AB 97 PHARMACY PROVIDER EXEMPTION APPLICATION

The information requested on this form is required by the Department of Health Care Services, Pharmacy Benefits Division, for purposes of identification and document processing.

1. Date Application Submitted

Submit Form MC 3154 and Supporting Documentation using one of the methods below:

Mail to:
Pharmacy Benefits Division, MS 4604
P. O. Box 997413
Sacramento, CA 95899-7413
Attn: AB 97 Pharmacy Provider Exemption Applications **or**

Email to: ab97pharmacy@dhcs.ca.gov **or**

Fax to: (916) 552-9563

2. Provider Business Name				3. Provider NPI	
4. Pharmacy Type (Choose Type) Chain	5. Provider Business Address		City	State	Zip
6. Contact Name		7. Contact Phone Number	8. Contact Email		

9. ☐ **Check box to serve notice to DHCS of intent to withdraw as a Medi-Cal provider due to AB 97 Pharmacy Payment Reductions**.

9a. Date Provider is requesting to be withdrawn from Medi-Cal.

/ / (MM/DD/YYYY)

9b. *Optional: (*Please briefly explain any unique characteristics of your pharmacy which may be relevant to maintaining beneficiary access to care)

10. Provider Certification Statement

By signing below, the provider acknowledges that the above information is required by Medi-Cal to review the provider's exemption request from the AB 97 ten percent payment reductions, that the information contained above is true, accurate, and complete, and that Medi-Cal's review may be delayed or the review may not occur if the form is not completed with true, accurate, and complete information. The provider also acknowledges that a change in status may occur based on the above information; that any falsification, or concealment of material fact, may be prosecuted under Federal and/or state laws; and that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, physical or mental disability. The provider agrees to keep for a minimum period of three years from the date signed below, all records which are necessary to disclose fully the extent of information provided to Medi-Cal. The provider agrees to furnish these records and any information regarding the provider's eligibility criteria for exemption from AB 97, on request, to California Department of Health Care Services: Medi-Cal Fraud Unit, California Department of Justice, Medi-Cal Audits Project, Office of State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives.

11. Provider Signature (Signature of provider or person authorized by provider to bind provider by signature below to statements and conditions contained on this form.)	12. Date Signed
13. ☐ Check if providing supporting documentation (optional). You may attach any supporting documentation that you would like DHCS to consider; however, this is not a requirement for application consideration	14. Total Number of Pages Submitted Including Form

DHCS REVIEW (DEPARTMENT USE ONLY)

DHCS Review Date	DHCS Decision: ☐ Pharmacy Provider exemption approved ☐ Pharmacy Provider exemption denied	Date Contacted Provider:	Provider Contacted By: ☐ Email ☐ Mail ☐ Phone ☐ Fax

Comments:

DHCS Reviewer Printed Name:	DHCS Reviewer Signature:

INSTRUCTIONS FOR COMPLETION OF THE AB 97 PHARMACY PROVIDER EXEMPTION APPLICATION
(Please Read Carefully)

The information on this form will be used by the Department of Health Care Services (DHCS) Pharmacy Benefits Division (PBD) for purposes of identification and document processing under the AB 97 pharmacy payment reduction drug exemption application program.

DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date, and initial in ink.

DO NOT LEAVE any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

1. Insert date application submitted.
2. "Provider Business Name" is the legal name of the business.
3. "Provider NPI" is the National Provider Identifier, a unique identification number for health care providers.
4. "Pharmacy Type". Please indicate if you are a Chain Pharmacy or an Independent Pharmacy. A Chain Pharmacy is part of an organization controlling 5 or more retail outlets, whereas, an Independent Pharmacy is a retail pharmacy that is not directly affiliated with any chain of pharmacies.
5. "Provider Business Address" is where services are provided to Medi-Cal beneficiaries
6. "Contact Name". To assist in the timely processing of the application package, enter the name of the individual who can be contacted by PBD staff to answer questions regarding the application package. Failure to provide this information may result in the application being returned for deficit item(s) that an applicant can readily provide by fax or telephone.
7. Insert contact phone number.
8. Insert contact email address.
9. Check the box indicating Provider's intention to withdraw as a Medi-Cal Provider.

9a. Enter date that the Provider would like to be withdrawn as a Medi-Cal Provider.

9b. Self-Explanatory.

10. Please read Provider Certification Statement.
11. Signature of Provider or person authorized by provider to bind provider by signature below to statements and conditions contained on this form.
12. Insert date application is signed.
13. Check box if attaching supporting documentation.
14. Insert total number of pages enclosed including the form.

Remember to attach any supporting documentation.

CRITERIA FOR PROVIDER EXEMPTION
(EXCERPT FROM STATE PLAN AMENDMENT (SPA) 12-014)

2. If a pharmacy provider notifies the Department that they intend to withdraw as a Medi-Cal provider as a result of the ten percent payment reduction for drugs dispensed on or after March 31, 2012 described in Paragraph M, the Department will exempt that provider from the ten percent reduction in payments if the Department determines that doing so is necessary in order to assure beneficiary access consistent with the following geographic metrics:

- In urban areas, at least 90 percent of Medi-Cal beneficiaries, on average, live within 2 miles of a participating retail pharmacy.
- In suburban areas, at least 90 percent of Medi-Cal beneficiaries, on average, live within 5 miles of a participating retail pharmacy.
- In rural areas, at least 70 percent of Medi-Cal beneficiaries, on average, live within 15 miles of a participating retail pharmacy.

a. The start date of exemptions granted pursuant to Paragraph M (2) will be the date the provider requests to be withdrawn as a provider, subject to the Department's determination that such a withdrawal would result in an access issue, per the above stated geographic criteria.

b. At least annually, the Department will review exemptions granted pursuant to Paragraph M (2). If the Department determines that access has been restored consistent with the geographic criteria, (e.g. as a result of new pharmacies being built, or fewer beneficiaries residing in the area), the Department will notify exempted providers that their exemption no longer applies.

For more information regarding the Medi-Cal AB 97 provider exemption criteria or to view the complete version of SPA 12-014 approved by the Centers for Medicare and Medicaid Services (CMS), please visit the DHCS webpage.