From: DMHC Licensing eFiling

Subject: APL 20-035 - Medi-Cal Pharmacy Benefit Carve Out - Medi-Cal Rx

Date: Tuesday October 6, 2020 4:45 PM

Attachments: APL 20-035 - Medi-Cal Pharmacy Benefit Carve Out - Medi-Cal Rx (10.6.2020).pdf

Dear Health Plan Representative:

Please find attached, APL 20-035 for guidance and filing instructions to Medi-Cal health care service plans (MCPs or Plans) regarding the transition of pharmacy services from managed care to fee for service pursuant to Governor Gavin Newsom's Executive Order N-01-19.

Thank you.

Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th Street, Suite 500
Sacramento, CA 95814
Phone: 916-324-8176 | Fax: 916-255-5241
www.HealthHelp.ca.gov

ALL PLAN LETTER

DATE: October 6, 2020

TO: All Medi-Cal Health Care Service Plans

FROM: Nancy Wong
Acting Deputy Director
Office of Plan Licensing

SUBJECT: APL 20-035 (OPL): Medi-Cal Pharmacy Benefit Carve Out - Medi-Cal Rx

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The Department of Managed Health Care (DMHC) issues this All Plan Letter (APL) to provide guidance and filing instructions to Medi-Cal health care service plans (MCPs or Plans) regarding the transition of pharmacy services from managed care to fee for service pursuant to Governor Gavin Newsom's Executive Order N-01-19.[1] The Medi-Cal pharmacy benefits and services administered by the Department of Health Care Services (DHCS) in the fee for service (FFS) delivery system is identified collectively as "Medi-Cal Rx."

I. BACKGROUND

Governor Newsom issued Executive Order N-01-19 on January 7, 2019, ordering the DHCS to take necessary steps to transition all pharmacy services for Medi-Cal managed care to a fee for service benefit by January 2021. The transition applies to **all MCPs**, including AIDS Healthcare Foundation, but does not apply to Senior Care Action Network (SCAN), Programs of All-Inclusive Care for the Elderly (PACE) plans, or Cal MediConnect plans.[2]

Beginning January 1, 2021, the following services will be carved out of Medi-Cal managed care and transitioned to fee for service when billed on a pharmacy claim:

- Covered Outpatient Drugs, including Physician Administered Drugs (PADs)
- Medical Supplies
- Enteral Nutritional Products[3]

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[1] Governor Newsom's Executive Order N-01-19.
[2] Refer to FAQ No. 5 found on the Medi-Cal Rx Transition Website.
[3] *Id*. at FAQ No. 8.

The transition to fee for service will **not** apply to the provision of pharmacy services in an inpatient or long-term care setting (including Skilled Nursing Facilities, other Intermediate Care Facilities, and some outpatient settings such as infusion centers) when billed on a medical or institutional claim.[4]

A. Plan Roles and Responsibilities

Following the transition, Plans will retain responsibility for overseeing and maintaining care coordination activities for Medi-Cal enrollees, providing oversight of all clinical aspects of pharmacy adherence, including providing disease and medication management, and processing and payment of all pharmacy services billed on medical and institutional claims.

B. Medi-Cal Rx Contractor Roles and Responsibilities

Following the transition, the Medi-Cal Rx Contractor will assume responsibility for the following.

- Providing claims administration, processing, and payment functionalities for all pharmacy services billed on pharmacy claims.
- Providing customer service support (e.g. for MCPs, prescribers, pharmacies, beneficiaries) for all pharmacy services billed on pharmacy claims.
- Overseeing coordination of benefits with other health coverage, including Medicare.
- Providing utilization management functionalities, including ensuring pharmacy prior authorization adjudication occurs within 24 hours.
- Providing Prospective and Retrospective Drug Utilization Review (DUR) services.
- Providing drug rebate administration services, which are compliant with federal and state laws, and adhere to the Department's policies and direction.

For additional information regarding the scope of services to be performed by DHCS, the Medi-Cal Rx Contractor, and plans, before and after the transition, please refer to Medi-Cal Rx Scope document.[5]

II. FILING REQUIREMENTS

By **November 6, 2020**, all MCPs must submit an **Amendment** to the DMHC via eFiling titled, "Medi-Cal Pharmacy Benefit Carve Out – Medi-Cal Rx," with the following exhibits and information:

[4] *Id.* at FAQ No. 9.
[5] The scope document may be found at the Medi-Cal Rx Transition Website.

A. Exhibit E-1 Summary of eFiling Information

Submit an Exhibit E-1 which includes a description of the plan's efforts to implement the Medi-Cal Rx requirements by January 1, 2021. The Exhibit E-1 should, at a minimum, address the areas identified below: (1) Grievances & Appeals, (2) Independent Medical Review, (3) Utilization Management, (4) Network Adequacy, (5) Provider Directories, (6) Standard Formulary Template, (7) Continuity of Care, (8) Administrative Capacity, (9) Financial Standing, and (10) Other Documents.

1. Grievances & Appeals

The transition to Medi-Cal Rx will affect the grievance and appeal rights and processes of Medi-Cal enrollees. As a result of the transition, enrollees will no longer be required or permitted to submit grievances related to pharmacy services to the Plan for services rendered after December 31, 2020. All complaints or grievances relating to pharmacy services rendered after December 31, 2020 should be submitted directly to the Medi-Cal Rx contractor. Any such complaints or grievances received by a Plan should be immediately sent to the Medi-Cal Rx contractor for handling. Plans should cooperate with the Medi-Cal Rx contractor, but should **not** engage in the processing of enrollee complaints and grievances related to pharmacy services.

Similarly, all appeals relating to pharmacy benefits carved out to Medi-Cal Rx should utilize the standard State Hearing Process. Such appeals received by a Plan should be referred to the California Department of Social Services, State Hearings Division. Plans should cooperate with the State Hearings Division, but should **not** engage in the processing of enrollee appeals related to pharmacy benefits carved out to Medi-Cal Rx.[6]

In accordance with the above, in the Exhibit E-1, Plans shall acknowledge and affirm the bulleted statements below. If a bulleted statement does not apply, explain why it does not apply to the Plan.

- The Plan [*has revised* or *will revise*][7] its grievance and appeals policies and procedures as necessary to reflect changes required by Medi-Cal Rx.
- The Plan [*has revised* or *will revise*] its contracts as necessary to reflect changes required by Medi-Cal Rx (including, but not limited to PBM contracts, provider contracts, plan to plan agreements, contracts for administrative services, etc.).

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[6] Refer to DHCS's APL on Governor's Executive Order N-01-19, Relative to Transitioning Medi-Cal Pharmacy Benefits to from Managed Care to Fee-for-Service for additional information regarding handling of grievances and appeals. The forthcoming APL will be available on DHCS's Managed Care All Plan Letters – 1998 to Current webpage.

[7] Within the bulleted statements, italicized items within brackets identifies either-or choices for the Plan to select.

2. Independent Medical Review

As a result of the transition to Medi-Cal Rx, Medi-Cal enrollees will no longer have the right to apply for an Independent Medical Review for pharmacy services carved out to Medi-Cal Rx. Therefore, all appeals relating to pharmacy services carved out to Medi-Cal Rx should be referred to the California Department of Social Services, State Hearings Division. Medi-Cal enrollees retain the right for an Independent Medical Review for the provision of pharmacy services in inpatient settings, long-term care settings, or other settings not impacted by Medi-Cal Rx.

In accordance with the above, in the Exhibit E-1, Plans shall acknowledge and affirm the bulleted statements below. If a bulleted statement does not apply, explain why it does not apply to the Plan.

- The Plan [*has revised* or *will revise*] its policies, procedures, and forms related to Independent Medical Reviews as necessary to reflect changes required by Medi-Cal Rx.
- The Plan [*has revised* or *will revise*] its contracts as necessary to reflect changes required by Medi-Cal Rx (including, but not limited to, PBM contracts, provider contracts, plan to plan agreements, contracts for administrative services, etc.).

3. Utilization Management

Following the transition to Medi-Cal Rx, all utilization management and prior authorization services for pharmacy services billed on a pharmacy claim will be completed by the Medi-Cal Rx Contractor. Plans should **not** engage in the prior authorization or utilization management of pharmacy services carved out to Medi-Cal Rx. However, Plans are expected to coordinate with the Medi-Cal Rx contractor as necessary to assist with utilization management or prior authorization of pharmacy services carved out to Medi-Cal Rx.[8]

In accordance with the above, in the Exhibit E-1, Plans shall acknowledge and affirm the bulleted statements below. If a bulleted statement does not apply, explain why it does not apply to the Plan.

- The Plan [*has revised* or *will revise*] its utilization management and prior authorization policies and procedures as necessary to reflect changes required by Medi-Cal Rx.
- The Plan [*has revised* or *will revise*] its contracts as necessary to reflect changes required by Medi-Cal Rx (including, but not limited to PBM contracts, provider contracts, plan to plan agreements, contracts for administrative services, etc.).

[8] *See* Footnote 6.

4. Network Adequacy

Plans should continue to report all in-network providers in its network submissions to the Department. The Department will continue to review all networks, including Medi-Cal networks, for network adequacy related to the delivery of the health care services required under the Act. This includes any pharmacy benefits that are not encompassed by the fee for service carve-out referenced in this APL.

5. Provider Directories

Following the transition to Medi-Cal Rx, the requirements under Health and Safety Code section 1367.27 relating to pharmacy information within the Plan's online provider directory may be satisfied by directing members to the Medi-Cal Rx website and pharmacy directory. Accordingly, at the appropriate time, health plans should implement changes to update all applicable provider directories to reflect pharmacy providers that are no longer included in the Plan's network and to provide an appropriate reference to the Medi-Cal Rx pharmacy network.

In the Exhibit E-1, Plans shall acknowledge and affirm the bulleted statements below. If a bulleted statement does not apply, explain why it does not apply to the Plan.

- The Plan [*has revised* or *will revise*] its provider directory or directories as necessary to reflect changes required by Medi-Cal Rx and to minimize the potential for enrollee confusion (including removing pharmacies from the Plan's directories and online search tools and incorporating by reference the Medi-Cal Rx website and pharmacy directory).
- The Plan [*has revised* or *will revise*] its provider directory policies and procedures and all other plan documents as necessary to reflect changes required by Medi-Cal Rx and/or to minimize the potential for enrollee confusion.

6. Standard Formulary Template

Plans offering a prescription drug benefit are required to maintain a formulary in compliance with Health and Safety Code section 1367.205 and Rule 1300.67.205. Following the transition to Medi-Cal Rx, certain requirements under Health and Safety Code section 1367.205 and Rule 1300.67.205 may no longer be applicable to the Plan. If, following the transition to Medi-Cal Rx, the Plan offers a pharmacy benefit subject to the requirements of Health and Safety Code section 1367.205 and Rule 1300.67.205, the Plan must maintain a formulary in compliance with these provisions. If following the transition, the Plan does not offer a pharmacy benefit subject to the requirements of Health and Safety Code section 1367.205 and Rule 1300.67.205, the Plan does not need to maintain a formulary pursuant to these provisions.

In the Exhibit E-1, Plans shall acknowledge and affirm the bulleted statements below. If a bulleted statement does not apply, explain why it does not apply to the Plan.

- The Plan [*has revised* or *will revise*] its drug formulary documents as necessary to reflect changes required by Medi-Cal Rx (including, but not limited to Medi-Cal Drug Formulary, Preferred Drug List, etc.).
- The Plan [*has revised* or *will revise*] all other plan documents as necessary to reflect changes required by Medi-Cal Rx and/or to minimize the potential for enrollee confusion (including removing from plan documents any direct website links/URLs for the online formularies from the Plan's website, and any other references to drug formulary no longer applicable to Med-Cal enrollees).

7. Continuity of Care

Prior to the transition to Medi-Cal Rx, the Plan remains responsible for providing continuity of care consistent with Health and Safety Code section 1367.22 and the Medi-Cal Rx transition plan[9] for all pharmacy services.

In the Exhibit E-1, Plans shall acknowledge and affirm the bulleted statements below. If a bulleted statement does not apply, explain why it does not apply to the Plan.

- The Plan will not limit or exclude coverage for a drug for an enrollee if the drug previously had been approved for coverage by the Plan for a medical condition of the enrollee and the prescribing provider continues to prescribe the drug for the medical condition.
- The Plan will not discontinue or void existing prior authorizations the Plan has granted.
- The Plan will not, in connection with the transition to Medi-Cal Rx, schedule authorizations to automatically expire on or before December 31, 2020.
- The Plan will cooperate with the Medi-Cal Rx Contractor to prevent any disruption in services to members during the initial transitional period and beyond.
- The Plan [*has revised* or *will revise*] its continuity of care policies and procedures as necessary to reflect changes required by Medi-Cal Rx.

8. Administrative Capacity

The transition to Medi-Cal Rx may impact the Plan's administrative capacity.

In the Exhibit E-1, Plans shall acknowledge and affirm one of the two bulleted statements below. If both bulleted statements do not apply, explain why each does not apply to the Plan.

- The Plan determined the transition to Medi-Cal Rx will not require any changes to key personnel and staff that will negatively impact the Plan's ability to ensure administrative capacity.

[9] Refer to the Medi-Cal Rx Pharmacy Transition Policy, which can be found at the DHCS Medi-Cal Rx Transition Website.

- The Plan determined the transition to Medi-Cal Rx will require changes to key personnel and staff but the changes will not negatively impact the Plan's ability to ensure administrative capacity.

9. Financial Standing

The transition to Medi-Cal Rx may impact the Plan's financial standing.

In the Exhibit E-1, Plans shall acknowledge and affirm the bulleted statement below. If the bulleted statement does not apply, explain why it does not apply to the Plan.

- The Plan determined the transition to Medi-Cal Rx will not have a negative net financial impact that will cause the Plan to be non-compliant with the Act's financial solvency standards.

10. Other Documents

The transition to Medi-Cal Rx may impact plan documents not addressed in the preceding paragraphs. The Plan is responsible for reviewing and revising all plan documents impacted by the Medi-Cal pharmacy benefit carve out to ensure compliance with all applicable Statutes, Rules and guidance.

In the Exhibit E-1, Plans shall acknowledge and affirm the bulleted statements below. If a bulleted statement does not apply, explain why it does not apply to the Plan.

- The Plan [*has revised* or *will revise*] its contracts as necessary to reflect changes, apart from those identified above, necessitated by Medi-Cal Rx (including, but not limited to, PBM contracts, provider contracts, plan to plan agreements, contracts for administrative services, etc.).
- The Plan [*has revised* or *will revise*] its policies and procedures as necessary to reflect changes required by Medi-Cal Rx (including, but not limited to, Grievances and Appeals, Claims Processing, Quality Assurance, etc.).
- The Plan [*has revised* or *will revise*] its coverage documents as necessary to reflect changes required by Medi-Cal Rx (including, but not limited to Evidence of Coverage, Disclosure Form, Schedule of Benefits, etc.).
- The Plan [*has revised* or *will revise*] all other plan documents as necessary to reflect changes required by Medi-Cal Rx.

B. Exhibit I-9 Enrollee, Subscriber, and Group Contract Holder Notices

Plans shall submit a 30-day notice explaining the transition to Medi-Cal Rx to the Plan's enrollees. The notice should be based on the template notice issued by the DHCS. All changes to the notice should be highlighted in redline form.

III. Effective Date and Deadline

Medi-Cal Rx will be effective January 1, 2021. To acknowledge and affirm compliance with the requirements of Medi-Cal Rx, all MCPs are required to submit an **Amendment** filing due no later than November 06, 2020. Plan documents amended to comply with the transition to Medi-Cal Rx remain subject to the filing requirements of the Act at Health and Safety Code section 1352.

If you have questions or concerns regarding this APL, please contact your plan's assigned OPL reviewer.