



Retroactive Claim Adjustments

Pharmacy Reimbursement Project Actual Acquisition Cost Project Implementation

March 26, 2019 1:00 – 2:00

1-888-324-8106 Passcode 1856294



Agenda

- Welcome and DHCS Introductions
- Background
- Review of New Payment Methodology
- Scope of Claims Impacted
- Retroactive Claim Adjustments Schedule
- Request for Repayment Agreement
- Next Steps
- Q & A



Welcome and DHCS Introductions

- We welcome our Stakeholder Community
- Meet the DHCS Pharmacy Team
- Housekeeping Notes:
 - Participant phones will remain muted during the presentation, and individual phone lines will be unmuted by the Operator during the Q&A.



Background

- Efforts are driven by the Covered Outpatient Drug Final Rule (CMS-2345-FC) which required Medicaid Agencies to adopt an Actual Acquisition Cost (AAC) based reimbursement methodology for Covered Outpatient Drugs (CODs) with an effective date of April 1, 2017.
- The Centers for Medicare & Medicaid Services (CMS) approved State Plan Amendment (SPA) 17-002 on August 25, 2017.
- The system design and development life cycle activities required many months of work for DHCS and its Fiscal Intermediary.

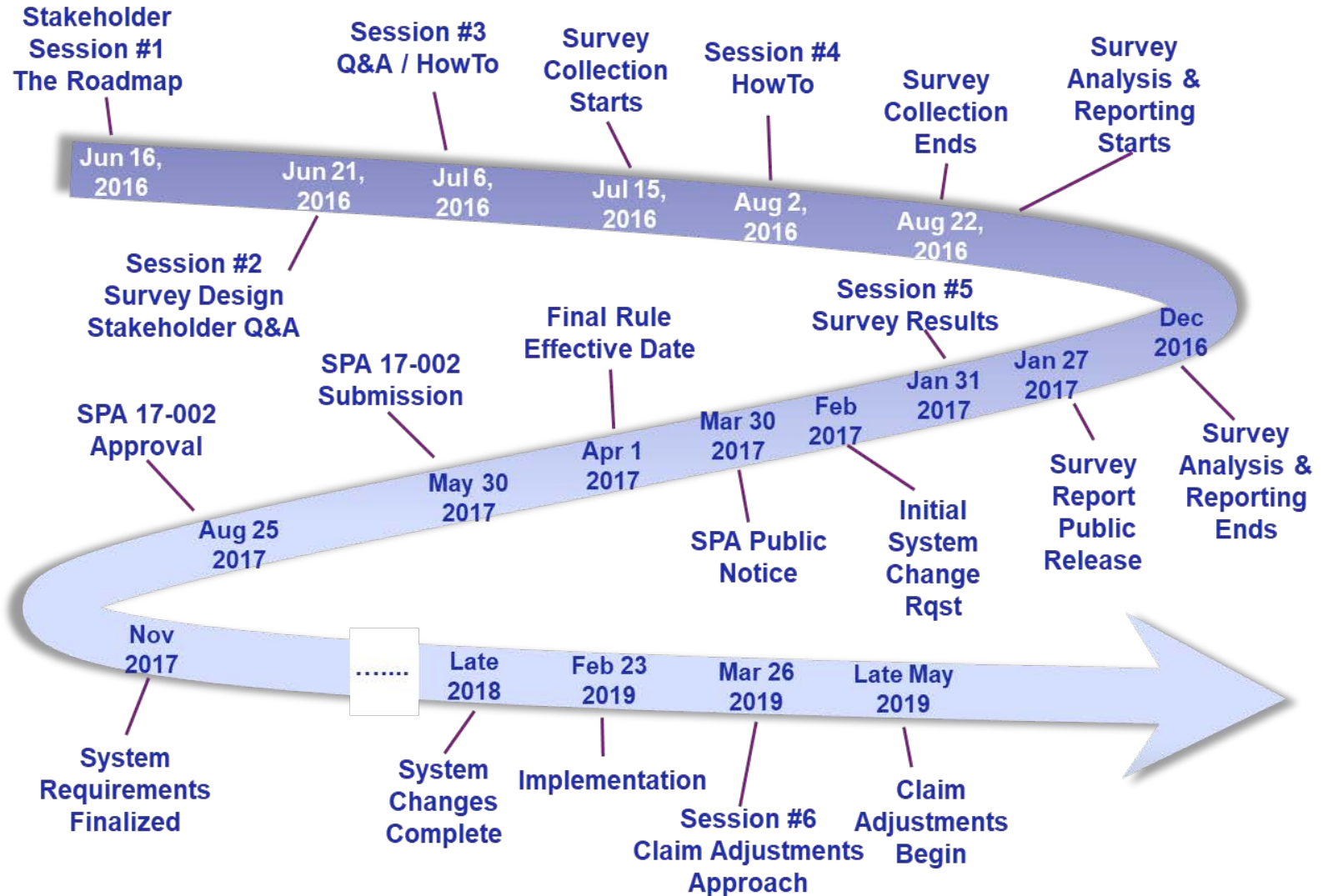


Background (cont.)

- DHCS began publishing bi-monthly provider bulletins announcing upcoming project implementation in July 2018.
- DHCS implemented the new AAC-based reimbursement methodology for covered outpatient drugs on February 23, 2019.
- DHCS must begin to make retroactive rate adjustments for claims with dates of service between April 1, 2017 and February 23, 2019.



Timeline





Review of New Payment Methodology

- Drug Ingredient Cost:
 - California has adopted the National Average Drug Acquisition Cost (NADAC) as the basis for AAC. It 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) plus 0 percent is used as the basis for reimbursement when a NADAC is not available.
 - The new methodology reimburses the lower of the NADAC (or WAC if no NADAC), Federal Upper Limit (FUL), Maximum Allowable Ingredient Cost (MAIC) plus the professional dispensing fee, or the pharmacy's usual and customary charge.

* Reminder - 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.



Review of New Payment Methodology (cont.)

- Professional Dispensing Fee (PDF) :
 - A two-tiered PDF based on a pharmacy's total (both Medicaid and non-Medicaid) annual claim volume as follows:
 - \$13.20 for less than 90,000 claims per year. Requires annual provider self-attestation.
 - \$10.05 for 90,000 or more claims per year.
 - Note: DHCS policy is that a claim is equivalent to a dispensed prescription; therefore, the attestation is for total dispensed prescription volume.
 - The attestation period for each calendar year will occur the following January for approximately six weeks, and will determine the PDF component of pharmacy claim reimbursement for claims for the state's following fiscal year.



Scope of Claims Impacted

- All paid pharmacy-related claims with dates of service on or after April 1, 2017, received prior to implementation on February 23, 2019, except the following:
 - Blood Factors
 - Enteral Products
 - Incontinence Supplies
 - Medical Supplies
 - Physician Administered Drug Claims
- Both the Ingredient Cost component and the Professional Dispensing Fee component will be recalculated and retotaled for each claim.
- 340B claims will only recalculate the PDF component, because the drug ingredient cost is already equal to the actual acquisition cost.



Retroactive Claim Adjustments Schedule

- Claim adjustments will be broken out into an estimated nine (9) iterations spanning 8 – 10 months, currently projected as follows:
 - Iteration 1: April 2017 claims
 - Iteration 2: May and June 2017 claims
 - Iteration 3: July - September 2017 claims (3rd Qtr 2017)
 - Iteration 4: October - December 2017 claims (4th Qtr 2017)
 - Iteration 5: January - March 2018 claims (1st Qtr 2018)
 - Iteration 6: April - June 2018 claims (2nd Qtr 2018)
 - Iteration 7: July - September 2018 claims (3rd Qtr 2018)
 - Iteration 8: October - December 2018 claims (4th Qtr 2018)
 - Iteration 9: January – February 22, 2019 claims



Request for Repayment Agreement

- Providers experiencing financial hardship may contact the Overpayments Unit to request a repayment agreement.
- Repayment Options:
 - Withholding from paid Medi-Cal claims
 - Direct payments (Checks or Electronic Funds Transfer)
- Overpayments Contact:
 - Email: GCU@dhcs.ca.gov
 - Phone: (916) 650-0575



Next Steps

- FAQs will be developed and uploaded to the Medi-Cal website reflecting questions asked during this session.
- Provider mailer will be sent to all impacted providers officially informing them of the upcoming claim adjustments.
- Be sure to sign up for the Medi-Cal Subscription Service to receive project-related articles at:

[MCSS Sign Up](#)



Q&A

- To pose a question, push the star “*” and then “1” (one).
- The operator will facilitate the questions by putting the individuals in the queue one at a time.
- One question plus one follow up question will be allowed per individual, and then we will proceed to the next person.



Thank You!

- Refer additional questions to the Medi-Cal Telephone Service Center at 1-800-541-5555 (outside of California, please call 916-636-1980), and select the following:
 - Option 1 for English or Option 2 for Spanish
 - Option 1 for Provider
 - Option 4 for Technical Help Desk
 - Option 2 for Pharmacy
 - Option 1 for Provider
 - Option 1 for NPI – enter NPI followed by the # sign
 - Option 2 for Pharmacy
- The caller will be directed to an agent.