POLICY AND PROCEDURE	
Title: Medicare Plan Finder Files (MPF) and MPF Accuracy	
Primary policy owner: Pharmacy	**Policy #:** PH41
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☐Behavioral Health & Social Services (BH/SS) 3) ☐ Benefits Administration (BA) 4) ☐ Case Management (CM) 5) ☐ Claims (CLMS) 6) ☐ Community Marketplace & Member Engagement (MAR) 7) ☐ Compliance (CMP/HPA) 8) ☐ Configuration (CFG) 9) ☐ Provider Contracting (CONT) 10) ☐ Cultural & Linguistics (CL) 11) ☐ Customer Service (CS)	12) ☐ Facilities (FAC) 13) ☐ Finance (FIN) 14) ☐ Human Resources (HR) 15) ☐ Information Technology / Core Systems (IT) 16) ☒ Pharmacy (PH) 17) ☐ Provider Networks (PRO) 18) ☐ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☐ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☐ Medical Management (MM)
Product Type: ☐Medi-Cal ☒D-SNP	**Supersedes Policy Number:** NA

I. PURPOSE

To ensure Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") is in compliance with all contractual requirements, applicable federal and state laws, and regulations for responding, preventing, reviewing, and investigating all reported and identified non-

compliance. Health Plan Workforce and Delegates develop and submit Part D Medicare Plan Finder files (MPF) for posting on the Medicare Plan Finder website in compliance with federal and state regulations and other program requirements.

II. POLICY

A. Health Plan must, through its Pharmacy Benefits Manager (PBM), submit current pricing (Pricing File) and pharmacy network information (Pharmacy Cost File) to Center for Medicare and Medicaid Services (CMS) on a biweekly basis, according to the latest CMS pricing data guidelines.

B. The Pharmacy Cost File must report on the contracted Pharmacy Network, dispensing fees (brand, generic and vaccine administration), services offered by the pharmacy (Specialty, LTC, Home Infusion), and whether it offers 90-day supply.

C. The Pricing File must report on the cost of every drug included in Health Plan's approved formulary. The Pricing File must also report on the cost of every drug included in Health Plan's supplemental drug file, if applicable. The file must also report the ceiling cost and ceiling quantity, if applicable.

D. The submission for the upcoming benefit year starts in July/August of the preceding year as test claims. Health Plan must review the test claims to ensure appropriate submission and to correct any errors.

E. CMS calculates the Medicare Plan Finder Accuracy Star rated measure by comparing the prices reported on the MPF files to the drugs' total costs reported on the Prescription Drug Events (PDE) files. Health Plan must ensure, through the PBM, that the price of the medications dispensed at the point-of-sale match the latest MPF pricing files.

   1. The magnitude of difference - considers both ingredient cost and dispensing fee and measures the amount that the PDE price is higher than the MPF price.

2. The claim percentage index – or frequency of difference - also considers both ingredient cost and dispensing fee while measuring how often the PDE price is higher than the MPF price.

III. PROCEDURE

A. Health Plan delegates the preparation and submission of the MPF files to the PBM.
B. The PBM submits test files to CMS for the upcoming benefit year as soon as instructed by CMS.
C. Throughout the benefit year, the PBM produces the Plan Finder files on a biweekly basis and transfer them to Health Plan Management System (HPMS) site.
D. Between the times in which the files are created to when they are submitted, Quality Assurance (QA) is performed by the PBM based on CMS Plan Finder QA checks, as well as traditional file format checks.
E. Once a file is submitted, PBM provides Health Plan with a copy of the submitted file as well as the status of the submission.
F. If Health Plan receives error notifications for reports published by CMS on HPMS following a submission – Health Plan communicates them immediately to the PBM for prompt resolution.
G. The PBM calculates, quarterly, the Plan finder accuracy score, by comparing the Plan Finder price to the PDE price and determining the magnitude and frequency of differences found when the PDE price exceeds the PF price. Of note, only the PDEs for date of service between Jan 1 and September 30 of the year measured are included in the calculations.
H. Health Plan works with the PBM to identify price accuracy errors, analyze root causes, and, if applicable, submit corrected PDE records as soon as possible.

IV. ATTACHMENT(S)

A. Glossary of Terms Link

V. REFERENCES

A. Content Requirements for Plan Finder: https://www.cms.gov/marketplace/about/affordable-care-act/content-requirements-plan-finder
B. Medicare Plan Finder Files (MPF) Price Accuracy Star measure description and technical note: https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf
C. State Medicaid Agency Contract (SMAC)
D. Health Plan Contract with Centers for Medicare & Medicaid Services (CMS)

VI. REVISION HISTORY

Version*	Revision Summary	Date
001		
002		
003		
004		
Initial Effective Date: 09/24/2025		
Published Date:09/29/2025		

VII. Committee Review and Approval To Be Completed by Compliance

Committee Name	Version	Date
Compliance Committee	001	09/24/2025
• Privacy & Security Oversight Committee		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review Committee		

Quality Improvement Health Equity Committee (QIHEC)		
• Quality Operations Committee		
• Grievance Committee		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare Services (DHCS)			
Department of Managed Care (DMHC)			

IX. *Approval signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy