

SENATE, No. 1253

STATE OF NEW JERSEY
219th LEGISLATURE

INTRODUCED FEBRUARY 3, 2020

Sponsored by:

Senator VIN GOPAL

District 11 (Monmouth)

Senator LINDA R. GREENSTEIN

District 14 (Mercer and Middlesex)

SYNOPSIS

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

CURRENT VERSION OF TEXT

As introduced.



(Sponsorship Updated As Of: 11/8/2021)

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

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 d. Reimbursement for covered clotting factors dispensed by a
5 specialty pharmacy or a Hemophilia Treatment Center shall be
6 based on the NADAC Retail Price Survey, in accordance with
7 section 1927(f) of the federal Social Security Act or the Wholesale
8 Acquisition Cost in the absence of a NADAC price, plus the State
9 professional dispensing fee, as defined at 42 CFR 447.502, of
10 \$10.92. Clotting factors shall be billed through a Point of Sale
11 System as of January 1, 2020.

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

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

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

28 29 STATEMENT

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

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

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

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

46 (3) the State Maximum Allowable Cost, plus the State
47 professional dispensing fee, as defined at 42 CFR 447.502, of
48 \$10.92;

1 (4) the State submitted ingredient cost, plus the State
2 professional dispensing fee, as defined at 42 CFR 447.502, of
3 \$10.92; or

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

7 Furthermore, the bill requires that the reimbursement for covered
8 outpatient drugs dispensed by a covered entity as defined in section
9 340B(a)(4) of the federal Public Health Service Act is be calculated
10 based on the lower of:

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

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

16 (3) the State Maximum Allowable Cost, plus the State
17 professional dispensing fee, as defined at 42 CFR 447.502, of
18 \$10.92;

19 (4) the State submitted ingredient cost, plus the State
20 professional dispensing fee, as defined at 42 CFR 447.502, of
21 \$10.92; or

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

25 And finally, the bill requires that the reimbursement for covered
26 clotting factors dispensed by a specialty pharmacy or a Hemophilia
27 Treatment Center is based on the NADAC Retail Price Survey, in
28 accordance with section 1927(f) of the federal Social Security Act
29 or the Wholesale Acquisition Cost in the absence of a NADAC
30 price, plus the State professional dispensing fee, as defined at 42
31 CFR 447.502, of \$10.92. Under the bill, clotting factors are
32 required to be billed through a Point of Sale System as of January 1,
33 2020.

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