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Via email

February 28, 2023

NYS Joint Legislative Budget Hearing-Health and Medicaid
Hearing Room B
The New York State Legislative Office Building
181 State Street
Albany, N.Y. 12247

Honorable State Senate Finance Committee Chair Senator Krueger, Honorable Assembly Ways & Means Chair Weinstein, Senator Rivera, Assemblymember Paulin and distinguished members.

I am pleased to provide this joint committee with written testimony in support of Governor Kathleen Hochul's Executive Budget Proposal initiative to implement and appropriate funds to carve out the Medicaid Prescription Drug Benefit from the New York State Medicaid Managed Care (MMC) program and into the New York State Medicaid Fee for Service (FFS) Program for 2023-2024.

My name is Vicki Cunningham, a registered pharmacist, and I am now retired from the **West Virginia** Bureau for Medical Services Pharmacy Program, in which I worked for 18 years. During the last 6 years of my tenure, I served as the Medicaid Pharmacy Director. I am pleased to share West Virginia Medicaid's 2017 carve out experience with this Committee. Due to increasing prescription drug costs under the managed care program, the West Virginia Medicaid program "carved out" the pharmacy benefit from managed care and placed it under the design and administration of West Virginia's Medicaid Pharmacy Fee for Service program. I believe that a carve out will result in savings to support Governor Hochul's initiative, just as a carve out resulted in savings for the West Virginia Medicaid Program.

During the first year after having "carved out" West Virginia's Medicaid prescription program from the Medicaid managed care program, The State of West Virginia achieved:

1. $54.5 million in NET savings
2. In order to comply with the federal Medicaid program outpatient drug reimbursement rule[1] to ensure adequate prescription reimbursement to preserve Medicaid recipients' access to prescription therapy care, West Virginia instituted pharmacy claims reimbursement based on the National Average Drug Acquisition Cost (NADAC) and a professional dispensing fee of $10.49 (approved by the Centers for Medicaid and Medicare). In contrast, the average dispensing fee paid by the managed care companies was $0.59 per prescription. The FFS dispensing fees to independent pharmacies stayed in West Virginia and allowed them to grow their businesses and assured access for Medicaid members in all regions of the state for all their Medicaid covered prescription needs.

[1] 42 CFR Part 447

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Even accounting for the higher fees paid to pharmacies (a difference of $116 million from the previous year), West Virginia was still able to achieve greater than expected savings in the Medicaid prescription program

3. The savings achieved were due to West Virginia's use of a transparent payment model by which West Virginia eliminated MMC PBM excessive administrative fees, estimated to be $10.52 per prescription.
4. Because of the transparent payment model and single source of prescription data, drugs which were not eligible for Federal and supplemental rebates were not dispensed, generating higher and more timely rebate payments for West Virginia Medicaid. Rebates were not included in West Virginia Medicaid's net savings calculation.
5. With advance planning for the carve out rollout by the West Virginia Medicaid Pharmacy staff, there were no disruptions in service to West Virginia Medicaid members.–patients, or prescribers and pharmacy providers were not inconvenienced during implementation. Because of the incorporation of medication history in the FFS system, patients were not put at risk for adverse drug interactions.
6. West Virginia's policy decision to move forward with a Medicaid prescription benefit-carve out was a win for West Virginia taxpayers, Medicaid patients (increasing their access to their preferred pharmacies for all their prescription needs), and the pharmacy providers that this vulnerable population depends upon.

Since West Virginia's "carve out" success in 2017, other states began investigating and ending overbilling from Medicaid managed care companies and their contracted PBMs. In my post-retirement work, I have had the privilege of working with some of them to address ways to eliminate overbilling for pharmacy services by managed care companies (MMC) and their contracted pharmacy benefits managers (PBMs). The following states ended MCO overbilling practices by implementing transparent payment methods:

1. **North Dakota**-Managed Care Carveout in 2019-Savings of $17 million
2. **California**-Managed Care Carveout in January 2022-Projected savings of $150 million
3. **Kentucky** Transparent Payment Model-A single claims processor implemented on July 1, 2021 Their savings report is expected to be released soon, but studies showed that managed care companies made $123,515,854 in spread pricing in 2018.
4. **Ohio**-Transparent Payment Model-A single claims processor was implemented on October 1, 2022-No report on savings is available yet, but audits of the managed care prescription claims determined that spread pricing cost the state $224.8 million in one year.
5. **Michigan**-Transparent Payment Model-This was implemented for independent pharmacies in February 2022. Savings reports are pending, but spread pricing up to $190 million was documented before the reimbursement model change.

Due to concerns about preserving vulnerable Medicaid patients access to prescription drug benefits at their community pharmacies, the states of **Iowa, Kansas, Louisiana, Mississippi, and North Carolina** mandated their Medicaid MCO utilize "cost-based" pass through reimbursement systems when MMC prescription drug benefits "carve ins" were implemented.

And while this committee is aware of the 3 studies done on overbilling of New York by Medicaid MCO's, states all across this country such as **Florida, Georgia, Illinois, Maryland, New Jersey, Pennsylvania,**

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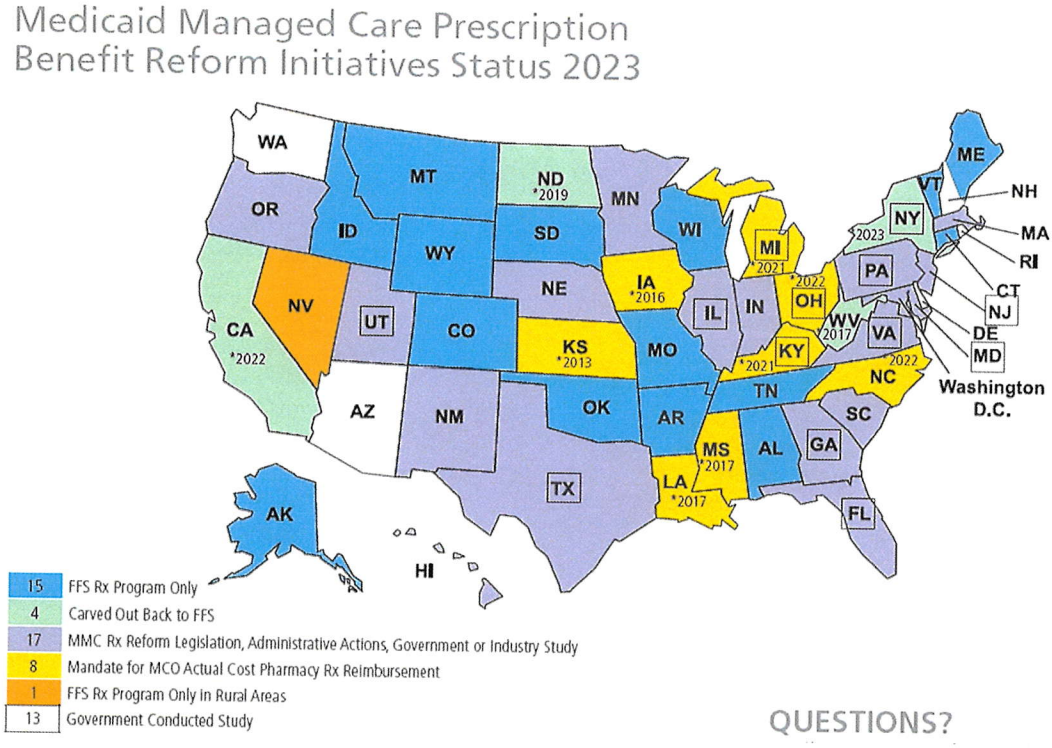
Texas, Utah and Virginia have or are in the process of conducting studies of their managed care "carve in" programs and have documented, so far, $435.5 million in Medicaid Managed Care (MMC) and their Pharmacy Benefit Managers (PBMs) overbilling of their state Medicaid prescription programs.



Beyond these government studies and reforms of MCO abuses of state Medicaid through overbilling for MMC prescriptions, Ohio started the legal process to hold the nation's largest Medicaid managed care entity – Centene Corporation – accountable for their overcharging for MMC prescriptions. To date Centene has paid $832 MILLION to 14 states **(Arkansas, California, Illinois, Indiana, Iowa, Kansas, Massachusetts, Mississippi, New Hampshire, New Mexico, Ohio, Oregon, Texas and Washington)** to settle Medicaid claims for prescription overcharges to publicly funded Medicaid prescription programs.[2]

[2] In filings with the U.S. Securities and Exchange Commission (SEC), Centene Corporations indicates it has set aside $1.2 BILLION to settle Medicaid managed care prescription billing overcharge fraud cases with the 35 states that have the prescription drug benefit "carved into" a Medicaid managed care program.

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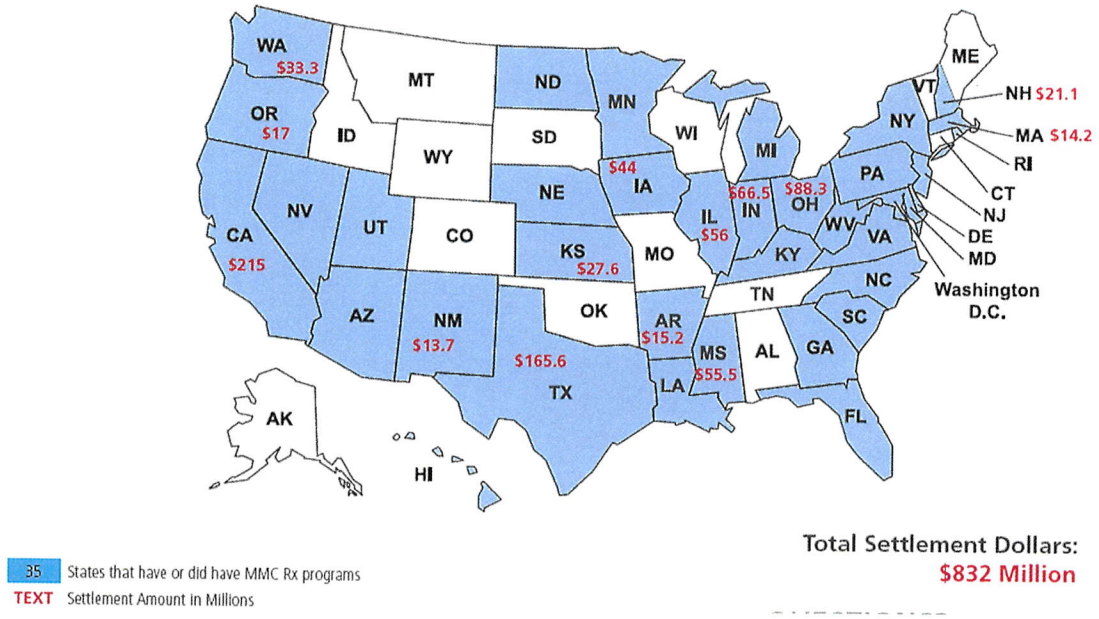
Centene MMC Rx Overbilling Settlements



These settled and ongoing State Attorneys General Medicaid lawsuits provide further evidence of the need for transparent reimbursement systems for Medicaid pharmacy benefits.

The number of states (11) that have moved to "carve out" or implement Medicaid Managed Care transparent prescription payment models due to identification of prescription program overbilling, states that have identified pharmacy benefit overbilling by Medicaid Managed Care Companies through audits and studies (13), and the repayment to 14 states of $830 Million (so far) in overbilling by one managed care company support adoption of and emphasize the need for a pharmacy carve out and transparent payment reimbursement system for the Medicaid Pharmacy Program of the State of New York.

The patterns of abuse nationwide by Medicaid Managed Care Organizations' PBMs have: 1) cost taxpayers hundreds of millions of dollars; 2) jeopardized Medicaid patients' access to their medication; and 3) adversely impacted their pharmacy providers of choice while enriching themselves.

I urge the New York State Legislature to follow the lead of 11 other states in recognizing that a Medicaid managed care "carve in" of prescription drug benefits without a requirement for a transparent payment model to prevent spread pricing and other excessive fees is costly to the Medicaid program and does not provide savings that could be used to meet other important Medicaid funding needs. I hope that this Committee and the entire New York State Legislature will move forward in the FY 2023-2024 State Appropriations law to adopt and fund the planned April 1, 2023, implementation of a Medicaid prescription drug "carve out" from MMC back to the FFS program. The taxpayers, New York State

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Medicaid patients, and the pharmacy providers they rely on will all benefit, as will other Medicaid programs in need of funding.

Thank you for your consideration of my experience with reform of the Medicaid prescription drug program, both in West Virginia and with other states who have worked to ensure a transparent payment model for Medicaid prescription drug programs. I am available for any questions the Committee has regarding my written statement.

Respectfully submitted,

Vicki M. Cunningham, R.Ph.
President
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