



Medi-Cal Rx

Transitioning Medi-Cal Pharmacy Services from Managed Care to Fee-For-Service

July 24, 2019 9:30 – 11:30 a.m.

1500 Capitol Avenue

DHCS Auditorium

Sacramento, California



Welcome and DHCS Introductions

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- Housekeeping Items:
 - For attendees participating remotely, webinar lines are in “listen-only” mode. No questions will be taken over the phone.
 - For attendees participating in-person, there will be an opportunity to ask questions at the end of the presentation.



Agenda

- Review pharmacy carve-out policy
- Review pharmacy carve-out fiscal
- Review Request for Proposal (RFP) for a pharmacy services vendor



Background

- On January 7, 2019, Governor Gavin Newsom issued Executive Order N-01-19 for the purpose of achieving cost-savings for drug purchases made by the state
- A primary component of the Executive Order requires that all Medi-Cal pharmacy services be transitioned from managed care (MC) to fee-for-service (FFS) by January 1, 2021



Background, cont.

Transitioning pharmacy services from managed care to FFS will, among other things:

- Standardize the Medi-Cal pharmacy benefit statewide, under one delivery system
- Improve access to pharmacy services with a pharmacy network that includes approximately 97 percent of the state's pharmacies
- Apply statewide utilization management protocols to all outpatient drugs
- Strengthen California's ability to negotiate state supplemental drug rebates with drug manufacturers

The Medi-Cal pharmacy benefits and services administered by DHCS in the FFS delivery system will be identified collectively as Medi-Cal Rx.



Which MCPs are Included?

- Medi-Cal Rx will impact all Medi-Cal Managed Care Plans (MCPs), including SCAN and AIDS Healthcare Foundation
- Medi-Cal Rx will not apply to PACE plans



What will be carved out of Managed Care?

Medi-Cal Rx includes the following when billed by a pharmacy on a pharmacy claim*:

- Covered Outpatient Drugs, including Physician Administered Drugs (PADs)
- Medical Supplies
- Enteral Nutritional Products

* Not within Medi-Cal Rx scope when billed on a medical or institutional claim by a pharmacy, or any other provider type. These claims will continue to be billed to the managed care plan, unless otherwise carved out of their contract (e.g. blood factor, HIV/AIDS drugs, antipsychotics, or drugs used to treat substance use disorder).



What will not change?

Medi-Cal Rx will not change:

- The scope of the existing Medi-Cal pharmacy benefit
- Provision of pharmacy services in an inpatient or long-term care setting, regardless of delivery system
- Existing Medi-Cal managed care pharmacy carve-outs (e.g., blood factor, HIV/AIDS drugs, antipsychotics, or drugs used to treat substance use disorder)
- The State Fair Hearing process



Utilization Management

DHCS is evaluating the following changes to FFS Utilization Management policies:

- Elimination of the statutory six prescription monthly limit
- Changes to prior authorization requirements, including but not limited to what requires prior authorization and multi-year authorization approvals
- Expansion of auto-adjudication functionalities and processes
- Other policies currently utilized by many MCPs, but not utilized in FFS today, such as: step therapy, opioid management, and pharmacy lock-in services



Continuity of Care

To assist Medi-Cal beneficiaries, pharmacies and providers with the initial transition, DHCS proposes a 90-day continuity period for transitioning beneficiaries. This 90-day period will allow for all prescriptions to be honored without prior authorization.

DHCS will develop a transitional continuity of care plan, which will describe the processes and methodology that will be used for the 90-day continuity period. The 90-day continuity period shall, at a minimum, include processes for:

- Drug Utilization Review requirements to ensure the safety of drugs prescribed
- Pharmacy, provider and beneficiary assistance

Notification of the 90-day continuity period and process will be sent to pharmacies, providers and beneficiaries.



Transition Activities

- Four to six months prior to transition, DHCS or its vendor, in coordination with managed care, will begin releasing a series of FFS trainings and educational materials notifying all providers of the transition
- 90 Day Notices to all Managed Care and FFS beneficiaries, additional notices as needed
- Managed Care Outbound Call Campaign from the Plans to their beneficiaries 30 days prior to implementation
- Managed Care Member Handbook (Evidence of Coverage) would be updated for the member handbook that is effective Jan 1, 2021
- Updates to the Provider Manual to reflect the transition
- Managed care contracts will be updated as needed to reflect the benefit change
- Inform plans on any managed care rate changes related to pharmacy and administration



Post-Transition Responsibilities: DHCS

DHCS and/or the new contracted vendor will retain responsibility for activities, including but not limited to:

- Processing and payment of all services billed by a pharmacy on a pharmacy claim
- Drug coverage and utilization management policy
- Final determination of prior authorization denials
- Negotiation of, and policy related to, contracting of state supplemental drug rebates
- Establishing pharmacy reimbursement methodologies
- Establishing and maintaining the Medi-Cal pharmacy provider network
- Medi-Cal beneficiary and provider customer support services, including a 24/7 call center
- Medi-Cal beneficiary and provider education/outreach activities



Post-Transition Responsibilities: MCPs

MCPs will retain responsibility for activities, including but not limited to:

- Beneficiary care coordination
- Clinical aspects of pharmacy adherence
- Disease and medication management
- Processing and payment of all pharmacy services billed on medical and institutional claims
- Participation on the Medi-Cal Global Drug Use Review (DUR) Board and other DHCS pharmacy committees, as needed

To ensure MCPs are able to continue meeting their existing coordination of care for Medi-Cal beneficiaries, DHCS will facilitate real-time data access, daily data feeds, and support to MCPs for the purposes of coordinating care.



Service Vendor Procurement

To facilitate and support the carve-out and ongoing management, DHCS evaluated utilizing existing FFS fiscal intermediary (FI) infrastructure or contracting with an external pharmacy services vendor.

Due to various system constraints, DHCS will seek to procure the use of an external pharmacy service vendor. Procuring a vendor instead of utilizing the existing FFS FI infrastructure will allow DHCS to:

- Modernize many existing pharmacy support systems
- Provide 24/7 call center support
- Allow for prior authorization review within 24 hours
- Provide daily data feeds to the Medi-Cal MCPs
- Allow for enhanced utilization management capabilities



Service Vendor Procurement (cont.)

The vendor will provide services to DHCS, which will include but not be limited to:

Claims and Utilization Management

- Claims administration, processing and payment
- Coordination of benefits for beneficiaries with other health coverage, including Medicare
- Process prior authorization services within 24 hours - all prior authorization denials will require DHCS review prior to final determination
- Prospective and Retrospective Drug Utilization Review services



Service Vendor Procurement (cont.)

Pharmacy Drug Rebate Administration

- Provide drug rebate administration services to DHCS that are compliant with federal and state laws, and adhere to DHCS policies and direction
- Assist with calculation, invoicing and collection of state and federal drug rebates

Provider and Beneficiary Support

- Provide a 24/7 customer services center to support all provider and beneficiary calls
- Provide outreach, training, and informing materials
- Provide web-based services to support communication
- Provide real-time data access, daily data feeds, and support for the purposes of coordinating care
- Work with DHCS and other contracted partners regarding continuity of care



Service Vendor Procurement (cont.)

Tentative Timeline:

- July 22, 2019: Draft Request for Proposal (RFP) was released, initiating a two-week public comment period
- August 5, 2019: RFP Public Comment period closes at 11:59 p.m. Comments must be submitted to: csbrfp1@dhcs.ca.gov
- Mid-Late August 2019: Final RFP is released
- October 4, 2019: Proposals are due
- October 24, 2019: Intent to Award is released
- November 2019: Contract Execution
- January 1, 2021: Assumption of Operations



Fiscal Overview

Dollars in Millions

	Total Fund	General Fund
Pharmacy Category of Service		
Estimated Managed Care Pharmacy Spend	(\$5,563)	(\$1,851)
Estimated Fee-For-Service Pharmacy Spend	\$5,708	\$1,900
Net Change in Pharmacy Spend	\$145	\$48
Managed Care Related Administrative Cost Savings	(\$522)	(\$174)
New Pharmacy Related Administrative Costs	\$92	\$23
Net Change in Admin Spend	(\$430)	(\$151)
Sub-Total Change	(\$285)	(\$103)
Additional Supplemental Rebates (12.0%)	(\$761)	(\$253)
Additional Savings Based on MAIC Implementation in FFS	(\$105)	(\$37)
Overall Net Change	(\$1,151)	(\$393)



Fiscal Overview (cont.)

Estimated General Fund (GF) savings of \$393 million related to the pharmacy carve-out, which is subject to a variety of variables and assumptions impacting the net cost to the state that include:

- An increase in supplemental rebates by 2023 due to DHCS' enhanced bargaining power as a result of the increased number of beneficiaries obtaining their medications through the FFS benefit (~2.3 to more than 13 million)
- Implementation of Maximum Allowable Ingredient Costs (MAICs) for drugs which have 3 or more generically equivalent options available
- Reduction of costs related to administrative functions of multiple Pharmacy Benefit Managers (PBMs) used by various MCPs



Fiscal Overview (cont.)

It is important to note, the fiscal is based on current FFS reimbursement methodology, which includes \$10.05/\$13.20 dispensing fees.

Additionally, 340B drugs were priced at what MCPs paid due to DHCS not having knowledge of the 340B entity acquisition cost to properly score the potential 340B savings. Therefore, potential savings associated with 340B reimbursement, other than what is already realized in managed care, are not included in the current fiscal.

The proposal does not change or eliminate the 340B Program in California.



DHCS' Transition Commitment

DHCS is committed to working with its external partners (including but not limited to, MCPs, counties, providers, consumer advocates and beneficiaries) to ensure a smooth and successful transition through the following:

- Publicly releasing the draft Request for Proposal (RFP) with a two-week public comment period, which will assist DHCS in determining the level of interest and/or any adjustments necessary to the external service vendor scope of work
- Ensuring MCPs, counties, providers, consumer advocates and beneficiaries receive timely and accurate information relating to the transition and associated implementation activities
- Providing status updates and gathering stakeholder feedback through various DHCS sponsored public meetings
- Maintaining a dedicated email inbox (RxCarveOut@dhcs.ca.gov) to provide responses to any and all inquiries related to the transition



Questions & Answer Session

(Note: For Attendees Participating In-Person Only)



Thank You!

Additional project inquiries may be directed to:

RxCarveOut@dhcs.ca.gov