

Medi-Cal Update

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12. Upcoming Pharmacy Fee-For-Service Reimbursement Changes for Covered Outpatient Drugs

As has been published in previous *Medi-Cal Updates*, the Department of Health Care Services (DHCS) is implementing a new fee-for-service reimbursement methodology for covered outpatient drugs. Although the policy effective date mandated by the Centers for Medicare & Medicaid Services (CMS) is April 1, 2017, it will take the state's Fiscal Intermediary additional time to update the claims processing system to reimburse using the new methodology. DHCS anticipates that the system changes will be implemented in late 2018. After system implementation, DHCS intends to make retroactive adjustments for all claims with dates of service between the policy effective date of April 1, 2017, and the date of system implementation. DHCS will engage stakeholders in the upcoming months with regards to how these claim adjustments will be rolled out.

As outlined in California's <u>State Plan Amendment 17-002</u> approved by CMS on August 25, 2017, the new reimbursement methodology reflects the following changes:

Adopts CMS's National Average Drug Acquisition Cost (NADAC) as the basis for ingredient cost reimbursement. The
NADAC is a national, drug-pricing benchmark determined by a federal survey, representing the national average
invoice price for drug products based on invoices from wholesalers and manufacturers submitted by retail community
pharmacies. Wholesaler Acquisition Cost (WAC) + 0% is used as the basis for reimbursement when a NADAC is not
available. The NADAC and WAC benchmarks replace Average Wholesale Price (AWP) - 17% in the existing drug
ingredient cost reimbursement methodology, which currently reimburses the lowest of AWP minus 17%, the Federal
Upper Limit (FUL), Maximum Allowable Ingredient Cost (MAIC) or the pharmacy's usual and customary charge.

DHCS reminds providers that it is their responsibility to monitor the published NADAC pricing on the CMS Pharmacy Pricing website. Providers may use the NADAC Request for Medicaid Reimbursement Review Form to request a rate review. The NADAC Help Desk will research inquiries and evaluate them for potential NADAC updates based upon invoice data collected from the provider initiating the review, additional pharmacy inquiries and other market factors such as compendia price changes.

- Replaces the current professional dispensing fee structure (\$7.25 for retail and \$8 for Long Term Care pharmacies) with the implementation of a two-tiered professional dispensing fee based upon a pharmacy's total (both Medicaid and non-Medicaid) annual claim volume, as follows:
 - Less than 90,000 claims per year equals \$13.20 (requires annual provider self-attestation)
 - 90,000 or more claims per year equals \$10.05

As has been published in previous *Medi-Cal Updates*, provider attestations for calendar year reporting periods 2016 and 2017 are now complete. Attestations for calendar year 2018 will begin in mid-January 2019. For additional information regarding the self-attestation process, providers can refer to the Pharmacy Provider Self-Attestation FAQs.

Pharmacy providers are reminded that until such time that DHCS implements the new fee-for-service reimbursement, the pharmacy dispensing fee shall be reimbursed according to the previous methodology (\$7.25 retail or \$8 for Long Term Care pharmacies). This includes the dispensing fee submitted for 340B drug claims by covered entities and their contract pharmacies pursuant to *Welfare and Institutions Code* (W&I Code), Section 14105.46.

Providers should refer to the Pharmacy Reimbursement Project page on the DHCS website for access to additional project

resources, including the <u>General Project FAQs</u> . DHCS strongly encourages the Medi-Cal pharmacy fee-for-service provider community to closely monitor upcoming <i>Medi-Cal Update</i> pharmacy bulletins for additional information regarding any future
stakeholder events, as well as implementation updates.