates that Medicaid claims do not include all the information required by third parties.

States reported that when their claims are denied for missing data they add the missing data if they have it and resubmit the claim. However, the constant reworking and resubmission of claims puts an added administrative and financial burden on States. We were told one PBM does not point out all the data elements missing from a claim the first time they deny it. After each resubmission the PBM may point out another missing data element from the same claim. States said this same PBM will also deny claims if the data elements are in the wrong sequence. Another State said PBMs were reimbursing their claims at a lower rate as a penalty for being in the wrong format.

Unreasonable filing time limits make it difficult for States to recover payments

Sixteen States said unreasonable filing time limits are a problem because if they submit claims past the third party's filing time limit the claims are automatically denied. States reported that common time limits are 30 to 90 days and the shortest was 7 days. States said they have a hard time meeting time limits when they pay and chase because their pharmacies may have 1 year or longer to submit claims. Therefore, by the time the State receives the pharmacy's claim, pays it, and tries to recover payment from the third party, the third party's filing time limit may have passed.

Unprocessed claims and vague denials keep Medicaid from recovering payments

Twelve States said their claims were not processed or were returned with vague denial codes from third parties. Some States reported getting back claims with no explanation as to why they were not processed. Other unprocessed claims are never returned and there is also no explanation. States also said that some third parties will only process claims that are submitted by a provider or a policyholder. While some States speculate that third parties may not understand Medicaid's pay and chase activity, or that Medicaid is the payer of last resort, 93 percent of the employers and insurers that provided us with data said they know that Medicaid is the payer of last resort.

States reported that when a claim denial code is vague or represents several possible reasons for the denial, the State cannot determine what information needs to be corrected in order to resubmit the claims. This has the effect of terminating the State's attempt to recover payments. One of these States reported receiving a batch of 21,000 claims from a PBM with such a denial code.

Inability to identify liable payers and claims processing entities makes recovery of payments almost impossible

Twelve States said that if liable payers and their claims processors are not identified correctly, States risk sending claims to the wrong entity and not recovering payments. Despite efforts to identify beneficiaries' other insurance, States said that information in their third-party files can be incomplete or erroneous. This is because the State may not receive complete and accurate information about the beneficiary's other coverage; the State may not be notified of coverage changes; or the beneficiary may have more than

one other insurer and the State may not know which one is primary and which is secondary.

States also have difficulty identifying the liable payer's claims processing entity. This is often due to insurers changing claims processors without notifying the State. In addition, States are sometimes given the name of an entity without the address. This is a problem because some entities have similar names and some have multiple billing addresses. Identifying the correct claims processor can be a problem for payers as well. One employer reported having multiple medical plan carriers. This employer said Medicaid claims do not identify the carrier and therefore the employer does not know which carrier is responsible for the claims.

More States had problems with pharmacy benefit management companies than with all other types of third parties combined

Thirty-two States experienced problems with pharmacy benefit management companies. As shown in Table 2 below, more States had problems with these companies than with all other types of third parties combined. In addition to having all the same problems with PBMs that they have with other third parties, 14 States said some PBMs will not process Medicaid claims because the PBMs' clients have not authorized them to do so. Furthermore, States reported that these companies have not been willing to identify the names and addresses of the liable payers. This is a serious problem for Medicaid given the volume of pharmacy claims processed by pharmacy benefit management companies. When PBMs do not process Medicaid claims and will not identify the liable payer, States cannot recover their payments.

Table 2. COMPARISON OF "PROBLEM" THIRD PARTIES

Type of Third Party	Number of States that Experienced Problems
PBM	32
Insurer/Carrier	13
TRICARE Standard*	6
Self-insured plan	4
Point-of-sale plan	1
Medicare	1

*The fee-for-service health care program for active duty and retired members of the uniformed services, their families, and survivors (formerly called CHAMPUS).

Source: State Medicaid agency data provided to OIG

The data we collected from insurers and employers indicates that 15 percent of those who contract with a pharmacy benefit management company had not given them authorization to process Medicaid claims. We have also learned that a list provided to CMS of over 600 organizations that contract with one of the largest PBMs indicated that 75 percent of these organizations do not authorize the PBM to process Medicaid claims.

Twenty-six States mentioned one particular pharmacy benefit management company as a problem. Two States said the company has not paid them for years. One of these States said they stopped sending claims to this pharmacy benefit management company because "they just ignored them." Another State said they had "talked with [the PBM's] attorneys and gotten a complete run around." The same State reported losing "tens of millions" of dollars because of this company. This company had also been identified as the biggest problem for States in the 1996 study by CMS and State Medicaid agencies.

While States have difficulty recovering payments, methods such as sharing information with third parties, using effective billing practices, and taking legal action have been successful for some States

While 33 States reported that less than half their efforts to recover payments from third parties were successful, some States mentioned recovery methods that have been successful. These methods include sharing information with third parties, using effective billing practices, and taking legal action.

Sharing information with third parties

Working with third parties can be a successful method for recovering payments according to 31 States. Some States said communication with third parties helps them keep beneficiary coverage information complete and accurate. This is done through a verification process or the matching of eligibility files. Under the verification process, States phone or write to the carrier to verify coverage information. The matching of eligibility files, on the other hand, can be done via tape sharing, database sharing, or on-line matching. Thirty-eight States said they match files with some insurers, 13 match with some self-insured plans, and 11 match with certain PBMs. Of the 88 insurers and employers that sent us data, 56 said they did not match their eligibility files with Medicaid files. Of those 56 respondents, 70 percent said they did not match files because Medicaid had not asked them to do so.

Information sharing with third parties has advantages beyond updating beneficiary coverage. For example, one State said an insurance carrier notifies them when they change PBMs so that the State can submit claims to the right PBM. Another State said a PBM provided a list of group insurance plans which the States could bill directly. Open communication also makes follow-up regarding claim issues easier for States.

Information does not always have to come from the third party—it can also come from providers. In one State, when a pharmacy learns that Medicaid beneficiaries have other insurance they note the third-party information on a card and mail it to the State. The State then uses this information to update their third-party database.

Using effective billing practices

Eleven States regard electronic billing as an effective way to recover payments. They said that once claim format and system compatibility issues are resolved, this is more efficient than paper claims. However, other States have been successful submitting paper claims that have been formatted to meet the requirements of third parties.

Five States said billing the insurance carrier directly (i.e., bypassing the PBM) or using the automated group capture system were helpful in recovering payments. Under the automated group capture system, when a State discovers that an insurer uses a particular PBM in the case of one beneficiary, they automatically send claims for all beneficiaries covered by that insurer to that company.

Taking legal action

Three States spoke about legal steps they have taken to recover pharmacy payments from liable third parties. One State described reaching a settlement in which a sample of Medicaid claims was adjudicated and the result was projected to the universe of claims. This same State also told employers who were not paying Medicaid claims that the State would put a lien on their properties. A second State uses internal legal counsel to draw up contracts to obtain eligibility files of third parties. The contracts protect the confidentiality of the information. This State has also expanded State law to include PBMs in the definition of third parties that must match eligibility files with the State. If third parties refuse to match files they are subject to penalties. A third State said their State Attorney General got involved when a PBM was not responding to claims. The problem was resolved when the PBM was taken out of the loop. That State now sends Medicaid claims directly to the insurance carrier for processing.

State recommendations for solving recovery problems include universal claim formats, eligibility data matches, and new rules for PBMs and insurers

Universal claim formats and timely filing limits

Twenty-five States said standardizing claim format and data elements for pharmacy claims is a solution to the problem of incompatible claim formats. Some States suggested that a universal claim format be mandated. Other States believe that the Health Insurance Portability and Accountability Act (Public Law 104-191), which requires a single

standardized format for all electronic claims, will solve the problem of incompatible claim formats. The compliance date for the requirement is October 2002 (2003 for small health plans). One State expressed the concern that the law may not result in a mandated claim format that allows for third-party coordination of benefits.

Nine States suggested changes to the filing time limits. The suggestions include (1) establishing a universal filing time limit for all claims processing entities, (2) waiving or lengthening filing time limits for Medicaid and, (3) requiring third parties to respond to Medicaid claims within an established time frame.

Eligibility data matches

Nine States believe third parties should be required to match their eligibility data with Medicaid eligibility data so that Medicaid could have reliable coverage information. This would reduce the number of invalid claims going to third parties and make cost avoidance and pay and chase systems more effective.

New rules for pharmacy benefit management companies and insurers

Several States said they believe PBMs must be included in the definition of third-party payer in any legislation or regulation affecting third-party payers. This would alleviate difficulties States face in getting these companies to process and pay Medicaid claims. Other legislative recommendations were to (1) require all insurers, including self-insured employers, to authorize the processing of Medicaid claims, or (2) exempt Medicaid claims from authorization requirements.

States also expressed the opinion that third parties should be required to pay Medicaid claims unless the claims are validly denied, making clear to payers and claims processors the factors that constitute a valid denial. This would address two problems: (1) the problem of third parties not processing Medicaid claims and not providing an explanation, and (2) the problem of vague denial codes.

RECOMMENDATIONS

To reduce the dollars at risk of being lost, we offer the following recommendations for CMS:

Waiver. Review States' cost-avoidance waivers for pharmacy claims to determine if they are meeting the cost-effectiveness criterion. Our findings indicate that, overall, pay and chase is not a cost-effective policy. The CMS should also review State policies to determine if some States are paying and chasing pharmacy claims without a waiver.

Best Practices. Continue working together with States to identify, develop, and disseminate the most successful methods in both avoiding and recovering Medicaid pharmacy payments that are the responsibility of liable third parties.

Tracking. Require States to track the dollar amounts they pay and chase and the amounts they recover on pharmacy claims if they have cost-avoidance waivers. This information is necessary to determine whether a State's paying and chasing is cost effective. Furthermore, unless States know how much money third parties owe, they cannot use their collection resources to the best advantage.

Claim format. Clarify for States whether claim standardization requirements under the Health Insurance Portability and Accountability Act will be applied to pharmacy services in a third party environment. Since implementation of these requirements is at least 1.5 years away, CMS should continue to assist States in seeking immediate remedies to get their claims processed. The types of roles CMS might play in this regard could be fact finder, technical advisor, or coordinator.

Education. Develop strategies, on a national level, to educate third parties about Medicaid and third-party pharmacy issues. In addition, CMS should collaborate with the Department of Labor to develop education targeted specifically to self-insured health plans regulated under the Employee Retirement Income Security Act (ERISA).

Legislation. Determine whether legislation is needed to:

- explicitly include pharmacy benefit management companies in the Medicaid program's definition of a third party,
- require third parties to match their eligibility files with Medicaid's eligibility files, and
- allow Medicaid up to 3 years to recover payments from liable third parties.

If legislation is determined to be needed, CMS should consider coordinating with the Department of Labor to discuss requiring similar items from ERISA-governed health plans.

AGENCY COMMENTS

The CMS concurred with our recommendations and stated they are committed to an aggressive strategy in resolving the issues and removing the barriers that stand in the way of full recovery of Federal and State dollars. They stated that they are planning to re-examine States' cost-avoidance waivers, and that cost avoidance will be emphasized at the August 2001 National Third Party Liability Conference. In addition, they have worked with States, third parties, and the National Council for Prescription Drug Programs to develop a claim format that could be used by Medicaid agencies for submitting electronic claims to third parties; and they will advise States of progress made by the National Council for Prescription Drug Programs regarding claim standardization under the Health Insurance Portability and Accountability Act. The CMS further stated they are continuing to help educate PBM's clients about Medicaid reimbursement issues, and have invited the U.S. Department of Labor to attend the August 2001 National Third Party Liability Conference.

The CMS concurred with the premise of our recommendation to require States with cost-avoidance waivers to track the dollar amounts they pay and chase and the amounts they recover on pharmacy claims. The CMS stated that setting up a system to track all pharmacy claims may not be the only method to substantiate the cost-effectiveness of a waiver. We recognize that this data may not be the sole factor in determining the cost-effectiveness of a waiver. However, we still believe that upon receiving a waiver, a State should be required to track this information.

Regarding the need for legislation in the area of third-party liability, CMS will continue to review the issues to determine what, if any, legislation is needed. The complete text of CMS's comments are in Appendix D.

APPENDIX A

Technical Terms Used in This Report

Below is an alphabetical list of some of the technical terms used in this report.

Cost avoidance: Method for processing claims for Medicaid beneficiaries who have other insurance. When Medicaid receives a claim from a provider, the claim is denied and the provider is informed that the beneficiary has another insurer who is financially liable for the claim. Cost avoidance also occurs when the provider knows of the Medicaid beneficiary's other insurer and sends the claims directly to that other entity and not to Medicaid.

Cost-avoidance waiver: When a Medicaid agency has been granted a cost-avoidance waiver it means that the requirement to use cost avoidance is waived, and the agency may pay for the claims and recover the payments from the liable insurers. Waivers are granted if the State can show that another method of processing claims is as, or more, cost-effective than cost avoidance.

Pay and chase: A method for processing claims wherein Medicaid pays the claims for a beneficiary who has other insurance and then, later, tries to recover the payments from the liable party.

Pharmacy benefit management company (PBM): Companies that manage prescription drug coverage for insurance carriers, self-insured employers, managed care organizations, and other entities. Services provided by PBMs include claims processing, pharmacy network development, drug utilization review, and formulary development.

Point-of-sale plan: An insurance plan which has a special electronic claims processing arrangement with pharmacies. The arrangement allows pharmacists to determine on-line, while a customer is waiting, whether the customer's insurance plan will pay for the prescription.

Self-insured plan: Many employer insurance plans are self-insured, i.e., the employer bears a portion of the risk for employees' medical claims. While health insurance plans are usually regulated by State Governments, self-insured plans are regulated by the U.S. Department of Labor under the Employee Retirement Income Security Act.

Third party: Any individual, entity, or program that is, or may be, liable to pay all or part of the medical cost for any medical benefit provided to a beneficiary. Third parties include private insurance plans or carriers, employer insurance plans, State insurance plans such as workers' compensation programs, and Federal insurance programs such as Medicare. In this report the term third party also refers to PBMs.

Third-party liability: A third party's financial responsibility for medical services provided to a Medicaid beneficiary.

APPENDIX B

1999 Medicaid Pharmacy Data for 50 States

States that pay and chase send claims to third parties they believe are responsible for the claims. However, due to Medicaid beneficiaries' changing coverage, or health plans not covering certain services, third parties may deny some of the claims. Therefore, the amount paid and chased for third-party pharmacy claims in the table below includes claims that could be denied for valid reasons.

State	Total Pharmacy Expenditures	Amount Paid and Chased for Third-party Pharmacy Claims	
AK	$45,881,080.83	$5,183,492.88	$817,471.04
AL	$314,946,162.00[d]	$5,018,902.00[cd]	$1,742,770.00[cd]
AR	$202,913,489.62[d]	$811,127.00[d]	$60,411.00[d]
AZ	$1,812,951.68	unavailable	$141.72
CA	$1,825,318,419.00	unavailable	unavailable
CO	$125,412,087.00	unavailable	unavailable
CT	$220,673,450.00[c]	unavailable	unavailable
DC	$43,419,240.00[c]	unavailable	unavailable
DE	$56,065,026.00	unavailable	$840,089.46
FL	$1,164,493,522.00	$28,452,000.00[b]	$3,625,500.00[b]
GA	$439,419,153.00[c]	$21,091,378.38[bc]	$2,277,868.87[bc]
HI	$52,477,014.00	$1,208.00	$1,208.00
IA	$179,987,630.03	$3,221,655.16	$1,929,713.16
ID	$72,370,224.00	unavailable	unavailable
IL	$718,299,628.00[d]	$70,512,870.00[d]	$9,336,728.00[d]
IN	$407,752,363.00	$27,170,728.00	$2,608,454.00
KS	$152,053,655.00	$2,937,187.00	$885,738.00
KY	$384,078,336.00[d]	$23,899,069.00[d]	$2,143,461.00[d]
LA	$430,423,799.00	$33,615,322.00	$2,278,064.00
MA	$600,192,000.00[c]	$13,272,730.00[cd]	$1,821,495.00[c]
MD	$180,000,000.00[b]	unavailable	unavailable
ME	$136,637,381.57[c]	$5,090,000.00[c]	$2,100,000.00[bc]
MI	$353,574,000.00	unavailable	unavailable
MN	$215,926,180.34	$4,940,572.17	$2,258,155.66
MO	$468,598,424.00[c]	$9,469,752.00[c]	$1,152,785.00[c]
MS	$294,754,745.46	$4,604,196.00	$1,594,088.00
MT	$45,500,000.00[c]	unavailable	$1,400,000.00[bc]
NC	unavailable	$28,902,407.19	$9,168,690.33

APPENDIX B

State	Total Pharmacy Expenditures	Amount Paid and Chased for Third-party Pharmacy Claims	Amount Recovered from Third Parties
ND	$33,931,400.00	unavailable	unavailable
NE	$126,866,802.45	$9,556,047.28	$3,869,239.38
NH	$73,332,966.00[d]	$4,713,111.00[d]	$2,827,866.00[bd]
NJ	$499,216,374.00[cd]	unavailable	unavailable
NM	$41,233,834.16	unavailable	unavailable
NV	$41,447,640.91	unavailable	unavailable
NY	$2,026,870,651.00[c]	$13,680,000.00[b]	$1,280,000.00[b]
OH	$831,871,859.89[d]	$3,109,904.11[d]	$59,699.71[d]
OK	$175,195,447.00[d]	unavailable	unavailable
OR	$119,205,296.00	$8,176,048.00	$4,206,869.00
PA	$662,431,412.00[c]	$9,393,597.00	$59,700.00
RI	$79,285,625.88	$221,595.24	$143,580.29
SC	$310,394,000.00	$12,262,009.50	$4,572,710.30
SD	$39,934,762.30[d]	unavailable	$421,062.00
TX	$900,000,000.00[b]	$45,000,000.00[b]	$2,800,000.00[b]
UT	$89,374,417.00[c]	unavailable	$2,802,415.26[bcd]
VA	$323,272,462.00[b]	$11,905,623.00[b]	$1,575,372.00[b]
VT	$75,241,758.00	$1,586,916.39[b]	$645,293.31[b]
WA	$339,500,000.00[d]	unavailable	unavailable
WI	$298,783,778.00	$23,721,457.00	$4,815,255.00
WV	$196,538,451.09[d]	$8,236,095.00[d]	$387,116.00[d]
WY	$24,298,621.59[b]	$400,000.00[b]	$128,563.73[b]
50[a]	**$16,441,207,520.80**	**$440,157,000.30**	**$78,637,574.22**

a. We collected data from 49 States and the District of Columbia. Data was not collected from Tennessee because their entire Medicaid population is in managed care.
b. Figure given is an estimate.
c. Figure given is for the fiscal year.
d. Figure given includes data for more than outpatient prescription drugs (e.g., inpatient pharmacy, over-the-counter drugs, syringes).
e. Figure given includes $8,652,082 that Massachusetts deemed "unrecoverable."

Source: State Medicaid agency data provided to OIG

APPENDIX C

Medicaid Pharmacy Dollars at Risk for 32 States

The table below shows the percentage of Medicaid dollars at risk in States that were able to provide the dollar amounts they paid and chased as well as the dollar amounts they recovered in 1999. The table lists States in descending order by total pharmacy expenditures.

States that pay and chase send claims to third parties they believe are responsible for the claims. However, due to Medicaid beneficiaries' changing coverage, or health plans not covering certain services, third parties may deny some of the claims. Therefore, the amount paid and chased for third-party pharmacy claims in the table below includes claims that could be denied for valid reasons.

State	Total Pharmacy Expenditures	Amount Paid and Chased for Third-party Pharmacy Claims	Amount Recovered from Third Parties	Percent of Dollars at Risk
NY	$2,026,870,651.00[b]	$13,680,000.00[a]	$1,280,000.00[a]	91%
FL	$1,164,493,522.00	$28,452,000.00[a]	$3,625,500.00[a]	87%
TX	$900,000,000.00[a]	$45,000,000.00[a]	$2,800,000.00[a]	94%
OH	$831,871,859.89[c]	$3,109,904.11[c]	$59,699.71[c]	98%
IL	$718,299,628.00[c]	$70,512,870.00[c]	$9,336,728.00[c]	87%
PA	$662,431,412.00[b]	$9,393,597.00	$59,700.00	99%
MA	$600,192,000.00[b]	$13,272,730.00[bd]	$1,821,495.00[b]	86%
MO	$468,598,424.00[b]	$9,469,752.00[b]	$1,152,785.00[b]	88%
GA	$439,419,153.00[b]	$21,091,378.38[ab]	$2,277,868.87[ab]	89%
LA	$430,423,799.00	$33,615,322.00	$2,278,064.00	93%
IN	$407,752,363.00	$27,170,728.00	$2,608,454.00	90%
KY	$384,078,336.00[c]	$23,899,069.00[c]	$2,143,461.00[c]	91%
VA	$323,272,462.00[a]	$11,905,623.00[a]	$1,575,372.00[a]	87%
AL	$314,946,162.00[c]	$5,018,902.00[bc]	$1,742,770.00[bc]	65%
SC	$310,394,000.00	$12,262,009.50	$4,572,710.30	63%
WI	$298,783,778.00	$23,721,457.00	$4,815,255.00	80%
MS	$294,754,745.46	$4,604,196.00	$1,594,088.00	65%
MN	$215,926,180.34	$4,940,572.17	$2,258,155.66	54%
AR	$202,913,489.62[c]	$811,127.00[c]	$60,411.00[c]	93%
WV	$196,538,451.09[c]	$8,236,095.00[c]	$387,116.00[c]	95%
IA	$179,987,630.03	$3,221,655.16	$1,929,713.16	40%
KS	$152,053,655.00	$2,937,187.00	$885,738.00	70%
ME	$136,637,381.57[b]	$5,090,000.00[b]	$2,100,000.00[ab]	59%
NE	$126,866,802.45	$9,556,047.28	$3,869,239.38	60%

APPENDIX C

State	Total Pharmacy Expenditures	Amount Paid and Chased for Third-party Pharmacy Claims	Amount Recovered from Third Parties	Percent of Dollars at Risk
OR	$119,205,296.00	$8,176,048.00	$4,206,869.00	49%
RI	$79,285,625.88	$221,595.24	$143,580.29	35%
VT	$75,241,758.00	$1,586,916.39[a]	$645,293.31[a]	59%
NH	$73,332,966.00[c]	$4,713,111.00[c]	$2,827,866.00[ac]	40%
HI	$52,477,014.00	$1,208.00	$1,208.00	0%
AK	$45,881,080.83	$5,183,492.88	$817,471.04	84%
WY	$24,298,621.59[a]	$400,000.00[a]	$128,563.73[a]	68%
NC	unavailable	$28,902,407.19	$9,168,690.33	68%
32	**$12,257,228,247.75**	**$440,157,000.30**	**$73,173,865.78**	**83%**

a. Figure given is an estimate.
b. Figure given is for the fiscal year.
c. Figure given includes data for more than outpatient prescription drugs (e.g., inpatient pharmacy, over-the-counter drugs, syringes).
d. Figure given includes $8,652,082 that Massachusetts deemed "unrecoverable."
Source: State Medicaid agency data provided to OIG

APPENDIX D

Centers for Medicare and Medicaid Services' Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: JUN 28 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *"Medicaid Recovery of Pharmacy Payments from Liable Third Parties"* (OEI-03-00-00030)

Attached are the Centers for Medicare and Medicaid Services' comments on the above-referenced draft report. We appreciate the opportunity to comment on the issues raised in the report.

Centers for Medicare and Medicaid Services (CMS) Comments on Office of Inspector General (OIG) Draft Report "Medicaid Recovery of Pharmacy Payments from Liable Third Parties" (OEI-03-00-00030)

We are very pleased that the OIG responded to CMS's request for assistance and has issued this report addressing many of the challenges state Medicaid agencies face when seeking recovery of pharmacy payments. States have an obligation to take all reasonable measures in identifying and pursuing liable third parties. CMS is committed to an aggressive strategy in resolving the issues and removing the barriers that stand in the way of the full recovery of Federal and state dollars. To that end, this report updates and confirms the findings identified in the Pharmacy Claims Reimbursement Team's (PCRT) study. In addition, this report provides quantitative and other helpful background data that further substantiate the extent of the problem and the need for resolution.

For the past 3 years, the PCRT has worked diligently to address many of the issues identified in this report. Below are CMS's comments on the report recommendations which include a number of initiatives that are underway to address the problems.

OIG Recommendation

Waiver - Review states' cost-avoidance waivers for pharmacy claims to determine if they are meeting the cost-effectiveness criterion. Our findings indicate that, overall, pay and chase is not a cost-effective policy. The CMS should also review state policies to determine if some states are paying and chasing pharmacy claims without a waiver.

Response

We concur that states' cost-avoidance waivers need to be re-examined. We are in agreement with the OIG's recommendation. We are cautious not to require cost avoidance too quickly due to the potential financial burden on pharmacies that might adversely impact beneficiary access in addition to the potential unnecessary administrative burden on states. We have been examining this issue, particularly in light of the future implementation of the Health Insurance Portability and Accountability Act's (HIPAA) administrative simplification requirements. HIPAA should facilitate the coordination of benefits for pharmacies when more than one payer is involved. In addition, systems changes necessary to convert to cost avoidance can be very costly for states. Since states are in the process of implementing HIPAA, it may be more prudent for states to convert to cost avoidance in conjunction with their HIPAA systems changes. CMS will carefully consider these factors as we make plans to re-examine states' cost-avoidance waivers.

Pharmacy workshops, emphasizing cost avoidance, were included in several conferences sponsored by CMS and states last year. Cost avoidance will be a major emphasis at the

Page 2- Michael F. Mangano

National Third Party Liability (TPL) conference this summer. CMS will continue to be instrumental in assisting states that have expressed an interest in cost avoiding to network with cost-avoidance states.

OIG Recommendation

Best Practices - Continue working together with states to identify, develop, and disseminate the most successful methods in both avoiding and recovering Medicaid pharmacy payments that are the responsibility of liable third parties.

Response

We concur with this recommendation. In addition to our continued networking and the pertinent information we provide via email to our state contacts, we are planning workshops to feature some of the states' initiatives at the National TPL Conference.

OIG Recommendation

Tracking - Require states to track the dollar amounts they pay and chase and the amounts they recover on pharmacy claims if they have cost-avoidance waivers. This information is necessary to determine whether a state's paying and chasing is cost effective. Furthermore, unless states know how much money third parties owe, they cannot use their collection resources to the best advantage.

Response

We concur with the premise of this recommendation. States must have adequate documentation to justify a cost-avoidance waiver by substantiating that pay and chase is at least as cost effective as the cost-avoidance method. In helping states to comply with this requirement, we do realize that setting up a system to track all pharmacy claims may not be the only means to substantiate the cost-effectiveness of a waiver. The State Medicaid Manual instructs states to use actual experience where applicable or to otherwise use estimates and fully explain their basis.

There may be factors involved, e.g., decrease in provider participation, that would not require explicit tracking data to acquire a waiver. When we re-examine the cost-avoidance waivers, we may ask states to consider seeking more restrictive waivers, if warranted. For example, states may present justification for paying and chasing claims for particular providers only. In the interest of state flexibility, we are reluctant to require states to make substantial systems changes in order to have a cost-avoidance waiver. We want to remain open to alternative approaches that states may have developed to justify a waiver.

Page 3- Michael F. Mangano

OIG Recommendation

Claim format - Clarify for states whether claim standardization requirements under the HIPPA will be applied to pharmacy services in a third party environment. Since implementation of these requirements is at least 2 years away, CMS should continue to assist states in seeking immediate remedies to get their claims processed. The types of roles CMS might play in this regard could be fact finder, technical advisor, or coordinator.

Response

We concur with this recommendation and remain committed to working with states and third parties to adopt a standard format. Last year, the PCRT worked closely with the National Council for Prescription Drug Programs to develop a standard format that could be used by Medicaid agencies for submitting electronic claims for reimbursement. Several states and contractors are now utilizing this standard format. In addition, CMS will continue to monitor NCPDP's development in regard to the HIPAA format and keep states apprised of the progress.

OIG Recommendation

Education - Develop strategies, on a national level, to educate third parties about Medicaid and third-party pharmacy issues. In addition, CMS should collaborate with the Department of Labor to develop education targeted specifically to self-insured health plans regulated under the Employee Retirement Income Security Act (ERISA).

Response

We strongly concur that educating third parties is a key element to improving states' recovery efforts. In fact, this is one of the key reasons we enlisted assistance from the OIG. States were encountering barriers in determining the identification of liable third parties since oftentimes pharmacy cards identify only the pharmacy benefit manager (PBM) or the claims processor. Initially, some PBMs were reluctant to either inform their clients of their legal obligation to process Medicaid claims or identify their clients so states could notify them directly. Through efforts of the PCRT working directly with PBM representatives, CMS did gain access to pertinent information and subsequently issued a letter to hundreds of the clients of one PBM to educate them in regard to Medicaid reimbursement issues. This effort is proving to be successful in that billing information has been coming into CMS and is being provided to states. The letter also included an invitation to the National TPL conference to learn more about the issues. We have also invited the Department of Labor to the conference.

Page 4- Michael F. Mangano

In the spring of 1998, CMS sponsored a meeting attended by several PBMs and representatives from state Medicaid agencies. Subsequent to that meeting, the PCRT has participated in numerous conference calls and continues to do so with PBM representatives. Among the issues discussed have been standardization of formats, clarification of denial codes, verification of eligibility, and the authorization to process Medicaid claims.

OIG Recommendation

Legislation - Determine whether legislation is needed to:

- explicitly include pharmacy benefit management companies in the Medicaid program's definition of a third party,
- require third parties to match their eligibility files with Medicaid's eligibility files, and
- allow Medicaid up to 3 years to recover payments from liable third parties.

If legislation is determined to be needed, CMS should consider coordinating with the Department of Labor to discuss requiring similar items from ERISA-governed health plans.

Response

We concur with this recommendation. The Department will continue to review the issues to determine what legislation, if any, is needed. Consequently, we take no position at this time on the specific legislative changes proposed in the OIG report.