FULL SLIDE DECK FOR ATTENDEES
NACHC POLICY UPDATES

2019 PENNSYLVANIA ASSOCIATION OF COMMUNITY HEALTH CENTERS ANNUAL CONFERENCE

OCTOBER 16, 2019

Bethany Hamilton, JD
Deputy Director, State Affairs
National Association of Community Health Centers
First Things First...
Way to go Pennsylvania!

307 Health Center Delivery Sites

818,679 Total Patients Served in 2018
Agenda

Hot Topics:
Health Center Funding

Other Policy Issues in Congress and the Administration, and Pharmacy/340B Policy Updates

NACHC Resources and Staying Connected
Hot Topic: Health Center Funding
Congress just passed a two-month extension of all health center federal grant funding, alongside an extension of funding for key workforce programs, changing our deadline from Sep. 30, 2019 to Nov. 21, 2019.
Appropriations: Annual decisions made by Congress about how the federal government spends some of its money.

- House and Senate must pass 12 Appropriations bills each year before the end of the fiscal year, every Sep. 30th
- Also known as discretionary spending

If Congress cannot come to agreement on a full year of funding for each bill, one of two things happens:

- Government funding lapses in full or in part (any department not funded shuts down)
- Congress can instead pass a short term extension of current funding levels known as a Continuing Resolution (CR) to buy more time to complete the process
Section 330 Health Center Grant Funding

Community Health Center Fund
- Mandatory
  - Required spending, unless Congress changes law
  - Year 9 of funding - originally authorized for 5 years in 2010 and extended twice (2-yr increments)
  - Currently $4 billion/year (FY19)

Annual Appropriation
- Discretionary
  - Annual, up to Congress (Appropriations Committees) to determine amount
  - Prior to 2010, this was the only source of federal grant funding for CHC program
  - Currently $1.63 billion/year (FY19)

Two Sources Combine to Form One Program
In 2015 & 2018, CHC advocates succeeded in getting 2-year extensions (Gray & Green).

2010: Congress created a dedicated 5-year fund for growth in CHCs (Orange).

CHCs were only funded through the annual budget prior to 2010 (Blue).

In 2015 & 2018, CHC advocates succeeded in getting 2-year extensions (Gray & Green).

September CR included a 2-month extension of all CHC funding (FY20).
NHSC
National Health Service Corps

- NHSC supports clinicians in underserved areas through loan repayment & scholarships
- 54% of the roughly 11,000 NHSC clinicians nationwide practice in health centers
- Extended through 11/21 in September CR
  - NHSC Trust Fund is $310M (mandatory)
  - Discretionary NHSC Funds is $105M

THCGME
Teaching Health Centers Graduate Medical Education

- Brings residency training for physicians/dentists into community-based setting
- Most of 56 THCGME sites are health centers
- Residents trained in THCGME sites are more likely to stay and practice at rural/underserved areas
  - Over 630 new providers have trained at THCs
- Extended through 11/21 in September CR
  - THCGME funded at $126.5M annually
Where do CHCs fit on Congress’s agenda?

2-Month Extension
- CHC Fund
- NHSC
- THCGME
- Other program extensions (Special Diabetes Programs, PCORI, CCBHCs)
- Medicaid relief for Puerto Rico and other U.S. territories
- FY20 Labor-HHS Approps

Ongoing Work
- Surprise medical billing
- Drug pricing
- Telehealth package
- Rural health
- Maternal mortality
- Oversight of VA Community Care program
- Gun violence
- Immigration issues

***All of which are complicated by an extremely challenging political environment.
• Roughly Two Months to Finalize Everything that Must Pass by 11/21:
  • Omnibus bill or another Continuing Resolution (CR) to keep the government running
  • Bill to address extenders, including CHC, NHSC, THCGME & other policies such as Medicaid for US territories
What Happens Next?

- **Best Case Scenario: A long-term deal before 11/21**
  - Pass the rest of FY20 Appropriations funding (omnibus bill)
  - Agree on way to pay for long-term funding for CHCF, THC, NHSC (e.g. finalize proposal to surprise medical bills or drug pricing package)

- **Fallback Plan: Another Short-Term Funding Extension (2\textsuperscript{nd} CR)**
  - Extend current funding levels while big political fights continue (e.g. Southern border wall, family planning)
  - CHCF, NHSC, THCGME could be once again attached and extended for matter of months or even weeks

- **Worst Case Scenario: NO DEAL**
  - No agreement on anything and no bills passed before 11/21 – Government shutdown and no assurances for timing of CHC funding
Focus on our Goal

We appreciate this funding patch, BUT our ask continues to be 5 years of funding with increases over time to allow for growth.

We need Congress to take URGENT ACTION to extend the CHC Fund for as long as possible, with as much growth as possible.
Current Options for Long Term Funding

**Senate**
- In June, Senate HELP Committee passed *Lower Health Care Costs Act* (Vote of 20-3)
- **Includes 5 yrs of level funding for CHCF, NHSC, THCGME**
- Also addresses Special Diabetes Programs, surprise billing, youth tobacco use, maternal mortality, health care costs

**House**
- In July, House E&C Committee passed a series of bills, including a REVISED version of *CHIME Act* (Voice Vote)
- **Includes 4 yrs of level funding for CHCF, NHSC, THCGME**
- Also includes DSH funding, Medicaid $ for territories, Medicare extenders, surprise billing, other public health programs
Our Ask

1. Help us Secure the Longest, Most Robust Funding Extension Possible—*Before the November 21 Deadline*

2. Join Us in Taking Public Action to Show Support for a Fix
   - Every single House member and Senator can play a role.
   - This is all about our patients! You can’t go wrong when you put them first.
   - Public actions are the truest measure of support – get a commitment!
Arguments for Action

• **URGENCY:** Already passed the original deadline. Health centers are small businesses and need to plan for the future. We cannot keep waiting until the last minute to know whether funding will be there.

• **LONG-TERM SOLUTION:** Without sustainable and predictable funding, health centers will continue to experience operational and service-related impacts, placing our patients’ care in jeopardy.

• **GROWTH:** Health centers are meeting unprecedented demand for services (opioids, veterans, etc). The NHSC and THC programs cannot support current/future workforce needs without additional resources.
What Do We Mean By Public Support?

Members showing their support in PUBLIC and ON THE RECORD will be the key to success.

NACHC “Menu of Options” on HCAdvocacy.org includes:

- Press releases/statements
- Op-Eds and Blog Posts
- Social Media
- Individual/Delegation support letters
- Short Speeches on the House/Senate Floor
- Visit a local health center
Your advocacy will get us across the finish line.
Resource Hub: Fall Funding Blitz

• Take Action!
• Talking points
• One-pagers and fact sheets
• Congressional Maps
• Impact Estimator
• ...and more!

www.hcadvocacy.org/fallfundingblitz
Stay Engaged and In-the-Know

facebook.com/HCAadvocacy
Twitter: @HCAadvocacy

Sign up for the weekly Washington Update, calls to action, and other important advocacy communications at www.hcaadvocacy.org/join
Other Policy Issues in Congress and the Administration
Congressional Attention on 340B

What happened last Congress? A lot!
- Hearings, bills introduced, reports released, letters sent
- Health center use of the program not specifically targeted

340B in the 116th Congress
- Less interest from Congress and less pressure from critics to address 340B reforms
- Drug pricing conversation taking center stage
- Complex issue to find consensus on any legislative action

What can you do? Tell Your Story!
- How does 340B allow your patients to better access care at your health center?
Telehealth

• Congressional RFI earlier this year
• Expecting legislation introduced soon!
• For FQHCs & RHCs, legislation would include provisions to authorize reimbursement within Medicare as DISTANT & ORIGINATING site providers
• **S. 1190/H.R. 2594 Rural Access to Hospice Act** (Sens. Capito/Shaheen, Reps. Kind/Walorski): would allow FQHCs/RHCs to be reimbursed as attending physicians for their patients in hospice care.

• **Draft legislation related to reimbursement for physical therapy**: NACHC working with the American Physical Therapy Association to introduce bill to reimburse health centers for physical therapy services under Medicare/Medicaid.

• **S. 22/H.R. 2951 Medicare Dental Benefit Act** (Sen. Cardin/Rep. Barragan): would provide Medicare coverage for dental and oral health services

• **Variety of Medicare-for-All and Medicare Option/Buy-In proposals**
States turn to waivers!

Focus is on the states, particularly as CMS has expressed interest in “fast tracking” waivers that include provisions previously approved

- States seeking variety of provisions (e.g., block grants or per capita caps, work requirements, premiums, lockouts, co-pays, drug testing, asset testing, eliminating retroactive coverage)

- FQHC PPS protections

- Really important for health centers to work with their PCAs and Networks to ensure thoughtful, coordinated responses to complex proposals
Medicare & Medicaid: Recent Federal & State Regulatory Activity

Federal Regulations
- CMS and ONC Interoperability Rules – NACHC Commented
- Section 1557 Proposed Rule – NACHC Commented
- Medicaid Access Monitoring Recession Proposed Rule – NACHC Commented
- USDA's NPRM “Revision of Categorical Eligibility in the Supplemental Nutrition Assistance Program (SNAP)” – NACHC Commented
- Medicare Physician Fee Schedule Proposed Rule – NACHC Commented

State Activities – Waivers, Waivers, Waivers!
Medicaid blockbuster waivers in 2019:
- Utah – per capita caps
- Tennessee – block grant

In the Courts
- Texas v. Azar
- Various work requirement waiver lawsuits (Kentucky, Arkansas, New Hampshire, and Indiana)
State Resources

Medicaid Resources – Updated!
• PPS Checklist
• Emerging Issues in PPS
• Change in Scope
• Medicaid Wraparound Issues

340B
• State Legislative Toolkit
• Monthly Pharmacy Office Hours 3rd Thursdays at 2 p.m. ET

Telehealth
• Monthly Office Hours starting September 12, 2019 at 2p eastern

Payment Reform
• Payment and Delivery Reform Summit
• APM Academy, Round 2 coming soon

State Affairs Staff
• Call or email with any questions state@nachc.org
Effective date planned for Oct. 15 is postponed as a result of nationwide preliminary injunctions issued by federal courts.

The Trump Administration’s rule would increase the likelihood that an immigrant will be considered a public charge, by expanding the list of public benefits considered.

- A “public charge” is a legal immigrant who – in the view of an immigration official – is “primarily dependent” on government benefits.

Things to keep in mind:
- Several lawsuits are challenging the new rule, so the situation will continue to evolve.
- NACHC resources:
  - NACHC webpage on “Caring for Immigrant Patients.”
  - Additional resources available through the National Health Center Immigration Workgroup
- Other resources: immi.org and NILC.org
Auto-HPSAs and the NHSC

• The updated auto-HPSA scores will go into effect for the 2020 NHSC recruiting cycle.
  • Some health centers can still increase their scores by 1 to 3 points. See the “Next Steps” document on the NACHC Shortage Designation webpage.

• NACHC recognizes that the updates have negatively impacted many health centers, and we are continuing our efforts to:
  • Identify additional resources to support health centers’ workforce needs.
  • Work with HRSA to address the shortcomings of the current system.
Pharmacy and 340B Policy Issues
The 340B Program Basics

Policy and Operational Updates

Discriminatory Contracting

• Overview of the issue and possible solutions
  • Bonus issue: DIR Fees
• Evaluate state legislation on discriminatory contracting and considering Medicaid policy/compliance issues
340B Drug Pricing Program

Let’s review the basics...
The 340B Drug Pricing Program provides eligible health care providers, such as health centers, access to outpatient drugs at reduced prices.

By purchasing medications at lower cost, health centers can pass the savings along to their patients through reduced drug costs AND use the additional savings to support their mission to expand access and improve health outcomes for their patients.

Health centers are required by statute and regulation to reinvest 340B savings into activities that further their mission of expanding access to care for the medically underserved.

Health centers use 340B savings in a variety of ways, including:

- expanding clinical pharmacy services,
- providing opioid treatment services, such as MAT
- expanding access to dental care
- And more!
340B-uzzzzzzzing!
• If unfamiliar groups reach contact you with questions or opportunities around 340B – be cautious!

• An increasing number of groups are actively seeking info or action from health centers for reasons that are not aligned with our patients’ best interest and/or the intent of the program.
If contacted by an unfamiliar group...

• Ask who is **funding** them and what are their intentions

• **Ask your health center colleagues** if they know the group
  • *NACHC’s Noddlepod Group allows for private peer to peer discussions.*

• **Be particularly suspicious** if they are offering to increase your patients or 340B revenue

• **If in doubt, do not respond and/or consult with legal counsel**
  • *Exception: Kalderos – a private group seeking data re: duplicate discounts on behalf of drug manufacturers*
Increased Announcements of Overcharges

• The number of manufacturers publicly acknowledging that they have overcharged for 340B drugs has more than doubled this year.

• FQHCs may start seeing checks from manufacturers for overpayments.
  - NACHC will monitor HRSA website announcing overpayments & alert health centers if action needed to receive refunds.
  - Please join Noddlepod to help us monitor developments.
HRSA 340B Audits: Getting conditions for not having annual external audits, particularly of contract pharmacies. Increased findings around clinic-administered drugs and devices.

OSV: In 2015, BPHC added questions about 340B to the official OSV protocol.
  • They involved demonstrating appropriate P&Ps, contracts, etc.

Good News: Earlier this year, BPHC officially removed the 340B questions from the OSV protocol.

Rx Sliding Fee Discounts:
  • Remember this is a point of intersection of the 340B Program with our 330 Program Expectations
  • Recently a fog has settled over previous clarity regarding SFDs for pharmacies
  • NACHC – in collaboration with its 340B resource pool – is working to clear the fog
  • In the meantime...

Scope: What goes where on Form 5? More to come on this!

If you have a question or get a condition for not having a SFS at a contract pharmacy, please contact Colleen at cmeiman@nachc.org.
Does your focus on and investment in 340B compliance truly reflect the importance of the program to your health center and its patients?
In addition to extending health center funding, along with NHSC and THCs, health centers support:

- **340B**: Ensuring health centers ability to continue to utilize program
- **Medicaid**: Protecting a strong Medicaid program
- **Behavioral Health/SUD Treatment**: Targeting investments and policy changes to address challenges
- **Telehealth**: Ensuring sustainable reimbursement
Providing Comprehensive Care through the 340B Drug Pricing Program.

Health centers support protecting the 340B program and ensuring that health centers can continue to use 340B savings to provide more comprehensive care to more patients, as Congress intended.
The Broader Environment

Drug pricing is the “hot” issue!

• Drugs prices increased 10.5% in the last 6 months
• Addressing price inflation is not easy
<table>
<thead>
<tr>
<th>Initiative</th>
<th>Status</th>
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<tr>
<td>Eliminating PBM rebates in Medicare and Medicaid Managed Care</td>
<td>Not publishing a Final Rule</td>
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<td>Changes to DIR fees</td>
<td>Changes not included in Final Rule</td>
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<td>Limiting Medicare coverage for drugs in “protected classes”</td>
<td>Changes not included in Final Rule</td>
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<td>Requiring TV ads to show Rx list prices</td>
<td>Blocked by courts</td>
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<td>Excluding rebates from “medical loss ratio” calculations</td>
<td>In effect</td>
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What’s the Climate on the Hill?
Congressional Attention on 340B

What happened last Congress? A lot!
- Hearings, bills introduced, reports released, letters sent
- Health center use of the program not specifically targeted
- Questions about how to calculate savings, how savings are being used, benefit to uninsured patients

340B in the 116th Congress?
- Significantly less attention in this Congress. This is largely due to the fact that we now have a split Congress
- While not specific to 340B, both the House and Senate have introduced bills that include differing approaches for lowering drug prices
- Given the complexity of this issue, different approaches, and the current political environment, there are low expectations that Congress will be able to successfully move forward with an agreed upon drug pricing package
- We are closely monitoring efforts

What can you do? Continue to Tell Your Story!
- How does 340B allow your patients to better access care at your health center?
Newton

The First Law of Motion: Law of Inertia

Every body continues its state of motion or rest in the absence of an external force.
Wait, or did we experience the Third Law of Motion?

What about the Second Law of Motion?

What about it? We’re not here for physics 101. There’s action in the states! So, let’s keep it…moving.
Let’s talk about the state level action to address the challenges!
What are DIR Fees?
• Direct and Indirect Remuneration
• Coined by CMS to help determine the true costs of Medicare Pt D drugs, including those not captured at the point of sale.
• In the Pharmacy context, DIR fees are different. Here, it could mean pay-to-play fees or retroactive pharmacy DIR fees applied to various quality measures after the point of sale. (Note: copay clawbacks are different.)

Solutions:
• Education stakeholders, policymakers and legislators
• Transparency for TPAs, including PBMs
• Prohibit retroactive DIR fees on pharmacies
• Form alliances & see NCPA

Source: NCPA
State Legislation Example: Louisiana (DIR Fees and other regulations mechanism)

• Louisiana, [LA S 41 019](https://www.ncpcanet.org), 06/06/2019 - Enacted
• Regulation Of Pharmacy Benefit Managers
• Sponsors: Mix of Rs and Ds
• Summary:

  Louisiana Board of Pharmacy, authority to regulate pharmacy benefit managers (PBMs). The board shall promulgate rules and regulations to implement the provisions of this Part and the applicable provisions of the Pharmacy Benefit Manager Licensing Law....

  A pharmacy benefit manager in Louisiana shall not: Participate in "spread pricing", Directly or indirectly engage in patient steering, Penalize a beneficiary or provide an inducement to the beneficiary for the purpose of getting the beneficiary to use specific retail, mail order pharmacy, or another network pharmacy provider in which a pharmacy benefit manager has an ownership interest, Retroactively denying or reducing a claim of a pharmacist or pharmacy for payment or demanding repayment of all or part of a claim, after the claim has been approved by the pharmacy benefit manager.

See [www.ncpcanet.org](https://www.ncpcanet.org) or [www.ncsl.org](https://www.ncsl.org).
State Legislation Example: Delaware (Copay clawbacks)

• Delaware, DE H 24, Enacted - 06/19/2019
• Prescription Drug Copayments and Coinsurance
• Sponsors: Majority Ds
• Summary: Prohibits health insurers and pharmacy benefit managers from engaging in the practice of clawbacks, which is the imposition of copayments or coinsurance requirements, for a covered prescription drug that exceeds specified coverage amounts.

See www.ncpcanet.org or www.ncsl.org.
And now on to our most “favorite” topic!
What is Discriminatory Contracting in 340B?

• Health centers are finding that third parties are subverting the Congressional intent for the 340B Program by finding to access the savings meant for covered entities for themselves.

• For privately-insured patients, third parties may include: private insurers, PBMs, TPAs, Contract Pharmacies, and some groups offering to manage 340B programs.
Discriminatory Contracting

What Factors are at Play?

PBM s often have the leverage to mandate lower reimbursement for 340B drugs
• A health center often cannot afford to be outside of a PBM network
• A health center loses the ability to ensure patients have access to affordable medication when patients go to other pharmacies

Medicaid Managed Care Organizations (MCOs)
• The state tells MCOs not to cover 340B drugs (meaning covered entities and their contract pharmacies must use non-340B drugs)
• The state tells MCOs that they must pay no more than a certain amount for 340B drugs
• The state itself dictates how and when 340B drugs can be used or billed and for what amount
Discriminatory Contracting

What does it *typically* look like?
A Payer (e.g., TPA, PBM, etc.):

- Reimburses less for drugs purchased under 340B than for the same drug purchased outside 340B.
  - Pay only the actual acquisition cost (AAC), or an arbitrarily lower rate.
- **Refuses to cover drugs purchased under 340B**
  - Refuse to allow 340B pharmacies into your insurance network.
  - Under Medicaid managed care, require the FQHC to “carve-out” these patients (i.e., not fill their prescriptions with 340B drugs.) – Reminder: This can be required by the state, as well as an MCO or contract pharmacy.
- **Charges more than fair market value for services involving 340B drugs.**
  - Contract pharmacy, TPA, or consultant contracts that retain a percentage of the 340B savings.
- **Charges fees to 340B CEs/contracted pharmacies not other charged to non-340B entities**
What can Health Centers do?

• **Raise awareness** with stakeholders, policymakers and legislators
  • Messaging, messengers and venue matters.

• **Transparency and prohibition in state statutes and regulations** for TPAs, including PBMs
  • States with legislation passed include: MN, MT, OR, SC, SD, and WV.

• **Form strategic alliances**
  • Groups (like NCPA) are pushing for PBM transparency and reform in states around the country.

• **Consider the business strategies**
  • Know the rules, the numbers, the stakeholders, and the impact
Let’s Take a Look at State Legislation: West Virginia

- West Virginia unanimously passed a PBM reform bill (Assembly Bill 489) this legislative session; Effective February 2019
- Related to Pharmacy Audit Integrity Act
- **Summary:** No PBM or insurer can pay a 340B covered entity or contracted pharmacy less than it pays a non-340B entity/pharmacy with similar claims volume. No extra fees can be charged to 340B covered entities or contracted pharmacy that are not charged to non-340B entities.
Issues to consider in statutory language to address discriminatory contracting against 340B covered entities:

• Which categories of drugs would be protected?
• Who is blocked from engaging in discriminatory contracting?
• How broadly is discriminatory contracting defined?
• Who is responsible for enforcement, and how?
• Are there new requirements for health centers?
• Does the language reflect an adequate understanding of drug reimbursement policy?
Discriminatory Contracting

**West Virginia**
- 3/1/19 Gov signed into law SB489
- A PBM cannot reimburse 340B entities at a rate lower than non-340B entities

**South Dakota**
- 3/07/19 Gov signed into law HB1137
- No PBM can discriminate against a pharmacy participating in a health plan as an entity authorized to participate in 340B program.

**Montana**
- 4/30/19 Gov signed into law SB335
- A PBM cannot pay less than the state-surveyed average drug acquisition cost or WAC for 340B dispenses

**Minnesota**
- 5/20/19 Gov “approved” into law SF278
- A PBM may not reimburse an entity or pharmacy under contract with such entity differently that other similarly situated pharmacies
- Does not apply to PBMs under contract with state for Medicaid MCO

**Oregon**
- 7/15/19 Gov signed into law HB2185 (effective 1/1/2020)
- A PBM registered under ORS 735.532 may not reimburse a 340B pharmacy differently than any other network pharmacy based on its status as a 340B pharmacy.
Messaging Matters! When talking about 340B and discriminatory contracting, make sure your messaging can answer the following questions correctly:

- **What is a community health center?**
- **What is the 340B Drug Pricing Program?**
- **How does 340B expand access for health centers’ medically underserved patients?**
  - Example:
    - Expanding access to critical services, such as dental and substance use disorder services;
    - Adding evening and weekend hours so that patients who work during the day do not have to miss work to see the doctor;
    - Helping patients in remote areas access their medications, such as by funding delivery services.
- **What is discriminatory contracting in the 340B program?**
- **Is discriminatory contracting permissible under the 340B statute?**
- **What can be done at the state level to prevent 340B discriminatory contracting from harming health center patients?**
Phew! Is there anything else?

Glad you asked!
Intersection of Medicaid and 340B

• To Carve In or Carve Out, this is the question for state Medicaid agencies.
  • States want/need to control costs
• Preventing Duplicate Discounts
  • See other state models, e.g., Oregon
• Always position yourself as an ally!
  • Access and affordability for your patients
  • Compliance with the rules
Medicaid

When an FQHC provides a drug to a Medicaid patient, there are two possible discounts:

• FQHC – can get a 340B discount up-front

• Medicaid – can get a post-purchase rebate

BUT! Only one discount can be provided.
The rules are different for Fee-for-Service (FFS) Medicaid than for Medicaid managed care.

**FFS RULES**

In 2017, CMS regulations limited reimbursement for FFS drugs to the sum of:

- Actual Acquisition Cost (AAC)
- Plus
- “professional dispensing fee” (PDF)

**AAC ensures that Medicaid gets the savings:**
- If the FQHC purchases the drug under 340B, the state gets the benefit of paying the 340B price (or the even-lower price negotiated by Apexus, etc.)
- If the FQHC purchases the drug outside 340B, then the state gets to claim the rebate.

*States were required to adjust their PDFs in 2017 to reflect recent data and actual costs.*
- Now averaging $10 - $13 per prescription.
Other Important State-Level Issues

The rules are different for Fee-for-Service (FFS) Medicaid than for Medicaid managed care.

Medicaid Managed Care

- Unlike under FFS, there are no Federal requirements dictating how Medicaid must reimburse for Rx purchased under managed care.
- There are no Federal rules requiring States to keep the savings, but nothing preventing them from doing so.

TIP: Health centers and PCAs should stay abreast of developments in this area, and talk to their State Medicaid agencies.
Preventing Duplicate Discount Problems

Fee-for-Service

The Medicaid Exclusion File (MEF) was HRSA’s initial effort to prevent duplicate discounts in FFS.

- 340B providers who want to use 340B Rx for Medicaid patients must register on the MEF, which is part of OPAIS.
- Recent experience indicates that you should list all Medicaid Billing Numbers that might bill for 340B Rx, and associated NPIs.
- Must register by 15th day of last month of quarter, to be effective the first day of the next quarter.
- States are to exclude all Rx billed by providers on the MEF from their rebate requests.

Note: Per HRSA, the MEF applies only to Fee-for-Service. However, not all State Medicaid agencies are aware of this, or use the MEF in that manner.

Managed Care

FQHCs can negotiate this with their state. There are two general approaches:

1. FQHCs inform the state re: which prescriptions were filled with 340B drugs, and the state removes them from its rebate requests.
   - The “devil is in the details” here – who receives the data, who makes sure it’s accounted for correctly.
2. No 340B drugs are provided to Medicaid patients.
   - Called “carve OUT” – as in, Medicaid is OUTSIDE of your 340B program.
   - Then the state can request rebates on all drugs it paid for without needing to remove those purchased under 340B.
Are You Overpaying for Vaccines or IUDs?

- Neither vaccines nor IUDs are subject to mandatory discounts 340B.

- BUT... as a 340B provider, you are eligible for discounts on vaccines, and $50 IUDs (similar to Mirena.)

For info on discounted vaccines, contact Apexus at 888.340.BPVP or apexusanswers@340Bpvp.com

For info on $50 IUDs, contact mdiallo@medicines360.org or go www.medicines360.org
Resources available to the Health Center 340B Pharmacy Community

- NACHC 340B Compliance Manual
- 340B Office Hours
- Noddlepod, Noddlepod, Noddlepod
- 340B Coalition bi-annual conferences with CHC specific programming
- Apexus 340B University at CHI and P&I
- CEO and CFO Institute modules
- Upcoming open C-Suite webinars
- Training resources including programs tailored to the needs of states and individual health centers
- 1-1 technical assistance
Other NACHC Resources and Staying Connected
Two-Way Resource

NACHC Policy Team

- Heard from another group about a bill, a letter, any kind of legislative proposal?
- Met with a Member or any staff?
- What are the top issues for my Member?
- Need Spanish advocacy resources?
- Where can I find NACHC policy resources?

You

PCA Health Center

- Policymaker interested in visiting a health center?
- Need help making public comments on a policy issue?
- Need data or Congressional district level information?
- Where can I find NACHC policy resources?
Online Resources

For these and other materials, go to www.nachc.org/focus-areas/policy-matters
Discussion or Q&A

What can I answer or share with NACHC?

- General Questions/Concerns
- Best Practices
- Emerging Issues
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