NEW MEXICO

Drug Rebate Policies & Procedures

New Mexico Human Services Department
Medical Assistance Division
Administrative Services Division

August 2015

SIGNATURE PAGE:

This document has been compiled by the Medical Assistance Division (MAD), Administrative Services Division (ASD), and Information Technology Division (ITD).

Signed by:

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Revision History			
Version	**Date**	**Author**	**Comments**
V 1.0	February 2007	Sherry Montoya Donna Sandoval	Initial version of NM policy and procedures for drug rebate activities
V 2.0	May 2007	Sherry Montoya Donna Sandoval	Approved version of NM policy and procedures for drug rebate activities
V 3.0	April 2010	Sherry Montoya Usha Shannon	Approved revision of NM policy and procedures for drug rebate activities
V 4.0	January 2013	Tonya Pamatian	Approved revision of NM policy and procedures for drug rebate activities
V 5.0	March 2015	Sonya Miera	Transition activities to Xerox
V 6.0	July 06, 2015	Marvin Boyd	Update Xerox Responsibilities, entered clarifications, inserted DRAMS Application Code changes for Budget Reference and Class Code per project 13-1240.
V 6.1	August 11, 2015	Marvin Boyd	Added information regarding the update of the FMAP rate in the DRAMS system by Xerox.
V 6.2	January 18, 2017	Kathryn McCullough	Added interest information to Conduent duties.

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1. INTRODUCTION

OVERVIEW

This manual is designed to provide guidance to the Medical Assistance Division (MAD), Benefits Services Bureau and the Administrative Services Division (ASD), Accounts Receivable Staff in performing daily tasks related to the drug rebate program. It is a living document that is continually revised to meet CMS requirements and to reflect the business drug rebate processes of the Human Services Department (HSD).

This manual details what must be executed to successfully administer the Drug Rebate Program. It also contributes to better understanding of the drug rebate process as a whole.

This manual is divided into sections that logically define the standard drug rebate process. These sections include:

- Rebate Program Setup
- Quarterly Claims Cycle
- Quarterly Invoice Cycle
- Quarterly Payment Cycle
- Dispute Resolution Process
- Interface from DRAMS into the New Mexico State-wide Human Resources, Accounting and Management Reporting System (SHARE)
- Other Rebate Services

ASSUMPTIONS AND DEPENDENCIES

- The overall drug rebate process follows the uniform rules prescribed by the Centers for Medicare & Medicaid Services (CMS). Details of the CMS drug rebate process can be found in the "Medicaid Drug Rebate Operational Training Guide".
- This manual primarily covers the Federal Medicaid Drug Rebate program. New Mexico Human Services Department (HSD) currently utilizes Drug Rebate Analysis and Management System (DRAMS), a XEROX proprietary software program used for drug rebate activities.
- DRAMS utilizes claims data from the state's claims processing system and rebate data from CMS in order to complete the drug rebate process. DRAMS has the capability of accepting claims data from XEROX's pharmacy claims processing systems as well as third party vendors.
- This manual assumes that the rebate program data has been successfully set up in DRAMS at the initiation of the program. Therefore, this manual deals only with day-to-day operations of drug rebate administration and should not be used as a DRAMS user manual.
- This manual is not intended to be a definitive and exhaustive listing of all processes, procedures, or tasks necessary to implement and administer a drug rebate program.

- This manual can be used to supplement training materials for DRAMS but does not serve as a user manual for how to use the DRAMS system. Comprehensive DRAMS documentation is located in the Help file of the application.

DRAMS MISSION STATEMENT

It is the policy of HSD to administer drug rebate programs in a manner that maximizes drug rebate recoveries. Means used by DRAMS to accomplish this include the following:

- Complete and accurate invoicing
- Complete and accurate payment reconciliation
- Minimization or elimination of manufacturer disputes and unresponsiveness

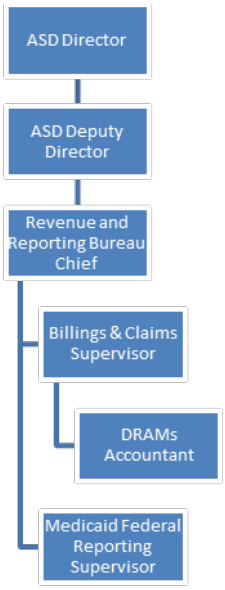
AUDIENCE

Those affected by this manual are all participating drug rebate staff associated with compilation of claims data for drug rebate aggregators and the distribution of drug rebate money. This manual is intended for the following parties:

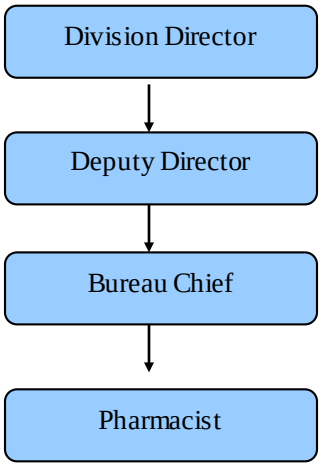
- CMS
- HSD Oversight Agencies
- HSD/Medical Assistance Division
- HSD/ Information Technology Division
- HSD/ Administrative Services Division
- XEROX, Medicaid Fiscal Agent

2. DEPARTMENTAL ORGANIZATIONAL CHARTS FOR DRUG REBATE

ADMINISTRATIVE SERVICES DIVISION



MEDICAL ASSISTANCE DIVISION



3. DIVISION OF DUTIES

MEDICAL ASSISTANCE DIVISION (MAD)

MAD administers DRAMS and enters manufacturer/invoice information, issues invoices to manufacturers and resolves disputes with manufacturers. MAD is responsible for all FFS invoicing and Dispute Resolution processes.

- Request Claim Audits for FFS program
- Research Claim Audits for FFS program quarterly
- Research Labeler Differences quarterly
- Research CMS Drug File Differences quarterly
- Calculate FFS invoice details quarterly
- Research Drug Audits for FFS program
- Research Under threshold Invoices for FFS program quarterly
- Freeze FFS invoices quarterly
- Contact Xerox to complete Invoice process (create electronic invoices, print invoices, mail invoices,
- upload invoices to RebateWeb, record mailing date)
- Create FFS utilization file quarterly. Contact Mike Ryan at Xerox to submit the file electronically to CMS after invoicing.
- Maintain Security as System Administrator
- Set and Reset Passwords as System Administrator
- Issue a Letter of Direction to the Medicaid contracted Managed Care Organizations on Drug Rebate reporting and resolution
- Ensure that the Information Technology Division of HSD maintains the MVS1 jobs which transfer the interface data from DRAMS into SHARE and generate the required inter-agency emails.

ASD

ASD processes payments and adjustments to DRAMS; validates/reconciles interface data, including cash receipts, federal and state revenues and accounts receivable, to the general ledger; and reporting drug rebate accounting transactions to CMS.

- Receive and Deposit checks from manufacturers
- Create and send daily Excel File check log and check copies to Xerox
- Log Batch Totals to track whether checks have been entered correctly into DRAMS
- Enter checks into DRAMS
- Submit CMS 64 with rebate information to CMS
- Maintain contact with labelers regarding payment
- Process daily and weekly interface files from DRAMs into SHARE, including requesting DRAMS reports, and reconciliation of detail data to journal entry, approval and posting of journal entry
- Maintain a current record of amounts billed and payments received from manufacturers for each quarter.

XEROX

XEROX is the Fiscal Agent for the Medicaid Management Information System (MMIS) for HSD and also owns the proprietary software program used for drug rebate activities, DRAMS.

- Generate quarterly MCO invoices
- Record mailing date quarterly for FFS and MCO invoices
- Mail collection letters on a timely basis
- Provide IT support for MAD and ASD
- Transmit SHARE interface files to MVS1.
- Ensure that a daily Procedure Results file is created.
- Monitor Procedure results to ensure that nightly processes in DRAMS have taken place, such as Master Control, Claim Load, Audit Claims, etc.
- Calculate invoice details for MCO quarterly process
- Ensure that invoices are frozen for MCO rebate quarterly invoices
- Maintain Ineligible Providers list to exclude from invoicing
- Conduct unit conversion for MCO invoice process from POS/J-codes for rebating purposes (with MAD approval)
- Create letter templates for dispute initiation and dispute resolution letters to manufacturers.
- Maintain manufacturer updates from CMS or other appropriate sources
- Maintain excluded NDCs list and exclude from invoicing
- Maintain CMS/ROSI discrepancies quarterly basis. CMS Drug data will be compared to existing data to determine what should be done with the CMS data and whether any audits need to be created.
- Maintain CMS/Drug File discrepancies quarterly. Compare CMS drug data to existing data to identify drug file mismatches
- Comparison of the CMS Drug File to ROSI/PQAS file. When CMS Drug data is loaded each quarter, many comparisons are made to existing data to determine what should be done with the CMS data and whether any audits need to be created. One of the types of audits that DRAMS creates is the CMS to ROSI/PQAS Discrepancy audits. There are four different types of discrepancies that may be noted. Audits may automatically be generated through DRAMS as defined by criteria set forth by the client, e.g. threshold amounts.
    - Correction record to zero URA, no payment on ROSI/PQAS.
    - Correction record, mod on ROSI/PQAS, bot no match.
    - URA modified on ROSI/PQAS, no CMs correction record.
    - No correction record, no payment 0 URA.
- Maintain Contact Anomalies to ensure that the invoices are sent to appropriate locations
- Maintain system parameters on default audits and default unit type audits
- Allocate Payments after ASD logs checks into DRAMS, Xerox will assist in allocating the check amount to the appropriate invoice. Payment, including principal and interest, is allocated by NDC for the current invoice (ROSI) or for prior quarters (PQAS).
- Create collection letters to labelers
- Enter weekly T-Bill rates from the Treasury Department in order to calculate interest. Interest will start to accrue on an invoice 38 days after being mailed out.
- Update the FMAP Rate for Medicaid for the upcoming Federal Fiscal Year. These updates should be applied by the 1st payment cycle in October.
- Calculate interest when creating collection letters
- When a check is declared allocated but the Total Allocated Amount is not equal to the Check Amount, suspend the check to examine possible overpayment, underpayment or credit balance.

- Maintain CMS/ROSI discrepancies done quarterly. CMS Drug data will be compared to existing data to determine what should be done with the CMS data and whether any audits need to be created.
- Develop letter templates to create collection letters
- Maintain manufacturer invoices for MCO Invoicing until they are less than $10.00
- Generate and send Claim Level Detail (CLD) reports per manufacturer request
- Assign disputes as directed by MAD
- Perform dispute resolution for MCO rebates
- Record tracking of a provider review as part of dispute resolution through to completion and the recording of results.
- Create Dispute letters to labelers.
- Maintain contact with labelers for correct information
- Zero out any interest that has accrued on rebate payments that were made timely, but were allocated later due to courier delay in delivery of payment documents.

4. ROLES AND RESPONSIBILITIES

MAD

Rebate Operations Manager, Pharmacist

- Responsible for managing Drug Rebate Operations
- Responsible for implementing all new drug rebate clients, managing all rebate operations staff and coordination with systems staff for enhancements
- Responsible for FFS rebate operations including invoice creation and dispute resolution
- Provide efficient and effective operation services
- Ensure that all processes and procedures are well documented and followed
- Proactively isolate operations problems, prepare action plans for resolution, and manage action plans through to successful completion
- Oversee the drug rebate dispute resolution process
- Serve as the Drug Rebate Pharmacist for the Medicaid Drug Rebate program
- Establish and review policies and procedures
- Interface with state personnel on Drug Rebate issues
- Review and interpret State and Federal Medicaid laws and regulations
- Ensure drug rebate process flow and process improvement
- Serve as an interface with PBM systems department and DRAMS developers
- Interface with external vendors involved in the rebate process
- Extract rebate data and provide rebate reporting
- Assist in development of new rebate initiatives
- Review dispute correspondence
- Examine FFS claims level detail for discrepancies
- Compare unit type discrepancies between CMS and FDB
- Contact labelers to determine basis for disputes on FFS invoices
- Contact pharmacy providers to resolve outlier claims on FFS invoices
- Contact medical providers to resolve outlier claims on FFS invoices
- Compare data utilization after adjustments have been made and determine a final balance due
- Finalize terms of dispute resolutions with labelers
- Conduct pharmacy provider education

ASD

ASD Accounts Receivable Bureau Chief

- Ensure compliance with financial guidelines of all contracts
- Ensure compliance with federal and state regulations
- Oversee quarterly generation of rebate reports
- Supervise the rebate accounting process
- Oversee the flow of funds between labelers and HSD
- Participate in DRAMS training on accounting functions
- Assist in the enhancement and testing of proprietary rebate software
- Maintain and manage financial files and records related to drug rebates
- Establish and review policies and procedures
- Review and interpret State and Federal Medicaid laws and regulations
- Assist in the development of Ad Hoc reporting for HSD Management

- Ensure the interface files from DRAMS into SHARE are reconciled to DRAMS detail supporting data and posted into SHARE
- Ensure compliance with financial guidelines of all contracts
- Produce and disseminate the CMS 64.9R report
- Assist in the development of new rebate initiatives

ASD Billing & Claims Supervisor

- Responsible for providing leadership in the implementation of rebate administration
- Responsible for drug rebate process flow and process improvement
- Assist Accounts Receivable Bureau Chief
- Ensure that the interface files from DRAMS into SHARE are reconciled to DRAMS detail supporting data and posted into SHARE
- Update Budget Reference and Class in interface files to coincide with the State's Fiscal Year
- Establish and review policies and procedures
- Interface with MAD and ASD staff on the status of drug rebate issues
- Interface with external vendors involved in the rebate process
- Assist in the development of web based enhancement to DRAMS v.2.0

ASD DRAMS Accountant

- Initiate manual wire transfers for rebate clients
- Records daily batch deposits from clients
- Contact labelers to resolve rebate accounting issues
- Return checks to labelers when labeler sends one check for both FFS and MCO invoices
- Provide support to the rebate accounting department
- Reconciliation of CMS64.9R data to SHARE

XEROX

- Calculate the MCO rebate amounts and bill as appropriate to the Manufacturers
- Allocate payments to the appropriate rebate quarters
- Administer the delinquent payment notice process
- Track outstanding balances
- Notify Rebate MAD Pharmacist of disputes
- Assist Sr. Rebate Accounting Specialist with the generation of delinquent payment notices
- Contact labelers to resolve payment allocation issues
- Assist in file maintenance
- Generate and send CLD reports to drug manufacturers
- Supervise the delinquent payment process
- Conduct MCO dispute resolutions
- Request MCO utilization file to be sent to CMS
- Create MCO utilization file quarterly. Contact Mike Ryan at Xerox to submit the file electronically to CMS after invoicing.
- Contact labelers to determine basis for disputes on MCO invoices
- Direct the MCOs to work with pharmacy and medical providers to resolve outlier claims on MCO invoices
- Contact medical providers to resolve outlier claims on MCO invoices

5. PROCEDURES

DRUG REBATE PROCESS OVERVIEW

Any manufacturer (also referred to as a labeler) interested in participating in the Federal Drug Rebate Program is required by law to sign a Medicaid Drug Rebate Agreement with the United States Department of Health and Human Services.

Once the labeler is participating in this federal program, current quarter pricing data - along with prior quarter updates, contact information, and product additions - are due to CMS within 30 days after the end of each calendar quarter. CMS processes the quarterly pricing data and generates unit rebate amounts (URAs) for each NDC. The URAs - along with labeler contact information changes and product additions - are released via tape to the states or the states' representatives on or about the 45th day after the quarter ends.

Within 15 days after receiving the URA data tape from CMS, DRAMS is required to submit invoices to each labeler for every rebate eligible NDC that has been included on a paid claim during the past quarter. For all invoicing, DRAMS must generate a separate record for each NDC billed to the labelers and submit a tape to CMS containing all utilization for the quarter.

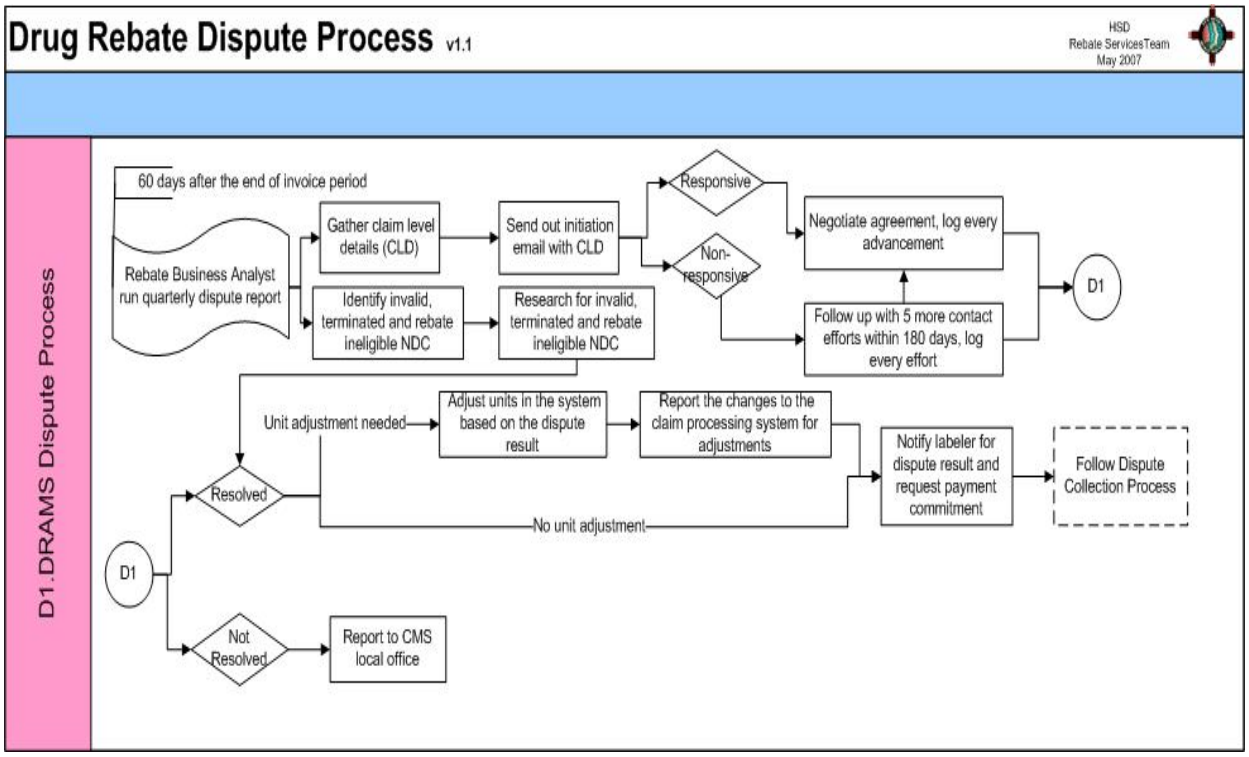
Within 38 days after the postmark of the state invoice, labelers are required to pay rebates for all invoiced NDCs, except for those NDCs that are disputed. Rebate payment checks are mailed to the Human Services Department Post Office Box together with ROSI/PQAS, envelopes and correspondence. As payments are received in the post office box, the checks are copied and kept with all supporting paperwork maintained and filed by deposit date with the Human Services Division, Administrative Services Division with the Accounts Receivable Bureau. The funds received in the post office box are deposited to the bank account of the State or the State's fiscal agent. Xerox will allocate the payment to each NDC to which the check applies.

If no payment or dispute is received within 38 days after the postmark of the state invoice, a collection letter will be sent to the labeler. After that MAD will proceed with further collection efforts, for those unresponsive labelers, according to guidelines provided by the State.

For disputed items, Xerox will follow the standard dispute resolution process. Once the dispute is resolved, a dispute resolution agreement letter that outlines the resolution will be sent to the labeler. If the dispute cannot be resolved, or no payment is received after the dispute is resolved, HSD will either proceed with further collection efforts according to guidelines provided by the State or forward the case to CMS local office.

DRUG REBATE PROCESS FLOW CHART

The chart on the following page explains the overall flow of the drug rebate process.



REBATE PROGRAM SETUP

PROGRAM AND PARAMETERS

At the inception of a rebate administration program, the state defined the issues that will affect day-to-day rebate administration. These issues included but are not limited to the following:

- parameters and thresholds set up in DRAMS;
- establishing contacts for CMS;
- identifying the state's recipient for the DRAMS produced CMS 64.9R9R; and
- the cash management policy for the rebate monies.

During rebate administration set-up, the state established a contact as the CMS Rebate Contact and Technical Contact. This allowed the CMS tape to be mailed to XEROX for loading to DRAMS for rebate invoicing. This also allows for CMS releases and memos to be received at XEROX for processing where required. This designee submits the state's utilization file to CMS after invoices have been created quarterly. If errors have occurred on either the CMS quarterly tape or the state's utilization file, CMS can contact the MAD Pharmacist for correction.

Certain parameters of the rebate program are configured in DRAMS with the input of the state. These parameters include the creation of an invoice cover letter, invoice threshold dollar amounts and handling details, and new drug inclusion methodology. Specifications for the cover letter include the state agency for which the invoices are being created, the address to which the rebates checks are to be sent, and any additional text required by the state. These parameters are generally constant throughout rebate program administration.

Claim and invoice audit parameters also have been specified for the rebate administration program. These parameters typically compare both unit quantities and rebate amounts to percentages of the historical values. These audit parameters also include unit conversions (where the CMS units and drug file units are different), and thresholds for unit values and dollar amounts as well. As there is limited DRAMS history at the beginning of the XEROX administration, these audit parameters are reviewed periodically and may be adjusted quarterly to better monitor outlier claim and invoice amounts. If the audit process is producing too few or too many DRAMS audits for practical review, the parameters can be adjusted and the audits can be rerun to generate functional results.

CASH MANAGEMENT

The post office box for the Accounts Receivable Bureau is owned by the New Mexico Human Services Department. All payments for Drug Rebate, including any accrued interest, will belong to the State of New Mexico Human Services Department. The Accounts Receivable Bureau will deposit checks within 24 hours of receipt. By mailing checks to the post office box, labelers are assured that all payments are deposited expeditiously after receipt.

QUARTERLY CLAIMS CYCLE

LOAD DATA

The claims /drug /provider data that will be used to process rebates need to be uploaded into the DRAMS system out of the claims processing system. Every Wednesday night pharmacy claims will be loaded into DRAMS and every Friday night medical claims will be loaded.

RUN CLAIMS AUDITS

Once the claims, drug, and provider data have been updated in DRAMS, the claims are audited based on the settings defined by the user. These settings include unit conversions, claim reimbursement thresholds and unit comparisons to historical trends. This is an automated process within DRAMS. After the audits have been performed, adjustments and modifications may need to be made to the claims, or adjustments may need to be made to the audit settings. These audits are reviewed throughout the quarter after a claims load. If discrepancies are identified, the units can be modified prior to invoice creation. This proactively reduces the number of labeler disputes.

QUARTERLY INVOICE CYCLE

The following sections detail the tasks that need to be completed during each quarter in order to ensure the accuracy of invoices that will be sent to manufacturers and labelers. Some of these tasks may need to be repeated more than once.

LOAD CMS TAPE

Quarterly invoices cannot be calculated until the CMS tape has been loaded for the current quarter. The CMS tape arrives approximately 45 days after the end of the quarter.
All the drug data and labeler information will be read from the tape and loaded into DRAMS. MAD will verify this process has been completed. If not, an email should be sent to the DRAMS support team for assistance. The CMS tape includes:

- Labeler
    - Set up new labelers and contracts or close out period of participation for labelers
    - Update Labeler Contact information – invoice, technical, legal (DRAMS checks the new data and makes updates)
- Drug file – Unit Rebate Amount (DRAMS checks the new data and updates new URAs. All prior quarter history is kept in the system)
    - Current quarter URA
    - Prior quarter URA

When the data load is successfully completed, MAD will be able to proceed to the Calculate Invoice task.

CALCULATE INVOICES

Once the claims data has been loaded for the quarter into DRAMS - and all other data necessary to calculate invoices has been loaded, such as updated drug data and updated provider data and audits reviewed and cleared - current quarter invoices can be calculated. The invoices are calculated either in masse or individually. The process for calculating invoices may be executed multiple times per quarter before the invoice data is acceptable.

RUN INVOICE AUDITS

Audits can be performed to alert the user to any unusual rebate invoice amounts that may end up in the dispute resolution process. The settings for audits are to be defined in the setup and configuration phase. These audits are comparisons to both current quarter rebate dollars and current quarter number of units invoiced as compared to past DRAMS quarters. After invoice calculation, these audits will be reviewed, units will be modified where applicable and invoices for these labelers will be recalculated. This process should be executed each time invoices are calculated.

REVIEW THE UNDER-THRESHOLD INVOICES

Prior to the invoice "freezing" process, invoices that fall below the "invoice threshold", must be reviewed and assigned an invoice handling code. Based on the values of the parameters set during the setup and configuration phase, there may or may not be invoices created that fall below the dollar thresholds defined. "Under threshold" invoices may be handled in three distinct ways. These invoices are either coded in DRAMS as "Forgive", "Retain", or "Mail". With an invoice that is coded as "Forgive", the balance due is written off and the labeler incurs no payment liability. The Human Services will only "Forgive" a balance when a bankruptcy notice is received from the labeler. With an invoice coded as "Retain", the balance of the invoice will be held over until the sum of the previous invoices exceeds the mailing threshold. The invoice will then be mailed for payment, covering all retained quarters.

LABELER ADDRESS AND CONTACT UPDATE

The labeler address, contact information, and rebate participation dates are updated in DRAMS from the CMS tape. This ensures the invoices are addressed with the most current address and contact listing. As part of the invoice "freezing" process, DRAMS will alert the user of Contact Anomalies. As each discrepancy is identified, the DRAMS user will be prompted to review all contact listings for the identified labeler to choose the proper contact to be used for invoicing. For Federal programs, the most current CMS contact and address will be used.

FREEZE INVOICES

After invoices have been calculated and the audits/reviews have been performed, MAD will freeze FFS invoices and Xerox will freeze MCO invoices. This process in DRAMS locks in the information included for each invoice for the current quarter. As a result, invoices cannot be recalculated once they are frozen. This process must occur before invoices can be printed. After the invoices are frozen MAD FFS will notify the XEROX Albuquerque Operation Support Team (ABQOPS), via email, that the invoices can be generated and mailed. Xerox will complete all areas of MCO invoicing.

GENERATE INVOICES

The process of generating invoices is executed to produce the actual hard copy invoices that will be sent to each manufacturer. Each invoice includes a cover letter specifying the address to where rebates should be sent, as well as a payment stub with the labeler's name and mailing address to fit in a window envelope. ABQOPS will be doing this.

MAIL INVOICES TO MANUFACTURERS

Distribution of invoices to manufacturers is the final step in the Calculate Invoice Cycle. ABQOPS may print an invoice register to be used as a control to ensure all rebate invoices are placed in envelopes and mailed. As each invoice is inserted into an envelope, the labeler code is verified against the invoice register and against all sections of the DRAMS invoice. The invoices are mailed as a bulk mailing. However, individual invoices may be held for investigative purposes and mailed at a later date. ABQOPS will enter the invoice mailing date into DRAMS for interest calculations. If an invoice is returned for any reason, ABQOPS will forward the returned envelope to MAD, who will contact the labeler for an address correction or fax number correction in order to ensure delivery of the invoice. Once the invoice is resent, the mailing date can be reset in DRAMS (whether on an individual labeler basis or a program as a whole) to account for the new mailing and/or faxing date.

STATE UTILIZATION FILE AND CONFIRMATION TO CMS

After the invoice process has been completed, a state utilization file is created and sent to CMS. MAD FFS/Xerox MCO working with XEROX in Atlanta creates the CMS Utilization file through a DRAMS function. The utilization file is then submitted to CMS electronically by Xerox in Atlanta.

QUARTERLY PAYMENT CYCLE

The following sections detail the tasks that need to be completed during each quarter in order to ensure the accuracy of the payment data in DRAMS. The steps may or may not be applicable based on the specific payment setup for each client.

PAYMENT RECEIPT AND ALLOCATION

Labelers mail rebate checks directly to the post office box. The Accounts Receivable Bureau will retain the following documentation daily:

- Photocopy of each deposited check;
- Copy of deposit slip for the daily post office box;

- Original invoice, remittance advice, and supporting documentation;
- Correspondence and other items with or without a check to deposit; and
- Original envelopes from the sender.

As each deposit batch is received daily, the Accounts Receivable Bureau staff will log the batch into DRAMS. The batch log number correlates to the deposit ticket. Deposits are then taken to the Human Services Fiscal Agent for deposit. The Accounts Receivable Bureau will maintain a copy of all deposits. Each check that is received from a manufacturer is based on a single specific invoice that was sent. As each check within a batch deposit is logged into DRAMS, it is assigned a unique drug rebate (DRAMS) check log number for payment processing. Information listed during the check logging process includes the following:

- Batch number
- Batch date
- Check number
- Check issuer
- Check date
- Receipt date
- Postmark date
- Check amount
- Whether or not the payment includes a dispute resolution payment.

The check is linked to a specific labeler and rebate quarter when the allocation process begins. DRAMS allow the user to allocate appropriate amounts of a check to the 11-digit NDC. The Accounts Receivable Bureau will return to the labeler any check sent that pays invoices from both the FFS and MCO programs. The bureau will only accept one check per program.

REBATES ACCOUNT RECEIVABLE PROCEDURE

One important aspect of any Drug Rebate Program is the collection process. The outstanding rebate balances are monitored through both the DRAMS Accounts Receivable functionality and through reports created by ASD and MAD.

DRAMS contains an accounts receivable subsystem that allows for the identification of outstanding balances, unallocated balances and outstanding disputed amounts. This functionality lets the DRAMS user view the accounts receivable on a program level with drill-down capability to the manufacturer level, the individual rebate quarter/manufacturer combination and, ultimately, to the individual NDCs that comprise the rebate quarter/manufacturer combination.

Xerox: In addition to the DRAMS Accounts Receivable functionality, also creates a monthly A/R collection report through a query of the DRAMS database. This report reflects the payment allocation and dispute resolution activities completed within DRAMS for all rebate quarters for which DRAMS created the rebate invoices. Using the most current URA, (supplied by CMS), and using the most current number of units, the report indicates the current rebate receivable amount for each labeler for each DRAMS rebate quarter. As such, this query reflects the most current status of the New Mexico's rebate program as the payments and units are updated in DRAMS.

This A/R collection report along with the DRAMS Accounts Receivable functionality is also used to track non-payers for the generation of Dunning Notices.

INTEREST

Interest is applied to disputed or unpaid amounts and late rebate payments. Interest begins to accrue 38 calendar days from the date the invoice is postmarked by the United States Postal Service or other common mail carrier.

Update T-Bill Rates

The interest calculation is based on a 365-day year with simple interest applied to the average of the yield of the weekly 91-day Investment rates from the Recent Treasury Bill Auction Results during the period for which interest is charged.

Auctions of 91-day Treasury bills are generally held each Monday. Periodically, information on rates is provided by CMS in releases to labelers and state agencies to ensure both parties are using the same interest rates when making calculations. Xerox will update and maintain the T-bill rate information in DRAMS.

Xerox validates the T-Bill rate information in DRAMS under the Maintain T-bill Rate window with the rate information supplied on the release. Xerox enters the T-Bill rates each week from the information published on the US Treasury, Bureau of Public Debt website.

http://www.treasurydirect.gov/instit/annceresult/annceresult.htm

Interest Calculation

As the Xerox Rebate Accounting Specialist receives payment data, the initial determination will be for timeliness of the payment. For all payments deemed to be later than the 38-day CMS payment window, the initial task performed will be the calculation of interest in DRAMS. The user will proceed to the DRAMS Tasks menu and choose Calculate Interest from the menu choices. The user will then enter the "As Of" date using the postmark date on the envelope of the payment, the Quarter Range should be set to identify all quarters for which there is payment. (However, the earliest quarter indicated should be no earlier than that of the initial quarter that DRAMS had calculated and generated the mailed invoices.) The Rebate Accounting Specialist should then make the choice of Manufacturer.

After the interest calculation has completed, the Rebate Accounting Specialist should begin the payment allocation process. The calculated interest will appear on the ROSI screen, beside which is a column to allocate interest paid.

Because the detail data by NDC was not available prior to DRAMS, interest calculation will begin with fourth quarter 2006.

INVOICE COLLECTION

Dunning Notices will be sent (by Certified Mail, Return Receipt Requested) to those labelers that have not paid by the 40th day after the postmark date of the invoice. This allows for the 38-day window set forth by CMS. These notices reflect balances owed for the rebate quarter. The dunning notices remind the manufacturer to calculate interest and include it with the payment. Payment is requested within 15 days of receipt of the letter. (See the sample letter in Appendix C).

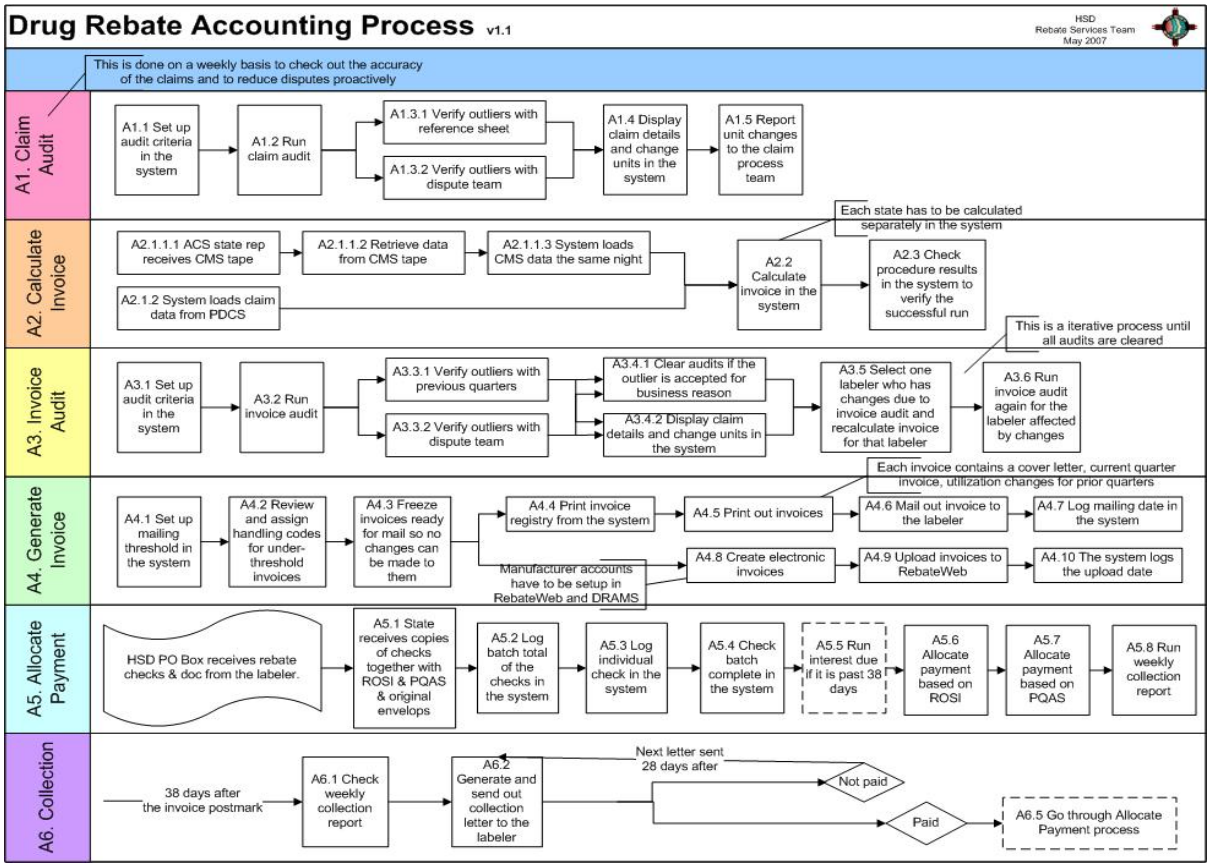
If there is no response from the labeler, the next attempt will be made 25 days later. If no response is received from the labelers, notification will be made to MAD and the labeler's information will be referred to CMS.

If there is not response from the labeler, and amounts remain unpaid for prior periods, a Demand Letter will be sent to the labeler. The Demand Letter will request payment in full of any prior period invoices less any disputed amounts within 30 days. If full payment is not received from the labelers, the information is referred to the CMS office.

In July 2008, AR implemented a process to address timely collections of past due invoices. AR has sent out all past due invoices to labelers that showed balances after the research was conducted; 60 and 30 day notices have also been sent out timely to labelers. All outstanding invoices prior to DRAMS have been sent out. Most labelers have sent responses to invoices not paid by either paying or showing that they have already paid. The process of collections will be going on.

DRUG REBATE ACCOUNTING PROCESS FLOW CHART

Note: The accounting team of the rebate department handles the quarterly claim, invoice and payment tasks. The following chart maps out the general flow of the accounting processes.



DISPUTE RESOLUTION PROCESS

Dispute resolution is an ongoing process that follows the CMS prescribed rules. This process usually involves several steps. Disputes are identified and reviewed for clerical input errors. Disputes are then addressed by providing claims level detail to labelers. If necessary, providers are contacted for unit amount clarification. Therapeutic review is conducted by MAD.

INTRODUCTION TO CMS DISPUTE GUIDELINES

CMS Release Number 45 describes the guidelines for the dispute resolution process. In general, there are two phases to the dispute resolution process. Phase I includes a period for the Drug Rebate Dispute Resolution Department, MAD, and the labelers to exchange information and seek resolution of the dispute through informal negotiations. Phase II is considered the formal review process that includes scheduling a hearing to determine resolution. The Drug Rebate Dispute Resolution Department and the labeler continue to attempt to settle disputes before the hearing is conducted by considering the following settlement options:

- Mediation Review
- Non-Binding Arbitration
- Binding Arbitration

- Administrative Review

CMS Release Number 45 gives clarification of the settlement options.

CMS has determined basic guidelines for handling drug rebate disputes. At their discretion, states may enter into disputes using the following guidelines:

- The labeler must pay rebates on all undisputed amounts 38 days after receiving the invoice. The labeler must identify, by NDC code, all items with disputed units.
- The labeler must also distinguish data inconsistencies versus legitimate disputes within the 38-day period.
- ASD will identify disputed units during the payment allocation process.
- MAD contacts the labeler and provides claim level detail as requested.

All dispute resolution activities performed are in accordance with CMS' Dispute Resolution Program (DRP) as set out in the *Best Practices Guide for Dispute Resolution under the Medicaid Drug Rebate Program.* (See flow chart in Appendix B for details).

COMMON DISPUTE REASONS AND RESOLUTIONS GUILDLINES

Preliminary research often reveals many disputes that result from recurring circumstances. The following sections identify the most common reasons for disputes.

Unit Type Discrepancy

A provider bills a claim utilizing a unit type that differs from the unit type that was utilized in calculating the rebate. Most claims processing systems allow providers to utilize only three (3) unit types when billing claims. CMS has eight (8) unit types for claims.

Claim Processing System Unit Types	CMS Unit Types
Each (caps, tabs, kits, and vials)	AHF (refers only to injectable Anti-Hemophilic Factor units)
Milliliters (liquids)	CAP (capsule)
Grams (solids)	SUP (suppository)
	GM (gram)
	ML (milliliter)
	TAB (tablet)
	TDP (transdermal patch)
	EA (each, refer to drugs not identifiable by any other unit type as given in program instructions)

The DRAMS software has unit conversions built into the claims load logic. As claims are loaded with NDCs that have unit type discrepancies that have been identified and quantified, the conversion is applied to all units where it is numerically applicable. This proactively reduces the number of unit type discrepancy disputes by labelers.

Data Entry Errors

Incorrect quantities can be entered during claims submission or data entry, as DRAMS and/or PDCS receives the claims. This can cause discrepancies in the actual units dispensed.

Decimals

In the instance the drug strength does not equal a whole number or the units of measure for package size has a decimal in the units or quantity recognized, MAD needs to review the claim detail history for billing errors. A decimal point in the units indicated on the claim could mean a typing error.

- To review the claim detail history, MAD would review the units on claims as listed on-line in DRAMS. PDCS, the claims processing system, can also be reviewed for additional understanding.
- Contact providers if necessary
- Calculate any new conversions necessary to determine the correct number of units to update the unit conversion spreadsheet and DRAMS unit conversion (if applicable).

Units or Quantities Appear Inconsistent

If the units billed for a particular NDC are inconsistent with the majority of claims on the claim level detail, the units billed may be in error. MAD verifies the NDC number and the number of units billed.

To verify this information MAD does the following:

- Review the appropriate claims on-line
- Contact the provider, if necessary, to verify the units billed
- Indicate the corrected number of units on the claim level detail for modification within DRAMS
- Advise the provider about the correct NDC number and the unit of measure or quantity

Terminated/Invalid NDCs

Terminated NDCs (dispute code N) are those products where the shelf life for last lot produced has expired. Per CMS guidelines, the affected labeler is required to submit pricing data and pay rebates for four (4) quarters past the termination date (but only for claims with a date of service prior to the termination date). The procedure for resolving these disputes is as follows-

For NDCs where a termination date is not confirmed by CMS

- Contact the manufacturer to obtain the termination date and determine whether said date has been provided to CMS. If advised that a termination date has been sent to CMS and a sufficient amount of time has elapsed since that submission (2 quarters), MAD will then contact selected providers involved (providers with the most claims for the drug and quarter in question) to determine whether they have the subject product on their shelf with an unexpired expiration date. If MAD is advised by the manufacturer that a termination date has not been sent to CMS, we request that it be included with the manufacturer's next quarterly pricing tape and revisit the

dispute after we receive the next quarter's CMS tape in order to confirm CMS' receipt of the termination date.

For NDCs that have a termination date supplied by CMS

- The affected claims are checked to confirm that all dates of service fall after the termination date. For those claims, an adjustment will need to be made. For claims less than one (1) year old, MAD will contact the providers and request they adjust the claims utilizing the correct NDC number. Where practical, this is the preferable way to handle claim adjustments as the entity that made the billing error actually corrects that error. For claims over one (1) year old MAD will specify their preferred method of dispute resolution:

  — Reversal only with no re-submission of the correct NDC number; or
  — Reversal with re-submission of the correct NDC number.

For NDCs not on the quarterly tape

- This usually occurs when the manufacturer submits product data to First Data Bank (who in turn provide the data to pharmacies) and then the manufacturer does not market the product (i.e., different product size for an existing product). Providers have the product data in their computers and then bill claims without using the NDC number from the actual product dispense. If the NDCs are reported by the manufacturers and are on the quarterly CMS tape, the manufacturer is contacted, reminded of that fact and a request for payment is made. If the NDC is not reported on the CMS tape, the provider is contacted to determine the actual product dispensed. The age of the claim will determine how MAD will proceed as set forth above.

A full listing of the CMS dispute/adjustment codes are in Appendix F.

Dispute Code of "Z" will be used in the case where the Labeler does not pay all units but did not indicate a CMS dispute code.

DISPUTE INITIATED

Disputes could be initiated through the following three ways.

1. Throughout each quarter, MAD reviews the claim level detail of NDCs that have historically been the cause of unit type discrepancies or rounding errors. This NDC listing is maintained outside of DRAMS as well as used to maintain the Unit Conversions within DRAMS. The listing is the compilation of NDCs identified by the DRAMS user community. This listing is updated constantly as new NDCs are identified as problematic by any of the DRAMS users. This method is a pro-active approach to dispute resolution.
2. After the invoice is generated and distributed to manufacturers, manufacturers review the units invoiced on an NDC level and may identify units as outliers, rounding problems or any other potential errors. They might contact MAD for resolution prior to the payment of the invoice.
3. Lastly, the manufacturers can submit their dispute notification together with their payments on the ROSI or PQAS.

DISPUTE PROCESS (GENERAL STEPS)

The dispute resolution process starts 60 days after the quarterly invoice period. (This date is set to allow enough time for the manufacturers to send in their quarterly rebate payment and the ASD accounting team to allocate all the payments received.) MAD will run the Dispute Report for all current outstanding disputes and will research the invalid, terminated, or rebate ineligible NDCs. For the rest of the disputed NDCs an initiation email will be sent to the labeler together with related claim level detail information.

If the manufacturer agrees with the claim level detail provided, the dispute is considered resolved and the steps in the below mentioned Dispute Resolved section will be followed. If the manufacturer disagrees, issues in the dispute should be pointed out and further research should be done. Further research includes, but is not limited to, contacting the provider for verification of billing and contacting the labeler for clarification of the dispute.

All the steps and efforts involved in the dispute resolution process are documented for audit purposes. If the dispute is not resolved within 180 days, further measures will be taken according to guidelines defined by the State.

DISPUTE RESOLVED

During the dispute resolution process, MAD will utilize every means to solve the dispute with a given manufacturer. If unit changes are necessary after a resolution, MAD will make appropriate changes in DRAMS, such as unit modification. Once XEROX receives the dispute payment, the disputed NDC will be eliminated from the dispute report. XEROX will notify MAD via email about the payment received.

DISPUTE WRITE-OFF GUIDELINES

The Human Services Department may write off dispute amounts only with a notice of bankruptcy from the labeler. The Accounts Receivable Bureau must maintain documentation that clearly identifies the labeler code, the drug by NDC, the applicable quarter, and the amount to which the write-off is applied.

In addition, the client-defined guidelines may be used for uncollected disputes researched with labelers, for those less than a pre-defined maximum per labeler and less than a pre-defined maximum amount per NDC. These thresholds are set to efficiently utilize rebate department resources and help avoid pursuing uncollectible dispute amounts. The following process must be followed prior to the write-off:

- The Drug Rebate Department notifies the labelers of the outstanding dispute amounts and provides pharmacy claim data for disputed NDCs.
- The labeler is given 30 days to respond. If the labeler does not respond, the Drug Rebate Department sends the labeler a notice on the 60th day.
- If the labeler does respond with information to substantiate their claim, but the response does not result in the resolution of the dispute, the Drug Rebate Department may write off the dispute.

Disputes are not written off if the labeler fails to respond. In accordance with CMS Release Number 45, there must be an exchange of information between the Drug Rebate Unit and the labeler prior to writing off any disputes.

DISPUTE COLLECTION

For manufacturers who agree to dispute resolution and do not make a payment, the following steps are followed:

Step 1: During the Dispute Resolution process, an agreement is made in regards to invoiced units. This agreement also includes a provision as to when the rebates will be paid. MAD will e-mail XEROX about the payment plan set up with the manufacturer.

Step 2: Most manufacturers pay their disputed amount with the next quarter's rebate payment. If disputed amounts are not paid within 10 days (mailing window and lockbox notification window) of the date promised, the first Dunning Notice is sent out. This notice should reference the Dispute Resolution Agreement. (See the sample letter in Appendix D). XEROX will e-mail MAD upon receipt of payment.

Step 3: Twenty-five days later (this includes the 15 day payment request window, the 8-day mailing window and the 2-day lockbox notification window), the next Dunning Notice will be sent, accompanied with a follow-up phone call - if payment is promised, confirmation of that fact, as well as when payment will be made occurs via e-mail - if payment is not promised, determination of the reason(s) and documentation of attempts are made and the process moves to step 4. XEROX will e-mail MAD upon receipt of payment.

Step 4: If there is still no response from the labelers, further collection efforts will be established upon guidance from the State.

INTERFACE FROM DRAMS INTO SHARE

Invoice data and payment data in DRAMS is interfaced into SHARE at a summary level to reflect these transactions in the general ledger. ITD Application Support Bureau will provide the maintenance to the DRAMS interface jobs. The interface process is described below.

Check File Interface

Each Monday through Friday, ITD will run jobs via the MVS1 Scheduler which uses FTP to transmit two check interface files from MVS1 to the SHARE import region. Both the Accounts Receivable Bureau and the Department of Finance and Administration (DFA) will be notified by e-mail that the transmission has been made. After DFA has imported the files into SHARE, the Accounts Receivable Bureau will be notified by return e-mail of the successful import. The Accounts Receivable Bureau will then review the journal entries created from the imports and reconcile the amounts to the "Check Information File Report" and "Check Information with State and Federal Amounts Report" from DRAMS (see DRAMS report for a description).

The data for each file will be sent using the "SHARE project – GL Journal Entry Import Flat File Layout" format found in Appendix I.

The first file will contain the total check amount for the day/period. It will consist of the required header row and two journal line entry rows. The first journal row will contain the total check amount entered in DRAMS. The system will determine which checks need to be reported based on the date of the last file sent. It will then sum the amounts for all checks entered from that date/time to the current date/time, excluding any adjustments made to checks entered on a prior day and any refunds.

The program will report all checks which:

- Have an entry date greater than the date and time the file was last sent and less than or equal to the date and time at which the interface processing began.
- Have a check amount greater than zero.

Using accounts 290900 Cash Receipts in Suspense and 139900 Miscellaneous Accounts Receivable, the journal entry from the first file will look like this:

DR/CR	Business Unit	Fund	Dept.	Account	Bud Ref	Class	Ledger Group	Source	Amount
Debit	63000	97600	8501000000	290900			ACTUALS	EXT	xxx.xx
Credit	63000	97600	8501000000	139900			ACTUALS	EXT	xxx.xx

The second check file will contain the amounts which will be applied to the federal and state accounts.

The first row will be the file header. The second will be the first journal entry. The journal entry amount in this row will contain the total check amount entered in DRAMS for the day/period. It will equal the debit amount sent in the corresponding check file.

Row three of the file will contain the amount to be applied to the federal account. This federal amount is calculated by multiplying each check amount for the day/period by the federal Medicaid matching assistance payment (FMAP) rate that applies on the day the check was received. The FMAP rate will be a value stored in DRAMS. The federal amounts for the day/period will be summed and then be multiplied by negative one to create a credit entry.

The fourth row of the file will contain the amount to be applied to the state account. The state amount is calculated by subtracting the absolute value of the federal amount from the total check amount and multiplying the result by a negative one to create a credit entry.

Using accounts 139900 Accounts Receivable, 135900 Allowance of Uncollectible Accounts, 451903 Federal Revenue and 496903 Miscellaneous Accounts Receivable, the journal entries from the second file will look like this:

DR/CR	Business Unit	Fund	Dept.	Account	Proj/Act	Analysis Type	Bud Ref	Class	Ledger Group	Source	Amount
Debit	63000	97600	8501000000	135900	n/a	n/a			ACTUALS	EXT	xxx.xx
Credit	63000	97602	8501000000	451903	HSDMAD101 MEDEDTREG	GLR	Changes Annually	Changes Annually	ACTUALS	EXT	xxx.xx
Credit	63000	97601	8501000000	496903	n/a	n/a	110	90000	ACTUALS	EXT	xxx.xx

DR/CR	Business Unit	Fund	Dept.	Account	Bud Ref	Class	Ledger Group	Source	Amount
Debit	63000	97600	8501000000	139900			ACTUALS	EXT	xxx.xx
Credit	63000	97600	8501000000	135900			ACTUALS	EXT	xxx.xx

A file will be sent nightly even if no checks have been entered in DRAMS during the recording period. In this case both entries will contain a monetary amount of zero.

NOTE: The Accounts Receivable Bureau completed the review and reconciliation of payment data for the years 2002 through 2005 in July 2008. The Accounts Receivable Bureau sent collection letters for any outstanding balances, and XEROX continues to work with labelers to resolve balance discrepancies and update DRAMS. In addition, collections letters are sent on a quarterly basis to labelers with outstanding balances 30 days or more past due.

SUPPLEMENTAL REBATES

New Mexico currently is not collecting Supplemental Rebates.

SUPPLEMENTAL REBATE PROCESS OVERVIEW

States that wish to pursue Medicaid supplemental rebates in addition to rebates already received under the National Drug Rebate Agreement have the option to negotiate such rebates with drug manufacturers as specified in Federal law. In recent years, CMS has approved plan amendments that allow states to negotiate additional state-specific supplemental rebates for their Medicaid population or participate in a multi-state pooling supplemental rebate agreement. Rebates received under state supplemental agreements are shared with the Federal government at the same rate as the national rebates.

SUPPLEMENTAL REBATE PROGRAM SETUP

This feature is not used at this time, but may be in the future. This documentation will be saved for the future usage.

One of the many capabilities of DRAMS (Drug Rebate Analysis & Management System) is to administer a supplemental rebate program. The initial set-up for a Supplemental Rebate Program mirrors that of the set-up of a Federal Medicaid Rebate Program. However, once the Supplemental Rebate Program parameters have been established, the Supplemental Rebate Program set-up requires additional information to be defined. This additional information includes the identification of Manufacturers, Drug Families and the recording of the contract detail, itself.

Initially, each manufacturer for the Supplemental Rebate Program needs to be defined. In this process, the DRAMS user will assign a manufacturer ID, a manufacturer name and the pricing timing code, as well as specifying the labelers, of which this manufacturer is comprised. Besides assigning the labelers, the manufacturer preferences for invoice format (paper, web-based, electronic, etc.) and the manufacturer contact will be established. All of this information will be available in each of the negotiated supplemental contracts.

The next step for the set-up of the Supplemental Rebate Program would be to establish the Drug Families linked to each of the manufacturers. The DRAMS user can define the drug families in terms that allow similar pricing calculations to occur together. Drugs may be linked here by dosages or drug names, whatever convention is used to define the drug family in the Supplemental Rebate Program contract. Also contract start and end dates can be specified for each of the drug families.

The final step in the Supplemental Rebate Program set-up process is to enter the contract information. Each contract will consist of the drug families covered by the specific manufacturer. In this step, the contract start and end dates are specified and the Rebate Pricing Method for each drug family is recorded. Also, the values for the format of the invoice and the pricing timing code overrides can be defined at the contract level if different from that of the manufacturer.

Finally the Supplemental Rebate Program contract invoice contact is selected. This contact will be the name that appears on the Supplemental Rebate Program invoices for mailing.

INVOICE GENERATION

[Note: This feature is not used at this time, but may be in the future. This documentation will be saved for the future usage.]

The initial step in calculating invoices for the Supplemental Rebate Program is to calculate the URAs for the current rebate quarter. The DRAMS user will choose the Task - Calculate URAs. The DRAMS user will then choose the Supplemental radio button and indicate the correct rebate quarter. The final step is to Process the request and the URAs can be calculated immediately, or set to calculate overnight as to free up the system for current use.

As the claims information for the Supplemental Rebate Program in DRAMS is also used in the processing of the Federal Drug Medicaid Rebate Program, the assumption is made that all claims have been through the claims audit and invoice audit process. This process includes review of outlier claims, research as to the validity of these outlier claims, and unit modification in DRAMS of these claims as deemed necessary. Therefore the next step in the Supplemental Rebate Process would be to calculate and generate the invoices. Invoice calculation can again be queued to execute immediately or overnight as not to impact the workflow.

Once calculated, the invoices will be printed and put in envelopes. The invoices will be mailed and the mail date will be recorded in DRAMS for interest calculation purposes.

Payment Allocation is not used at this time, but may be in the future. This documentation will be saved for the future usage.

The next step in the process will be the manufacturers remitting payment with the ROSI/PQAS (Reconciliation of State Invoice/Prior Quarter Adjustment Statement). The payments will be sent directly to the post office box. The Accounts Receivable Bureau will deposit all received checks to the state's fiscal agent. This process ensures that all rebates are received expeditiously in the State's account and the allocation of such payments can occur in a timely manner.

The allocation process would be similar to the allocation process for the Federal Medicaid Drug Rebate Program. All funds would be allocated to the correct 11-digit NDC and any interest remitted could be applied at the 11-digit NDC level or applied to the invoice as a whole if the labeler did not specify individual NDC payments of interest

IMPLEMENTING & ADMINISTERING A SUPPLEMENTAL REBATE PROGRAM

[As noted above, this feature is not used at this time, but may be in the future. The documentation below is for future usage.]

The steps involved in implementing and administering supplemental rebates:

- Developing a standard supplemental drug rebate agreement template
- Helping secure CMS approval of the agreement template
- Developing a strategy for conducting negotiations with manufacturers

- Send email blast to all manufacturers notifying them of the State's request for supplemental rebates
- Conducting kickoff meetings for manufacturers
- Implementing and maintaining a dedicated website
- Establishing a secure connection (XEROX PBM FTP server) for manufacturer bid submission (see the exhibit following this bulleted list)
- Supplying aggregate utilization data (market share data) to assist manufacturers in developing supplemental rebate bids
- Conducting supplemental rebate negotiations with manufacturers
- Collecting supplemental rebate bids and analyzing the proposals
- Presenting supplemental rebate bid analysis to the Pharmacy & Therapeutics Committees
- Facilitating the execution of the supplemental rebate agreements by the manufacturers
- Invoicing and reconciliation of supplemental rebates

The supplemental rebate negotiation process begins with XEROX conducting a kickoff meeting. All pharmaceutical manufacturers who participate in the CMS Medicaid Drug Rebate Program are invited to attend. The meeting covers the following topics:

- Introduction of the State and XEROX personnel who will be involved in the process
- If appropriate, review of the enabling legislation and all other State legislation pertinent to PDL development, supplemental rebate procurement, and confidentiality
- Explanation of the process for the development of the PDL
- Explanation of the process for initiating supplemental rebate contract negotiations
- Delineation of timeframes for the completion of contract negotiations

Following the kickoff meeting, XEROX provides manufacturers with the supplemental rebate contract template that the State has submitted to CMS in conjunction with the State Plan Amendment. XEROX also supplies the manufacturers with aggregate utilization data (e.g., quantity, total pharmacy reimbursement paid by the State, total prescription count). Manufacturers may choose drugs for which they want to bid rebates and thus have included on the PDL. In the interest of maintaining program integrity, we provide contract information and protocols to guide discussions and ensure that negotiations between manufacturers and XEROX staff are properly handled. We conduct discussions with designated manufacturer representatives in accordance with policies approved by the State.

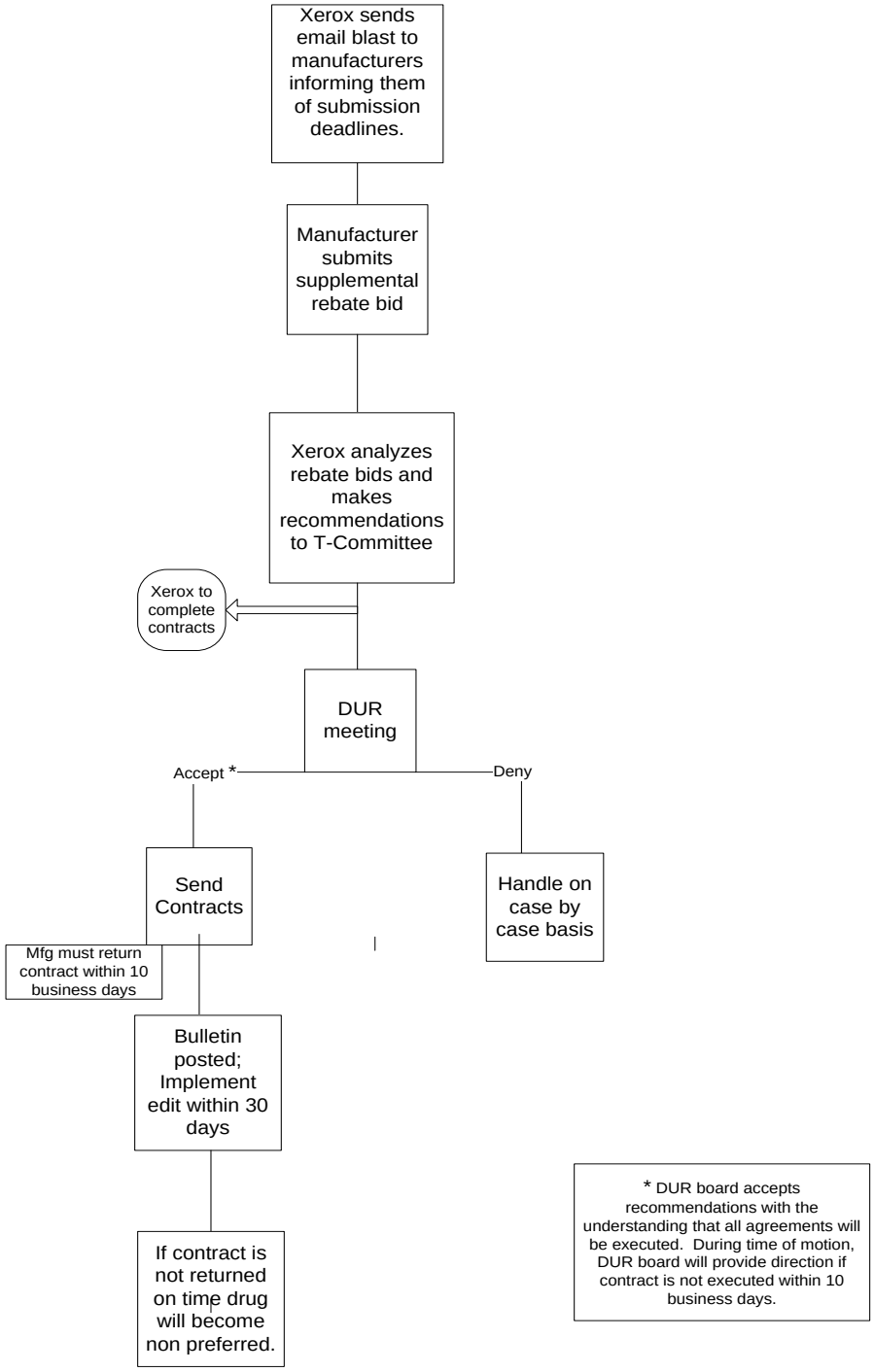
Manufacturers are notified via email approximately two weeks prior to the kickoff meeting. Following the kick-off meeting manufacturers are sent an email delineating all timelines for submission of supplemental rebate bids and the provisions of this process. This email also contains the supplemental bid form and links to the website and FTP site (see Appendix G for Sample bid form).

XEROX Supplemental Rebate Provisions are as follows:

- Manufacturers will be given the opportunity to submit bids based on the following levels of product exclusivity within a therapeutic class:
  - One of One (exclusive)
  - One of Two
  - One of Many (defined as three or more products)

- With the advice of the P&T Committee, the State & the DUR Board will determine the level of exclusivity (number of preferred products) within a therapeutic class
- Supplemental rebate per unit amounts will be based on Wholesale Acquisition Cost (WAC)
- The WAC which is in effect the last day of the subject quarter as reported by First Data Bank, Medi-Span or other publications of drug pricing data
- Submission of a supplemental rebate bid will ensure that the product is considered for inclusion on the Preferred Drug List but does not guarantee preferred status
- XEROX, on behalf of the State, will be seeking supplemental rebate agreements with a term of one year
- Bundled contracts will not be accepted because each product must stand on its own clinical and economic merits
- If the supplemental rebate bid is accepted, the manufacturers must return the signed supplemental rebate contract to XEROX within 10 business days of FTP delivery. Failure to deliver will result in drug status movement to Non-PDL status

Supplemental Rebate Process Flow



Net Cost Evaluation is not used at this time, but may be in the future. This documentation will be saved for the future usage.

XEROX receives the bids from manufacturers and analyzes them to determine the most cost-effective drug in each class. The supplemental rebate analysis is performed for each of the therapeutic classes being reviewed.

The rebate model looks at the following factors:

- Utilization for the immediate previous month
- Amount Medicaid program reimburses to providers
- Impact of federal rebates
- Impact of supplemental rebates (for each exclusivity level)
- Net cost (Amount Paid less federal and supplemental rebates)
- Current market share
- Predicted market share movement
- Expected PA volumes
- If available, PA cost to the client
- Expected denied claims

To provide an accurate calculation of net cost for the P&T Committee's review, XEROX obtains information for all dosage forms being reviewed and all strengths of those dosage forms. Net cost per unit is derived using the State's pharmacy provider reimbursement, less the CMS federal rebate and any supplemental rebate offered. In instances where more than one NDC exists for a drug strength and dosage form (due to package size differences), Clinical Services uses a blended approach, weighted by utilization. Using average daily consumptions (DACONs) and the calculated cost per unit, XEROX provides the advisory committee with a cost per day. This approach offers the most accurate measure to compare the cost of agents within most therapeutic classes. For some therapeutic classes, a cost per day analysis does not provide the most accurate measure. An example of such a class would be narcotics, where daily doses vary per prescription. In an instance like this, XEROX employs a cost per unit or cost per prescription approach. XEROX delivers manufacturer supplemental rebate bids to the P&T Committee when it meets to review the classes and make recommendations. This ensures that committee members have access to complete clinical and economic data related to each class. The supplemental rebate bids are shared during closed-door executive sessions in order to ensure confidentiality.
Our analysis takes into account the number of enrollees who would be affected by requiring prior authorization for a specific drug as well as the potential cost savings available by driving market share to a lower-priced product. Requiring a prior authorization becomes a "hassle factor" that could undercut support of the entire program in instances where the available cost savings is minimal and a substantial percentage of enrollees would be affected by a change. Additionally, the cost of processing the prior authorization requests may more than offset any savings.

The intended goal is to provide the P&T committee with an accurate estimate of the savings based on our recommendations, changes to our recommendations from the Committee, various market share shifts, and PA and denied claim cost to the program. Also, the Committee will be able to see savings that can be attributed to provider reimbursement changes, federal rebate changes and supplemental rebate receipts.

It is XEROX policy to move all agents to a preferred status after final contract execution.

OTHER REBATE SERVICES

HCPCS CODES

To receive maximum federal rebate dollars, New Mexico must identify all drugs used in an outpatient setting by their NDC code. However, most states use procedure codes to identify physician-administered drugs. DRAMS will invoice for all physician administered drugs. The Crosswalk Table

All outpatient medical claims that contain physician-administered drugs must be reviewed. This is accomplished by analyzing the CMS-1500 (formerly HCFA-1500) claims, UB-92 (formerly HCFA-1450) claims, and 837 claims. Second, DRAMS captures all Healthcare Common Procedural Coding System (HCPCS) codes used to bill for drugs. This is accomplished by extracting all HCPCS codes from the aforementioned medical claims. MAD analyzes only those codes that are used to report drugs used in an outpatient setting. Therefore, the following codes are incorporated in the crosswalk table.

- C Codes are temporary codes that are used exclusively for services paid under the Outpatient PPS (Prospective Payment System).
- J Codes are used for drugs administered in an outpatient setting, other than oral-method drugs and biologicals, if:

  — They are of the type that cannot be self-administered.
  — They are not excluded i.e., immunizations.
  — They are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered and they have not been determined by the FDA to be less than effective.
  — They meet all general requirements for coverage of items as incident to a physician's services.

- Q Codes are assigned by CMS to procedures, services, and supplies on a temporary basis. If a permanent code is subsequently assigned (J Code), the Q Code is deleted and cross-referenced.
- S Codes are used by Blue Cross/Blue Shield and other commercial payers to report drugs, services, and supplies. These codes are used by the Medicaid program, but are not payable by Medicare.
- Currently, the crosswalk table is built using only single-source drugs (brand-name drugs without generic equivalents) and certain generics (where only one generic brand is available). This table consists of the following fields: HCPCS Code, NDC, Unit Conversion Factor, Effective Date, and Termination Date.

Systematic Approach

XEROX has established a process to extract HCPCS code claims and load them into DRAMS for rebate processing. XEROX obtains the paid medical claims file from the medical claims processing system. The header information is stripped from the medical claim, as well as the last date of service and the HCPCS Code. The date of service and the HCPCS Code are processed through the HCPCS Code crosswalk and an applicable unique NDC is attached to the claim. The HCPCS Codes are then compared against those present on the last quarter's crosswalk. If new HCPCS Codes are identified, XEROX and the MAD pharmacist will analyze them for the proper identification of an appropriate single source NDC. The claim translation process looks at both the HCPCS Code and the associated date of service and compares it to the data elements in the crosswalk. If a match occurs, the file will link the HCPCS Code to specific NDC numbers. The claim is then loaded into DRAMS for processing of rebates.

Updates

In order to provide for accurate rebate invoicing and to prevent rebate disputes, XEROX and MAD performs quarterly updates to the crosswalk table. The updates include the identification of any new codes, changes to code status (temporary to permanent), and changes to the unit conversion factors.

REBATEWEB

RebateWeb is a XEROX proprietary Internet-based product that allows participating manufacturers to receive invoices over the Internet in addition or instead of paper invoices. Through this secure connection, registered users will gain access to their specific drug rebate information and download invoices electronically. Invoices through RebateWeb will be in the standardized CMS format. Labelers wishing to receive their invoices through RebateWeb should contact MAD, who will work with XEROX in Atlanta to update their contract.

CLAIM CORRECTIONS

For most states, a process is in place in which outlier claims are identified as erroneous in DRAMS and are modified both within DRAMS and the claims processing system. Using this process, the State can recoup funds overpaid to providers due to billing errors identified in the drug rebate invoicing process. At the end of each invoicing cycle, an Adjusted Claims Report is generated within DRAMS. MAD reviews these adjustments. The review is limited to those claims where unit type discrepancies (between CMS and First Data Bank) are not a factor. If claims are identified where the State has overpaid due to a provider-billing error, then these claims are modified in DRAMS and TCNs (transaction control number) are forwarded to the claims processing system (PDCS) for modification to correct the units. The reversal and replacement claims are processed within PDCS in a timely manner. MAD will also work with providers regarding the adjustments for medical claims. Once the reversal/replacement claims have processed and have been loaded to DRAMS, MAD or ASD can create a report to reflect the Reimbursement Dollar Impact of the modifications.

CMS RELEASE PROCEDURES

CMS communicates with labelers and states on an ongoing basis. CMS sends its program releases to the technical contact person specified. Releases are written and distributed by CMS as needed to provide labeler addition and termination information, updated policy information, and discount rates.

Forward Release information

MAD reviews the release to determine the plan of action to take. Some items that require action are labeler additions and terminations to and from the Drug Rebate Program. All Divisions will work together to ensure are acted on accordingly.

CMS 64.9R9R

In order for the States to be eligible for Federal matching funds (also known as the Federal Medical Assistance Percentage), the States can only reimburse for covered outpatient drugs of labelers who have entered into a rebate agreement with HHS. Rebates (both Federal and Supplemental) are considered a reduction in the amount expended by the States for medical assistance for purposes of Federal matching funds. Because of this, they are shared with CMS in the same percentage as the Federal matching funds that are utilized to pay for the covered outpatient drugs for which the rebates were paid.

The Federal Medical Assistance Percentage (FMAP) is calculated annually based on a formula that compares the respective State's average per capita income level with the national average. The FMAP in effect at the time the drug rebate is received from the labeler will be applied to the drug rebate to determine the federal and state share. This is in accordance with correspondence received from CMS, see Appendix H.

DEPARTMENT OF HEALTH AND HUMAN SERVICES					FORM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO 0938-0067	
				STATE:		
MEDICAID DRUG REBATE SCHEDULE				AGENCY:		
				QUARTER ENDED:		
	TOTAL COMPUTABLE					
DRUG REBATE	QTR ENDING	QTR ENDING	QTR ENDING	QTR ENDING	QTR ENDING AND PRIOR	TOTAL
	(A)	(B)	(C)	(D)	(E)	(F)
1. BALANCE AS OF THE BEGINNING OF THE QUARTER (1)						
2. ADJUSTMENTS TO PREVIOUSLY REPORTED REBATES FROM DRUG LABELERS INCLUDED IN LINE 1 (2)						
3. REBATES INVOICED IN THIS QUARTER (3)						
4. SUBTOTAL (LINE 1. PLUS LINES 2. AND 3) (4)						
5. REBATES REPORTED ON THIS EXPENDITURE REPORT (HCFA-64.9 AND/OR HCFA-64.9p, Line 7.A) (5)						
6. BALANCE AS OF THE END OF THE QUARTER (LINE 4. LESS LINES 5) (6)						
Form CMS-64.9r (1-93)						

REPORT OVERVIEW

The CMS 64.9R report represents the financial impact of drug rebates for a given calendar quarter. This form is a part of a larger report filed by each state with CMS on a quarterly basis. It breaks down (by Rebate Quarters) rebate billing, collection and adjustment transactions that occur within a specific Calendar Quarter. Both Rebate and Calendar Quarters represent the four 3-month periods by which a calendar year can be divided (January-February-March, April-May-June, July-August-September, and October-November-December).

REPORT HEADER

State = State for which the rebates were invoiced and collected.

Agency = Name of the State agency that is involved (i.e., Division of Medical Assistance).

Quarter Ended = Calendar Quarter in which the activity on the report occurred.

COLUMN HEADERS

Column A = same quarter ending as at the top of the report. This column actually represents the Rebate Quarter immediately before the Calendar Quarter listed at the top of the report. The reason for this is due to the fact that rebates have to be billed after the subject Rebate Quarter ends. As a result, the column is named after the Calendar Quarter in which the rebates were initially created and sent to the labelers. Example = If the report above had a Quarter Ended date of 3/31/03, Column A would represent 4Q2002.

Column B = The Rebate Quarter immediately preceding the Rebate Quarter in Column A. In the example, Column B would represent 3Q2002.

Column C = The Rebate Quarter immediately preceding the Rebate Quarter in Column B. In the example, Column C would represent 2Q2002.

Column D = The Rebate Quarter immediately preceding the Rebate Quarter in Column C. In the example, Column D would represent 2Q2002.

Column E = The Rebate Quarter immediately preceding the Rebate Quarter in Column D as well as all other Rebate Quarters going back to the beginning of the Medicaid Drug Rebate Program (1Q1991). In the example, Column E would represent 4Q2001 back to 1Q1991.

Column F = Totals the six (6) horizontal rows.

ROW HEADERS

* Negative numbers are enclosed by brackets.

Line 1 [Balance as of the Beginning of the Quarter] = this row shows the balance of each Rebate Quarter (except the Rebate Quarter in Column A) as of the first day of the subject Calendar Quarter. These numbers are obtained from Line 6 of the previous 64.9R report. Column A does not have a value because the rebate invoices have not been created as of the first day of the subject Calendar Quarter (rebate invoices are generally created between the 45th and 60th day of the subject Calendar Quarter).

DRAMS NOTES = the first time the report is run for a specific Calendar Quarter the totals in Line 6 are automatically frozen. The frozen values from Line 6 are stored in the DRAMS database and carried over to the next quarter's report as the values that will populate Line 1 for Columns B, C, D and E. From then on, these numbers will be saved whenever the right-click option "Freeze Totals" is selected and not otherwise. This option will allow the user to re-freeze the amounts in Line 6.

Line 2 [Adjustments to Previously Reported Rebates from Drug Labelers Included in Line 1] = This line shows all the adjustments to the Rebate Quarters in Columns B through E that occurred in the Calendar Quarter of the 64.9R report. The adjustments would include the following:

1. Unit Rebate Amount (URA) changes received on the quarterly CMS tape. In order for the URA changes to be reflected, DRAMS must have utilization data for the NDC and Rebate Quarter affected by the URA change.

2. Utilization Changes from:

    a. Unit changes received on the claims extract from the Claims Processing System.
    b. Unit changes made on-line manually by the DRAMS User (after invoice in question has been frozen).
    c. Sent by labeler on a ROSI and/or PQAS and manually entered into DRAMS by the User.

3. Interest Calculated by DRAMS.

Line 3 [Rebates Invoiced in This Quarter] = this line shows the rebates that were initially created and invoiced in the subject Calendar Quarter. As a result, only Column A is populated since rebates for the other Rebate Quarters were initially created and invoiced in prior Calendar Quarters. Any invoices that have been forgiven are excluded from this total.

* Should never see a negative number on this line.

Line 4 [Subtotal] = this line shows the sum of Lines 1 through 3.

Line 5 [Rebates Reported on This Expenditure Report] = this line shows the rebate amounts received (both principal and interest) for the Rebate Quarters listed during the specific Calendar Quarter. The information contained here is what the State will enter on Line 7.A. of the CMS 64.9.

DRAMS NOTES: DRAMS utilizes the "Received Date" to determine whether the payment was received in the subject Calendar Quarter. In order for a check to be included in this line, it must be completely allocated.

* A negative number would represent credits taken by Labelers for previously submitted payments that were subsequently deemed overpayments due to URA or Utilization changes.

Line 6 [Balance as of the End of the Quarter] = this line shows the result of Line 4 minus Line 5. When frozen, the values for Line 6 are carried over to the next Calendar Quarter's 64.9R report.

Drug Rebate collections are reported on the CMS64.9 Base report, as an off-set to expenditures. The State reports Fee-For-Service (FFS) collections on line 7A1 and Managed Care Organization (MCO) collections on line 7A3. Labelers are asked to submit payment separately for FFS and MCO amounts due. The State applies payments to the corresponding accounts receivable balances. The DRAMS Accounts Receivable Summary Report and the amounts posted in the statewide accounting system, SHARE, are used to complete a DRAMS analysis each quarter by FFS and MCO. The analysis lists the amounts collected by quarter, calendar year and FMAP. The analysis is used as the supporting documentation for amounts reported on line 7A1 and 7A3 on the CMS 64.9 Base.

REPORTS

As a result of processing invoices, recording payments and overall administration of a drug rebate program, there is summary level information that NM can assess the status of the program. DRAMS provides numerous reports that can be run at any time during the quarter.

DRAMS REPORT

Report Name	Report Functions	Report Description
Accounts Receivable Summary by Manufacturer Report	This summarizes the total amounts invoiced, total unallocated balance, total amount in dispute, and the total interest due for the rebate program. This report allows for drill-down capability to manufacturer / rebate quarter combination and ultimately to the NDCs that comprise each manufacturer/rebate quarter combination individually.	The top of the report lists the criteria selected. This is followed by a grid which includes Manufacturer ID and Name. Sum Invoice Balance: The sum of the Invoice Balance amounts from each invoice within this range. If you have chosen the "Most Recent" URA option, this will be the sum of the amounts due for each drug for that manufacturer, quarter and program, calculated as the current number of units times the URA most recently used in payment (or the invoiced URA if no payment has been received) minus the amount paid. Unallocated Balance: Any unallocated balance that is outstanding for this program and manufacturer. These amounts will be subtracted from the Invoice Balance in order to determine the final amount owed to or from the manufacturer. Total Balance: The difference between the first two columns. Total Disputed Amounts: The sum of the disputed amounts for all drug / quarters included in the range. Disputed Amount is defined as URA (official or most recent, as selected) times Disputed Units when greater than zero. Total Interest Due: The sum of calculated interest for all drug / quarters in the selected range.
Disputed Amounts Report	This is a summary level report designed to give the user a quick look at all the items which are currently listed as a dispute for a selected manufacturer (or all manufacturers). It shows you the drug and quarter combinations for which there is a dispute.	The report window contains three sections: Header data. Informs the user of the selected rebate program and manufacturer, the quarter range, and the use of the report threshold. Quarter data. This is a summary of the manufacturer being shown at each quarter with any disputed amounts. For each quarter, it shows the current amount of the invoice, the amount currently in dispute and the percent of the invoice amount that is disputed. Drug data. This reflects disputed NDCs per quarter and manufacturer. Data included here is just NDC, Drug Name and Disputed Amount. It is here that the threshold is applied if it has been chosen.
Dispute Code Report	This report summarizes (at various levels) the amounts invoiced, paid	The top of the report lists the criteria selected. This is followed by a grid which includes

	and due. There are several choices that have varying impacts on the report window itself.	Time Period: Contains either an invoice quarter or year. Amount Originally Invoiced: Total Current Quarter Amount from the invoice at mailing. Calculated Payments to Date: Calculation that indicates current amount. Recorded Payments to Date: Reflects payments entered into DRAMS at NDC level. Amount Adjusted to Date: Current "invoice" amount for all drugs for the manufacturer, quarter and rebate program minus the original invoiced amount for the invoice. It represents all changes due to unit changes and URA changes. Amount Currently Owed: Obtained from the invoice data and is the invoice balance for this invoice. The invoice balance updates at each change in URA, units or a payment recorded which affects the balance due for an invoice.
Batch Total Report	This report provides a comparison between the number of checks and check amount received during specified period of time, with the number of checks and check amount allocated.	The report details: • Batch Number • Batch Date • Allocation Complete indicator • Total Number of Checks and Total Amount of Checks from both batch log and check log
Checks Report	This report provides the detail information on every check received; filtered by received date, batch date, check issuer and other conditions.	Detail information of a check includes: • Check Log Number • Batch Number • Batch Date • Check Number • Check Amount • Total Allocated Amount • Check Date • Postmarked Date • Received Date • Suspended Date • Check Issuer • Check Info
Invoice Register Report	This report gives a quick look at all the invoices created for a given Rebate Program and Quarter.	At the top of the report will be a summary of the parameters supplied in requesting the report. On the body of the report is a list of all invoices matching these criteria, containing the following information: • Invoice Number. • Manufacturer ID.

		• Current Quarter Amount. The sum of the original invoiced amounts for each drug shown on Section 1 of the invoice. • Unit Changes Amount. The sum of the changes to amount due caused by unit changes applying to the current quarter. • Informational Amount. The sum of all prior quarter amounts due from and to the manufacturer from all sources. • Invoice Handling Code. • Electronic Distribution Indicator. • Freeze Date. • Original Quarter.
Check Information File Report	This report gives the check data for a given batch number, and is used to reconcile the daily check file interfaced from DRAMS into SHARE.	The report will contain the following information: ▪ Date of Batch ▪ Batch# ▪ Check# ▪ Labeler Name ▪ Amount of Check This report is generated by A/R Bureau Staff. From the Display Menu select Check and enter the Search Criteria or batch number, right click and select Export. The user will enter a file name for the report following the same naming convention, "check_amt.date" with the date changing as each file is saved. This report is compared to the journal entry created by the daily check file interface for the prior day. Any discrepancies must be researched and resolved before the journal entry is posted to SHARE. NOTE: The information included in this report will be combined with the "Check Information w/State & Federal Amounts Report" information in a report to be produced by XEROX. The A/R Bureau Staff will continue to use the above procedures to reconcile until the report is produced by XEROX.
Check Information w/State & Federal Amounts Report	This report gives the check data for a given batch number with the federal and state share calculated. The report is used to reconcile the 2nd daily check file interfaced from DRAMS into SHARE.	The report will contain the following information: ▪ Date of Batch ▪ Batch# ▪ Check# ▪ Labeler Name ▪ FMAP Rate ▪ Total Amount of Check This report is generated by A/R Bureau Staff. You will use the same file you exported for the Check Information File Report and manually apply the FMAP

		rate. You can obtain the FMAP rates by accessing the Maintain Menu and select Rebate Program, right click and Process. Click the tab called "URA/Int"; this will have a listing of FMAP rates. Refer to the FMAP rate in effect for each check received date and enter this rate onto your file to calculate the federal and state amount. This report is compared to the journal entry created by the 2nd daily check file interface for the prior day. Any discrepancies must be researched and resolved before the journal entry is posted to SHARE. NOTE: The information included in this report will be combined with the "Check Information File Report" information in a report to be produced by XEROX. The A/R Bureau Staff will continue to use the above procedures to reconcile until the report is produced by XEROX.
Accounts Receivable Report	This report gives the amounts that will update the receivable amount on a monthly basis. The report is used to reconcile the accounts receivable filed interfaced from DRAMS into SHARE.	The report will contain the following information: ▪ Labeler Name ▪ Total Receivable Amount by Labeler ▪ Receivable Amount by Labeler for each Quarter ▪ Grand Total of Accounts Receivable for all Labelers This report is generated by Accounts Receivable Bureau Staff. From the Research Menu select Accounts Receivable and enter the Search Criteria, "Display By" must be manufacturer and "Report Quarter Option" has All selected, right click and select Process. This provides you will the balance due by manufacturer and has a total for all manufacturers at the bottom. To view the balance due for the manufacturer for each quarter right click and select "Go To Manufacturer Accounts Receivable". To view balances due for a specific quarter right click and select "Go To Accounts Receivable NDC Detail". For any of the options listed above right click and select export. The user will enter a file name for the report following the same naming convention, "recvble_amt.date" with the date changing as each file is saved. This report is compared to the journal entry created by the weekly receivable file interface for the prior week. Any discrepancies must be researched and resolved before the journal entry is posted to SHARE. NOTE: This report must be requested on Friday afternoon at 4:30 or later, and after the report has been requested no more payment data or disputes may be entered into DRAMS. Data entry must stop for the week in order to use this report to compare to the interface data into SHARE. Any discrepancies must be researched and resolved before

		the journal entry is posted to SHARE.

OTHER REPORTS

Ineligible provider

A dispute type that is becoming more commonplace in drug rebate is the subject of 340B / PHS entities. These are providers that purchase certain medications at a discounted rate on the front end of billing. The providers may not make any profit from these medications as they must dispense these medications at the actual acquisition cost. Indian Health Service Facilities (IHS) and Public Health Service (PHS) Providers are included in the ineligible provider list.

This also means that the claims billed for patients receiving these services are not eligible for rebate. If claims are invoiced for these medications and the providers are registered, recognized 340B providers as recognized by HRSA, this is commonly referred to as "double-dipping." In other words, the manufacturer would essentially be paying the discount for medication twice. This cannot occur.

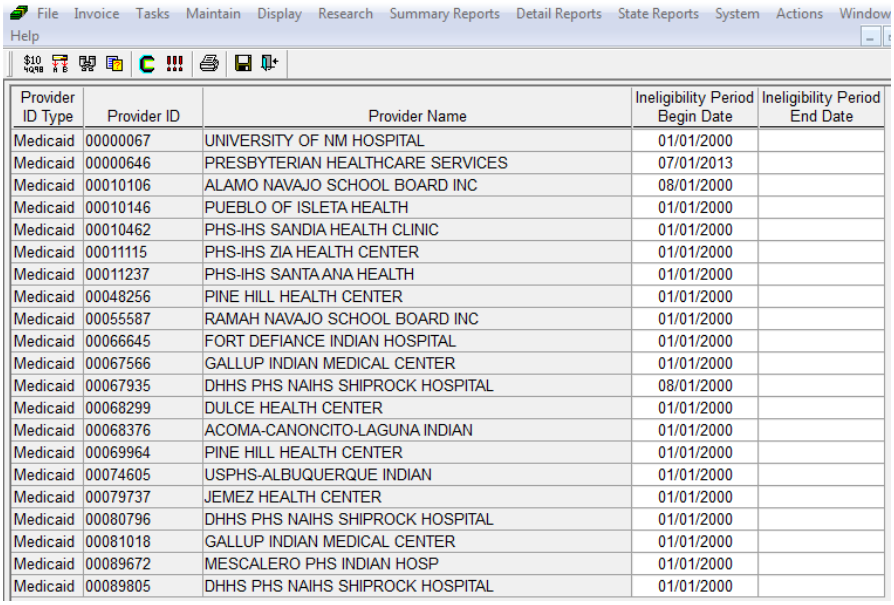
For 340B entities as maintained by HRSA, go to: http://opanet.hrsa.gov/opa/ and select 'Search Covered Entities'. In the Search Criteria window, select the State: New Mexico and click on 'search'. This will list all covered entities in New Mexico who are 340b providers. To receive a spreadsheet of all covered entities, click on 'Download Medicaid Exclusion File'. Once the file is downloaded it can then be sorted with information for New Mexico only.

DRAMS already have built into the system a mechanism which extracts all registered 340B providers. However, this list is dependent upon crosschecking the HRSA database to DRAMS and updating the DRAMS database via manual entry by the rebate analyst. This should be performed prior to any quarterly rebate invoice cycle. The list is found by clicking on **Maintain > Ineligible Providers** in the DRAMS system. Xerox will maintain Ineligible Provider Information. Xerox will gain approval from MAD if any changes to the Ineligible Provider List in DRAMS are needed.

Data Warehouse will provide a quarterly report of IHS Providers who are to be maintained in DRAMS' Ineligible Provider List. The criteria for the report are as follows:

- Provider IHS Indicator = 'Y' or Provider Type = '221', as of the run date, based on provider's base record as opposed to provider's claims/encounters
- Include such providers without regard to whether or not they have submitted claims or encounters at any time in the past
- Run quarterly based on the table below

The DRAMS system deals with ineligible providers by maintaining their provider numbers in a table. The ineligible provider numbers are loaded into the ineligible provider table.



Provider ID Type	Provider ID	Provider Name	Ineligibility Period Begin Date	Ineligibility Period End Date
Medicaid	00000067	UNIVERSITY OF NM HOSPITAL	01/01/2000	
Medicaid	00000646	PRESBYTERIAN HEALTHCARE SERVICES	07/01/2013	
Medicaid	00010106	ALAMO NAVAJO SCHOOL BOARD INC	08/01/2000	
Medicaid	00010146	PUEBLO OF ISLETA HEALTH	01/01/2000	
Medicaid	00010462	PHS-IHS SANDIA HEALTH CLINIC	01/01/2000	
Medicaid	00011115	PHS-IHS ZIA HEALTH CENTER	01/01/2000	
Medicaid	00011237	PHS-IHS SANTA ANA HEALTH	01/01/2000	
Medicaid	00048256	PINE HILL HEALTH CENTER	01/01/2000	
Medicaid	00055587	RAMAH NAVAJO SCHOOL BOARD INC	01/01/2000	
Medicaid	00066645	FORT DEFIANCE INDIAN HOSPITAL	01/01/2000	
Medicaid	00067566	GALLUP INDIAN MEDICAL CENTER	01/01/2000	
Medicaid	00067935	DHHS PHS NAIHS SHIPROCK HOSPITAL	08/01/2000	
Medicaid	00068299	DULCE HEALTH CENTER	01/01/2000	
Medicaid	00068376	ACOMA-CANONCITO-LAGUNA INDIAN	01/01/2000	
Medicaid	00069964	PINE HILL HEALTH CENTER	01/01/2000	
Medicaid	00074605	USPHS-ALBUQUERQUE INDIAN	01/01/2000	
Medicaid	00079737	JEMEZ HEALTH CENTER	01/01/2000	
Medicaid	00080796	DHHS PHS NAIHS SHIPROCK HOSPITAL	01/01/2000	
Medicaid	00081018	GALLUP INDIAN MEDICAL CENTER	01/01/2000	
Medicaid	00089672	MESCALERO PHS INDIAN HOSP	01/01/2000	
Medicaid	00089805	DHHS PHS NAIHS SHIPROCK HOSPITAL	01/01/2000	

Refer to the DRAMS user manual or the DRAMS drop down help menu for complete, detailed instructions.

Ineligible Provider Updates will be done between the 1st and 14th of the Months indicated below.

January	
February	X
March	
April	
May	X
June	
July	
August	X
September	
October	
November	X
December	

Claim reimbursement analysis

The discount received by PHS providers is equal to or greater than the discount from a federal rebate. However, since 340B pricing is confidential MAD will perform a reimbursement analysis on the listed 340B providers. This analysis looks at the submitted amount versus the allowed amount to determine whether the providers are submitting all or some NDCs with 340B pricing.

QUALITY ASSURANCE (QA)

REBATE ACCOUNTING

Invoice QA

After the invoices are generated, MAD selects random invoices from each rebate program for review then validates the claims data, the URA assigned to each NDC, and the calculation of the invoiced rebate amounts due. MAD then validates the QA results against the database to ensure invoice accuracy.

Batch Deposit Authentication

The Accounts Receivable Bureau staff will file each day's deposit information, which includes copies of the checks and all original paperwork (ROSI/PQAS, correspondence and envelopes). The Accounts Receivable Bureau staff will then log the batch deposit information into DRAMS. The information provided includes the batch number as assigned by the deposit ticket, batch date, client name, number of checks in the batch, and total batch deposit amount.

The Accounts Receivable Bureau staff then logs each individual check into DRAMS. DRAMS generate and assign a unique check log number to each entry. The check log entry includes the batch number, batch date, check number, and check issuer, miscellaneous information (typically the labeler number), check date, postmark date, received date, check amount, check payee, format, and whether or not the check includes a dispute resolution payment.

DRAMS systematically compare the information recorded for each batch deposit to the check log information entered. If the number of checks associated with each batch and their respective payment amounts equal the batch information, DRAMS indicates that the batch is "complete". If any component of the information does not equate, the batch remains "incomplete" until completed or corrected. The Accounts Receivable Bureau staff monitors the accuracy of the batch deposit entry as well as the accuracy of the check log.

Check Level QA

After each check is logged into DRAMS, it is recorded on a list of checks waiting to be allocated. As the allocation of payment begins, the Xerox staff selects a check to allocate and then associates that check with a labeler number and quarter to which it should be allocated. This allocation is performed on an NDC level for the selected quarter provided on the ROSI (Reconciliation of State Invoice) and any previous quarters for which there is a PQAS (Previous Quarter Adjustment Statement). Although the CMS-provided URA remains official within DRAMS, an adjusted URA can be entered during the allocation process, as well as a figure for disputed units and/or adjusted units. After the appropriate data lines are populated and the rebate is (re) calculated, DRAMS will indicate if the check has been fully allocated and balances to the previously recorded totals. Once this occurs, the allocation of the check is declared complete, and the check will no longer appear in the list of unallocated (or not fully allocated) payments. Therefore, DRAMS systematically provides verification of the payment allocation process from the initial batch deposit entry through the posting of payments to the NDC level.

DISPUTE RESOLUTION

Every quarter, MAD details all outstanding disputes. MAD then initiates the dispute resolution process for all labelers. MAD will follow up with all labelers and provide all necessary information for dispute resolution. This occurs via email and phone calls. All correspondence is documented into a database with date, time, and contact name and subject line information (for emails).

During dispute resolution, communication is primarily made through email to facilitate electronic documentation. If a dispute remains unresolved for an extended period of time the reason can be documented (i.e. labeler unresponsive). MAD can monitor the progress of the dispute by running a dispute progress report at the end of each month. By comparing the report to that of the previous month, MAD is able to track the progress of the resolution process.

SECURITY

HSD follows all security rules and regulations as defined under the Health Insurance Portability and Accountability Act (HIPAA).

TECHNICAL SECURITY

Technical security is maintained throughout the drug rebate process. Processes are put in place to protect, control, and monitor information access.

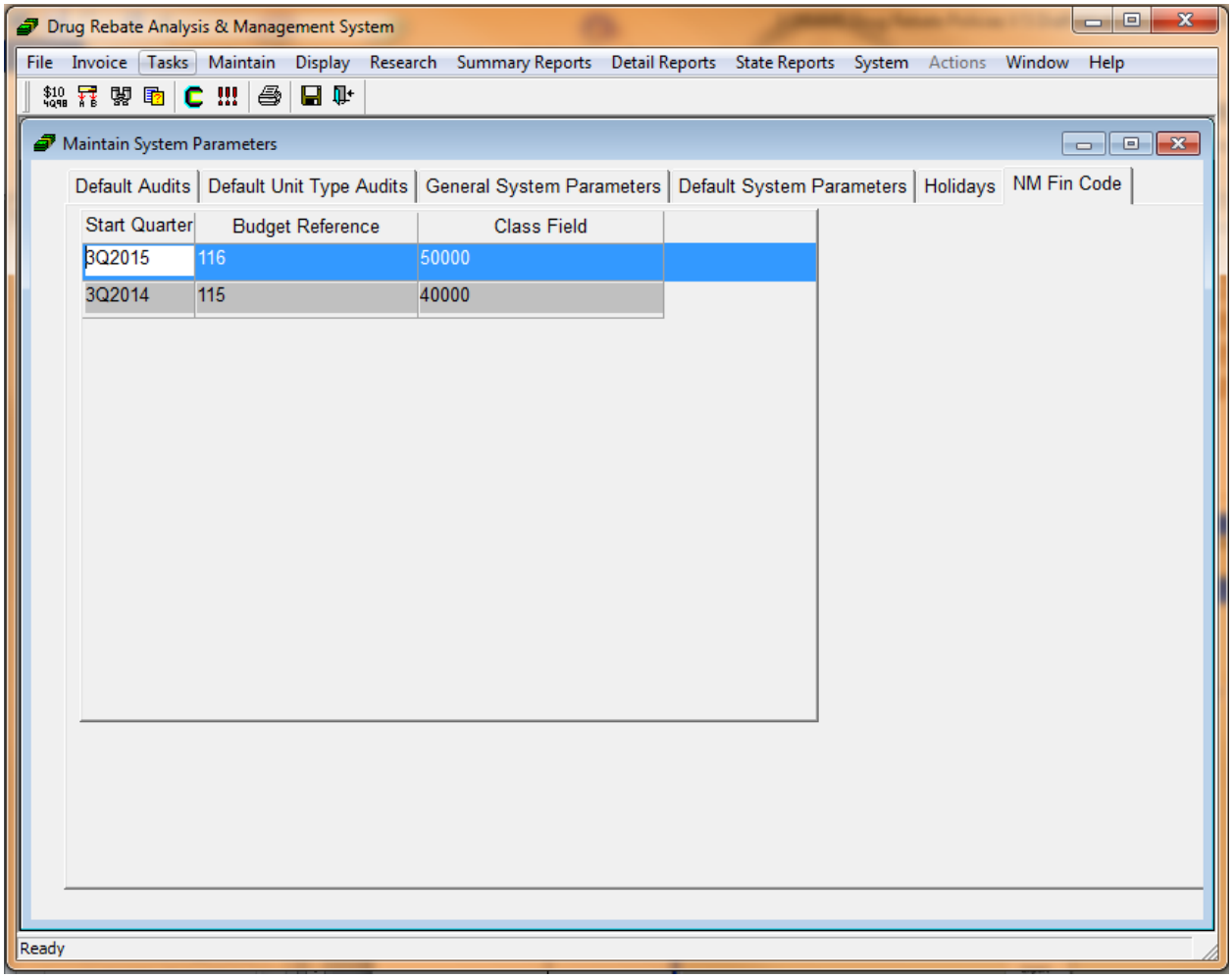
The application is designed for role-based security. The application users will only be able to access the information defined in the role, and nothing beyond that. MAD has system administrator role responsibilities. Any request for passwords in DRAMS must be requested via email for tracking purposes. Each application user will have a unique user id and password. When the employee is terminated, their application account will be removed immediately.

DRAMS Application Code Changes

Beginning with federal fiscal year 2016, changes to the budget reference and class codes can be modified directly in DRAMS. Project 13-1240 requested the DRAMS application be modified to allow ASD to enter in the budget reference and class codes vs. sending a numbered memo for the DRAMS team to systematically make these changes. The AR2 file was modified to use the data entered on-line for these two fields; therefore, eliminating the hard-coding. All other values, except Budget Reference and Class Field, will remain hard coded in the package for the AR2 file. The values for the AR1 file will remain hard coded.

The DRAMS application was modified to include a new tab next to the Holidays tab on the System Parameter window (See Figure 1 below for a mockup of the window). This tab will be specific to New Mexico and only accessible in the New Mexico environment. On the tab there will be a grid which will allow entry of Start Quarter/year, Budget Reference (eight characters) and Class Field (five characters). The users will be allowed to enter values in advance for an upcoming quarter/year change allowing the change to be proactive.

Figure 1: System Parameters



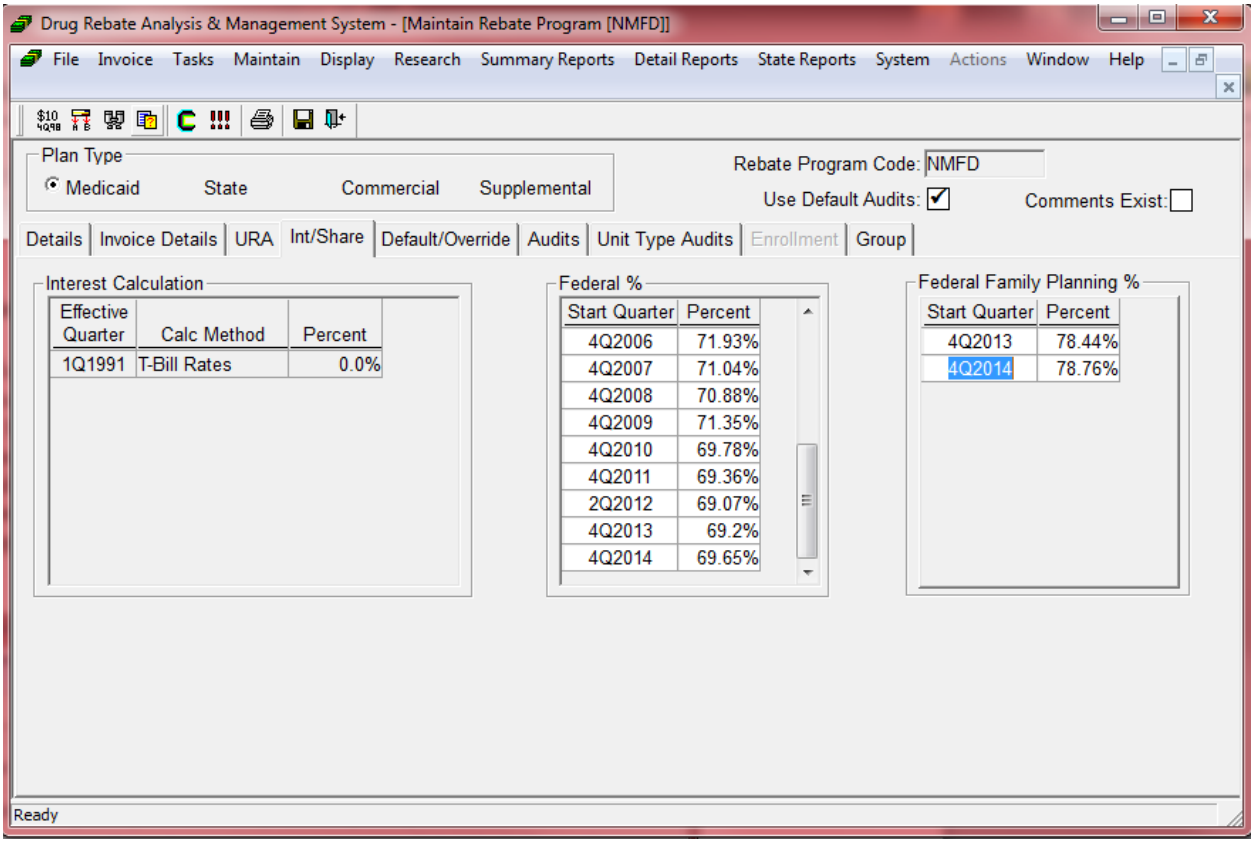
The window will allow a row to be changed if the value has not already been used by the system. If the system has determined that the value has already been used, it will prompt the user to add a new row. The system will not allow a row to be entered for a prior quarter, although there can be multiple rows for the same quarter/year. The DRAMS process will use the values from the most recently added row when generating the AR2 file for a quarter/year with multiple entries. The window will have the standard date/quarter validation and a new row in the grid begins a new period. The most recent information will be listed in the first row of the grid with the remaining data listed in descending order.

There will be right click options on the tab which will allow the addition of a new row, insertion of a row or deletion of a row. The 'Add' option adds a row at the top of the grid. This will be the last row added. When the user selects 'Insert' a row will be added above the currently highlighted row. 'Delete' will remove the row which was highlighted when the 'Delete' option was selected if the data has not been used for processing a file. Before the deletion is saved, the user will be asked if they really want to save. If they select yes, then the action is saved. The selection of no will cancel the deletion process and the row will not be removed. The deletion process will also check to see if data from the row has been used, if it has then DRAMS will not allow the user to delete the data.

Update the FMAP Rate for Medicaid expenditure report for the upcoming Federal Fiscal Year.

Any changes made to the Federal Medicaid Matching Assistance Payment (FMAP) percentage will need to be made in the DRAMS application via the Maintain; Rebate Program window (see below). When the FMAP percent is added or modified the data will be saved in a table called RPC_PARAM. The RPC_PARAM table will save all percentages used in this process along with a start and end quarter. The program will not use the new percentage until the effective start quarter. If the updated percentage is supplied to the DRAMS team after its effective start quarter, the program will calculate the Federal and State cumulative amounts with the new percent starting with the current day. No adjustments will be sent by the program for past days affected by the new percentage. The State will need to manually adjust the accounts in SHARE.

Changes to the FMAP rates should be applied prior to the first payment cycle in October.



APPENDIX A: TERMS AND DEFINITIONS

This section is provided to give a basic understanding of the terms and processes surrounding drug rebate program and those terms used within DRAMS. Terms used within DRAMS are indicated by **bold print.**

Adjustment / Dispute Code - A code specifying the reason for a change or dispute on an invoice line item NDC, supplied by the manufacturer on the ROSI or PQAS. These codes were created, defined and released by CMS. Per CMS guidelines, a manufacturer may utilize up to 3 adjustment codes and 3 dispute codes per line item NDC.

Adjust Check - An artificial NDC created for each manufacturer that is used to adjust the amount allocated for a check so the check amount and allocated amount balance. This is used to balance insignificant discrepancies due to rounding differences at the NDC level (+ $0.01) between labelers and DRAMS in the calculation of rebates.

Adjust Invoice - An artificial NDC created for each manufacturer that is used to adjust the amount allocated for a check so the check amount and allocated amount balance. This is generally used to adjust quarters prior to DRAMS historical claims data.

Allocated Amount – This is a running sum of the amount of a check that has been allocated to invoice for NDC line items thus far.

Allowed Amount - The amount that a claims payment system would pay, prior to co-pays and TPL payments. Within DRAMS, will be the Calculated Allowed Amount if available.

Audit - Number of units or dollar amount occurrence detected by the system that is being brought to the users' attention.

Batch Date - The date associated with a batch of checks received by the Rebate Services staff. Deposit date of record is commonly used for batch date.

Batch Number - An identifier assigned by DRAMS users to a batch of checks received by Rebate Services staff. This number is usually associated with the Deposit I.D. Number from the lockbox.

Billed Unit Factor - For a unit conversion, a number of unit that the units on a claim must be divisible by in order for the unit conversion to take place (i.e. conversion of 3 units to 2.5 units for correction of rounding errors would occur in multiples of 3. These multiples of 3 would be the "billed unit factor".)

Calculated Allowed Amount - The amount that would be paid based on straight calculations - for example, number of units times a pricing factor plus dispensing fee. This is before any comparison to submitted amount is made - the lesser of this amount and the submitted amount is what will actually be paid.

Check Log Number - A unique system-generated number that identifies a check. These are assigned in the Log Check process. When this window is opened or you tab to a new line, a new Check Log Number is assigned, and if you don't create a check, that number is not used for anything.

CMS – Centers for Medicare and Medicaid Services. A Federal agency that is responsible for administering the Medicare and Medicaid programs.

Claims Support – Is a detailed statement of the prescription claims by NDC, rebate program, quarter and year.

DRAMS – Acronym for the Drug Rebate Analysis and Management System (proprietary rebate administration system of XEROX).

Dunning Notice – This is a notification that is sent to drug manufacturers with unpaid rebate balances, which includes interest. The notices are sent at set intervals of 38 from the date the subject quarter's rebate invoice was mailed to the manufacturer in question and then 28 days after that. The notice identifies the outstanding balance and demands immediate payment thereof.

Frozen Invoice – This is an invoice that can no longer be recalculated.

Hold for Investigation - A flag that can be turned on to prevent a specific invoice from being frozen even if it meets other criteria of a group of invoices being frozen.

Interface – Is the crossover that allows the invoice data and payment data in DRAMS to post into SHARE at a summary level to reflect these transactions in the general ledger.

Invoice Contact - The contact to whom invoices should be mailed for the contract to which this is associated.

Invoice Handling Code - A code used on an Under Threshold invoice to specify the action that should be taken for that invoice (mail, retain or forgive).

MMIS - Medicaid Management Information System - a system that pays claims as well as maintaining associated information and performing extensive analysis.

National Association of Boards of Pharmacy Number (NABP Number) **-** Formerly owned an identification scheme that assigns a unique identifier to each pharmacy. (Now is the NCPDP Identification Number.)

National Council for Prescription Drug Programs (NCPDP) **- Current** owner of the pharmacy identifier formerly known as the NABP Number, now properly referred to as the NCPDP Provider ID.

National Drug Code (NDC) - A unique identifier associated with a drug. Within DRAMS, this term always refers to the 11-digit identifier. This consists of three parts: the first five digits represent the Labeler Code, the next four digits represent the Product Code and the last two digits represent the Package Size Code.

PDCS – Prescription Drug Claim System operated by XEROX Government Healthcare Solutions.

Public Health Service Provider (PHS or 340B Provider) - Pharmacy providers who participate in the 340B Drug Pricing Program (these providers are sometimes referred to as 340B providers). The claims of these providers are not included in drug rebate invoices due to the substantial drug discounts these providers receive through the program that are passed on to the state Medicaid agencies.

Prior Quarter Adjustment Statement (PQAS) - A CMS prescribed form that is provided by the drug manufacturer to the State Medicaid Agency. The Statement details rebate adjustments resulting from rebate formula calculation modifications or utilization changes for prior quarters.

Quarterly CMS State Tape – A tape created quarterly by CMS. The tape contains two files. The first file consists of the Unit Rebate Master File that contains one record for each NDC. Each record contains NDC, product name, unit type, UPPS (units per package size), URA, therapeutic equivalency code, drug type, drug category and DESI code. The second file provides the labeler code, labeler name, effective date in program, termination date (if applicable), current name, address and phone number of labeler contacts (legal, invoice and technical), and an indicator as to whether or not they are participating in the federal rebate program.

Quarterly Labeler Pricing Data – Tapes created quarterly by the drug manufacturers and sent to CMS detailing by NDC, drug category, therapeutic equivalency code, DESI indicator, AMP/BP, market date, FDA approval date, and unit type.

Quarterly Utilization Data Tape – A tape created quarterly, after invoice processing, by the State Medicaid Agency containing the state code and period covered and listing by NDC, product FDA registration name, rebate amount per unit, total units reimbursed, total rebate claimed, number of prescriptions and total amount reimbursed by the State.

Rebate – With respect to the Federal Drug Rebate Program, a quarterly payment made by the drug manufacturer to the State Medicaid Agency, calculated and remitted in accordance with section 1927 of the Social Security, for covered outpatient drugs purchased by the State Medicaid Agency.

Rebate Formula Adjustments – Drug manufacturers have the latitude to adjust/correct their rebate algorithm and retroactively adjust the rebate amounts due. There is a three year limit to the number or frequency of formula revisions. The contract entity or its' agent generally must rely on the accuracy of the revision.

Reconciliation Of State Invoice (ROSI) - A CMS prescribed form that is provided by the manufacturer to the State Medicaid Agency. The form lists by NDC any rebate per units changes, utilization disputes and rebate payments being made for the most recent rebate quarter.

SHARE – Statewide Human Resources, Accounting and Management Reporting System is utilized by all state agencies to record human resources and accounting transactions.

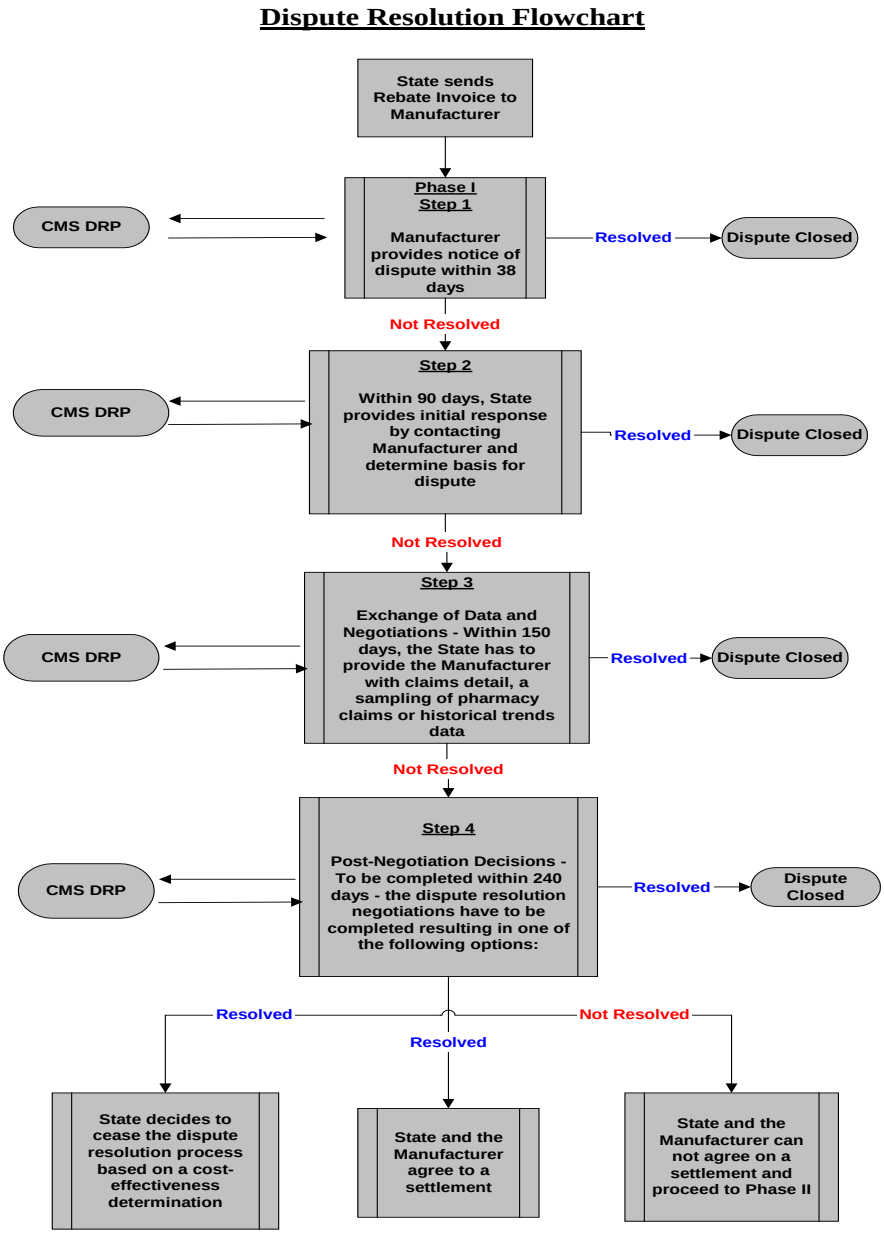
Specific Therapeutic Class (STC) - A class coding system in which drugs are grouped primarily based on their mechanisms of action.

Under Threshold Invoice Parameter – A system and/or rebate program parameter that is set for a specific dollar amount under which an invoice must be assigned a handling code of *Mail, Retain or Forgive*. (An invoice with a zero URA will not be considered as under threshold.) *Mail* can be used for those labelers under the umbrella of a multi-labeler manufacturer that typically inquires about the invoice for all labelers. *Retain* is used so that the balance for each quarter will be carried forward until the balance exceeds the mailing threshold. *Forgive* indicates that the invoice will be disregarded.

Unit Rebate Amount (URA) - The amount of rebate that will be paid by a manufacturer for each unit of a given drug that is being invoiced. URA multiplied by the number of units gives the invoiced rebate amount for each drug, quarter and rebate program combination. This is Synonymous with Rebate per Unit (RPU).

Unit Variance Adjustment Process – A process or routine within DRAMS that compares prescription claims data (First Data Bank information in PDCS) to rebate contract data (Quarterly CMS State Tape). Example: If the unit quantity data within the claim does not equate (10 ML) to the unit quantity data within the contract (1 bottle), the process converts the claims data to the equivalent unit of measure within the contract (CMS -1 bottle). The process was designed to reduce the number of rebate payment disputes from the drug manufacturer and is necessary because of the differences between the data stored within First Data Bank and CMS.

APPENDIX B: DISPUTE RESOLUTION PHASES

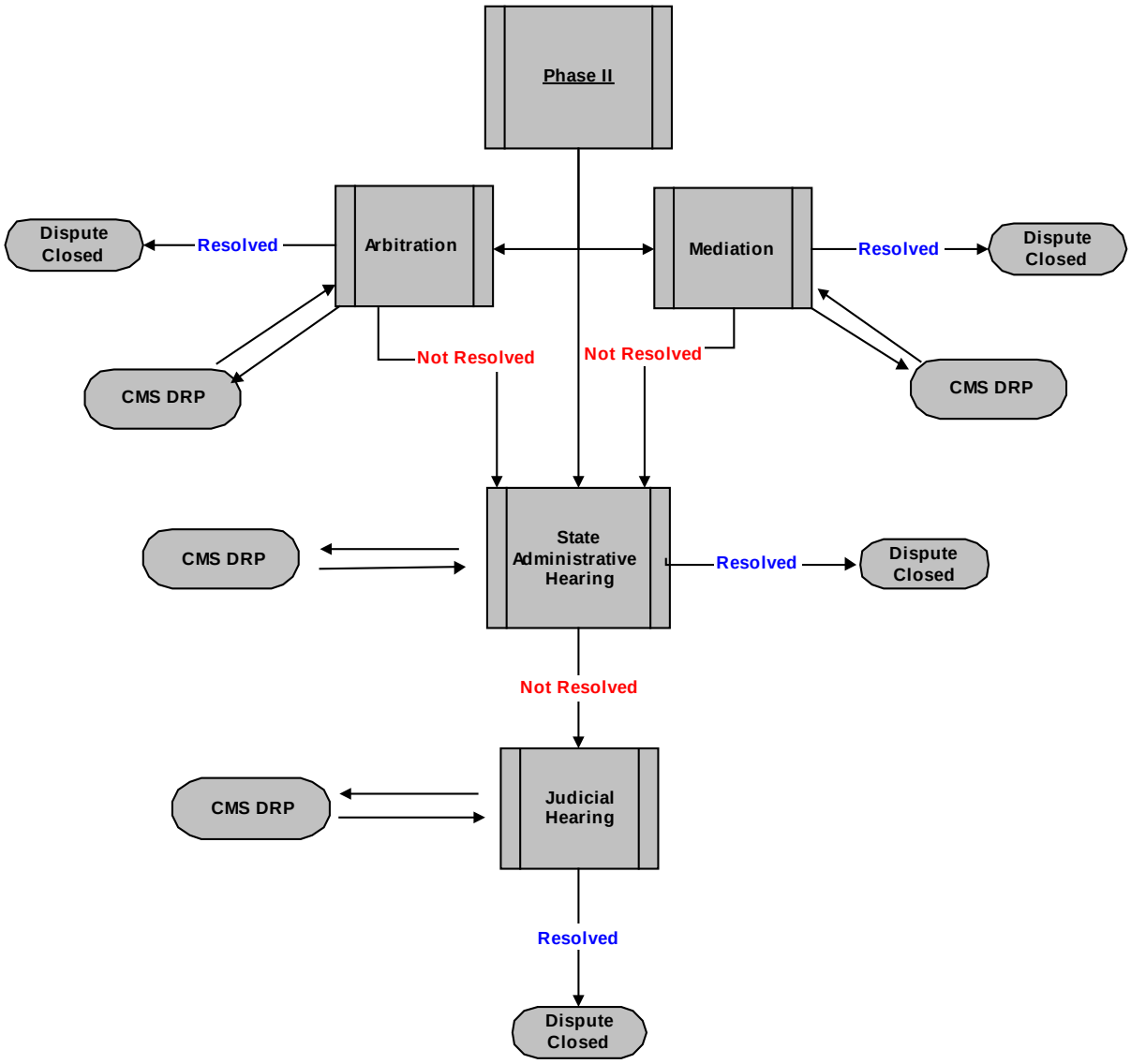


A dispute can proceed directly to Phase II, without proceeding through all the steps of Phase I, if:

1. **One party does not comply with the requirements under any step of Phase I and**
2. **The compliant party requests the dispute proceed to Phase II.**

State must schedule a hearing within 30 days of the completion of Phase I or within 30 days of the request by the compliant party to proceed to Phase II.

Hearing must be conducted no later than 1 year from the 240th day after the State receives notice of the dispute.



APPENDIX C: INVOICE COLLECTION LETTER SAMPLE

Date
Invoice Number

As of this date, our records indicate that payment for x Quarter Year xxxx, New Mexico Human Services Department Medicaid Drug Rebate, has not been received.

Payment of «Total_Invoice_Amount» **(including interest)** will be expected within 15 days of the date of this letter.

Make check payable to **NM Human Services Department** and send all payments and ROSI/PQAS to:

NM Human Services Department
ASD, Accounts Receivable Bureau
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

If you have questions regarding payment, please do not hesitate to contact Sandra Salazar at (505) 827-9474 or by email at Sandra.Salazar1@state.nm.us. If you have questions regarding disputes, please contact Sonya Miera at (505) 827-3145 or via email at Sonya.Miera@state.nm.us.

Thank you,

APPENDIX D: DISPUTE COLLECTION LETTER SAMPLE

STATE MEDICAID DRUG REBATE PROGRAM

Re: Disputed NDC's

Dear Labeler xxxxx

This correspondence confirms the resolution of disputes involving the NDC number(s) and rebate quarter(s) as set forth in the attachment to this correspondence.

In the event your company is owed a credit (as indicated by an amount in the Labeler Credit Owed column), please be advised that a credit will be posted to your company's account. If applicable, interest will be calculated pursuant to CMS guidelines. Both rebate credits as well as interest credits will be posted to your company's account by the date of this correspondence.

In the event there is a Rebate Balance Due to the State and payment is being made more than thirty-seven (37) days after the postmark date of the applicable State utilization data, please calculate and remit the interest due and owing. For information regarding CMS' interest calculation guidelines, please visit CMS at http://www.cms.hhs.gov/MedicaidDrugRebateProgram/11_InterestCalc.asp

Please remit your company's dispute resolution payment (including interest) and accompanying documentation (ROSI / PQAS) to:

NM Human Services Department
ASD, Accounts Receivable Bureau
P.O. Box 2348
Santa Fe, New Mexico 87504-2348

All checks should be made payable to **NM Human Services Department**. In addition, in order to ensure your company's account is properly credited, please include a copy of this correspondence with your payment.

If you have questions regarding payment, please do not hesitate to contact Sandra Salazar at (505) 827-9474 or by email at Sandra.Salazar1@state.nm.us. If you have questions regarding disputes, please contact Sonya Miera at (505) 827-3145 or by email at Sonya.Miera@state.nm.us . New Mexico appreciates your assistance in resolving these disputes and your company's continued participation in the Medicaid Drug Rebate Program.

Yours truly,

APPENDIX E: DISPUTE RESOLUTION EMAILS

Dear Labeler,

Our current report shows that you have the following NDCs in dispute. For your reference we have attached the claim level detail information for all disputed NDCs. In order to resolve these disputes in a timely manner we are asking you to review the information provided and respond to us within 2 weeks.

Thank you for your cooperation and we look forward to working with you.

Sincerely,

Sonya Miera
New Mexico Medicaid Pharmacy Program
505.827.3145
Attachment

****

Dear Labeler,

While we appreciate your cooperation in resolving disputes between (labeler and client) we would like to mention that the adjustment / dispute code(s) (dispute codes) will not be directly addressed. These codes are a result of URA or utilization changes that are not being disputed by either party. If you have a specific question regarding one of these codes, please contact Sonya Miera at 505.827.3145 or at Sonya.Miera@state.nm.us.

Thank you.

Sincerely,

Sonya Miera
New Mexico Medicaid Pharmacy Program
505.827.3145

****

Dear Labeler,

This email is to confirm resolution of the dispute(s) regarding NDC (fill in NDC number or numbers). As discussed, the Rebate Amount Due is ($ amount). Please submit your payment by (15 days after date of email).

In the event your company is owed a credit, please be advised that a credit will be posted to your company's account. If applicable, interest will be calculated pursuant to CMS guidelines. Both rebate credits as well as interest credits will be posted to your company's account by the date of this correspondence. In the event there is a Rebate Balance Due to the State and payment is being made more than thirty-seven (37) days after the postmark date of the applicable State utilization data, please calculate and remit the interest due and owing.

Thank you for your cooperation.

Sincerely,

Sonya Miera
New Mexico Medicaid Pharmacy Program
505.827.3145

APPENDIX F: ADJUSTMENT/DISPUTE CODE FOR ROSI AND/OR PQAS

A. Rebate per unit amount (RPU) has been revised by labeler and reported to CMS, as required.
B. Labeler has calculated RPU and/or rebate where none was reported by state.
C. Units invoiced adjusted through mutual agreement between labeler/state.
D. Labeler/State unit type and/or Units per Package Size (UPPS) value discrepancy (e.g. unit type and/or UPPS reported on invoice do not match CMS tape).
E. Labeler/State decimal discrepancy or rounding problems (e.g., State invoice does not reflect decimal value on CMS tape).
F. *Package size discrepancy (e.g., could include correction to package size by labeler).
G. *Transferred NDC to another labeler code or company. (Labeler code is ultimately responsible for rebate payment).
H. Utilization change from the state.
I. RPU amount adjusted through correspondence between labeler/State. USE THIS CODE ONLY when the State has reported a RPU not based on the CMS tape and code A is not applicable.
J. No State reimbursement reflected on the claims level detail.
K. *J-Code to NDC crosswalk requires validation data (e.g., crosswalk to products with multiple NDCs and/or package sizes).
L. Generic Substitution
M. Duplicate Claim
N. Discontinued/terminated NDC for which the shelf life expired more than one year from the dispense date. (Documentation should support dispensed date).
O. Invalid/miscoded NDC
P. *State units invoiced exceed unit sales. (Documentation should include supporting methodology and data source.)
Q. Utilization/quantity is inconsistent with the number of prescriptions.
R. *Utilization/quantity is inconsistent with State historical trends or current State program information. (Documentation should include trend/program information).
S. *Utilization/quantity is inconsistent with State historical trends or current State program information. (Documentation should include trend/program information.)
T. Utilization/quantity is inconsistent with lowest dispensable package size.
U. *Product not rebate eligible (e.g., product was not reported to CMS because the product is not a covered outpatient drug, product is for a non-Medicaid State-only program, an HMO non-fee-for-service program, etc…).
V. *No record of sales directly to State or State history of purchase from out-of-State provider (e.g., border pharmacies, mail order pharmacies, etc.).
W. Closed out. All disputes resolved.
X. *PHS entity not extracted from State data. (Documentation should include PHS provider number).

*Supporting Documentation REQUIRED.

Note: Some adjustment/dispute codes are specifically noted to require supporting documentation; however, supporting documentation can always be submitted, even for those instances where it is not specifically mentioned on this document.

APPENDIX G: SAMPLE BID FORM

FOR SUPPLEMENTAL REBATES: This feature is not used at this time, but may be in the future. This documentation will be saved for the future usage.

Medicaid Supplemental Rebate Program

Bid Submission Information

Name:
Title:
Manufacturer Name:
Bid Submission Date:

NDC Number	Product Name	Pricing Reference WAC	WAC	Federal Rebate RPU	Federal Rebate RPU %	One-of-One % Bid	One-of-Two % Bid	One-of-Many % Bid	Comments

The terms of this agreement are not subject to negotiation. By submitting the bid, the manufacturer does hereby acknowledge and agree to the following:
1) Manufacturer has received and reviewed the supplemental rebate agreement.
2) The terms of the supplemental rebate agreement will not be negotiated.
3) The manufacturer agrees to the terms of the supplemental rebate agreement.
4) The bid is submitted with the understanding that any existing applicable step edits will continue in effect for the new contract period.
5) If the submitted bid is accepted by Medical Assistance Division, manufacturer shall execute a supplemental rebate agreement based on the bid submitted.

****

Medical Assistance Division
P.O. Box 2348
Santa Fe, NM 87504-2348

APPENDIX H: DRAMS TO SHARE INTERFACE FILE LAYOUT

COLUMN	RECORD DESCRIPTION	
	01 HEADER-REC.	
1	05 REC-TYPE-H	PIC X(01) VALUE 'H'.
2	05 BUSINESS-UNIT-H	PIC X(05) VALUE '63000'.
7	05 JOURNAL-ID	PIC X(10) VALUE 'NEXT'.
17	05 JOURNAL-DATE	PIC X(08) VALUE SPACE.
25	05 VALUE SPACE	PIC X(12).
37	05 LEDGER-GROUP	PIC X(10) VALUE 'ACTUALS'
47	05 VALUE SPACE	PIC X(21).
68	05 SOURCE	PIC X(03) VALUE 'EXT'.
71	05 VALUE SPACE	PIC X(08).
79	05 DESCR	PIC X(30) VALUE SPACE.
109	05 VALUE SPACE	PIC X(33).
142	05 SYSTEM-SOURCE	PIC X(03) VALUE 'EXT'.
145	05 VALUE SPACE	PIC X(20).
165	05 BUDGET-HDR-STATUS	PIC X(01) VALUE 'N'.
166	05 VALUE SPACE	PIC X(16).
182	05 WS-NMS-IU-TRAN-CD	PIC X(08) VALUE SPACE.
190	05 VALUE SPACE	PIC X(176).
	01 LINE-REC.	
1	05 REC-TYPE-L	PIC X(01) VALUE 'L'.
2	05 BUSINESS-UNIT-L	PIC X(05) VALUE '63000'.
7	05 JOURNAL-LINE	PIC 9(09) VALUE ZERO.
16	05 LEDGER	PIC X(10) VALUE 'ACTUALS'.
26	05 ACCOUNT	PIC X(10).
36	05 VALUE SPACE	PIC X(10).
46	05 DEPTID	PIC X(10).
56	05 OPERATING-UNIT	PIC X(08).
64	05 PRODUCT	PIC X(06).
70	05 FUND-CODE	PIC X(05).
75	05 CLASS-FLD	PIC X(05).
80	05 PROGRAM-CODE	PIC X(05).
85	05 BUDGET-REF	PIC X(08).
93	05 VALUE SPACE	PIC X(25).
118	05 CHARTERFIELD1	PIC X(10).
128	05 VALUE SPACE	PIC X(20).
148	05 PROJECT-ID	PIC X(15).
163	05 VALUE SPACE	PIC X(25).
188	05 MONETARY-AMT-X.	
188	10 MONETARY-AMT	PIC -9(14).999.
207	10 FILL10	PIC X(09).
216	05 VALUE SPACE	PIC X(18).
234	05 JRNL-LN-REF	PIC X(10).
244	05 LINE-DESCR	PIC X(30).
274	05 VALUE SPACE	PIC X(08).
282	05 FOREIGN-AMT-X.	
282	10 FOREIGN-AMOUNT	PIC -9(14).999.
301	10 FILL13	PIC X(09).
310	05 VALUE SPACE	PIC X(17).
327	05 BUSINESS-UNIT-PC	PIC X(05).
332	05 ACTIVITY-ID	PIC X(15).
347	05 ANALYSIS-TYPE	PIC X(03).
350	05 RESOURCE-TYPE	PIC X(05).
355	05 RESOURCE-CATEGORY	PIC X(05).
360	05 RESOURCE-SUB-CAT	PIC X(05).

APPENDIX I: LETTER OF DIRECTION TO MEDICAID MANAGED CARE ORGANIZATION ON REBATES

DATE: February 16, 2015

TO: Centennial Care Managed Care Organizations

FROM: Nancy Smith-Leslie, Acting Director
Medical Assistance Division

SUBJECT: Centennial Care Letter of Direction #37

This Letter of Direction (LOD) provides direction to the Centennial Care Managed Care Organizations (MCO) to work with the Xerox Drug Rebate Analysis and Management System (DRAMS) staff on the drug rebate dispute resolution process.

Xerox will continue to send drug rebate invoices to manufacturers based on the encounter data pharmacy and medical claims submitted by the MCO. Xerox will receive the manufacturers' checks. If the manufacturer does not pay the invoice in full because the manufacturer disputes some of the data on the invoice, Xerox will refer manufacturer disputes to the appropriate MCO staff.

Typically, when the manufacturer thinks the invoice may be based on incorrect data on the claims, the manufacturer will ask for claim level detail (CLD). Xerox will send the claim level detail to the manufacturer when it is requested.

After the manufacturer reviews the CLD, the manufacturer may issue a dispute in the form of an email or letter, and request that the payer review the claims.

When a dispute is reported to the MCO, the MCO is responsible for reviewing their pharmacy claims data to determine if the data needs to be corrected or if the data is, in fact, correct. This entails reviewing claims and possibly contacting pharmacy and medical providers to obtain information to resolve the dispute. The MCO must report the resolution of the dispute to Xerox within 30 days from the date of receiving the notice of the dispute.

A smaller number of disputes are initiated after the manufacturer has already paid the invoice. These disputes will be handled in the same manner as other disputes.

Xerox will review the MCO pharmacy and medical drug claims data before it is printed to invoices in an attempt to minimize disputes. Often, for specific drug items, reporting the correct number of units is a common problem and the correction may be obvious to Xerox. In such cases it will make the change prior to printing invoices. Usually this will be instances for which the standard payments units are different than the units that CMS expects to be used on the rebate invoices. It also may occur when an MCO allows a provider to bill incorrect units. Xerox will notify an MCO of any situation where the MCO continues to make the same error in data and the MCO will be required to implement corrections in their processing of claims.

COMMON DISPUTE REASONS

Disputes frequently result from recurring circumstances and often for the same drug items for every quarter. When the error that will likely lead to a dispute originates with the provider and the MCO does not detect the error when processing the claim, the MCO will be asked to correct their claims processing editing to avoid continual disputes.

The following sections identify the most common reasons for disputes.

Unit Type Discrepancy

A provider bills a claim utilizing a unit type that differs from the unit type that was utilized in calculating the rebate. Most claims processing systems allow providers to utilize only three (3) unit types when billing claims. CMS has eight (8) unit types for claims.

Common Claim Processing System Unit Types

- Each (caps, tabs, kits, and vials)
- Milliliters (liquids)
- Grams (solids)

CMS Unit Types

- AHF (refers only to injectable Anti-Hemophilic Factor units)
- CAP (capsule)
- SUP (suppository
- GM (grams)
- ML (milliliter)
- TAB (tablet)
- TDP (transdermal patch)
- EA (each, refer to drugs not identifiable by any other unit type as given in program instructions)

Xerox staff will convert the common claims processing unit types before preparing manufacturer invoices. If a dispute occurs based on the unit conversion or for units that were not converted, Xerox will make the correction in order to resolve the dispute.

If the unit type appears to be incorrect on the original encounter claim, the dispute will be sent to the MCO DRAMS designate for resolution.

Refer to Communicating to Xerox on Disputes and Correcting Errors, below.

Data Entry Errors Regarding the Quantity

Incorrect quantities are sometimes entered on the claims by the provider. If the MCO does not detect the incorrect quantities, this can cause discrepancies because of the number of units shown as dispensed on the claim.

In resolving this type of dispute, the MCO DRAMS designate should review the claims data in question and determine if the provider billed incorrectly. This will entail looking at the claim; contacting the provider and requesting what the units represent (ML, GRAMS, and EACH). If it is an “each”, determine

what the "each" represents (capsules, tablets, kits or vials). If the claim was billed incorrectly, the provider must adjust the claim with the correct units.

Refer to Communicating to Xerox on Disputes and Correcting Errors, below.

Decimals

When the drug strength does not equal a whole number, or the units of measure or package size has a decimal in the units, a decimal point in the units indicated on the claim could mean a provider error.

If the MCO does not detect the incorrect quantities, this can cause discrepancies because use of a decimal point may be illogical for many unit types for drug items. This type of dispute usually turns out to be provider error.

In resolving this type of dispute, the MCO DRAMS designate should review the claims data in question and determine if the provider likely billed incorrectly. It may be necessary to contact the provider if the units are unusual and the MCO DRAMS designate cannot tell whether the provider's units are correct or incorrect.

Refer to Communicating to Xerox on Disputes and Correcting Errors, below.

Units or Quantities Appear Inconsistent

If the units billed for a particular NDC are inconsistent with the number of prescriptions, the pharmacy reimbursement or lowest dispensable package size, the drug manufacturers will question the amount dispensed if it appears to be an unexpected amount.

In resolving this type of dispute, the MCO DRAMS designate should review the claims data in question and determine if the provider likely billed incorrectly. It may be necessary to contact the provider if the units are unusual and the MCO DRAMS designate cannot tell whether the provider's units are correct or incorrect.

Refer to Communicating to Xerox on Disputes and Correcting Errors, below.

Terminated/Invalid NDCs

Terminated NDCs (dispute code N) are those products where the shelf life for the last lot produced has expired. Per CMS guidelines, the affected manufacturer or labeler is required to submit pricing data and pay rebates for 4 quarters past the termination date, but only for claims with a date of service prior to the termination date.

Xerox will contact the manufacturer to obtain the termination date and determine whether said date has been provided to CMS. If advised that a termination date has been sent to CMS and a sufficient amount of time has elapsed since that submission (2 quarters), Xerox will provide the MCO DRAMS designated staff with a list of the providers involved (i.e., those with the most claims for the drug and quarter in question). The MCO DRAMS designate will need to contact the providers to determine whether they have the subject product on their shelf with an unexpired expiration date. If the product is on the shelf, they will need to provide the lot number and expiration date from the product and give that information to Xerox staff.

The affected claims must be checked to identify all dates of service that fall after the termination date. For those claims, an adjustment will need to be made. The provider must adjust the claim if the incorrect NDC code was used.

Refer to Communicating to Xerox on Disputes and Correcting Errors, below.

State Units Exceed Expected Sales/No Record of Sales in the State

Manufacturers tend to have a threshold on their NDC numbers and if they hit that threshold they will dispute based on units exceed expected sales. They also will dispute if they show no record of sales of their product within the state.

In resolving this type of dispute, the MCO DRAMS designate should contact the provider and determine if they really used the NDC code reported. Sometimes the provider can show they did order an item from out of state or have other documentation that their billing was correct. The MCO must obtain documentation from the provider of purchase, such as an invoice from their wholesaler with the NDC in question and the amount purchased. This must be forwarded to Xerox so that it may provide the information to the drug manufacturer when requested. Note that the provider must adjust the claim if the incorrect NDC code was used originally.

Refer to Communicating to Xerox on Disputes and Correcting Errors, below.

Inaccurate NDC

A pharmacy or medical provider may submit a claim in which the NDC billed is not the NDC dispensed. In resolving this type of dispute, the MCO should contact the provider and determine if they really used the NDC code reported.

The provider must adjust the claim if the incorrect NDC code was used.

Refer to Communicating to Xerox on Disputes and Correcting Errors, below.

COMMUNICATING TO XEROX ON DISPUTES AND CORRECTING ERRORS

The MCO is to notify Xerox of claims on which the units were incorrect. Xerox will enter a comment into DRAMS that the units were incorrect and that the MCO is working on adjustments. Xerox will notify the manufacture regarding the status of the dispute.

Xerox cannot change the units on the claim. Instead, it is necessary for the MCO to have the provider adjust the claim. When the encounter data is adjusted, the DRAMS system will back out the original incorrect quantity and new invoices will carry the new quantity as a prior quarter adjustment.

If the MCO verifies that some of the disputed quantities are correct, the MCO must notify Xerox. Xerox will enter a comment into DRAMS that the units were correct and state how the quantity was verified such as a call to the provider. Xerox will notify the manufacturer. The manufacturer may request further documentation such as an invoice from the provider. When further documentation is requested, Xerox will notify the MCO who will be responsible for obtaining the documentation.

The Xerox DRAMS staff that will be contacting the MCO are as follows:

Marvin Boyd (Marvin.Boyd@Xerox.com)	505-924-2011
Koren Billie (Koren.Billie@Xerox.com)	505-246-9988 Ext. 813-1115
Mark E. Light (Mark.Light2@Xerox.com)	505-246-9988 Ext. 813-1103

Should you have any questions on this LOD, please feel free to contact Sonya Miera at 505-827-3145 or Sonya.Miera@state.nm.us. If you have questions or concerns on operational matters related to drug rebates, please contact the Xerox staff listed above. Thank you.