



Safety Net Hospitals for Pharmaceutical Access

December 19, 2011

Jason A. Helgeson
Medicaid Director & Deputy Commissioner
Office of Health Insurance Programs
New York State Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

RE: Concerns Regarding Identification of 340B Medicaid Managed Care Claims

Dear Mr. Helgeson:

Safety Net Hospitals for Pharmaceutical Access (SNHPA) is writing to express concern regarding New York Medicaid's recent announcement that pharmacies participating in the federal 340B drug discount program must identify 340B claims by using National Council for Prescription Drug Programs (NCPDP) value "09" when billing Medicaid managed care plans.¹ The intended purpose of this requirement is to ensure that manufacturers are not billed for rebates on 340B claims.² While SNHPA and its New York members strongly support this goal, the nature of the 340B program makes it impossible for pharmacies to comply with your agency's request. We are interested in working with your agency to develop an alternative method of identifying 340B claims that would be equally effective, while not imposing such significant compliance challenges. We request a meeting to discuss this with you further.

SNHPA represents nearly 800 public and private non-profit hospitals, including 46 in New York, that qualify for and participate in the 340B drug discount program by virtue of serving a large number of uninsured and underinsured patients. Consistent with the intent of the 340B program, our member hospitals rely on the savings generated from the program to help finance their mission of serving low-income patients.

A. It Is Impossible for Most Pharmacies to Comply with the Reporting Requirement

The purpose of the 340B program is to give safety net health care providers access to discounted drugs to help them stretch their scarce resources, so that they may "reach more patients" and furnish "more comprehensive services."³ Many 340B providers own retail pharmacies that dispense 340B and non-340B drugs to the providers' patients. To improve access for their

¹ N.Y. Dep't of Health, 27 New York Medicaid Update No. 12 (Sept. 2012), http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-09_pharmsped_edition.htm.

² *Id.*

³ H.R. Rep. 102-384, pt.2, at 12 (1992).

patients, many 340B providers also contract with independent and chain pharmacies to dispense 340B drugs to the providers' patients. The overwhelming majority of these pharmacies do not know at the time a claim is processed whether or not it relates to a 340B drug. Therefore, as discussed below, it is impossible for the pharmacies to identify 340B drugs with the "09" value when initially submitting claims.⁴ Because they cannot use the "09" value at the point of sale, their only option for submitting claims that comply with the guidance would be to reverse and resubmit each and every 340B claim. This process would be so burdensome and expensive, that 340B providers would effectively be forced to purchase their Medicaid managed care drugs outside the 340B program. This option, often referred to as the "carve-out" option, involves covered entities purchasing covered outpatient drugs at higher non-340B prices which, in turn, drives up their pharmacy costs.

Covered entities are prohibited under federal law from dispensing their 340B discounted drugs to anyone other than their patients. To comply with this anti-diversion requirement, most 340B pharmacies, including those in New York, rely on what is commonly called a "virtual" 340B inventory system. A virtual 340B inventory system allows covered entities to keep their 340B and non-340B inventories separate using a computerized replenishment process which is both more effective and less costly than the alternative, i.e., keeping the inventories physically separate. The pharmacy dispenses from a single inventory to both eligible and ineligible patients and then, after the drug has been billed and paid for, either the pharmacy or its third-party administrator identifies which prescriptions were eligible to be filled with 340B drugs and tracks how many units of a particular drug were 340B-eligible. Once the number of 340B-eligible units reaches a full package size, the covered entity purchases at a 340B price the same drug in the same package size in order to replenish the drug that was already dispensed. With a virtual inventory, a pharmacy does not know a drug's 340B status at the time it is dispensed, making it impossible for pharmacies to use the "09" modifier when initially submitting a claim.⁵

As a result, in order to identify 340B Medicaid managed care claims, pharmacies would have to reverse all 340B claims and then resubmit them with the "09" value. Pharmacies would have to do this even for claims that are not Medicaid managed care, because they usually do not know whether a claim relates to a Medicaid or commercial plan. Most managed care plans use the same bank identification number (BIN) for both their Medicaid managed care and commercial lines of business and, in some cases, the same group identification number. Pharmacies would be forced to manually reprocess hundreds of claims each day, which would require significant extra staff time and divert precious resources away from patient care. Such an expensive and burdensome process is simply not workable for most 340B pharmacies. As a result, the "09" billing requirement effectively forces pharmacies to carve their Medicaid managed care business out of the 340B program, and not access 340B discounts.

⁴ See Nat'l Council of Prescription Drug Programs, 340B Information Exchange Reference Guide 12 (July 2011), p.12-13, http://www.ncdp.org/pdf/340B_Information_Exchange_Reference%20Guide_v1.0.pdf.

⁵ *Id.* p. 12 ("replenishment efforts can be thwarted due to out-of-stock items, discontinued items, recalls, NDC changes, cessation of the contract pharmacy arrangement with [the Health Resources and Services Administration], price fluctuations making it economically fruitless, [and] market conditions affecting future demand.")

B. The “09” Billing Requirement Frustrates the Purpose of the 340B Program and Is Otherwise Inconsistent with Federal Law

Forcing 340B entities to carve-out their Medicaid managed care drugs undermines the purpose of the federal 340B statute. It also conflicts with the Patient Protection and Affordable Care Act (PPACA), which specifically preserves use of the 340B program for purchasing Medicaid managed care drugs and puts the burden on states, not pharmacies, to identify 340B Medicaid managed care claims.

1. The “09” Value Billing Requirement Undermines Congressional Intent by Forcing Pharmacies to Carve-Out of 340B

State Medicaid programs were required under PPACA to collect rebates on Medicaid managed care claims for prescription drugs. Prior to PPACA, drugs furnished by Medicaid managed care plans were exempt from rebate requirements. PPACA extended Medicaid fee-for-service drug rebate requirements to Medicaid managed care. Importantly, 340B drugs were specifically exempted from this requirement.⁶

This federal protection is consistent with Congressional intent to assist safety net providers to stretch their resources, but is thwarted if 340B covered entities are required by states to carve out their Medicaid managed care claims. The 340B savings that covered entities receive from Medicaid managed care claims represents the very benefit that Congress intended to give providers when it established the 340B program. As discussed in a recent report by the Government Accountability Office (GAO), 340B providers are using the additional revenue they receive to further the program’s purpose, such as by maintaining services and lowering medication costs for patients.⁷ The GAO also reported that many covered entities do not generate enough revenue from the 340B program to offset drug related costs.⁸ By limiting covered entities’ access to the 340B discount, the “09” value requirement undermines the very nature of the 340B program and will result in fewer services and other assistance for vulnerable patient populations.

2. The Burden for Identifying 340B Claims Is Being Impermissibly Placed on Safety Net Providers

PPACA placed the responsibility of reporting to manufacturers a list of the covered outpatient drugs that Medicaid reimbursed during a rebate period squarely on the state Medicaid programs.⁹ Importantly, Congress exempted 340B drugs from the new requirement that states obtain rebates

⁶ 42 USC §1396r-8(j)(1).

⁷ Drug Pricing Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement, GAO-1-836 (Sept. 2011).

⁸ *Id.*

⁹ 42 USC §1396r-8(b)(2)(Each State agency ... shall report to each manufacturer...information on ... each covered outpatient drug... for which payment was made..., including such information reported by each managed care organization...)

on Medicaid managed care drugs.¹⁰ As a result, 340B providers have no obligation under the statute with respect to states' and Medicaid managed care organizations' responsibility to ensure that drugs subject to 340B discounts are excluded from Medicaid rebate requirements. By imposing the responsibility of identifying 340B claims on 340B covered entities, the New York Medicaid Program is impermissibly shifting the burden of compliance onto safety net providers.

3. The "09" Billing Requirement Creates Such a Barrier to 340B Participation That It Is Pre-Empted by Federal Law

The federal 340B statute mandates that drug manufacturers discount their drugs when the drugs are purchased by covered entities.¹¹ There is nothing in the statute that permits states to prohibit 340B providers from accessing these discounts. The U.S. Supreme Court recognizes that, pursuant to the Supremacy Clause of the Constitution, any state law that conflicts with a federal law is without affect.¹² Conflict exists when it is impossible to comply with both laws, or when the state law serves as an obstacle to accomplishing and executing Congressional objectives.¹³ New York Medicaid's requirement that pharmacies use the "09" value at the point of sale effectively prevents pharmacies from accessing 340B discounts, in direct conflict with the federal law. Therefore, the requirement to use the "09" value when submitting 340B claims to Medicaid managed care entities is pre-empted by federal law.

C. New York Medicaid Should Consider Less Burdensome Alternatives

SNHPA has been working with its New York members to identify alternative means of reporting 340B claims that would be less burdensome for pharmacies, but would still permit the state to exclude 340B claims from rebate requests. Since the nature of the 340B program prohibits identification of 340B claims at the point of sale, any workable solution must involve a retrospective identification of 340B claims. Also to avoid being overly burdensome for 340B pharmacies, the alternative may not require pharmacies to individually rebill every 340B claim. Finally, since 340B claim identification typically occurs within 90 days of the original transaction, a viable solution should allow 340B pharmacies up to 90 days from the initial transaction to inform the New York Medicaid program of claims that qualify as 340B.¹⁴

One alternative would be to require pharmacies to prepare spreadsheets (or other workable file format) on a regular basis that identify their 340B claim specific data, and submit them to the New York Medicaid program or to managed care organizations, so that these parties may ensure that such claims are not included on New York Medicaid's rebate requests to manufacturers.

¹⁰ 42 USC §1396r-8(j)(1)(Covered outpatient drugs are not subject to the requirements of this section if such drugs are (A) dispensed by ... Medicaid managed care organizations...; and (B) subject to discounts under section 340B of the Public Health Service Act).

¹¹ 42 USC §256b(a)

¹² *Altria Group, Inc. v. Good*, 555 U.S. 70 (2008).

¹³ *Edgar v. Mite Corp.* 457 U.S. 624, 631 (1982)(quoting from *Florida Lime & Avacado Growers, Inc. v. Paul*), 373 U.S. 132, 142-143 (1963); *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941); and *Jones v. Rath Packing Co.*, 430 U.S. 519, 526, 549-551 (1977).

¹⁴ Nat'l Council of Prescription Drug Programs, 340B Information Exchange Reference Guide 12, p. 14, (July 2011).

Alternatively, New York Medicaid could create a clearinghouse into which 340B entities could enroll and then submit claim specific information on their 340B claims within 90 days of the original transaction. The submission would be in a standard electronic format. Either the New York Medicaid office or the Medicaid managed care entities could pull data monthly from this clearinghouse to identify 340B claims before submitting rebate requests to drug manufacturers.

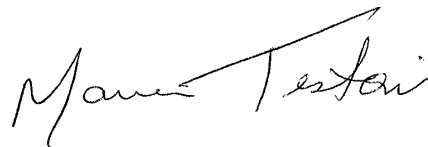
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For the reasons set forth above, SNHPA requests that New York Medicaid withdraw the current requirement and adopt an alternative. We recommend that New York Medicaid adopt a method of retrospective identification that allows pharmacies to submit information regarding a large volume of claims at once and to do so within 90 days of the claims' original transaction. We appreciate your consideration of our perspective and proposed alternatives and would welcome the opportunity to discuss them with you. If you have any questions, please feel free to contact SNHPA President and General Counsel at william.vonoehsen@snhpa.org or 202-872-5890, or SNHPA Assistant General Counsel Maureen Testoni at maureen.testoni@snhpa.org or 202-552-5851.

Sincerely,



Bill von Oehsen
General Counsel



Maureen Testoni
Assistant General Counsel

Cc: Cindy Mann, Deputy Administrator and Director, Center for Medicaid, CHIP, and Survey and Certification
Larry Reed, Director, Division of Pharmacy, Disabled and Elderly Health Programs Group
Dr. Mary Wakefield, Administrator, Health Resources and Services Administration
CDR Krista M. Pedley, Director, Office of Pharmacy Affairs
Michelle Herzog, Office of Pharmacy Affairs



Safety Net Hospitals for Pharmaceutical Access

Safety Net Hospitals for Pharmaceutical Access

Written Testimony to the New York State Assembly Committee on Health for Public Hearing on the Medicaid Managed Care Prescription Drug Carve-In Implementation

December 19, 2011

On behalf of Safety Net Hospitals for Pharmaceutical Access (SNHPA), we are submitting this written testimony regarding implementation of the Medicaid managed care prescription drug carve-in requirements. SNHPA represents nearly 800 public and private non-profit hospitals, including 46 in New York, that qualify for and participate in the 340B drug discount program by virtue of serving a large number of uninsured and underinsured patients. Consistent with the intent of the 340B program, our member hospitals rely on the savings generated from the program to help finance their mission of serving low-income patients.

SNHPA is submitting this testimony to express concern regarding how the Medicaid managed care prescription drug carve-in requirements are being implemented with respect to health care providers that participate in the federal 340B prescription drug discount program. It is virtually impossible for these safety net providers to comply with the new reporting requirements. We have contacted the Medicaid Director at the New York State Department of Health to express our interest in working with that agency to develop an alternative method of identifying 340B claims that would be equally effective, while not imposing such significant compliance challenges. We ask the New York State Assembly Committee on Health to encourage the New York Medicaid program to promptly address this critical issue.

I. Background on the 340B Program

The 340B Drug Pricing Program (340B program) is a federal program designed to reduce the amount that safety net providers spend on outpatient drugs. Enacted in 1992, and named for the section of public health statute under which the program was established, the 340B Program requires pharmaceutical manufacturers participating in Medicaid to provide discounts on covered outpatient drugs purchased by specified government-supported facilities, known as “covered entities,” that serve the nation’s most vulnerable patient populations. Congress intended for covered entities to use the benefit of the discount to reach more eligible patients and provide more comprehensive services.¹ Eligible “covered entity” hospitals include disproportionate share hospitals (DSHs), children’s hospitals exempt from the Medicare prospective payment system, cancer hospitals exempt from the Medicare

¹ H.R. Rep. 102-384, pt.2, at 12 (1992).

prospective payment system, sole community hospitals, rural referral centers and critical access hospitals (CAHs). Hospitals must be not-for-profit and either be owned or under contract with state or local governments. With the exception of CAHs, they must also serve a disproportionate share of low-income patients by meeting payer mix criteria related to the Medicare DSH program.

Certain non-hospital covered entities are eligible for the program because of their status as federal grantees, including the following: Federally qualified health centers (FQHCs); FQHC “look-alikes”; state-operated AIDS drug assistance programs; the Ryan White CARE Act Part A, Part B, and Part C programs; tuberculosis, black lung, family planning and sexually transmitted disease clinics; hemophilia treatment centers; public housing primary care clinics; homeless clinics; Urban Indian clinics; and Native Hawaiian health centers.

We have attached to this testimony a letter we recently submitted to Jason A. Helgerson, Medicaid Director & Deputy Commissioner, Office of Health Insurance Programs, New York State Department of Health (the Department), detailing the consequences of the Department’s managed care carve-in implementation plan and requesting that the agency adopt alternative reporting requirements. The provision in question is the recent announcement that pharmacies participating in the federal 340B drug discount program must identify 340B claims by using National Council for Prescription Drug Programs (NCPDP) value “09” at the point of sale when billing Medicaid managed care plans.² The intended purpose of this requirement is to ensure that manufacturers are not billed for rebates on 340B claims.³ While SNHPA and its New York members strongly support this goal, the nature of the 340B program makes it impossible for pharmacies to comply this request.

II. It Is Impossible for Most 340B Pharmacies to Comply with the Managed Care Carve-In Reporting Requirement

The purpose of the 340B program is to give safety net health care providers access to discounted drugs to help them stretch their scarce resources, so that they may “reach more patients” and furnish “more comprehensive services.”⁴ Many 340B providers own retail pharmacies that dispense 340B and non-340B drugs to the providers’ patients. To improve access for their patients, many 340B providers also contract with independent and chain pharmacies to dispense 340B drugs to the providers’ patients. The overwhelming majority of these pharmacies do not know at the time a claim is processed whether or not it relates to a 340B drug. Therefore, as discussed below, it is impossible for the pharmacies to identify 340B drugs with the “09” value when initially submitting claims.⁵ Because they cannot use the

² N.Y. Dep’t of Health, 27 New York Medicaid Update No. 12 (Sept. 2012), http://www.health.ny.gov/health_care/medicaid/program/update/2011/2011-09_pharmsped_edition.htm.

³ *Id.*

⁴ H.R. Rep. 102-384, pt.2, at 12 (1992).

⁵ See Nat’l Council of Prescription Drug Programs, 340B Information Exchange Reference Guide, p. 12-13, (July 2011), http://www.ncpdp.org/pdf/340B_Information_Exchange_Reference%20Guide_v1.0.pdf.

“09” value at the point of sale, their only option for submitting claims that comply with the guidance would be to reverse and resubmit each and every 340B claim. This process would be so burdensome and expensive, that 340B providers would effectively be forced to purchase their Medicaid managed care drugs outside the 340B program. This option, often referred to as the “carve-out” option, involves covered entities purchasing covered outpatient drugs at higher non-340B prices which, in turn, drives up their pharmacy costs.

Covered entities are prohibited under federal law from dispensing their 340B discounted drugs to anyone other than their patients. To comply with this anti-diversion requirement, most 340B pharmacies, including those in New York, rely on what is commonly called a “virtual” 340B inventory system. A virtual 340B inventory system allows covered entities to keep their 340B and non-340B inventories separate using a computerized replenishment process which is both more effective and less costly than the alternative, i.e., keeping the inventories physically separate. The pharmacy dispenses from a single inventory to both eligible and ineligible patients and then, after the drug has been billed and paid for, either the pharmacy or its third-party administrator identifies which prescriptions were eligible to be filled with 340B drugs and tracks how many units of a particular drug were 340B-eligible. Once the number of 340B-eligible units reaches a full package size, the covered entity purchases at a 340B price the same drug in the same package size in order to replenish the drug that was already dispensed. With a virtual inventory, a pharmacy does not know a drug’s 340B status at the time it is dispensed, making it impossible for pharmacies to use the “09” modifier when initially submitting a claim.⁶

As a result, in order to identify 340B Medicaid managed care claims, pharmacies would have to reverse all 340B claims and then resubmit them with the “09” value. Pharmacies would have to do this even for claims that are not Medicaid managed care, because they usually do not know whether a claim relates to a Medicaid or commercial plan. Most managed care plans use the same bank identification number (BIN) for both their Medicaid managed care and commercial lines of business and, in some cases, the same group identification number. Pharmacies would be forced to manually reprocess hundreds of claims each day, which would require significant extra staff time and divert precious resources away from patient care. Such an expensive and burdensome process is simply not workable for most 340B pharmacies. As a result, the “09” billing requirement effectively forces pharmacies to carve their Medicaid managed care business out of the 340B program, and not access 340B discounts.

⁶ *Id.* p. 12 (“replenishment efforts can be thwarted due to out-of-stock items, discontinued items, recalls, NDC changes, cessation of the contract pharmacy arrangement with [the Health Resources and Services Administration], price fluctuations making it economically fruitless, [and] market conditions affecting future demand.”)

III. The “09” Billing Requirement Frustrates the Purpose of the 340B Program and Is Otherwise Inconsistent with Federal Law

Forcing 340B entities to carve-out their Medicaid managed care drugs undermines the purpose of the federal 340B statute. It also conflicts with the Patient Protection and Affordable Care Act (PPACA), which specifically preserves use of the 340B program for purchasing Medicaid managed care drugs and puts the burden on states, not pharmacies, to identify 340B Medicaid managed care claims.

A. The “09” Value Billing Requirement Undermines Congressional Intent by Forcing Pharmacies to Carve-Out of 340B

State Medicaid programs were required under PPACA to collect rebates on Medicaid managed care claims for prescription drugs. Prior to PPACA, drugs furnished by Medicaid managed care plans were exempt from rebate requirements. PPACA extended Medicaid fee-for-service drug rebate requirements to Medicaid managed care. Importantly, 340B drugs were specifically exempted from this requirement.⁷

This federal protection is consistent with Congressional intent to assist safety net providers to stretch their resources, but is thwarted if 340B covered entities are required by states to carve out their Medicaid managed care claims. The 340B savings that covered entities receive from Medicaid managed care claims represents the very benefit that Congress intended to give providers when it established the 340B program. As discussed in a recent report by the Government Accountability Office (GAO), 340B providers are using the additional revenue they receive to further the program’s purpose, such as by maintaining services and lowering medication costs for patients.⁸ The GAO also reported that many covered entities do not generate enough revenue from the 340B program to offset drug related costs.⁹ By limiting covered entities’ access to the 340B discount, the “09” value requirement undermines the very nature of the 340B program and will result in fewer services and other assistance for vulnerable patient populations.

B. The Burden for Identifying 340B Claims Is Being Impermissibly Placed on Safety Net Providers

PPACA placed the responsibility of reporting to manufacturers a list of the covered outpatient drugs that Medicaid reimbursed during a rebate period squarely on the state Medicaid programs.¹⁰ Importantly, Congress exempted 340B drugs from the new requirement that states obtain rebates on Medicaid managed care drugs.¹¹ As a result, 340B providers have no obligation under the statute with respect to states’ and Medicaid managed care organizations’ responsibility to ensure that drugs subject to 340B discounts are excluded from Medicaid rebate requirements. By imposing the responsibility of

⁷ 42 USC §1396r-8(j)(1).

⁸ Government Accountability Office, Drug Pricing Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement, GAO-1-836 (Sept. 2011).

⁹ *Id.*

identifying 340B claims on 340B covered entities, the New York Medicaid Program is impermissibly shifting the burden of compliance onto safety net providers.

C. The “09” Billing Requirement Creates Such a Barrier to 340B Participation That It Is Pre-Empted by Federal Law

The federal 340B statute mandates that drug manufacturers discount their drugs when the drugs are purchased by covered entities.¹² There is nothing in the statute that permits states to prohibit 340B providers from accessing these discounts. The U.S. Supreme Court recognizes that, pursuant to the Supremacy Clause of the Constitution, any state law that conflicts with a federal law is without affect.¹³ Conflict exists when it is impossible to comply with both laws, or when the state law serves as an obstacle to accomplishing and executing Congressional objectives.¹⁴ New York Medicaid’s requirement that pharmacies use the “09” value at the point of sale effectively prevents pharmacies from accessing 340B discounts, in direct conflict with the federal law. Therefore, the requirement to use the “09” value when submitting 340B claims to Medicaid managed care entities is pre-empted by federal law.

IV. New York Medicaid Should Consider Less Burdensome Alternatives

SNHPA has been working with its New York members to identify alternative means of reporting 340B claims that would be less burdensome for pharmacies, but would still permit the state to exclude 340B claims from rebate requests. Since the nature of the 340B program prohibits identification of 340B claims at the point of sale, any workable solution must involve a retrospective identification of 340B claims. Also to avoid being overly burdensome for 340B pharmacies, the alternative may not require pharmacies to individually rebill every 340B claim. Finally, since 340B claim identification typically occurs within 90 days of the original transaction, a viable solution should allow 340B pharmacies up to 90 days from the initial transaction to inform the New York Medicaid program of claims that qualify as 340B.¹⁵

One alternative would be to require pharmacies to prepare spreadsheets (or other file formats such as delimited, CSV, etc.) on a regular basis that identify their 340B claim specific data, and submit them to the New York Medicaid program or to managed care organizations, so that these parties may ensure that such claims are not included on New York Medicaid’s rebate requests to manufacturers.

¹⁰ 42 USC §1396r-8(b)(2)(Each State agency ... shall report to each manufacturer... information on ... each covered outpatient drug ... for which payment was made..., including such information reported by each managed care organization...)

¹¹ 42 USC §1396r-8(j)(1)(Covered outpatient drugs are not subject to the requirements of this section if such drugs are (A) dispensed by ... Medicaid managed care organizations...; and (B) subject to discounts under section 340B of the Public Health Service Act).

¹² 42 USC §256b(a).

¹³ *Altria Group, Inc. v. Good*, 555 U.S. 70 (2008).

¹⁴ *Edgar v. Mite Corp.*, 457 U.S. 624, 631 (1982)(quoting from *Florida Lime & Avacado Growers, Inc. v. Paul*), 373 U.S. 132, 142-143 (1963); *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941); and *Jones v. Rath Packing Co.*, 430 U.S. 519, 526, 549-551 (1977).

¹⁵ Nat’l Council of Prescription Drug Programs, 340B Information Exchange Reference Guide, p. 14 (July 2011).

Alternatively, New York Medicaid could create a clearinghouse into which 340B entities could enroll and then submit claim specific information on their 340B claims within 90 days of the original transaction. The submission would be in a standard electronic format. Either the New York Medicaid office or the Medicaid managed care entities could pull data monthly from this clearinghouse to identify 340B claims before submitting rebate requests to drug manufacturers.

V. Conclusion

For the reasons set forth above, SNHPA requests that the New York State Assembly Committee on Health encourage the New York Medicaid program to revisit its plan for implementing the managed care pharmacy carve-in option. We recommend that New York Medicaid adopt a method of retrospective identification that allows pharmacies to submit information regarding a large volume of claims at once and to do so within 90 days of the claims' original transaction. We appreciate your consideration of our perspective and proposed alternatives. If you have any questions, please feel free to contact SNHPA President and General Counsel at william.vonoehsen@snhpa.org or 202-872-5890, or SNHPA Assistant General Counsel Maureen Testoni at maureen.testoni@snhpa.org or 202-552-5851.

