Medi-Cal Rx Pharmacy Fee-For-Service Covered Outpatient Drugs – Frequently Asked Questions (FAQs)

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DHCS
CALIFORNIA DEPARTMENT OF
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General

1. **Why did the Department of Health Care Services (DHCS) change its Medi-Cal fee-for-service (FFS) pharmacy reimbursement for covered outpatient drugs (CODs)?**

   The Centers for Medicare & Medicaid Services (CMS) published its Final Rule for Covered Outpatient Drugs (CMS-2345-FC) on February 1, 2016. Under the Final Rule, each state Medicaid agency was required to adopt an Actual Acquisition Cost (AAC)-based methodology for CODs. To satisfy this requirement, California, along with many other state Medicaid agencies, adopted CMS' National Average Drug Acquisition Cost (NADAC) as the basis for AAC for drug ingredient reimbursement.

2. **When were these changes implemented?**

   The reimbursement changes went live on February 23, 2019. Per the Final Rule, the new reimbursement methodologies were mandated to be effective April 1, 2017. Although State Plan Amendment (SPA) 17-002 was approved by CMS on August 25, 2017, it took time for the state to update the claims processing system to reimburse using the new methodology. DHCS will make retroactive adjustments for impacted claims with dates of service (DOS) from the policy effective date of April 1, 2017, through the implementation date of February 23, 2019. However, these retroactive adjustments are currently on pause.

AAC and Ingredient Cost Reimbursement

3. **What is the NADAC and how does CMS calculate it?**

   The NADAC is a national reference benchmark that state Medicaid programs may use when determining their reimbursement to pharmacy providers. It represents the national average invoice price derived from retail community pharmacies for drug products based on invoices from wholesalers and manufacturers. It does not reflect off-invoice discounts, rebates, or price concessions. CMS has published its methodology for developing the NADAC for interested stakeholders. You may access the Methodology for Calculating the NADAC for Medicaid Covered Outpatient Drugs online.

4. **Is the AAC based on my individual pharmacy's acquisition cost?**

   For non-340B pharmacy claims, the answer is no. NADAC is the national pricing benchmark developed by CMS that DHCS is using to represent AAC for reimbursement, not your individual pharmacy's acquisition cost.

5. **Is Medi-Cal using the NADAC for both brand and generic drug products?**

   Yes, Medi-Cal is using the NADAC as the pricing benchmark for both brand and generic drug products.

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6. **A NADAC price is not available for all drugs. What does Medi-Cal use as a backup benchmark when a NADAC price is not available?**

   When a NADAC price does not exist, Medi-Cal uses the Wholesale Acquisition Cost (WAC) + 0 percent as the price benchmark.

7. **Where can I access the NADAC pricing files to see if they cover my acquisition costs?**

   The NADAC pricing files are published weekly on the CMS Pharmacy Pricing website.

8. **The NADAC reimbursement does not cover my acquisition cost for certain drugs. What should I do?**

   If a provider determines that the NADAC reimbursement does not cover their acquisition cost for a drug, DHCS strongly urges those providers to immediately use the *NADAC Request for Medicaid Reimbursement Review* form to submit a rate review request to the CMS NADAC Help Desk. The CMS 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. Without taking that action, no change will be considered to the NADAC for the drug in question.

9. **Why are drugs exempt from the 10-percent reduction per Assembly Bill (AB) 97 being paid with the new methodology? I thought these drugs were exempt from reductions.**

   Per state law, the 10-percent reduction from AB 97 was discontinued for all CODs with the implementation of the new reimbursement methodology.

10. **I have noticed that a drug product is no longer reimbursable that was previously reimbursable. What should I do?**

    There may be infrequent instances in which a NADAC, WAC, or Federal Upper Limit (FUL) price is not on file for a specific NDC that was previously reimbursable. When this situation occurs, DHCS recommends Medi-Cal pharmacies dispense the prescribed medication available from an alternative manufacturer that is shown to be reimbursable under the new methodology.

11. **Does SPA 17-002 modify the reimbursement methodology for blood factors?**

    No. DHCS did not include this specific change in SPA 17-002 because blood factor products are governed under their own SPA and reimbursement methodology. Providers should refer to *Blood and Blood Derivatives Reimbursement* section in the *Medi-Cal Rx Provider Manual* for the most accurate and current information.

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Professional Dispensing Fee

12. Why was the Long Term Care (LTC) dispensing fee removed?

The survey data reported by LTC pharmacies did not result in an average dispensing cost statistically different from the results of the two-tier professional dispensing fee structure. Therefore, there will no longer be a distinct dispensing fee for LTC pharmacies.

13. Where can I find more information on the provider self-attestation for the two-tier dispensing fee?

Providers may refer to the *Pharmacy Provider Dispensing Fee Self-Attestation – Frequently Asked Questions (FAQs)* for general instructions and a link to the Pharmacy Provider Self-Attestation portal.

14. Why does the professional dispensing fee change at a net annual claim volume threshold of 90,000?

The decrease in the cost of dispensing flattened out for pharmacies filling more than 90,000 dispensed prescriptions each year, thus providing a natural demarcation point for dispensing fees. Claims can be equated to prescriptions dispensed.

15. How long will DHCS keep this new dispensing fee structure?

There is no predetermined duration identified with this new methodology. DHCS will retain this new methodology until circumstances dictate revisiting it.

16. Why were specialty pharmacies not given their own dispensing fees as a result of this study?

The survey results for costs of dispensing did not justify the creation of professional dispensing fees unique to specialty pharmacies.

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