# STATE OF CONNECTICUT

*DEPARTMENT OF SOCIAL SERVICES*

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## Working Group for the Prescription Drug Pricing Program Pursuant to Section 340B of the federal Public Health Service Act (Established by Connecticut Public Act 23-171, Section 16)

## MEETING MINUTES for November 7, 2023 Meeting

**1. Introductions**. Workgroup members introduced themselves.

**2. Overview of Workgroup's Purpose:** Mehul Dalal, DSS, read the statute that is the basis for this working group:

> CT Public Act 23-171, Sec. 16. (Effective from passage) "(a) The Commissioner of Social Services shall convene a working group to evaluate (1) the current status of the federal 340B drug pricing program authorized by 42 USC 256b, as amended from time to time, (2) national efforts to strengthen and sustain such program, and (3) opportunities for state action to protect 340B revenues of federally qualified health centers from unfair administrative barriers or unnecessary conditions based on such centers' status as a 340B covered entity. Such evaluation shall consider (A) the ability of and any legal precedent for states to regulate the conduct of drug manufacturers and pharmacy benefits managers, as defined in section 38a-479aaa of the general statutes, (B) opportunities to facilitate patient access to on-site pharmacies of a federally qualified health center, (C) opportunities to establish on-site pharmacies across federally qualified health centers, and (D) national trends to sustain such program. As used in this subsection, "340B covered entity" means a provider participating in the federal 340B drug pricing program authorized by 42 USC 256b, as amended from time to time.
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> (b) Not later than January 31, 2024, the Commissioner of Social Services shall report, in accordance with the provisions of section 11-4a of the general statutes, on the findings and recommendations of the working group to the joint standing committees of the General Assembly having cognizance of matters relating to insurance, public health and human services."

**3. National Landscape and Trends of 340B Program**

Drew Gattine, NASHP: Walked through slide presentation on key elements of 340B program, including that it has significantly increased as a proportion of drug purchasing. Congressional intent to make federal funds go as far as possible. It is a federally administered program by the Health Resources Services Administration (HRSA) Office of Pharmacy Affairs, which is a key reason that historically, states did not take much action on 340B. Initial federal law provisions of 340B had a narrow set of covered entities and narrow rules on the potential use of contract pharmacies.

The program was changed by federal law over time to expand the scope of covered entities to include more hospitals and sites affiliated with hospitals and the expansion of unlimited number of contract pharmacies. Significant proportion is participation by disproportionate share hospitals (DSH). As a

result, significant expansion in the number of covered entities and contract pharmacies. Significant financial growth in the scope of program

Complex rules for flow of funds with contract pharmacies under 340B program.

Sample of state activity to date, including some states regulating pharmacy benefit managers (PBMs) and other attempts by payers to provide lower reimbursement to covered entities for 340B purchased drugs. Some states have passed laws (Louisiana, Arkansas) to address situations of contract pharmacies. Recent bills have been proposed in the state legislatures of Iowa, Louisiana, and Nevada.

Transparency legislation passed in 2023 in Maine (beginning in 2024 requires hospitals to report on 340B expenditures, savings, and use of the savings), Minnesota (reporting requirements for covered entities to report drug acquisition costs), and Washington State (requires the state to establish a reporting requirement for 340B covered entities).

Q. Gui Woolston, DSS: What are states' levers to be able to take action regarding 340B?

A. Drew Gattine: There are limited options but states are trying to gather more information to be able to consider other drug pricing regulation because they do not yet have the data. States perceive the program as originally intended to improve access for individuals with low-income. States also trying to understand implications for carve-in or carve-out (such as Oregon and California).

Q. CT State Sen. Somers: Recommends representation from PhRMA and PNPs on this workgroup. What opportunities does a state have on regulating 340B, including status of lawsuits in other states? Also referencing transparency. Aware that hospitals have used these funds for capitalization funds.

A. Drew Gattine: In Arkansas, state defended its statute in federal district court, currently on appeal to federal circuit court of appeals. In Louisiana, the drug manufacturers have sued the state to challenge the statute.

A. Mehul Dalal, DSS: DSS welcomes the opportunity to invite industry representatives and had previously reached out to a lobbyist for PhRMA but had not received a response.

Sen. Somers: There needs to be more education of legislators and the public on how 340B actually works, which is much more complex than most assume.

**4. Summary of the Current Status of the 340B Program in Connecticut**

Herman Kranc, DSS: DSS uses a 340B exclusion file to ensure that CT Medicaid does not pay based on a duplicate discount because federal law prohibits both 340B discount and Medicaid prescription drug rebate.

Nina Holmes, DSS: DSS ensures that those rules are followed across providers other than those enrolled as pharmacies.

Mehul Dalal, DSS: DSS will provide a brief written overview.

Sabrina Griswold, First Choice Community Health Center (designated representative of the Community Health Center Association of CT) explained that FQHC expanded to additional contract pharmacies; eventually the in-house pharmacy also opened; that FQHC's 340B savings are used to expand services for any area that the FQHC determines are needed (including: LGBTQ program, medication-assisted treatment program, optometry services and retail vision services, opening additional sites). She also sits on the DSS pharmaceutical and therapeutics committee. As a Medicaid fee-for-service only state, in order to prevent duplicate discounts, the provider needs to have a different NPI to ensure that the 340B discounts are captured but very few pharmacies have different NPIs. Believes that there are no duplicate discounts happening. Different impact on FFS vs. MCO Medicaid states.

Paul Kidwell, CT Hospital Association: All but one hospital in CT participates in 340B program through the DSH eligibility (about 15, different thresholds set in federal statute). For-profit hospitals are not eligible to participate in 340B. Hospitals use the savings to stretch scarce resources. Nonprofit hospitals report to the IRS on Medicaid underpayment, uncompensated care, and community benefits. Medicare reimbursement for hospitals starting in 2018 reduced payment for 340B drugs, U.S. Supreme Court affirmed decision in favor of hospitals, and just last week, CMS revised the Medicare reimbursement methodology.

**5. Proposed Agendas for Upcoming Meetings**

Need to ensure that the workgroup addresses the remaining pieces of the statutory requirements and incorporates feedback from this working group.

The upcoming meetings of the workgroup will be Tues. 11/28 at 9am and Tues. 12/19 at 9am

**6. Process for Gathering Feedback from Workgroup Members**

There was a brief conversation about the process for working group members to share information and feedback with DSS that can then be shared with the entire working group, including at future meetings.

**7. Other Business**

There was no other business identified.

**8. Adjourn**

The working group adjourned.