Maine Prescription Drug Affordability Board
Monday March 24th @ 10:30 am
Microsoft TEAMS Meeting
In Person Location: 109 Capitol St, Augusta Maine, 04330

Board Members in Attendance: Kelsie Snow, Peter Hayes, Noah Nesin, Jennifer Reck, Rhonda Selvin, Julia Redding, Sharon Treat
(Total = 7)

Board Members Absent: Susan Wehry
Vacant Seat(s): 0

Others Present: Dr. Sayeh Nikpay, Hannah Hudson
Advisory Council: Jennifer Kent, Kate Ende, Kristy Gould, Christina Moylan, Jonathan French
OAHC: Meg Garratt-Reed, Katie Senechal, Ceilidh Shea
All Others: Shuri Senbanjo, Lisa Kimbrough, Nancy Chng, Matthew Marston, Evelyn Pereira, Jessica Lynch, Lucas Perry, Rachel Cottle Latham, Neva Parsons, Lisa Nolan, Tiffany Westrich-Robertson, Jim Pitt, Amy Yee, Zack Friend, Josh Ney, Olivia Backhaus, Grey Louisos, Emily McGann, Keisha Vaughn, Trevor Putnoky, Helen Fitzpatrick, Charles Luce

Agenda Item:	Discussion:	Action/Next Steps:
I. Call to Order	**Meg Garratt-Reed** called the meeting to order.	
II. Introductions	Board members were introduced.	
III. Approval of the Minutes (January 27th and February 24th, 2025)	There were no changes to the minutes discussed.	Sharon Treat made a motion to approve the minutes from January 27th, 2025. Noah Nesin seconded the motion. The minutes were unanimously approved. Sharon Treat made a motion to approve the minutes from February 24th, 2025. Rhonda Selvin seconded the motion. The minutes were unanimously approved.

IV. Administrative Update	**1. Presentation from Dr. Sayeh Nikpay** Meg Garratt-Reed introduced Dr. Nikpay, Associate Professor in the Division of Health Policy and Management at the University of Minnesota. Dr. Nikpay is also a member of the Minnesota PDAB. Meg Garratt-Reed said Dr. Nikpay will present on 340B. She said that after a Q&A, the Board will hear from Hannah Hudson, Director of Policy at Maine Primary Care Association about upcoming legislation on 340B in Maine. Dr. Nikpay said she is an Associate Professor at the University of Minnesota at the School of Public Health and member of the Minnesota PDAB. Dr. Nikpay shared that she is also a member of the Minnesota PDAB and has been working on 340B, in some ways, by accident. Dr. Nikpay said that she has always been interested in safety net health care, which eventually led her to work on 340B. As a member of a PDAB, she noted that 340B is very important program for PDABs to understand. It is vital to keeping the safety net functioning, but it is also very flawed. It does not always get those dollars to the organizations where they are going to do the most good work. Before starting her presentation, Dr. Nikpay shared that none of her presentation is representative of the Minnesota PDAB. She also shared that she receives fundings from Arnold Ventures, Commonwealth Fund, the NIH, CMS, the Minnesota Department of Health, and Health Affairs Scholars. Dr. Nikpay said that 340B is extremely complicated, so as a PDAB, you really need to understand it. On a national level, it is really only well understood by a couple of people. 340B was designed to give clinics, that were very dependent on government funding, a discount on drugs during a period of rapid prescription drug price growth. Today, however, it has morphed into a much bigger program that provides this subsidy. Dr. Nikpay said that a 340B subsidy is an economic benefit a covered entity would get from participating in 340B. The 340B subsidy depends directly on keeping drug prices high because the subsidy is generated from the difference in drug prices and how much they cost under the discount program. The goal of the PDAB, of course, is to try to make drugs more affordable. This is the central tension between 340B and PDABs. Dr. Nikpay said that many PDABs weigh the implementation of Upper Payment Limits (UPLS). Part of that decision to enact a UPL is consideration of how much	

	harm the policy would do. How much harm is there to consumers from having a high drug price? How much harm would there be to other consumers not necessarily using the drugs? Dr. Nikpay said that an important consideration of UPLs is also whether 340B entities continue to generate subsidies. The research literature, both peer reviewed and gray, suggests that 340B doesn't always translate to better access for patients given the program is so poorly targeted. So, when the Board is weighing whether or not to do a UPL that doesn't exempt 340B covered entities. Dr. Nikpay shared that the 340B program requires manufacturers to provide upfront discounts. This happens before the transaction has occurred for prescriptions drugs, which come in two forms. The first is prescription drugs that would usually get through your retail or specialty pharmacies and take yourself. The second kind are physician administered drugs. The goal of these discounts, as stated by HRSA, which regulated 340B, is to stretch scarce federal resources as far as possible to reach more patients and providing more comprehensive services. So, HRSA's interpretation of 340B discounts is to allow safety net organizations that often operate on a fixed budget from state or federal money, to make their budget go farther. D. Nikpay said, though, that this language does not actually appear in statute. Dr. Nikpay explained that she is involved in a project funded by the Commonwealth Fund that involves interviewing the staffers, lobbyists, advocates, and anyone else who may have been involved in the 1992 creation of 340B. Through that process, she said they are learning a lot about the context in which 340B was born. An important story that needs to be told and understood about 340B is that it is an accident of history. In 1990, the Medicaid Drug Rebate Program was created to grant Medicaid agencies rebates, who were essentially paying list prices for drugs up until then. The goal was essentially to get them the best prices. However, by creating this Medicaid drug rebate program, which passed best price to the Medicaid agencies, it triggered significant price increases for other payers, especially for safety net organizations. For example, manufacturers have been providing very low prices to the VA and Department of Defense since World War II. The idea was that it was a relatively small share of the market. As manufacturers, that was feasible enough. Essentially, those became the best prices.	

	Dr. Nikpay shared an example of testimony from someone working at a Title X clinic. Specifically, Leslie Lori, the Executive Director of the Family Planning Council of Western Massachusetts. She came to testify before Congress on the bill that eventually became 340B. In talking about the fallout of the Medicaid Drug Rebate program, she says, "Our experience this year became a predictable pattern. As each pharmaceutical contract expired, we braced for the drug company sales' representative to announce shockingly high increases and lament the federal government's new Medicaid law." Dr. Nikpay said that the choice that Title X clinics who were largely dependent on grant funds were left with, was to eat these price increases, which would be anywhere from twenty to one hundred percent at the expense of more services. The Family Planning Council of Western Massachusetts served around 14,000 women in the area and care to those people would become jeopardized if cuts were rolled back. Essentially, while Congress was considering this original 340B legislation, their perspective was that they needed to help these Title X clinics – your Ryan Whites and FQHCs. The thinking was that Congress should give these clinics discounts using the same formula that Medicaid uses to help offset these huge price increases as fallout from the Medicaid Drug Rebate program. Dr. Nikpay went on to discuss which types of entities participate in the 340B program, using a guide form the Government Accountability Office. She explained that included in the program are federal grantees. These are all organizations that are somehow tied to the Public Health Service Act. It's changing a bit now because of Medicaid expansion, but a lot of these organizations have fixed budgets that depend on state and federal grants. The are the original targets of 340B. FQHCs are the largest constituent of this federal grantee group. As you can see in the chart, hospitals are also included, she said. Hospitals weren't actually part of the original discussion on 340B. However, someone made the decision that hospitals actually should be included because public hospitals because they are similar to community health centers. Then, as a condition of signing on, Orrin Hatch added all kinds of Utah non-profits. So, they picked an eligibility criterion where all the Utah non-profits became eligible for 340B and that became encoded in law towards the end of the legislative process. Although the program targeted at Title X clinics, hospitals represent most of where the juice gets squeezed on this program. While this includes the disproportionate share hospitals, who were included in the 1992 list of covered	

	entities, you can also see critical access hospitals and the four other types of hospitals. Those got added in 2010 as part of the Affordable Care Act. Dr. Nikpay said that the inclusion of hospitals in the 340B program as morphed it over time. In almost the first decade of the program, there was a pretty fixed group of covered entities that included about 5,600 federal clinics. About 100 public hospitals were also original constituents. Fast forward to today, we've had many different expansions, advances in pharmaceuticals, and changes in the market. So, when looking at 340B participation today, we can see that instead of massive clinic participation and less hospital participation, you can see that clinics represent only about 1/3 of participants while hospitals represent 2/3. She shared that another interesting fact about this program is that close to almost two out of every three non-profit hospitals are participating in this program. Dr. Nikpay said that it is somewhat unexpected that two out of every three nonprofit hospitals are on par with FQHCs in terms of safety net engagement. Dr. Nikpay said that another way to understand the size of this program is to look at spending rather than participation. The most up to date number from HRSA in 2023, is $66 billion in purchases. When you think about discounted expenditures, it's that same pattern today where the vast majority of dollars spent on this program are going through hospitals. Specifically, nine out of ten dollars are passed through hospitals, whereas one in ten are going to clinics. Spending, in some ways, is also a reflection of participation. Another consideration is that drugs being used in primary care at FQHCs are going to be very different that drugs used at a cancer center in a hospital. So, part of this makes a lot of sense because FQHCs are often using lower cost drugs. However, part of it is also that hospitals have really outpaces clinics in participation in the program. Dr. Nikpay shared data from the Congressional Budget Office acquired from APEX. These are essentially groups of purchasing organizations for 340B that HRSA contracts with each year. Dr. Nikpay said this is an interesting topic for PDABs to look into, because what you can see is that if you look at that $66 billion of purchases now, this is going to be different year to year. In looking at 2023 numbers, a big chunk of spending is on cancer agents, followed by anti infective agents, which is where things like Ryan White drugs would go. But as	

	shown in the chart, cancer is a huge category. There are very few oncology practices that aren't touched by 340B. Th next slide shared exemplifies that high-cost drugs are largely used by hospitals, whereas anti infective agents make up a large portion of drugs used at clinics. Just from talking to participants in her state, Dr. Nikpay shared that there are safety net providers who have top claims for vitamins. The populations clinics see have very different needs. For example, people working in clinics serving specific populations might dispense a disproportionate share of Advil, given it can be used to treat SUD. Dr. Nikpay shared that the debate around 340B can sometimes include discussion about safety net providers using their money on things other than direct care. There is actually nothing illegal about that. The policy was set up so that participants serving large shared of uninsured and Medicaid patients could remain committed to serving those populations. They have requirements to include patients on their FQHC boards. They have requirements to provide free or sliding scale care. The thinking is that anything an FQHC does is going to be good for patients. However, the further you go towards hospitals, particularly non-profit hospitals with a lesser share of safety net patients, we see fewer of those requirements to share discounts with patients and provide care to safety net populations. It's important to state that there really aren't any requirements in 340B that anyone do anything. With the subsidy they generate, it's hoped that, because of the nature of the patients that they serve, those population will benefit from the subsidy. Dr. Nikpay shared that more than half of FQHC board members must be patients. This is important context in thinking about how FQHCs might assess how to use 340B dollars compared to a large horizontally and vertically integrated hospital system. In thinking operationally, the way this works is that there are wholesalers involved in the transaction, as well as manufacturers. Essentially, though, it is the manufacturers that are providing the discounts to the covered entities and the covered entities are prescribing drugs to patients. There are two ways to make the subsidy benefit work. One is buy low sell low, meaning you buy a drug at a discount price and give it to patients at a discounted price. There may be a dispensing fee included, but this typically looks like dispensing the drug at the acquisition cost. Another option is to buy low sell high because 340B discounts can be given out to all of your patients	

	regardless of indigent status. Remember, the program is about supporting participants, not patients, although we hope the participants will do good with the dollars. Distributing drugs to an insured patients benefits the participant, because they actually generate revenue. Dr. Nikpay said that as an economist, she would call the payments you take in minus the acquisition cost the profit. But the 340B discussions can become emotional very quickly and the words used are highly political. She mentioned using the term revenue based on the way Minnesota describes aspects of the program. Other may refer to it as spread revenue, prices, or profit. Dr. Nikpay said that the question of how big the 340B program has become has been really important in Minnesota recently, given there was a state legislator who was trying to remove pharmacy benefit in Medicaid, out of managed care and into fee for service. They were trying to pursue this because they wanted to protect rural and independent pharmacies, and when they proposed this option, many 340B providers stood up and said if they would lose all of their 340B money. The policymaker, who is very experienced, responded that there are really only two rules in 340B. The first is that you cannot give these drugs out to anyone who is not your patients. And second is that manufacturers do not have to pay duplicate discounts (which would mean giving out a Medicaid and 340B discount). The legislator did not understand how taking Medicaid out of managed care and putting int eh fee for service determines how much revenue you get from Medicaid or how much money you bring in from the 340B program. They wanted to know how these things are connected. This legislator advocated to put in transparency reporting in legislation to get to the bottom of some of the numbers. Dr. Nikpay said that as a researcher in this work, she was elated to finally see transparency policy recommendations at work. She mentioned Maine has some transparency policies and looks forward to seeing the results of those reports. Dr. Nikpay said that what Minnesota has learned from their covered entity report is how benefit there has been from the 340B program, not counting the part of the program that's buy low sell low. What is captured is the part of the benefit from 340B that's buy low sell high. As shown in the figure, Minnesota covered entities took in $1.5 billion on drugs that were largely just dispense drugs. None of this represents physician administered drugs. The report found that covered entities took in $1.5 billion for dispensed drugs and bought those drugs for $734million. The nets out $766 million in gross 340B revenue	

	generated in Minnestoa. In talking to lawmakers in the state, Dr. Nikpay said, it's not like there's just cash floating around. Organizations are using this for operations, it sort of goes into their general fund. For many organizations, this revenue is very important to them. What she has heard anecdotally is that even through the pandemic, the only service line that has consistently remained in the black has been pharmacy. My hunch is that this is 100% due to 340B, she said. Dr. Nikpay said that Minnesota's question was how is it that you're going to lose all of this money off of Medicaid. It turns out that covered entities in Minnesota were accepting about $170 million in payments for Medicaid for drugs that they purchased at a much lower price. In the end, it basically meant that these covered entities were largely hospitals, because FQHCs can't collect, they have to bill Medicaid at their acquisition costs. It's almost $90 million of that 340B subsidy that was coming off of Medicaid, which most legislators were likely unaware of. Dr. Nikpay said that in terms of revenue realized from the 340B program, the revenue seen by hospitals represents a much bigger share of overall program revenue. If you add the dish hospital line (seen in the chart) and the other hospital lines (also represented in the chart), you see that about $600 million of $630 million total dollars that are generated are going to the hospitals. It's very little that is ultimately going to federal grantees. Circling back to why this issue is important, Dr. Nikpay said that the connection between higher drug prices and the 340B subsidy should be clear now. One thing we know is that commercial payers tend to pay more for all kinds of services, including drugs, and what you can see in this chart is that the total amount of 340B revenue that was generated in the state are going to be running through commercial insurers. They are where the lion's share of the 340B revenue is coming from. So, the more patients you have that pay higher rebates, the more 340B subsidy you're going to generate. The more uninsured and Medicaid patients you serve, the less 340B revenue you will generate. This puts many of the public health service grantees at a disadvantage in terms of the second form of 340B benefit. Next, Dr. Nikpay transitioned to an overview of research literature on 340B. She said that what she hopes the group will take away from the review, is that the	

	program is poorly targeted. What we know from peer reviewed studies using statistical methods that are agreed upon by academics, is that there isn't a lot of evidence on federal grantee clinics, which is a shame. Part of it may be the academics don't know very much about federal grantee clinics and tend to forget about them, so a lot of evidence is focused on hospitals. But, the few studies where we do have evidence about FQHCs, federal grantee clinics, Ryan Whites, etc. is that when these organizations expand their 340B programs to potentially bring in more 340B revenue, they do actually see a boost in safety net care provision. A Watts study, that Dr. Nikpay is also an author on, found that when clinics generate some 340B revenue off of their few privately insured patients, they're much more likely, in the next year, to provide more uninsured care. They are basically doing the things that Congress initially intended, which was to expand your charitable footprint. Dr. Nikpay explained that we also have a number of studies that look at new 340B participation. This is beginning in the mid 2000s all the way through the ACA expansion when most hospitals started participating. What we have seen is that when a hospital begins participating, on average, there is no corresponding jump in any measure of safety net engagement that is meaningful. What we do see, though, are minor movements and shuffling in community benefit categories. So, an increase in charity care that is fully offset by reductions in donations to community organizations, for example. The one exception to this is a study from the University of Arkansas, that actually breaks out public and non-profit hospitals. What they found is that public hospitals really do behave differently than non-profit hospitals. They tend to go after those less profitable services and do more safety net engagement activities. Dr. Nikpay emphasized why the results of 340B are so mixed. In part, she explained, this is due to averaging many different organizations that are extremely different from one another. For horizontally and vertically integrated entities, for example, you have to separate them out to see what is really going on. She pointed to s a study she conducted a while ago that aimed to get at the issues of the program's poor targeting. She took an eligibility criteria that has been used historically in the nonprofit tax exemption, which was five percent of one's budget and applied it to charity care spending, using that as the measurement for eligibility as a nonprofit hospital, only 15% of hospitals participating would remain eligible, but a full 27%, almost 1/3 would drop out of	

	the program due to not providing enough charity care. So essentially, the program is not well targeted. Other reasons you may get mixed results, she said, is because the story used to be about pharma versus hospitals. Hospitals have historically been the ones out on the front fighting, usually involved in conversations about how to do discounts and whether the program is working as intended, for example. However, the fight has changed somewhat and is now more triangular. Pharma and hospitals are still represented, and federal grantee clinics are usually left out. Now, though, we see the presence of vertically integrated pharmacy chains. One of the ways you can dispense discounted drugs and generate this 340B subsidy is through contract pharmacies. In 2011, HRSA relaxed a requirement that had been in place since the beginning of the program that covered entities could have one offsite, not wholly owned pharmacy, through which they could dispense drugs to patients. If you have a significant number of patients that live far away and/or who may lack access to transportation, they would be able to pick up their 340B medication at their local pharmacy. When this requirement was relaxed in 2011, we saw an explosion of contract pharmacies. Dr. Nikpay mentioned she conducted a study where she linked a bunch of administrative data and data matching. What she found is that today, about 40% of US retail pharmacies have at least one contract. When you think about the height of the bar here, you know what almost half of them have multiple contracts. CVS, for example, CVS, has two different contracts with two different covered entities. This is important because the majority of these contracts are not with independent pharmacies. Often, they are with grocery stores, not small local chains. They're with the big four, basically your Walgreens, CVS, Walmart, and Rite Aid. This may be outdated at this point, because there are so many mergers, but it's about 2/3 of the contract relationships that are with these big pharmacy chains. Many of these companies have interesting private equity involvement. Dr. Nikpay said that when you have these third-party pharmacies involved, it may end up diluting both the safety net orientation of the program and also diluting the amount of 340B revenue that's available. She presented a GAO study from 2018 that included them compelling different covered entities to give them a bunch of contracts for contract pharmacy relationships to analyze. One of the things they found is that often those contracts didn't have provisions to share their discounts with indignant patients. This is a problem because it might	

	result in an uninsured patient going to their local CVS trying to fill a prescription and being charged a list price. That is not a good outcome. So, sometimes pharmacies make this connection weaker, and they sometimes charge fees. In Minnesota, one of the things the covered entity report did was it tried to actually quantify the fees that the covered entities pay. The figure (as shown in slides) shows that for a hypothetical $100.00 of gross 340B revenue, how much of that money disappears in fees to contract pharmacies and third-party administrators. For about half of dish hospitals, it's about $8 or less of that $100 of 340B revenue for critical access. Half of them are paying $17.00 or less. But when you start looking at the 25th percentile, which is the amount that 25% or more of the organizations pay in terms of fees. So, about 25% of critical access hospitals in Minnesota are paying almost half of what they generate in fees to pharmacies and software companies that help with the pharmacy transactions. When you look at safety net guarantees, which are going to include FQHCs, tribal health centers, and other types of health centers, in some cases, this is eating up their entire 340B revenue. The next slide shows an example of the fees, which were also found in GAO's report. While the examples are almost ten years out of date and have missed all the post COVID inflation. But, back in 2018 there might be a dispensing fee of $1,800 for a specialty medicine. That's a lot in fees negotiated with pharmacies, which means that the more market power that pharmacy, such as CVS or Walgreens has, the more fees they can charge the more economic theory tells us. The higher those fees, the more they command in those contracts. There are also fees that are a percentage of the gross revenue. There are some contracts that have both dispensing fees and a percentage of that revenue. Dr. Nikpay said that this is a real reason why we might not see that tight relationship because a lot of this money is sort of leaking out to large for-profit parties. Dr. Nikpay shared another example of third parties leaking 340B revenue. Today, there are organizations called third party administrators. They are largely software companies that sit on top of 340B transactions. They do things like ensure compliance, link data, and help the covered entity get a 360-degree view of the program. Hospitals are more likely to use these entities than federal grantees because they are quite expensive. They have per prescription fees and also per contract fees that really just add up. The reason this report was in the Washington Post is because a journalist there was looking into potential conflicts	

	of interest for the new CMS director Dr. Oz, who apparently owns or co-owns one of these companies that does third party administration and fee assessment. She mentioned she also did some work here because she could not find anything about third party administrators. A couple of years back Dr. Nikpay looked for any firms on Crunchbase to see what their ownership structures look like. The orange bars in the chart presented on her slides represent software based third party administrators. They're often also owned by private equity companies or large vertically integrated pharmacy chains. Lastly, Dr. Nikpay outlined how the Maine PDAB may consider enacting a UPL, the group might expect a lot of input from 340B covered entities because drug prices affect the amount of subsidy that's available for them to do things with. She recommended the group think about weighing the policy for each drug and each potential set of covered entities that are affected, considering the benefits of increased affordability for specific prescription drugs that are targeted for the UPL against possible decreased affordability. If there's a drug that is heavily used by FQHCs, enacting a UPL and not exempting them might end up having that FQHC make cuts in other areas. But, she said, you can't just assume that there is always going to be cuts in services because it's going to depend on whether those covered entities are passing on discounts to their patients. Everyone is doing some of both, that being buy low sell low and buy low sell high, but overall, the effects are going to depend on which type of organization you're looking at and the amount of safety net care provided. Dr. Nikpay concluded her presentation and let members know they could reach out to her for additional information or with any questions. **2. Presentation from Hannah Hudson** Hannah Hudson introduced herself as Policy Director at Maine Primary Care Association (MPCA). She shared that MPCA is a membership organization for Maine's community health centers or FQHCs. The aim of her presentation, she said, is to help introduce their network and view of 340B in Maine, including its importance to their members. Hannah Hudson said that the 340B drug pricing program allows qualifying covered entities to purchase outpatient drugs at a discount and those savings are then used to benefit the community. The savings really help expand services	

	at FQHCs to reach as many people as possible in our service area and to provide more comprehensive services, all at no cost tot he taxpayer or government. One unique aspect of FQHCs is that they have a requirement that their governing boards be 51% patient majority. So, there is strong knowledge within the organizations about what communities need and how to best provide care. Maine is a big, rural state and FQHCs operate in both rural and urban areas. She said that their membership is present from up in Aroostook Count, in Down East, and Western Maine, but also in the Lewiston, Bangor, and Portland areas. Being in so many different locations means there are very different needs in those communities. FQHCs provide a variety of services across the board to best respond to those needs. This can include direct discounts to on drugs, but as we discussed, the program is not necessarily directed to do just that. For many FQHCs this is an essential program that makes a big difference for both their bottom line and allows them to be able to provide substance use disorder treatment, behavioral and mental health care, ability to bring in more workforce, and keep wrap around services available. That can look like transportation, heating assistance, and food pantries, for example. These are some really basic essential services and for some people, a health center is the only place they are receiving that care and access. Hannah Hudson said that 340B is a critical program for MPCA members and as they begin to see more threats to federal funding, rates have of course remained low and times are tough across the board. FQHCs receive some set funding from the federal government but it really is only about ten to fifteen percent of their bottom line, their operating margin. So, it's not a fully federally funded organization, therefore, each FQHC is trying to make up that difference and keep themselves in operation. Over the years, 340B has become that essential lifeline for many of them. She said FQHCs have already started to see cuts throughout the state on different things and oftentimes an FQHC is making that decision based on a decrease in 340B savings, which we attempt to address in our legislation. Hannah Hudson explained that there are a number of compliance and audit requirements that exist for FQHCs and also a number of steps Maine has taken to become a leader in transparency. Right now, Maine providers are using the savings from 340B as Congress intended. She mentioned a meta study that synthesized various angles and interpretations of the program and after looking at about 900 documents and 283 studies, they found that 340B is an essential	

	and successful part of serving low-income populations. It found that any restrictions or elimination of the program would have devastating impacts. She mentioned that MPCA like to use this report given it synthesizes such a high volume of information. Hannah Hudson said that the restrictions MPCA members are seeing are having a negative impact on health centers. She provided some background on how they created their legislation. Beginning in 2020, she said they started to see a number of restrictions placed on covered entities put in place by pharma. They are seeing contract pharmacy restrictions, specifically, which is how pharma has put restrictions on who an FQHC or a hospital can partner with to participate in the 340B program. This contract pharmacy restriction represents huge financial loss. They're seeing millions of dollars across the state's whole safety net, leaving the state and not going back anywhere else but to pharma. Hannah Hudson stated that HRSA, which is their federal oversight entity, has attempted to protect this provider pharmacy relationship. When they lost that through their dispute resolution system, some states decided to step in and protect providers against discrimination themselves. Arkansas is one of the leaders in this movement. Their legislation focused on contract pharmacy restrictions. This was upheld all the way to the Supreme Court, who recently declined to hear pharma's continued attempt to overturn the law. They've seen for a number of years now, many other states, both red and blue, taking up contract pharmacy restriction legislation to help protect covered entities in their states. Hannah Hudson explained that their legislation is not attempting to figure out every single issue that exists with the 340B program. From her personal point of view, she said, it is a difficult way to fund a healthcare system. But, for MPCA right now, the contract pharmacy restrictions have an outsized financial impact and is causing the loss of services across the state, impacting access to care. This legislation is one way to address that immediately. Overhauling the entire system is a federal level discussion and while there have been attempts in Congress to pass legislation that does that, those dropped off and need to be reintroduced. This legislation though, focuses on contract pharmacy restrictions. Hannah Hudson showed a map of the country that shows a number of states that have passed a similar law and a number, including Maine, who have introduced similar legislation this session. They've seen the legislation be	

	successful in other states. The bill in Maine is based on legislation and work done in Arkansas and Louisiana. She then shared some legislative language with the group, explaining that she'd be happy to provide more materials to the group or answer any questions. She said that the bill is focused on the discriminatory practices that pharma has taken against contract pharmacy relationships. The goal of the bill is to honor those prices at partner pharmacies. The bill gives enforcement capabilities to the Attorney General, and it preserved savings in the Medicaid program. She said they have a strong bi-partisan co-sponsor and a number of folks from the HCIFS committee. The legislation has been endorsed and brought forth in partnership with Maine's Pharmacy Association and the Society of Health for System Pharmacists. She mentioned that a comment in the chat about size of our state and its rural nature. Oftentimes there is conversation about big out of state pharmacies and/or having to do mail order fulfillments. There's a lot of nuance and ensuring we're able to maintain contract pharmacy relationships is essential to make sure people have access to care. **3. Q&A** Peter Hayes commented that the PDAB has heard about 340B in the context of not costing anyone anything. What concerns him, though, is that any discounts manufacturers are giving to 340B drugs they're making back on every other drug that all of us are using. It really is a hidden tax. Nationally, the value of this program is $60 billion, which is being harvested by different players. Peter Hayes asked Hannha Hudson where MPCA falls on the PBM piece. Are you trying to prevent the PBMs from being the contract providers even after seeing some of the fees they're taking? Or are you trying to expand the number o contract pharmacies that can participate in 340B? Hannah Hudson responded that they are trying to maintain current relationships that exist and have been restricted by pharma. PBMs are different actors in the space. Their legislation is focused on contract pharmacy restrictions. Members have had difficulties with PBMs from the FQHC perspective around discriminatory practices and administrative burden. At the end of the day, she said, MPCA sees it as either millions of dollars staying in Maine providing direct services to patients and keeping access open or it's millions of dollars going to pharma and leaving our state.	

	Dr. Nikpay responded that she likes the JAMA study Hannah Hudson referenced in her presentation. The piece is a good way to look at what has already been written. But what she would argue is that a lot of those studies tend to be more on the anecdotal side. There needs to be more weighing of evidence. From the studies from which you can draw a causal interpretation, these do not lend themselves to the conclusion that paper comes to. Dr. Nikpay also said that PBMs are something people talk about a lot and it's confusing to know where they fit into the 340B space because a PBM shouldn't want 340B drugs filled at 340B prices. They would want to steer people away from 340B contract pharmacies because they jeopardize the manufacturer and the rebates that PBMs negotiate on behalf of employers. But what we are seeing more and more is that because a lot of these pharmacies are owned by companies that also have a PBM, the PBM is happy to let that negotiated rebate for the employer go and benefit from all of those fees through contract pharmacies that come from each time a drug is filled. There are some really important interactions here and she would also argue that some of those laws, which she understands help preserve the 340B subsidy, don't necessarily come at a cost to anybody. In Minnestoa, they have one of those laws, but it means that no insurer can vary the rate so that the state employer can save come money by not paying the full reimbursement on a 340B drug in a time of rising premiums and lower wages. Meg Garratt-Reed for clarification on whether commercial payers can receive a rebate on the payment for a drug that is subject to 340B. Her understanding is that they cannot. In which case it is her expectation that they are paying more for that drug than they would otherwise. She also asked for more information on where some of the revenue is coming from, given it is her understanding that it can come from commercial payers and employers or people on the individual market. Dr. Nikpay said that is an accurate understanding. She said she has talked to some employers who are trying to find the best deal for their employees so that they can do things like increase wages rather than continuing to pay more and more for health insurance. She said she thinks it is the fact that you can't vary reimbursements because of these PBM rules that forecloses that pathway for employers who might want to save some money by paying the 340B providers a bit less.	

	Hannah Hudson said that from MPCA's point of view, they are confused about whether new 340B data on impact for employers is coming from and whether it could be driven by pharma. The data they have access to in Maine wouldn't really substantiate that, so there is some caution to be exercised when making blanket statements that 340B causes losses to employers. Noah Nesin said that there is limited evidence, but some evidence that FQHCs and hospitals use savings to provide safety net care does exist. He said he has personal experience with this and mentioned that when SUD treatment wasn't covered by MaineCare, he was able to provide treatment for SUD patients using 340B savings. When there were limitations on treating Hepatitis C for people on MaineCare or uninsured patients, he was able to treat those patients. He said they were also able to expand mental health treatment. He said that there is no question that there is no free lunch. The questions is, though, when there is money invested in something like this and you can demonstrate real benefit from it, how do you preserve that really important benefit while addressing some of those very legitimate concerns about rapid expansion of the program where money disappears into bigger systems that have lack of evidence as to how they make use of the revenue. Hannah Hudson responded that they've chosen an approach that focuses on distribution systems. It's a place where states have seen success and have been able to act. They're avoiding pricing discussions that usually bring in preemption at the federal level, so there is a balance here because it is a federal program, this is a specific place where they've seen success in preserving access. They're seeing reports of declining access as systems and clinics are closing. It can be a lot of anecdotal evidence for members and often they are not necessarily though of as the voice bringing this up in conversation. Sharon Treat asked whether data in Maine on contract pharmacies is the same as what was concerning in Minnesota, or whether that was national data. She asked how many of those contract pharmacies are truly independent and how many of them are owned by the big national players that are also actually integrated with PBMs? Hannah Hudson responded that she does not have specific data or numbers but they are seeing big chains close quickly throughout our state, particularly Down East with the closure of Walgreens. They're also seeing inconsistent hours and a	

	lack of available staff. It's a workforce shortage across the board. She said their relationships with independent pharmacies are important to keep these contract pharmacy arrangements. But, if a CVS is the only space available, for example, those are the places they want their patients to be able to access as well. So, for MPCA, it's more a concern of location at the moment given Maine is a pharmacy desert. She shared that Washington county is considered a 100% pharmacy desert. Sharon Treat asked about how the data presented earlier on software companies and fees relate to the legislation MPCA is bringing forward. Hannah Hudson said that is not necessarily a focus of their legislation, but she would be happy to raise the question with members. Sharon Treat responded that she is interested because this legislation is very complicated. She said she is wondering how it intersects with all these different players, whether it be the PBMS or software companies and the extent to which it preserves the status quo. She said she it almost seems to be about keeping prices high and if software companies and other players aren't really benefitting patients, how does that work? Hannah Hudson responded that that is not the focus of their legislation. As a hospital or FQHC they do not control prices of a retail pharmacy sale. If they do it in house, usually that price is the same for all patients and is determined by coverage. She said there are members of her team with more knowledge on this that would be happy to chat. Dr. Nikpay shared that what Hannah Hudson said is true, FQHCs have very little power to push back on fees and sometimes, like with CVS, those fees include fees for third party administrators. Often, they actually force the covered entity to use them even if they have their own software company and they have to pay fees twice. She said there are also fees that aren't in the form of dispensing or percentage feeds. There are also fees the come in the form of fines. Sometimes if you're an FQHC or a hospital, contract pharmacies with charge full price and deduct that from the 340B revenue that they would remit back to the covered entity. She said she is aware Maine has it's own transparency program, but when she read the MPCA bill she found that there was a lot of stuff in there about contract pharmacies and third party administrators. She said she would	

	encourage, for the sake of transparency and preserving subsidies, to really dig into that given there are quite a few fees that come with contract pharmacy. Rhonda Selvin said that the implications of what Hannah Hudson said about lack of pharmacy availability is profound to her patients. She said they have transportation issues, particularly for folks with time sensitive medication need. Meg Garratt-Reed said it is definitely a nuanced and complicated issue and the Board appreciates these presentations. She said that it would be best to hold on the public payors questionnaire until the next meeting. She also shared an update on the PDAB's legislation, saying that it went through the hearing and work session, getting a majority ought to pass vote out of committee on party lines. She thanked Sharon Treat for speaking to the committee during their orientation.	
VII. Open Discussion		
VIII. Adjourn	Meg Garrat-Reed adjourned the meeting.	

Next meeting: May 19th, 2025