Policy:	PA.9002
Title:	**Pharmacy Claims Processing**
Department:	CalOptima Health PACE
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 06/20/2024*
Effective Date:	12/01/2014
Revised Date:	06/01/2024
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ PACE ☐ Administrative

I. PURPOSE

This policy outlines the procedure by which the CalOptima Health Program of All-Inclusive Care for the Elderly (PACE) employees will ensure accurate and timely processing and payment and reporting for claims submitted by Participating Pharmacies on behalf of Participants.

II. POLICY

A. CalOptima Health PACE's Pharmacy Benefit Manager (PBM) shall:

1. Operate an online claims processing system that operates in real- time to adjudicate claims submitted by participating pharmacies.

2. Operate a paper claims processing system to pay claims submitted by non-participating pharmacies on behalf of Participants.

3. Ensure Prescription Drug Event (PDE) records include active and valid prescriber National Provider Identification (NPI) numbers;

4. Confirm the validity of prescriber Drug Enforcement Agency (DEA) numbers on Schedule II-V claims;

5. Rapidly adopt any new messaging approved by the National Council for Prescription Drug Programs' (NCPDP) workgroup to adjudicate a Part D claim, and appropriately coordinate benefits in real time;

6. Regularly update its systems with the most current information on Office of Inspector General (OIG) sanctioned Providers and have processes in place to identify and prevent payment of Part D claims at point-of-sale when such claims have been prescribed by excluded Providers;

7. Utilize Health Insurance Portability and Accountability Act (HIPAA) Complaint transactions, where applicable;

8. Document the manner and extent to which it has tested benefit designs and plan parameters such as True Out-of-Pocket (TrOOP) Costs and benefit intervals (phases) pre-implementation and ongoing;

9. Assign and exclusively use unique:

    a. Part D cardholder identification number (RxID) for each CalOptima Health PACE Participant, and

    b. Part D identifiers (RxBIN/RxPCN) for each Part D line of business.

10. Maintain current policies and procedures documenting the process for negotiation with prescription drug manufacturers and others for rebates, discounts, or other price concessions on prescription drugs as applicable;

11. Provide annual reports of Direct and Indirect Remuneration (DIR) dollars for payment reconciliation on an annual basis in the manner specified by the Centers for Medicare & Medicaid Services (CMS) as applicable;

12. Maintain records and documentation to verify the DIR data reported to CMS as applicable;

13. Provide information related to PBM transparency as specified in Section 6005 of the Affordable Care Act.

B. CalOptima Health PACE and the PBM shall maintain policies and procedures detailing the claims adjudication process, claims detail management, access to claims information, and the claims data retrieval process.

C. CalOptima Health PACE Pharmacy Management shall provide oversight of the PBM functions.

III. PROCEDURE

A. The PBM shall operate an online claims processing system that operates in real time to pay claims submitted by participating pharmacies. The online claims processing system shall:

1. Respond to ninety-eight percent (98%) of claims submitted within four (4) seconds after submission;

2. Pay ninety-nine and five tenths percent (99.5%) of all Clean Claims without errors; and

3. Have system availability ninety-nine and five tenths percent (99.5%) of the time, twenty-four (24) hours a day, three hundred sixty-five (365) days a year, excluding scheduled maintenance and downtime.

B. The PBM shall operate a paper claims processing system designed to pay claims submitted by non-participating pharmacies. The paper claims processing system shall:

1. Process one hundred percent (100%) of claims requiring no intervention within fourteen (14) calendar days after receipt;

2. Process one hundred percent (100%) of claims requiring intervention within thirty (30) calendar days after receipt; and

3. Pay ninety-nine percent (99%) of all manually keyed claims without errors.

C. The PBM shall maintain a claims adjudication system available for CMS inspection that includes:

1. Hardware and software;

2. Operating system;

3. Commercial organization from which applicant receives pricing files, including file revision history;

4. Number of sites processing claims (including disaster recovery back-up systems); and

5. System volume in covered lives including the number of transactions the system can support per day and per hour.

D. The PBM shall make available to CMS, upon request, policies and procedures that include a complete description and flow chart detailing the claims adjudication process for each of the following:

1. Contracted Network Pharmacies;

2. Paper claims;

3. Out-of-network pharmacy claims submitted by beneficiaries;

4. Non-electronic claims submitted by network pharmacies, and other payers seeking to coordinate benefits;

5. Batch-processed claims;

6. Retroactive claims adjustments within forty-five (45) calendar days;

7. Manual claim entry (e.g., for processing direct Participant reimbursement).; and

8. Long-Term Care (LTC) pharmacies:

a. May submit claims for reimbursement up to ninety (90) days after the date of service; and

b. Shall dispense drugs and reports information as required by Title 42, Code of Federal Regulations, Section 423.154.

E. The PBM shall make available to CMS, upon request, policies and procedures that include a complete description of claim detail management, including:

1. The length of time that detailed claim information is maintained online (not less than twelve (12) months);

2. The data storage process after it is no longer online; and

3. The length of time that detailed claim information is stored when it is no longer online (not less than ten (10) years).

F. The PBM shall make available to CMS, upon request, policies and procedures that include a complete description of the accessibility of this information for data capture purposes, and flow chart of the claims data retrieval process for each of the following:

1. Entire claims history file;

2. File claims adjustments including records of reimbursements and recoveries due to network pharmacies and beneficiaries;

3. Prescription Drug Event (PDE) file creation, submission, quality reviews and error resolution;

4. Deductible files/TrOOP/ and gross covered prescription drug cost accumulator;

5. Reporting of Financial Information Reporting (FIR) incoming and outgoing transaction responses; and

6. Rx Transaction history and application to claims.

G. CalOptima Health PACE Pharmacy Management shall provide oversight of the PBM functions reported quarterly.

1. PDE file format and content accuracy and monthly submission timeliness;

2. Claims processing oversight;

a. Part D versus Part B versus supplemental drug classification

b. TrOOP calculations

c. Benefit phase

3. Pharmacy Network oversight; and

4. PBM call center reporting review.

H. CalOptima Health PACE shall reconcile Part D data to CMS enrollment/payment reports received daily, weekly, and monthly.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health PACE Program Agreement
B. Medicare Managed Care Manual, Chapter 4: Benefits and Beneficiary Protections (Revised April 22, 2016)
C. Patient Protection and Affordable Care Act, § 6005
D. Title 42, Code of Federal Regulations (CFR), Part 423, Subpart G
E. Title 42, Code of Federal Regulations (CFR), §§ 423.120(c)(4), 423.154, 423.520, 423.466, 423.504(b)(20), and 423.568(b)
F. CalOptima Health PBM Services Agreement

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/2014	PA.9002	Pharmacy Claims Processing	PACE
Revised	01/01/2015	PA.9002	Pharmacy Claims Processing	PACE
Revised	05/01/2016	PA.9002	Pharmacy Claims Processing	PACE
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Revised	05/01/2023	PA.9002	Pharmacy Claims Processing	PACE
Revised	06/01/2024	PA.9002	Pharmacy Claims Processing	PACE

IX. GLOSSARY

Term	Definition
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Contracted Network Pharmacies	Licensed pharmacies, including retail, home infusion, and institutional pharmacies, under contract with a Part D sponsor to provide covered Part D drugs at negotiated prices to Part D enrollees.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Participant	An individual enrolled in the CalOptima Health PACE program.
Pharmacy Benefit Manager (PBM)	An entity that provides pharmacy benefit management services, including contracting with a network of pharmacies; establishing payment levels for network pharmacies; negotiating rebate arrangements; developing and managing formularies, preferred drug lists, and prior authorization programs; maintaining patient compliance programs; performing drug utilization review; and operating disease management programs.
Program of All-Inclusive Care for the Elderly (PACE)	PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all needed preventive, primary, acute and long-term care services so seniors can continue living in their community.
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
True Out-Of-Pocket (TrOOP) Cost	True out-of-pocket (TrOOP) costs are the payments that count toward a Part D beneficiaries' Medicare drug plan out-of-pocket threshold. TrOOP costs determine when a beneficiaries' catastrophic coverage will begin.