Save NY's Safety Net

340B Saves Lives

Medicaid Drug Carve Out MYTH/FACT Sheet

S.5136 (Rivera) Alternative to the Medicaid Pharmacy Benefit Carveout

Recently, there have been several news articles and letters on the pending Medicaid pharmacy carve out, which contain inaccurate information. This sets the record straight on some key points:

MYTH: S.5136 "compromises patient pharmacy care in underserved communities"

FACT: S.5136 *improves* Medicaid patients' access to pharmacy services by creating a single drug formulary that will be simpler to navigate for patients and providers, including pharmacists. S.5136 ensures that patients have the choice to access their local pharmacy and/or use mail-order options from these same pharmacies. S.5136 will also ensure that community health centers and Ryan White care management organizations, who are the only health care providers in some "underserved communities" will continue to utilize 340B revenue to reinvest in patient services. Under S.5136, HIV Special Needs Plans will continue to provide over 16,000 people living with HIV/AIDS access to life-extending therapies through their strong care management models that integrate the Medicaid pharmacy benefit into whole-person care through the use of real-time access to pharmacy data.

MYTH: The Executive budget proposal already provides the solution for legitimate safety-net providers and will be more reliable than the federal 340B program

FACT: The proposal in the Governor's proposed budget to make 340B providers "whole" is an administrative action proposed by DOH that consists of a single line in a Medicaid scorecard without any statutory language to implement it.[1] The plan would require approval by the Federal CMS to receive matching federal funds which has not yet been submitted. The CMS approval process may take many months, leaving 340B providers in a significant fiscal hole until they can receive retroactive payments upon CMS approval. Community health centers already operate on miniscule margins and would not be able to absorb the millions of dollars of revenue loss.

Since there is no statutory authorization for these payments, the funding would be subject to annual reauthorization by DOH in the budget process – hardly a reliable funding stream. Additionally, there is no provision for "growth" of this funding stream in future years.

[1] SFY 2023-24 Executive Budget Medicaid Scorecard - https://www.health.ny.gov/health_care/medicaid/redesign/2023/docs/2023-24_exec_budget_scorecard.pdf

MYTH: A Federally approved State Plan Amendment (SPA) will guarantee and secure the future of the reinvestment pools

FACT: A SPA is an agreement between the state and CMS when a state seeks to change their Medicaid plan. When CMS approves a SPA, it generally includes a determination by CMS that the federal share of the costs of the change can be utilized. However, this approval merely allows for the federal matching funds, it does not necessarily obligate the state to fully disburse the funds. In fact, there have been several instances when the state has not fully "disbursed" all budgeted monies from an administrative action that was subject to a SPA. For long term security and stability, statutory language would need to be enacted that would provide guarantees of annual funding and distribution of the funds.

MYTH: S.5136 will significantly increase costs to the Medicaid program

FACT: S.5136 would actually cost $449 million *less* overall than the scheduled carve-out from managed care, and $167 million less in state-share Medicaid spending.[2] Additionally, reports have shown that the Medicaid pharmacy benefit transition to fee-for-service to managed care may actually *increase* total Medicaid spending by $235 million.[3] S.5136 contains many of the same "savings" that the carve-out would achieve through a single preferred drug list and limiting PBM administrative fees, while not requiring the almost $650 million in "reinvestment" to make 340B community health centers and hospitals "whole."

MYTH: S.5136 helps to protect insurers and PBM's power in the Medicaid pharmacy benefit administration

FACT: S.5136 significantly reduces the roles of PBM's and requires all of the managed care plans to utilize a single uniform formulary for determining coverage of prescription drugs. S.5136 reduces the PBM's role to merely claim processing, data transfer and encounter submissions. The bill also removes the PBM's ability to negotiate drug rebates since all managed care plans will need to utilize the single preferred drug list.

MYTH: Pharmacists will go out of business if the drug carveout does not begin on April 1

FACT: Currently, pharmacies are reimbursed for dispensing drugs to Medicaid enrollees under managed care at the acquisition cost of the drug plus a dispensing fee of between 50 cents and $1.50.[4] Under the fee-for-service program, pharmacists are reimbursed for the drugs at ingredient cost plus a professional dispensing fee of $10.18 (a 10-fold increase).[5] Under S.5136, pharmacists will also be reimbursed the ingredient cost plus a tiered dispensing fee with a "floor" of $8.50 (which is at least an 8 fold increase over current dispensing fees under the current

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[2] See "Estimate of Savings Associated with Proposed Alternative Compared to Carve-out" dated 3.8.23

[3] *Estimated New York Medicaid Pharmacy Carve-out Financial Impact* December 15, 2022 prepared by Wakely for the Health Plan Association. *https://nyhpa.org/wp-content/uploads/2022/12/Wakely-Estimated-Pharmacy-Carve-out-Financial-Impact-20221215-3.pdf*

[4] https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/budget/docs/2021-12-30_pharm_fee_dispense_rpt.pdf

[5] NY Medicaid Pharmacy Manual Policy Guidelines (January 2023) https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Policy_Guidelines.pdf

program). A tiered dispensing fee will allow for smaller, low-volume pharmacies to receive a higher dispensing fee than the $8.50 floor, and possibly even higher than the $10.18 that they would receive under the drug carve out.

MYTH: S.5136 will hurt local small pharmacists

FACT: Besides increasing pharmacist dispensing fees by times their current rate, S.5136 also includes several protections for pharmacists that they have been seeking for years. Specifically, S.5136 prohibits insurance plans and PBM's from denying pharmacies from participating in another provider's pharmacy network and prohibits an insurer or PBM from denying a patient the choice to filling their prescription at a brick-and-mortar local pharmacy and using these local pharmacies for delivery of prescriptions via the mail or courier services.