



340B Advocacy Toolkit

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Encourage Staff to Sign Up to be a Community Health Center Advocate

Community Health Centers (CHC) are the backbone of our nation's primary health care system and critical to strengthening our communities. CHC staff can be a part of the movement to ensure comprehensive care and services to our neighbors by signing up to be an advocate to support the health center community today at www.hcadvocacy.org/join. We need your support in helping keep our doors open!

Millions of patients' lives are at stake across the country. Health center operations and budgets face devastation amid an overwhelming public health pandemic. Community Health Centers invest the savings from the federal 340B discount drug program into essential services that are not always reimbursed by federal health programs or insurance. NACHC (National Association of Community Health Centers) estimates that 10 million patients (about half the population of New York) with low incomes will suffer reduced access to health center services and affordable medicine unless Health and Human Services acts now to address the prescription drug

manufacturers' threats to the 340B Drug Pricing program. We encourage you to act using the resources in this toolkit to help protect the 340B program.

Sample Video Script – It's Time to Tell Your Story!

NACHC believes in the power of personal appeal. We hope many people on your team will record an advocacy video for social media. There is power in numbers. Below is a sample script along with tips on taking a good video with your smartphone (or Zoom). When you post on social media, make sure to **tag your member of Congress, your PCA (Primary Care Association), NACHCACHC** ([Facebook](#)/[Twitter](#)), and **local media**. For instructions on uploading a video to a business page on Facebook, click [here](#).

Consider sharing a patient testimonial. If you would prefer to do a video with a friend, click [here](#) for a sample script. Remember to include:

- Your name, profession/role, and health center name
- Brief background on your health center
 - Where you are located,
 - populations you serve— see examples below
 - migratory/farm workers
 - people experiencing homelessness
 - people with chronic conditions such as diabetes, heart disease
 - Racial/ethnic minorities
 - how long you have served your community
- What is the 340B program?
- What services and/or programs have you had to cut because of manufacturer restrictions? Give specific examples.
- If you lost 340B savings, what programs would you have to cut?
- What other sources of funding do you have that supports programs funded by 340B savings?
- Urge for support of PROTECT 340B Act and for PROTECT Act 2.0 (contract pharmacy legislation)
 - Refer to the Talking Points below for ideas

Video Tips

1. **Test, test, test.** Always record a 10-second test with the setup you will be using to film your full-length video. It will help you see if there are any issues with lighting, background, or audio and fix them before you film the full video.
2. **Keep it steady.** If you have a tripod, a selfie stick, or even a stack of books, that will be better than holding the phone in your hand. If you can ask a friend or coworker to hold it, that works, too.
3. **Do NOT use the zoom function on your camera.** Physically move the camera forward or backward to make sure you are in the center of the shot. The built-in zoom only enlarges the picture digitally, which will make the video look grainy or pixelated.
4. **Find good lighting.** Try to film in natural light. You can position yourself facing a window and use the sun.
5. **Keep it horizontal.** Because your videos will be used on social media, you want to make sure you are shooting the format native to the platform.
6. **Find a backdrop.** Your video will look best in front of a solid-colored background, if possible.
7. **Poor camera or no tripod? Use Zoom!** You can use Zoom and your computer to record a video if that is easier for you. Click [here](#) to learn how to do it.

Sample Social Media Posts

Below, you will find sample social media posts that you can customize for your health center. We recommend utilizing the graphics in your posts. (We have graphics available that you can use.) As a reminder, you should always **tag your members of Congress** [TAG MOCs] in your post so that they can see your messages. If you have questions, contact grassroots@nachc.org.

Social Media Graphics – [available here](#)

340B Advocacy Page - <https://www.hcadvocacy.org/340b-advocacy/>

340B Email your MOCs Page - <https://www.hcadvocacy.org/340b-advocacy/email/>

Sample Tweets and Facebook Messages:

Hashtags (*NOTE: best practice on Twitter is to limit hashtags to no more than 3*): #Protect340B #ValueCHCs

- Each day, patients go without vital medications because of the prohibitive cost of prescription drugs. The #340B program enables health centers to provide patients with the most effective medication at affordable prices. #340B savings are reinvested to increase access to affordable, comprehensive care for all patients. #Protect340B #ValueCHCs [TAG MOCs]
- Congress created the #340B program to help safety net providers provide pharmacy services and comprehensive care to the most medically-underserved communities. The 340B program helps health centers fulfill their mission to provide care to all individuals, regardless of their ability to pay.
- Since 2020, drug manufacturers have refused to ship vital 340B medications to our contract pharmacies. As health centers continue to fight COVID-19 on the front lines, we are losing critical 340B savings that enable health centers to serve all people, regardless of their ability to pay. Tell @hhs.gov to use its authority to #Protect340B and #ValueCHCs. [TAG MOCs]
- Community Health Centers reinvest #340B savings into their community. #340B savings help build new centers, pay for patient transportation, hire more clinicians, fund innovative technology, engage with people experiencing homelessness, and care for uninsured patients. #Protect340B #ValueCHCs [TAG MOCs]
- Millions of low-income patients will suffer reduced access to health center services and affordable medicine unless @hhs.gov acts now to protect the federal #340B drug discount program. #Protect340B #ValueCHCs [TAG MOCs]
- #RxDrug manufacturers are attacking the federal discount drug pricing program called #340B and are harming health centers and vulnerable patients. @hhs.gov: please use your authority to #Protect340B and #ValueCHCs. [TAG MOCs]

Op-Ed Template and Writing Tips and Tricks

Do not underestimate the power of local media coverage. Op-Eds and Letters to the Editor in local publications can generate new audiences for your messages and can catch the eye of your Members of Congress. We encourage you to check out this [Op-Ed Tips and Tricks](#) worksheet to help you get started. Also, check out our [Op-Ed writing workshop recording](#) for more information on how to begin writing and pitching op-eds. As always, please feel free to reach out to the Grassroots Advocacy Team at grassroots@nachc.org with any questions.

For your convenience, we are including this [op-ed template](#) to help you share your 340B story.

Additional Educational Resources and Templates

- [340B and FQHCs Overview](#) – one pager
- [Pick Pocketing Overview](#) – one pager
- [Additional 340B Advocacy Resources](#)
- [340B Anti-Discrimination Legislation Model Draft](#)
- [340B Sample Op-Ed \(State\)](#)

General Talking Points on the 340B Program

How Patients Benefit from the 340B Program:

1. By law and statute, health centers are required to invest *every penny* of 340B savings into activities that expand access for their patients.
2. Health centers abide by that promise by using 340B savings to expand non-revenue generating services like clinical pharmacy programs, community health workers, specialty care services, and extended hours of operation to better meet patient needs.
3. The 340B program enables health centers to provide affordable discounted or free medications to uninsured or underinsured patients.

What is the 340B program?

1. The 340B Drug Pricing Program garnered bipartisan support in Congress and passed in 1992.
2. To have drugs reimbursed by Medicare and Medicaid, drug manufacturers must participate in the 340B program to provide discounts for their products to certain types of safety net providers, including Community Health Centers.
3. The program's purpose is to enable safety net providers "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."
 - a. Prior to 340B, most health centers were unable to offer affordable pharmaceuticals to patients given their lack of market power to negotiate discounts from the sticker price.
 - b. When the 340B program was created, most eligible safety-net providers did not have in-house pharmacies. Legislative history demonstrates Congress anticipated the use of contract pharmacies to serve patients.

Duplicate Discounts and How CHCs Do Their Part:

1. Duplicate discounts occur when manufacturers are asked to provide both a 340B price and a Medicaid rebate on the same unit of a drug.
2. Community Health Centers strive to prevent duplicate discounts by doing several things, including:
 - a. Ensuring Medicaid billing numbers and National Provider Identifier numbers are correct in both the Office of Pharmacy Affairs database and the Medicaid Exclusion File to avoid accidental double charging.
 - b. Performing ongoing internal audits of both their in-house and contract pharmacies.
 - c. Providing necessary documentation when resolving a claim to identify it as "340B."

Talking Points on the PROTECT 340B Act

1. Health centers rely on the 340B program to provide patients with access to affordable medications and comprehensive health services like dental care, behavioral health, and other specialty care.
2. **Why we need the 340B Act:** Everyone wants a slice of the 340B savings pie. There is no recourse when Pharmacy Benefit Managers (PBMs) and insurers treat 340B pharmacies differently or lower their reimbursement because of their 340B status. The PROTECT 340B Act will prohibit health insurers and PBMs from redirecting our 340B savings to their pocket, a practice that has increased significantly over the last few years.
3. **What does the 340B Act do:** This legislation protects against discriminatory practices by PBMs like pickpocketing our 340B savings to make up for their lost revenue, and from health insurers, in the commercial market, Medicare Part D, and managed care.
 - a. While the PROTECT 340B Act does not address the contract pharmacy issue, it is still connected. Covered entities would feel more comfortable sharing data if there were guarantees that PBMs would not retaliate against covered entities by taking away the discount when their rebates are cut by manufacturers. Unfortunately, covered entities bear the consequence of being caught between manufacturers and PBMs.
4. **State-level legislation success:** This type of legislation has been successful in 17 states. All health centers and covered entities should have this protection; it should not depend on the state where you live.
5. **Transparency:** This bill provides the transparency that manufacturers are requesting through a third-party neutral clearinghouse to review data to prevent Medicaid duplicate discounts.

Talking Points on the Contract Pharmacy Legislation (PROTECT 340B ACT 2.0)

1. **What the PROTECT Act 2.0 does:** This legislation serves an extension of the PROTECT 340B Act (protections against PBM discriminatory business practices) *and* includes protections to ensure 340B-priced drugs are sold and shipped to contract pharmacies, without any limitations or preconditions.
 - a. Civil Monetary Penalties will include the refusal to ship drugs to locations designated by the covered entity or imposition of conditions or restrictions as violations.
 - b. It will explicitly protect the use of contract pharmacies by requiring HRSA to codify their 2010 contract pharmacy guidance into regulation.
2. **Why we need the PROTECT 2.0 Act:** For more than two years, during the COVID-19 pandemic, 340B covered entities have waited for HRSA and the Courts to require manufacturers to comply with the 340B statute and resume shipping 340B drugs to contract pharmacies. As health centers continue to fight on the front lines of the Public Health Emergency, pharmaceutical manufacturers' profit margins continue to rise due to 340B program restrictions. This means manufacturers are profiting at the expense of health centers losing critical savings to support patient care and patients losing access to life saving medications in their communities.
 - a. Over 86% of health centers utilize contract pharmacies, including health centers with in-house pharmacies.
 - b. Contract serve as an extension of the health center, allowing them to partner with local pharmacies, mail order pharmacies, and specialty pharmacies to extend patient access to affordable medications.
 - c. It is through these contractual arrangements that health centers can alleviate burdens related to social determinants of health to ensure patients can access the medications they need, at the most affordable prices.

3. Contract pharmacy legislation will provide permanent stability back into the 340B program. As the 340B litigation works its way through the appeals process, health center patients are suffering the consequences.
 - a. Health centers are using every possible avenue to hold manufacturers accountable for violating the 340B statute. Legally, health centers are not allowed to file 340B related lawsuits against manufacturers. Our only recourse against manufacturers is the Alternative Dispute Resolution (ADR) process, which manufacturers have done everything in their power to slow down.
 - b. A number of Court decisions recognized that Congress needs to provide clarity that the 340B statute requires manufacturers to ship to contract pharmacies.
 - c. We know manufacturers have deep pocket to keep the litigation going for a very long time. Health centers are depending on Congress to put an end manufacturers' attacks on the 340B program.

Manufacturer Restrictions and the Importance of Contract Pharmacies

1. **Manufacturer restrictions:** Since 2020, 18 drug manufacturers have restricted sales of 340B-priced drugs to covered entities' contract pharmacies; 8 of those affect CHC grantees.
2. Manufacturers are holding 340B savings hostage by requiring Covered Entities (CE) to submit claims data if they want 340B priced drugs shipped to their contract pharmacies.
 - To get 340B-priced drugs shipped to contract pharmacies, they have to submit claims-level to the manufacturers' website called Second Sights/340B ESP.
 - Due to extreme financial challenges, some health centers have started to submit data to the manufacturers' website called Second Sights/340B ESP. Health centers and other covered entities have experienced a variety of challenges in their attempt to comply with manufacturers' demands.
 - The site is plagued with administrative problems that cause significant delays for covered entities to resume purchasing 340B priced drugs for their contract pharmacies even after submitting the required claims data.
 - Some health centers have estimated needing at least 2 full time employees to navigate the varying manufacturer data requirements and maintaining uploads.
 - Second Sights does not have the technical capacity to provide adequate support and instructions to covered entities. Health centers have reported meeting with Second Sights multiple times a month to correct errors related to internet browsers and information exchanges with wholesalers.
3. We know manufacturers want covered entities' claims data to eliminate the voluntary rebates they pay PBMs on 340B drugs. However, PBMs will make up for their profit losses by charging 340B covered entities additional fees, claw backs, and lowering their reimbursement. That's why covered entities need the PROTECT 340B Act.
4. **Importance of contract pharmacies:**
 - a) Health centers' ability to use contract pharmacies is critical; contract pharmacies can enhance patient access to 340B drugs because they may be located more conveniently for the patient.
 - b) Some health centers do not have the financial resources to open an in-house pharmacy. More than 56% of health centers utilize only contract pharmacy allows to offer pharmacy services to patients.
5. **Negative impact:** The harm caused by PBMs' actions around 340B extends far beyond pharmaceuticals; it impacts underserved patients' ability to access a wide range of health care services.

Issue-Specific 340B Talking Points

340B and Communities of Color

- 1) Community health centers are the primary care health home for over 30 million people in medically underserved areas, serving 1 in 5 Medicaid beneficiaries and 1 in 3 people living in poverty.
- 2) Under the law, health centers located in medically underserved areas serve a higher proportion of patients from communities of color:
 - a. Sixty-five percent of health center patients are members of racial or ethnic minority groups – twenty percent higher than the national average.¹
 - b. One in seven of all Americans of racial or ethnic minority background rely on health centers for their primary care.²
 - c. Related to COVID-19, 72% of patients vaccinated and 61% of patients tested for covid are from racial/ethnic minority backgrounds.³
- 3) Health centers are mandated under federal law to provide care to every patient that comes through our door, regardless of ability to pay.
 - a. Around 90% of health center patients are low-income (below 200% of FPL) and 67% of health center patients live in poverty (below 100% of FPL).
 - i. Health centers are required to provide eligible patients a sliding fee discount which facilitates access to substantial discounts for medical services and medications.
 - ii. Savings from the 340B program are critical to the health center’s ability to provide care to patients that experience financial barriers when accessing comprehensive primary care and other services.
 - b. Health centers estimate that without access to affordable discounted or free medications, many of their patients would go without needed treatment:
 - i. 32% of health centers estimate that more than half of their patients would go without needed medications if they did not have access to 340B discounts.
 - ii. 88% of health centers believe that at least 10% of their patients would go without needed medications if they did not have access to 340B discounts. Nationally, this could translate to 3 million or more patients losing access.
- 4) The 340B program is more than access to affordable medications. Health centers use 340B savings to directly address both whole-person care as well as social determinants of health. This often includes substance use disorder (SUD) services, behavioral health counseling, non-emergency medical transportation, patient outreach services and methods to address food insecurity.
 - a. Nationally, Black, Hispanic, and other people of color experience more challenges compared to White people across most examined measures of social determinants of health, including food insecurity and access to adequate health care and transportation.⁴
 - b. Health centers are working to address this gap using 340B savings:

¹ <https://www.nachc.org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf>

² <https://www.nachc.org/wp-content/uploads/2022/03/Chartbook-Final-2022-Version-2.pdf>

³ <https://www.nachc.org/wp-content/uploads/2020/10/2021-Snapshot.pdf>

⁴ <https://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-social-determinants-of-health/>

- i. Health centers use savings to expand comprehensive clinical and enabling services they otherwise may be unable to support, such as non-billable services and providers (87%) and care coordination or enabling services (69%).
- 5) The recent attacks on the 340B program by drug manufacturers have direct impact on communities of color. Health centers utilize contract pharmacies to increase access to affordable medications in medically underserved areas. Health centers contract with independent pharmacies in their communities that provide the health center's sliding fee discount to eligible patients. Drug manufacturers are interfering with the most vulnerable patients' access to life saving medications.
- 6) 340B directly benefits health center patients living with chronic conditions like diabetes and hypertension. 340B savings stretch beyond affordable medications, they also support the vital medical and social support patients need to improve health outcomes.
 - a. Some communities of color experience disproportionately high rates of chronic conditions like diabetes and hypertension. Similarly, health center patients present with higher rates of chronic conditions, including diabetes and hypertension, than patients of other provider types. The clinical service that would be most impacted by manufacturers' failure to comply with 340B guidelines are diabetes and hypertension, according to 89% and 81% of health centers, respectively.
 - i. 94% of health centers say that diabetes is the top disease state treated with medications purchased through the 340B program.
 - ii. 88% of health centers say that hypertension is the top disease state treated with medications purchased through the 340B program.
 - b. Further, 89% of health centers say that the 340B program has resulted in improved medication adherence and improved patient clinical outcomes. These improved patient health outcomes result from health centers using 340B savings to meet the unique needs of their patient populations through affordable medications and comprehensive services
 - i. This includes important roles at the health center like case management, nutrition programs, and education classes.

Opposition Arguments to PhRMA Talking Points

- *The current situation exploits a federal health program with little transparency or oversight and drives up profits by unscrupulous actors on the backs of communities of color.*
 - Federally qualified health centers and other grantees have specific reporting requirement and government audits that review the use of 340B savings and how those funds reach underserved communities.
 - Health centers are required by federal law to reinvest every penny of 340B savings back into patient care. This goes beyond just affordable medication, but the services patients need to manage and improve their health conditions.
 - Health centers generate 340B savings when providing medications to insured patients. Health centers do not generate profits when serving low-income patients. The 330 grant and 340B savings provide health centers the resources to provide discount services to communities of color.
- *The program has expanded in ways that Congress never intended, and there is little evidence that vulnerable communities are seeing the benefits.*
 - Many providers included in the original 1992 program lacked in-house pharmacies, so legislative intent is clear: Congress knew providers would need to contract services out.

- Health centers are required by law to contract out for services that they cannot provide in-house; according to a recent NACHC survey, 56% of health centers have in-house pharmacies, meaning the rest rely on contract pharmacies to provide pharmaceuticals for their patients.
 - Without 340B savings, many health centers would be forced to close their doors or significantly reduce the services available to their patients.
 - 92% of health centers use savings generated from 340B to increase access for low-income and rural patients by maintaining/expanding services in underserved communities
 - For many health centers, 340B savings help support services that are not reimbursable such as adult dental care, prescription drug delivery or transportation and food insecurity services. Without 340B savings, many of these services would be difficult to offer.
 - Health centers rely on 340B savings to sustain and expand comprehensive clinical and enabling services they otherwise may be unable to support, such as non-billable services and providers (87%) and care coordination or enabling services (69%). Many essential health services are not billable through public or private insurance, and health centers must find creative ways to maintain them while operating on razor-thin margins.
 - Patients and communities of color directly benefit from these expanded services, and given that 6 out of 10 health center patients are members of racial or ethnic minority groups, any effort to curtail the program would have dire consequences.
- *The 340B program is not improving access to health care for communities of color because participating pharmacies are often not located where these communities live. Areas with limited or no access to pharmacies – often called “pharmacy deserts” – are primarily found in Black and Latino neighborhoods.*
 - To qualify as a federally qualified health center, FQHCs must be located in areas designated by the federal government as health professional shortage areas. Contract pharmacies enable FQHCs to extend their reach to areas that don’t have a health center.
 - A recent NACHC survey found that 86% of health centers use contract pharmacies, which allow health centers to service hundreds of zip codes. Any proposal that would restrict the utilization of “contract pharmacies” would only restrict access to communities of color.
 - Contract pharmacies help reach patients who do not have access to an on-site pharmacy at their health center, or who must travel far to reach a health center with a pharmacy.
- A recent [JAMA article](#) that has circulated Capitol Hill purports that contract pharmacies are not as prevalent in lower socioeconomic communities.
 - This article **fails to consider 340B utilization**. The location of a contract pharmacy doesn’t tell us anything about **who** is benefitting from discounts. In fact, contract pharmacies function to serve high-need patients who live outside of the high-need areas already served by in-house pharmacies.

- Contract pharmacies are essential for patients who live in more “affluent” areas but live below the median income and may be in the minority. This is an important consideration for folks living in an area with significant income inequality which may skew the median income. These areas have an even greater need for contract pharmacies since they may not have a health center site (which by definition are in high-need areas).
- The authors fail to consider that contract pharmacy expansion includes contracts with large conglomerates like CVS and Walgreens, the locations of which are not tied to need. This is going to impact the ratio (their primary metric) and is very misleading.
- A [2018 Government Accountability Office \(GAO\) report](#) recommends more oversight requirements be placed on covered entities’ given their use of contract pharmacies. The report purports that based on their findings, the lack of oversight means there is no way to ensure total compliance with the 340B program. Counterarguments to assertions made in this report are:
 - GAO used a **nongeneralizable sample**. This means that their sample is not representative of the entire system, and that the conclusions can NOT be applied to any other health centers or health centers in general.
 - They only reviewed 30 contracts out of nearly 20,000(?) that exist.

Medicare and Commercial Insurance Issues with the 340B Program:

1. **Duplicate discounts happen in commercial and Medicare Part D:** To increase sales of their drug products, drug makers agree to pay voluntary rebates to PBMs/payers for each unit of their drug that the PBM/payer covers.
 - a. Unlike Medicaid, there are no laws or regulations that prohibit claiming a 340B price and manufacturer rebate on the same drug.
 - b. PBMs receive manufacturer rebates in exchange for drug formulary placements and other incentives. They are not tied to making drugs “cheaper.”
2. If a drug maker does not know which drugs are sold under 340B, they end up providing both the voluntary rebate and the 340B discount on these drugs
 - a. **Why they want our claims data:** Drug manufacturers can see all the 340B claims and decide to stop selling them at a discount, circumventing the intent of the 340B program that provides health centers savings that then we pass on to our patients.

Anti-Discriminatory Contracting Legislation, The PROTECT 340B Act, and How PBMs Game the System

1. PBMs have no official role in the 340B program—they are not mentioned in the statute—yet they continue to pickpocket.
 - a. They discriminate against pharmacies that dispense drugs purchased under the 340B program.
 - b. They pick the intended 340B savings out of CHCs’ pockets through actions such as decreasing reimbursement for 340B drugs and charging different dispensing fees, chargebacks, and clawbacks.
 - c. They leverage unequal bargaining power and force health centers to enter contracts that keep CHCs from benefitting from Congress’ intended purpose of the program.
2. PBMS have been gaming the system and hurting CHCs by:

- a. Making up for the “lost” rebate: PBMs can lower reimbursement for the 340B drugs by using the information provided by the manufacturer regarding which claims were filled with 340B drugs to pinpoint claims that will receive lower reimbursement.
- b. Avoiding “losing” the rebate in the first place by instituting policies, including:
 - i. Refusing to include a pharmacy in its network if it dispenses any 340B drugs
 - ii. Imposing higher fees on pharmacies that dispense 340B drugs.
3. Efforts to combat anti-discriminatory contracting have been gaining traction at both the state and federal levels over the past few years.
4. State level legislation focuses on implementing protections against these discriminatory practices, prohibiting actions, including:
 - a. Reimbursing 340B covered entities at a rate lower than non-340B covered entities.
 - b. Assessing fees, chargebacks, or other adjustments on 340B-covered entities based on their participation in the program.
 - c. Requiring 340B covered entities to identify claims involving 340B drugs for payers other than Medicaid.
 - d. Restricting access or requiring participation in specific networks for any 340B covered entity.
 - e. Restricting the methods by which a 340B-covered entity may dispense or deliver 340B drugs.
5. National-level legislation: HR 4390, the PROTECT 340B Act
 - a. **Why we need the PROTECT 340B Act:**
 - i. Everyone wants a slice of the 340B savings pie.
 - ii. There is no recourse when PBMs and insurers treat 340B pharmacies differently or lower their reimbursement because of their 340B status.
 - iii. The PROTECT 340B Act will prohibit health insurers and PBMs from redirecting our 340B savings to their pocket, a practice that has increased significantly over the last few years.
 - b. **What does the 340B Act do:** This legislation protects against discriminatory practices by PBMs like pickpocketing our 340B savings to make up for their lost revenue, and from health insurers, in the commercial market, Medicare Part D, and managed care.
 - c. While the PROTECT 340B Act does not address the contract pharmacy issue, it will address part of the problem. Covered entities would feel more comfortable sharing data if there were guarantees that PBMs would not retaliate against covered entities by taking away the discount when their rebates are cut by manufacturers. Unfortunately, covered entities bear the consequence of being caught between manufacturers and PBMs.
 - d. **Transparency:** This bill provides the transparency manufacturers want through a third-party neutral clearinghouse to review data to prevent Medicaid duplicate discounts.

Medicaid Carve Out Pharmacy Benefit into Fee-for-Service

1. **Background:** States have the option to allow managed care organizations to manage the Medicaid pharmacy benefit (carving it in). If a state delegates the pharmacy benefit to managed care, CHCs can use 340B drugs for managed care patients and receive the 340B price.
2. **An uptick in interest to carve out pharmacy benefits:** Over the last several years, states such as California and New York have fought to prevent the pharmacy benefit from being carved out of managed care and moved back into fee-for-service. State motivations include:
 - a. The state wants to eliminate or otherwise significantly curb the role of PBMs in managing their Medicaid prescription drug benefit.
 - b. The state wants to remove managed care from the entirety of its Medicaid program.
 - c. The state wants rebates on 340B-eligible drugs to flow to its state Medicaid budget rather than to 340B covered entities.

3. Due to the Centers for Medicare and Medicaid Services (CMS) regulation, state Medicaid agencies cannot pay more than the ceiling price for 340B drugs reimbursed through fee for service (FFS).

Unintended consequence:

- a. A state's decision to carve the pharmacy benefit out of managed care and transitioned back into FFS means health centers will lose 340B savings on managed care drugs. This impacts health centers because it eliminates the 340B savings that are otherwise allocated to support vital services.
 - b. Because over 60% of CHC patients have Medicaid, this will negatively affect a health center's finances due to lost managed care 340B savings.
 - c. They need to maintain separate inventories for 340B-eligible patients and their Medicaid patients
4. **Negative impacts on the patient:** By carving out the pharmacy benefit, Community Health Centers will lose savings, meaning the health center may have to make cuts to certain enabling services or adjust hours of operation to keep their doors open.