

ASSEMBLY, No. 1028

STATE OF NEW JERSEY

219th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

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SYNOPSIS

Requires prescription drug services covered under Medicaid program to be provided via fee-for-service delivery system.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 **AN ACT** concerning prescription drug services provided under the
2 Medicaid program and supplementing Title 30 of the Revised
3 Statutes.

4
5 **BE IT ENACTED** *by the Senate and General Assembly of the State*
6 *of New Jersey:*

7
8 1. a. Prescription drug services provided under the Medicaid
9 program, established pursuant to established pursuant to P.L.1968,
10 c.413 (C.30:4D-1 et seq.), shall be administered by the Division of
11 Medical Assistance and Health Services in the Department of
12 Human Services under a fee-for-service delivery system.

13 b. Reimbursement for covered outpatient brand name and
14 generic drugs, as well as covered outpatient specialty drugs
15 dispensed by a mail order pharmacy, shall be calculated based on
16 the lower of:

17 (1) the National Average Drug Acquisition Cost (NADAC)
18 Retail Price Survey, in accordance with section 1927(f) of the
19 federal Social Security Act or the Wholesale Acquisition Cost in the
20 absence of a NADAC price, plus the State professional dispensing
21 fee, as defined at 42 CFR 447.502, of \$10.92;

22 (2) the federal upper limit, plus the State professional
23 dispensing fee, as defined at 42 CFR 447.502, of \$10.92;

24 (3) the State Maximum Allowable Cost, plus the State
25 professional dispensing fee, as defined at 42 CFR 447.502, of
26 \$10.92;

27 (4) the State submitted ingredient cost, plus the State
28 professional dispensing fee, as defined at 42 CFR 447.502, of
29 \$10.92; or

30 (5) the provider's usual and customary charge, including any
31 discount price which may be in effect on the date the drug is
32 dispensed to the Medicaid beneficiary.

33 c. Reimbursement for covered outpatient drugs dispensed by a
34 covered entity as defined in section 340B(a)(4) of the federal Public
35 Health Service Act shall be calculated based on the lower of:

36 (1) the Actual Acquisition Cost, which shall not exceed the
37 federal 340B program ceiling price, plus the State professional
38 dispensing fee, as defined at 42 CFR 447.502, of \$10.92;

39 (2) the federal upper limit, plus the State professional
40 dispensing fee, as defined at 42 CFR 447.502, of \$10.92;

41 (3) the State Maximum Allowable Cost, plus the State
42 professional dispensing fee, as defined at 42 CFR 447.502, of
43 \$10.92;

44 (4) the State submitted ingredient cost, plus the State
45 professional dispensing fee, as defined at 42 CFR 447.502, of
46 \$10.92; or

47 (5) the provider's usual and customary charge, including any
48 discount price which may be in effect on the date the drug is
49 dispensed to the Medicaid beneficiary.

1 d. Reimbursement for covered clotting factors dispensed by a
2 specialty pharmacy or a Hemophilia Treatment Center shall be
3 based on the NADAC Retail Price Survey, in accordance with
4 section 1927(f) of the federal Social Security Act or the Wholesale
5 Acquisition Cost in the absence of a NADAC price, plus the State
6 professional dispensing fee, as defined at 42 CFR 447.502, of
7 \$10.92. Clotting factors shall be billed through a Point of Sale
8 System as of January 1, 2020.

9
10 2. The Commissioner of Human Services shall apply for such
11 State plan amendments or waivers as may be necessary to
12 implement the provisions of this act and to secure federal financial
13 participation for State Medicaid expenditures under the federal
14 Medicaid program.

15
16 3. The Commissioner of Human Services shall adopt rules and
17 regulations pursuant to the "Administrative Procedure Act,"
18 P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of
19 this act.

20
21 4. This act shall take effect on the 90TH day next following the
22 date of enactment, but the Commissioner of Human Services may
23 take such anticipatory administrative action in advance thereof as
24 may be necessary for the implementation of this act.

25
26
27 STATEMENT

28
29 This bill requires prescription drug services covered under the
30 Medicaid program to be provided via fee-for-service delivery system.
31 Currently, the majority of prescription drug services are provided
32 through managed care delivery system.

33 Specifically, the bill requires that the reimbursement for covered
34 outpatient brand name and generic drugs, as well as covered
35 outpatient specialty drugs dispensed by a mail order pharmacy, is
36 calculated based on the lower of:

37 (1) the National Average Drug Acquisition Cost (NADAC)
38 Retail Price Survey, in accordance with section 1927(f) of the
39 federal Social Security Act or the Wholesale Acquisition Cost in the
40 absence of a NADAC price, plus the State professional dispensing
41 fee, as defined at 42 CFR 447.502, of \$10.92;

42 (2) the federal upper limit, plus the State professional
43 dispensing fee, as defined at 42 CFR 447.502, of \$10.92;

44 (3) the State Maximum Allowable Cost, plus the State
45 professional dispensing fee, as defined at 42 CFR 447.502, of
46 \$10.92;

47 (4) the State submitted ingredient cost, plus the State
48 professional dispensing fee, as defined at 42 CFR 447.502, of
49 \$10.92; or

1 (5) the provider's usual and customary charge, including any
2 discount price which may be in effect on the date the drug is
3 dispensed to the Medicaid beneficiary.

4 Furthermore, the bill requires that the reimbursement for covered
5 outpatient drugs dispensed by a covered entity as defined in section
6 340B(a)(4) of the federal Public Health Service Act is be calculated
7 based on the lower of:

8 (1) the Actual Acquisition Cost, which shall not exceed the
9 federal 340B program ceiling price, plus the State professional
10 dispensing fee, as defined at 42 CFR 447.502, of \$10.92;

11 (2) the federal upper limit, plus the State professional
12 dispensing fee, as defined at 42 CFR 447.502, of \$10.92;

13 (3) the State Maximum Allowable Cost, plus the State
14 professional dispensing fee, as defined at 42 CFR 447.502, of
15 \$10.92;

16 (4) the State submitted ingredient cost, plus the State
17 professional dispensing fee, as defined at 42 CFR 447.502, of
18 \$10.92; or

19 (5) the provider's usual and customary charge, including any
20 discount price which may be in effect on the date the drug is
21 dispensed to the Medicaid beneficiary.

22 And finally, the bill requires that the reimbursement for covered
23 clotting factors dispensed by a specialty pharmacy or a Hemophilia
24 Treatment Center is based on the NADAC Retail Price Survey, in
25 accordance with section 1927(f) of the federal Social Security Act
26 or the Wholesale Acquisition Cost in the absence of a NADAC
27 price, plus the State professional dispensing fee, as defined at 42
28 CFR 447.502, of \$10.92. Under the bill, clotting factors are
29 required to be billed through a Point of Sale System as of January 1,
30 2020.

31 The transition is expected to generate significant prescription
32 drug savings due to a reduction in program administration costs and
33 modifications to dispensing cost formulas. West Virginia's
34 Medicaid agency implemented a similar transition in July 2017,
35 anticipating a \$30 million savings for the state. In March 2019, the
36 West Virginia Bureau for Medical Services released a report
37 showing actual savings of \$54.4 million to the state Medicaid
38 program for the first year of the carve-out, allowing for certain
39 State funds to be utilized for other priorities, such as roads,
40 education, and law enforcement. The report also notes that in
41 addition to the savings, the prescription drug benefit carve-out
42 resulted in \$122 million paid to West Virginia pharmacies in the
43 form of fixed dispensing fees, money that had formerly gone to out-
44 of-state pharmacy benefit managers.