DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
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CENTER FOR MEDICARE & MEDICAID SERVICES

DATE: May 19, 2014

TO: Medicare -Medicaid Plans

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SUBJECT: Change to reporting requirements for MMPs participating in the Capitated Financial Alignment Initiative.

This memo is to alert Medicare-Medicaid Plans (MMPs) participating in the Capitated Financial Alignment Initiative of a change in the reporting timeframes for MMP core measure 1.2: "Pharmacy point-of-sale (POS) claims denied during the first two weeks of passive enrollment, by denial reason" using the new specifications below. This change takes effect for reporting beginning on June 1, 2014 and will require MMPs to report every two weeks instead of every 72 hours.

The update to this measure is intended to provide the following improvements- 1) CMS will receive a larger universe of claims from which to draw a sufficient sample size- 2) The requirement for MMPs to submit data every 72 hours will be removed, thus decreasing the burden on the plans.

1.2 Pharmacy point-of-sale (POS) claims denied during the first two waves of passive enrollment, by reason of denial.

IMPLEMENTATION				
Reporting Section	**Reporting Frequency**	**Level**	**Reporting Period**	**Due Date**
1. Access	Following 14 days during the first month of each of the first two waves of passive	Contract	14 days Ex: 12:00a.m. on January 1st through 11:59p.m. ET on January 14th.	5:00p.m. ET three days following the end of the reporting period Ex: Data is due by 5:00p.m. ET on January 17th for the reporting period that ends at 11:59p.m. ET on January 14th.

The list of pharmacy POS denied claims will be limited to claims denied for the following reasons: non-formulary, prior authorization, and step therapy. A template for providing these claims is located at the CMS Financial Alignment website:

http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/InformationandGuidanceforPlans.html

A. Data elements definitions-details for each data element reported to CMS and the state, including examples, calculation methods, and how various data elements are associated.

- Required file format is Microsoft Excel file.
- The file name extension should be ".xlsx"
- File name= RX_(STATEABBREVIATION)_(CONTRACTID)_(REPORTING PERIOD)_(SUBMISSIONDATE).xlsx.
- Replace (STATEABBREVIATION) with the two-character state abbreviation (e.g., Massachusetts is MA), (CONTRACTID) with the contract ID, (REPORTINGPERIOD) with the month and year of the beginning of the reporting period in YYYYMM format (e.g., February 2014 would be 201402), and (SUBMISSIONDATE) with the year, month, and day of the submission in YYYYMMDD format (e.g., March 31, 2014 would be 20140331).
- The first worksheet in the template should be named "Rejected Claims."
- The second worksheet in the template should be named "Key Acronyms."
- The third worksheet in the template should be named "Addl Reject Codes_Pharmacy Msgs."

File Layout

Field Name	Field Description	Allowable Values
HICN	Health insurance claim number (HICN) refers to the number assigned by the Social Security Administration to an individual for the purpose of identifying him/her as a Medicare beneficiary. HICN will be shown in the beneficiary's insurance card and it is on the basis of this number that a beneficiary's Medicare claims are processed.	Field Type: Alpha-numeric
Member Enrollment Date	Identifies the date that each member enrolled. Enrollment eligibility begins on the 1st of the month. If a member has a gap in coverage, provide the most recent enrollment date.	Field Type: Date in MM/DD/YYYY format
Member Disenrollment Date	Identifies the date that each member disenrolled. Eligibility continues through the last day of the month that the member disenrolls.	Field Type: Date in MM/DD/YYYY format If a member is still enrolled during the reporting period, please insert 12/31/9999 to indicate the member is currently enrolled.
Cardholder ID	Insurance ID assigned to the cardholder or identification number used by the MMP. May be the same as HICN.	Field Type: Alpha-numeric
CCN	Claim Control Number (CCN). A claim control number is a unique number given to each claim.	Field Type: Alpha-numeric
CMS Contract ID	Designation assigned by CMS that identifies a specific sponsor.	Field Type: Alpha-numeric
Plan Name	Plan Name	Field Type: Text
NDC 11 (no hyphens)	National Drug Code Drug products are identified and reported using a unique, three-segment number, called the National Drug Code (NDC), which serves as a universal product identifier for drugs. FDA publishes the listed NDC numbers and the information submitted as part of the listing information in the NDC.	Field Type: Numeric Note: 11-digit NDC code with no hyphens
Date of Service	Identifies date the prescription was filled. This date may be outside the reporting period as long as the associated Date of Rejection is after the Date of Service.	Field Type: Date in MM/DD/YYYY Format

Field Name	Field Description	Allowable Values
Date of Rejection	Identifies the date the claim was rejected. The Date of Rejection must occur during the reporting period.	Field Type: Date in MM/DD/YYYY Format
Claim Quantity	Quantity dispensed expressed in metric decimal units.	Field Type: Numeric Allowable Values: >0
Claim Days Supply	Estimated number of days the prescription will last.	Field Type: Numeric Allowable Values: >0; < 999
Compound Code	Code indicating whether or not the prescription is a compound.	Field Type: Numeric Allowable Values: 0 = not specified 1 = not a compound 2 = compound
Rejection Category (1=NF, 2=PA, 3=ST)	Rejection Category: Use category 1 if the rejection is for Non-Formulary drug. Use category 2 if the rejection is for Prior Authorization. Use category 3 if the rejection is for Step Therapy.	Field Type: Numeric Allowable Values: 1=Non-Formulary 2=Prior Authorization 3=Step Therapy
Reject Code 1	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 1	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 2	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 2	Reject Message used in MMP's claim adjudication system.	Field Type: Text
Reject Code 3	Reject code used in MMP's claim adjudication system.	Field Type: Alpha-numeric
Pharmacy Message 3	Reject Message used in MMP's claim adjudication system.	Field Type: Text
MMP must provide all reject codes and messaging, not limited to the number of fields in the "Rejected Claims" template. Please insert additional columns in the "Addl Reject Codes_Pharmacy Msgs" template as necessary.	Provide any additional reject codes and messaging.	

B. QA Checks/Thresholds - procedures used by CMS and the state to establish benchmarks in order to identify outliers or data that are potentially erroneous.

- An audit of a sample of claims will be performed. Claims not excluded from the analysis will be flagged as "potentially inappropriate." A sample of up to 30 potentially inappropriate claims will be selected for further review, including: protected class drugs and non-protected class drugs. If at least 15 protected and 15 non-protected class drugs are submitted, 15 protected and 15 non-protected class drugs will be sampled. If fewer than 15 claims are submitted in either drug class, additional claims from the opposing drug class will be selected, until a sample of 30 is reached (e.g., 13 protected and 17 non-protected drugs). If the plan submits fewer than 30 rejected claims, the sample will consist of all submitted rejected claims. MMPs will be required to review claims and address the following:
    - Was this claim an appropriate Rejection (Y/N).
    - Patient setting (e.g., nursing facility, acute care hospital, etc.).
    - Patient DOB.
    - Provide a brief explanation as to why the claim was appropriate or inappropriate, related to one of the three rejection categories.
    - Was the claim paid (Y/N).
    - If claim was paid, provide the date the claim was paid for the drug in question.

C. Edits and Validation checks - validation checks that should be performed by each MMP prior to data submission. Any claims that do not pass validation will be excluded from the analysis. These checks will include the following:

- The CMS Contract ID is formatted as 5 alpha-numeric characters.
- The CMS Contract ID matches the submitting Contract ID.
- The NDC consists of 11 numeric characters.
- The NDC is a valid NDC.
- The Date of Service is in the MM/DD/YYYY format.
- The Date of Rejection is in the MM/DD/YYYY format.
- The Date of Rejection is during the reporting period.
- The Date of Rejection is on or after the Date of Service.
- The Rejection Category is 1, 2, or 3.
- The Claim Quantity is greater than zero.
- The Claim Days Supply is greater than zero.
- The Claim Days Supply is between 1 and 3 numeric characters (1-999).

D. Analysis - how CMS and the state will evaluate reported data, as well as how other data sources may be monitored.

- CMS and the state will calculate an overall score once MMPs have reviewed and provided comments.
    - For all class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims sampled (denominator) to calculate an overall rate of inappropriate denials.
    - For protected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.

- For unprotected class drugs, the number of inappropriate denials (numerator) will be divided by the total number of potentially inappropriate claims for protected class drugs sampled (denominator) to calculate an overall rate of inappropriate denials.

E. Notes - additional clarifications to a reporting section. This section incorporates previously answered frequently asked questions.

- Reporting timelines are defined in terms of calendar days, not business days. If a reporting due date for Core Measure 1.2 falls on a weekend or holiday, MMPs may submit data on the following business day.
- This measure assesses only the following three denial types: non-formulary, prior authorization, and step therapy.
    - Non-formulary drugs are drugs that are not on an MMP's formulary.
    - Prior Authorization is defined as Approval that you must get from a Medicare drug plan before you fill your prescription in order for the prescription to be covered by your plan. Your Medicare drug plan may require prior authorization for certain drugs.
    - Step Therapy is a coverage rule used by some Medicare Prescription Drug Plans that requires you to try one or more similar, lower cost drugs to treat your condition before the plan will cover the prescribed drug.

- The reporting period for this measure will begin at the start of the passive enrollment period. Once reporting begins, members should be included regardless of whether the member was enrolled through passive enrollment or opt-in enrollment.
- Passive enrollment periods may vary by state. MMPs should refer to their state's contract and/or MOU for specific requirements.
- CMS reserves the right to extend the reporting frequency after the first two waves of passive enrollment, if necessary.
- MMPs should include all denied claims including adjusted and reprocessed claims, even if repeated claims are attempted on the same day.
- Date of Rejection must occur within the reporting period, but it is acceptable if the Date of Services is outside of the reporting period as long as the Date of Rejection is after the Date of Service.
- Rejections due to early refills should be excluded.

F. Data Submission - how MMPs will submit data collected to CMS and the state.

MMPs will submit data collected for this measure in the above specified format through a secure data transmission site established by CMS. This site can be accessed at the following web address: https://fm.hshapps.com/login.aspx?ReturnUrl=%2fdefault.aspx

Please forward any question to the Medicare-Medicaid Coordination Office at mmcocapsmodel@cms.hhs.gov.