Kansas Hospital Association 340B Compliance Workshop

June 18, 2019

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Speaker has nothing to disclose

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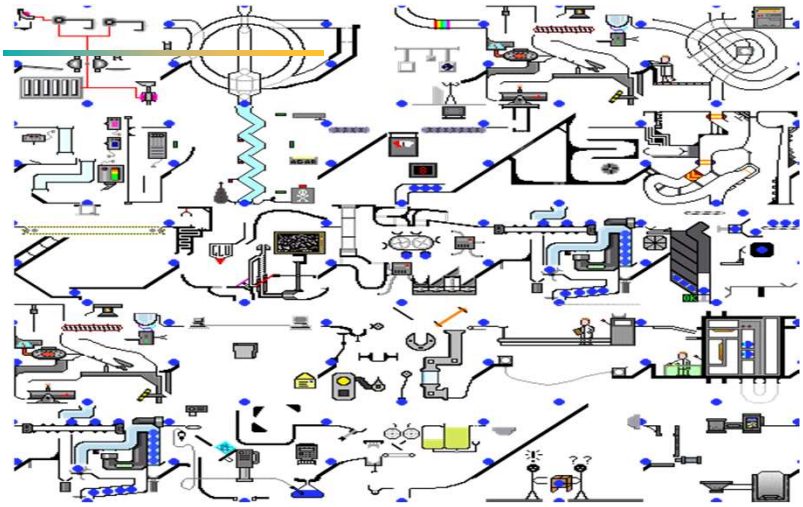
340B: It's not just one thing, it's a thousand little things



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340B Drug Pricing Program

PROTECTING PENNSYLVANIA'S SAFETY NET

For more than 25 years, Congress has provided relief from high prescription drug costs through the **340B Drug Pricing Program**. The program requires participating pharmaceutical companies to sell covered outpatient drugs at a discount to eligible health care organizations. To be eligible, hospitals must serve a disproportionate share of uninsured and low-income patients. This program gives patients better access to drugs they need and helps hospitals enhance care capabilities by stretching scarce federal resources.

Small Program, Big Benefits

2.8%
Portion of the United States' $457 billion in annual drug purchases made through the 340B program in 2015.

$3.5 BILLION
IN COMMUNITY BENEFIT FOR FISCAL YEAR 2015
340B creates valuable savings on outpatient drug expenditures to reinvest in patient care and health activities to benefit the communities they serve. It also saves money for state and federal governments.

1,084 PROVIDERS, INCLUDING 48 HOSPITALS IN PENNSYLVANIA PARTICIPATE IN THE 340B DRUG PRICING PROGRAM
340B increases access to care for our most vulnerable populations; participating hospitals provided $324.8 million in uncompensated care in fiscal year 2016.

Who are 340B Hospitals?

About **half** are urban; half are rural

80% of PA critical access hospitals (CAH) participate in 340B (12 out of 15)

45% of Pennsylvania hospitals (in 30 counties) participate in 340B

340B Hospitals Meet Rigorous Requirements

340B Eligibility
Hospitals must:

- Be designated as a not-for-profit hospital.
- Be classified as a Children's Hospital, Cancer Hospital, Sole Community Hospital, Rural Referral Center, Critical Access Hospital or a Medicare Disproportionate Share Hospital.
- Serve a large proportion of uninsured and low-income patients.
- Undergo random audits by the federal government and pharmaceutical manufacturers.
- Recertify annually as an eligible 340B provider.
- Maintain auditable inventories for 340B and non-340B prescription drugs.

PRESERVE THE 340B PROGRAM; PROTECT PENNSYLVANIA'S SAFETY NET
Sources: Health Resources and Services Administration, IMS Health, American Hospital Association, Apexus, 340BHealth, Pennsylvania Health Care Cost Containment Council, HAP

HAP
The Hospital + Healthsystem Association of Pennsylvania
Leading for Better Health
www.haponline.org

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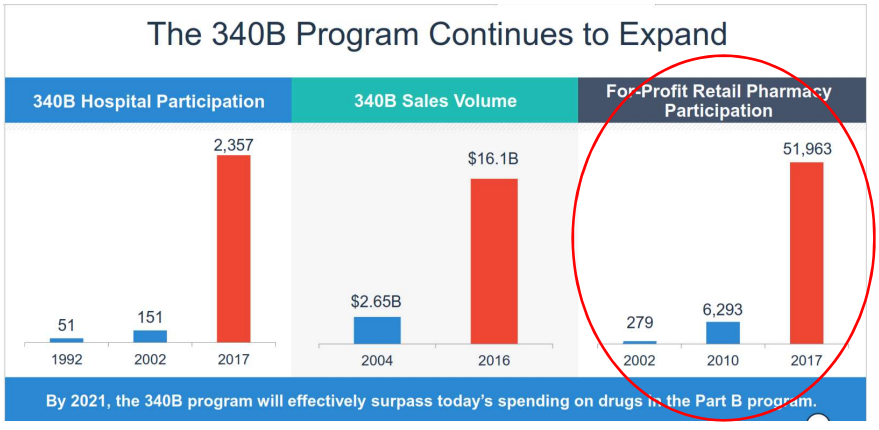
$$Expansion → Increased oversight/compliance

The 340B Program Continues to Expand



By 2021, the 340B program will effectively surpass today's spending on drugs in the Part B program.

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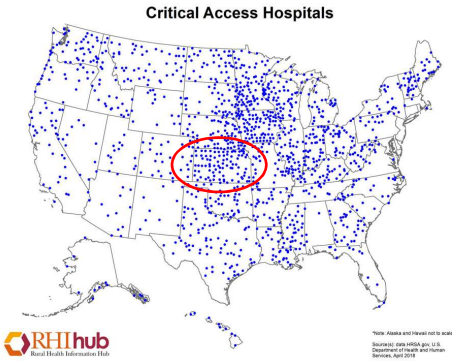
Critical Access Hospitals



Critical access hospitals (CAHs) are vital for maintaining *access* to high-quality health care services in rural communities

CAHs represent a quarter of all U.S. and more than two-thirds of all rural community hospitals

Access to care in vulnerable communities

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Compliance Observations from the field

- Registration inaccuracies
- Emphasis on Policies and Procedures
- Prevention of Duplicate Discounts
- Patient definition
- Healthcare Providers and eligibility based on policies
  - Correctional/Contracted/NP/PA's
  - Referral
- Program terminations due to failure to recertify (small and rural CE)
- Tracking and tracing accumulations and repurchase methodology

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HEARING: #SubOversight to Continue Review of 340B Drug Pricing Program
10.04.17
Overhaul of 340B program could happen this spring, key Republican says
By ERIN MERSHON @eemershon / JANUARY 11, 2018
Hospitals and PhRMA face off over drug prices and 340B program
By DAVID PITTMAN | 11/09/2017 08:30 AM EST
Health & Science
Heated And Deep-Pocketed Battle Erupts Over 340B Drug Discount Program
NOV 01, 2017 | MORE ON REIMBURSEMENT
UPDATED: Hospital groups to sue CMS over $1.6 billion cut to 340B payments
The final rule will also allow for higher payment when Medicare beneficiaries receive certain procedures in outpatient departments.
Susan Morse, Senior Editor
GAO
United States Government Accountability Office
Testimony
Before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives
DRUG DISCOUNT PROGRAM
Update on Agency Efforts to Improve 340B Program Oversight
Statement of Debra A. Draper
Director, Health Care
Deeper Than the Headlines: Lookout for Compliance Issues with the 340B Drug Pricing Program
Posted by CJ Wolf
Aug 7, 2017 1:39:25 PM
BRIEF
Hospitals defend 340B drug program amid scrutiny
FEDERAL REGISTER
The Daily Journal of the United States Government
340B Drug Pricing Program Omnibus Guidance
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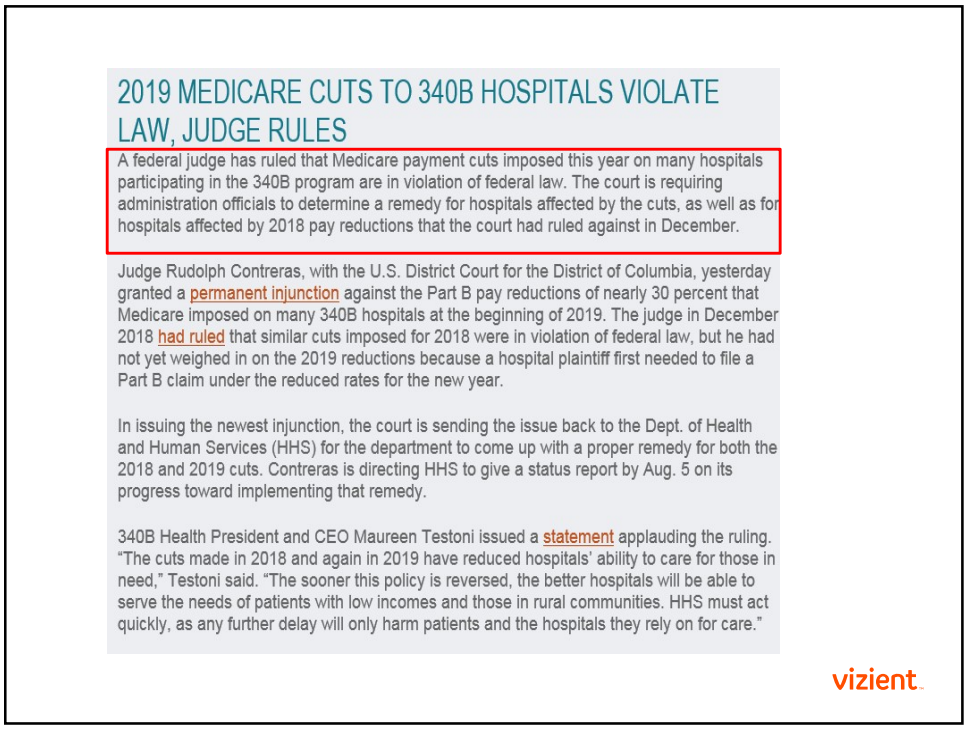
2019 MEDICARE CUTS TO 340B HOSPITALS VIOLATE LAW, JUDGE RULES
A federal judge has ruled that Medicare payment cuts imposed this year on many hospitals participating in the 340B program are in violation of federal law. The court is requiring administration officials to determine a remedy for hospitals affected by the cuts, as well as for hospitals affected by 2018 pay reductions that the court had ruled against in December.
Judge Rudolph Contreras, with the U.S. District Court for the District of Columbia, yesterday granted a permanent injunction against the Part B pay reductions of nearly 30 percent that Medicare imposed on many 340B hospitals at the beginning of 2019. The judge in December 2018 had ruled that similar cuts imposed for 2018 were in violation of federal law, but he had not yet weighed in on the 2019 reductions because a hospital plaintiff first needed to file a Part B claim under the reduced rates for the new year.
In issuing the newest injunction, the court is sending the issue back to the Dept. of Health and Human Services (HHS) for the department to come up with a proper remedy for both the 2018 and 2019 cuts. Contreras is directing HHS to give a status report by Aug. 5 on its progress toward implementing that remedy.
340B Health President and CEO Maureen Testoni issued a statement applauding the ruling. "The cuts made in 2018 and again in 2019 have reduced hospitals' ability to care for those in need," Testoni said. "The sooner this policy is reversed, the better hospitals will be able to serve the needs of patients with low incomes and those in rural communities. HHS must act quickly, as any further delay will only harm patients and the hospitals they rely on for care."
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340B Health President and CEO Maureen Testoni issued a statement applauding the ruling. "The cuts made in 2018 and again in 2019 have reduced hospitals' ability to care for those in need," Testoni said. "The sooner this policy is reversed, the better hospitals will be able to serve the needs of patients with low incomes and those in rural communities. HHS must act quickly, as any further delay will only harm patients and the hospitals they rely on for care."

The latest development does not immediately affect Medicare Part B payment rates for hospitals who received reduced rates in 2018 or who are receiving reduced rates this year. The court's order states that HHS "patently violated the Medicare Act's text" when it used the administrative process to impose the pay cuts. However, the judge also noted that striking down the rules entirely would be "highly disruptive" because the cuts to 340B hospitals were redistributed among all hospitals under Part B. Thus, repaying affected 340B hospitals under budget-neutrality requirements would involve recouping payments already made to other hospitals, a process the judge described as "an expensive and time-consuming prospect."

In deciding against vacating the 2018 and 2019 rules immediately, Contreras declined to grant the injunctive relief requested by the American Hospital Association, Association of American Medical Colleges, America's Essential Hospitals, and three hospital plaintiffs, whose lawsuit against HHS resulted in the injunctions. These plaintiffs had argued that Medicare could fully reimburse affected hospitals using supplemental payments without being required to use a budget-neutral process. The judge said he instead was following the HHS recommendation to give the department "the first crack" at coming up with a workable solution, but he noted that the court "may reconsider the remedy if the agency fails to fulfill its responsibilities in a prompt manner."

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- Ensure compliance through keeping price accuracy
- Communicate with 340B leadership for changes to cost report or locations

CEILING PRICE DATABASE WILL PROVIDE ADDITIONAL INFORMATION

Starting on July 1, 340B covered entities will be able to access important new information about drug prices through the federal ceiling price website.

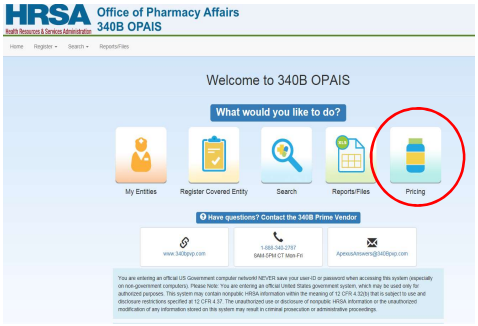
The Health Resources & Services Administration (HRSA) announced the changes to the pricing component of the 340B Office of Pharmacy Affairs Information System (OPAIS) in a May program update. The new data coming in July will include the raw ceiling price, package size, case pack size, and package adjusted price.

Since HRSA launched the ceiling price website on April 1, the agency has published a unit ceiling price rounded to two decimal places. Publishing the raw ceiling price will provide hospitals with the average manufacturer price minus the unit rebate amount before it is rounded to two decimal places.

Starting in July, hospitals also will be able to view a drug's package adjusted price. That price is equal to the raw ceiling price times the package size and case package size. The additional information will allow covered entities to understand the price that is paid in the market.

HRSA said an exception to the package adjusted price will be made when the ceiling price is less than $0.01. In these cases, the 340B ceiling price will be rounded to two decimal places (i.e., one penny) before being multiplied by the package size and case pack size to determine the package adjusted price.

New Pricing Tool released April 2019



As Urged by AHA, HRSA Launches Website for Checking 340B Maximum Prices

Apr 01 | Reach: 1,590

Share article :

American Hospital Association - The Health Resources and Services Administration today launched a new website that organizations participating in the 340B Drug Pricing Program can use to determine the maximum prices drug companies can charge them for medications sold under the program. Read More

Related Stories:

HHS Website Now Lists Ceiling Prices for 340B Drugs

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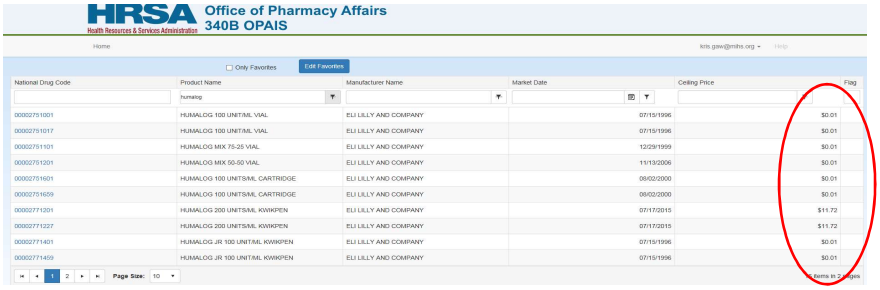

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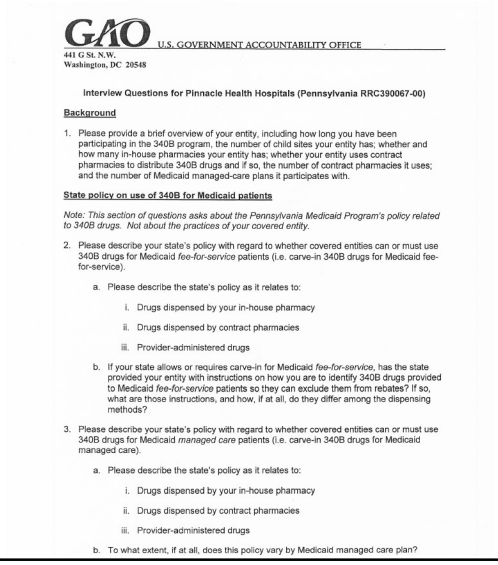
GAO Conducting Interviews on prevention of Duplicate Discount



GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

Interview Questions for Pinnacle Health Hospitals (Pennsylvania RRC390067-00)

Background

1. Please provide a brief overview of your entity, including how long you have been participating in the 340B program, the number of child sites your entity has; whether and how many in-house pharmacies your entity has; whether your entity uses contract pharmacies to distribute 340B drugs and if so, the number of contract pharmacies it uses; and the number of Medicaid managed-care plans it participates with.

State policy on use of 340B for Medicaid patients

Note: This section of questions asks about the Pennsylvania Medicaid Program's policy related to 340B drugs. Not about the practices of your covered entity.

2. Please describe your state's policy with regard to whether covered entities can or must use 340B drugs for Medicaid *fee-for-service* patients (i.e. carve-in 340B drugs for Medicaid fee-for-service).
   a. Please describe the state's policy as it relates to:
      i. Drugs dispensed by your in-house pharmacy
      ii. Drugs dispensed by contract pharmacies
      iii. Provider-administered drugs
   b. If your state allows or requires carve-in for Medicaid *fee-for-service*, has the state provided your entity with instructions on how you are to identify 340B drugs provided to Medicaid *fee-for-service* patients so they can exclude them from rebates? If so, what are those instructions, and how, if at all, do they differ among the dispensing methods?
3. Please describe your state's policy with regard to whether covered entities can or must use 340B drugs for Medicaid *managed care* patients (i.e. carve-in 340B drugs for Medicaid managed care).
   a. Please describe the state's policy as it relates to:
      i. Drugs dispensed by your in-house pharmacy
      ii. Drugs dispensed by contract pharmacies
      iii. Provider-administered drugs
   b. To what extent, if at all, does this policy vary by Medicaid managed care plan?

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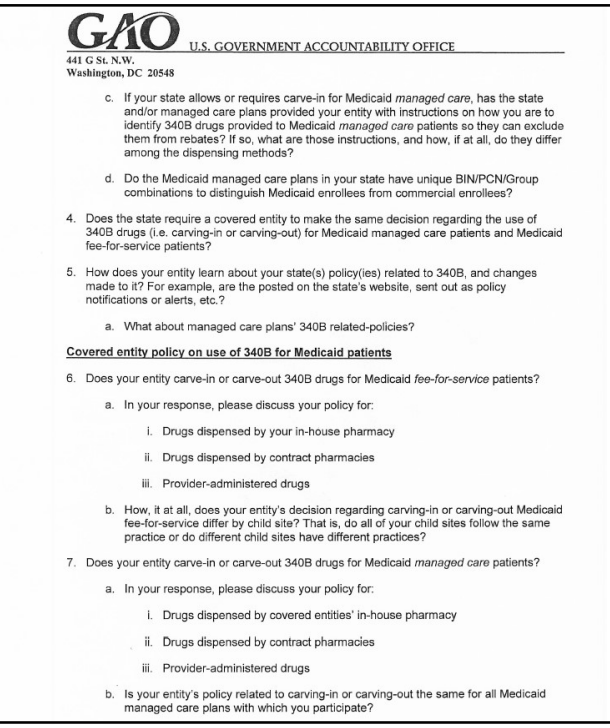

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   c. If your state allows or requires carve-in for Medicaid *managed care*, has the state and/or managed care plans provided your entity with instructions on how you are to identify 340B drugs provided to Medicaid *managed care* patients so they can exclude them from rebates? If so, what are those instructions, and how, if at all, do they differ among the dispensing methods?
   d. Do the Medicaid managed care plans in your state have unique BIN/PCN/Group combinations to distinguish Medicaid enrollees from commercial enrollees?
4. Does the state require a covered entity to make the same decision regarding the use of 340B drugs (i.e. carving-in or carving-out) for Medicaid managed care patients and Medicaid fee-for-service patients?
5. How does your entity learn about your state(s) policy(ies) related to 340B, and changes made to it? For example, are the posted on the state's website, sent out as policy notifications or alerts, etc.?
   a. What about managed care plans' 340B related-policies?

Covered entity policy on use of 340B for Medicaid patients

6. Does your entity carve-in or carve-out 340B drugs for Medicaid *fee-for-service* patients?
   a. In your response, please discuss your policy for:
      i. Drugs dispensed by your in-house pharmacy
      ii. Drugs dispensed by contract pharmacies
      iii. Provider-administered drugs
   b. How, it at all, does your entity's decision regarding carving-in or carving-out Medicaid fee-for-service differ by child site? That is, do all of your child sites follow the same practice or do different child sites have different practices?
7. Does your entity carve-in or carve-out 340B drugs for Medicaid *managed care* patients?
   a. In your response, please discuss your policy for:
      i. Drugs dispensed by covered entities' in-house pharmacy
      ii. Drugs dispensed by contract pharmacies
      iii. Provider-administered drugs
   b. Is your entity's policy related to carving-in or carving-out the same for all Medicaid managed care plans with which you participate?

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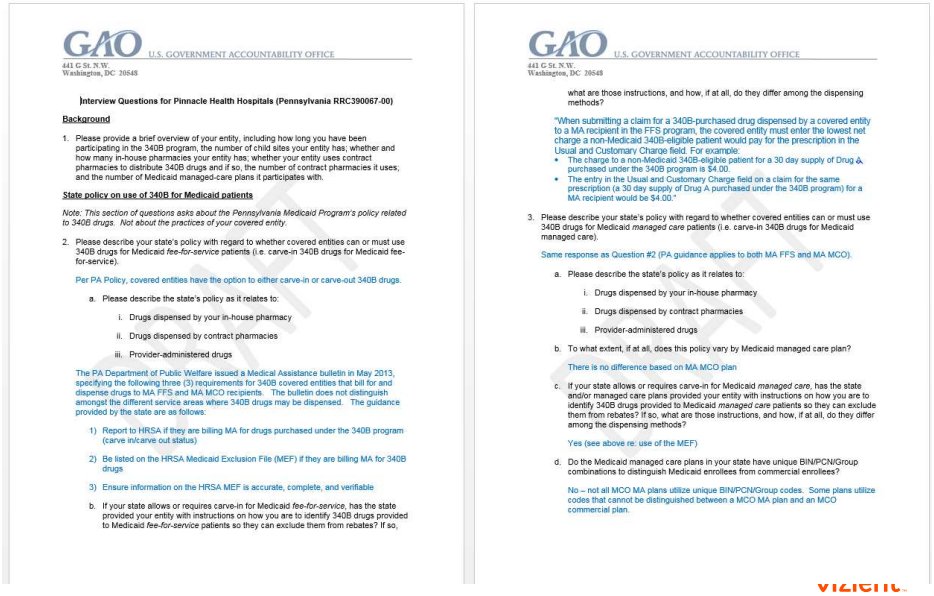
GAO Interviews underway on Duplicate Discount



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State policy on use of 340B for Medicaid patients

Note: This section of questions asks about the Pennsylvania Medicaid Program's policy related to 340B drugs. Not about the practices of your covered entity.

2. Please describe your state's policy with regard to whether covered entities can or must use 340B drugs for Medicaid *fee-for-service* patients (i.e. carve-in 340B drugs for Medicaid fee-for-service).

Per PA Policy, covered entities have the option to either carve-in or carve-out 340B drugs.

a. Please describe the state's policy as it relates to:
   i. Drugs dispensed by your in-house pharmacy
   ii. Drugs dispensed by contract pharmacies
   iii. Provider-administered drugs

The PA Department of Public Welfare issued a Medical Assistance bulletin in May 2013, specifying the following three (3) requirements for 340B covered entities that bill for and dispense drugs to MA FFS and MA MCO recipients. The bulletin does not distinguish amongst the different service areas where 340B drugs may be dispensed. The guidance provided by the state are as follows:

1) Report to HRSA if they are billing MA for drugs purchased under the 340B program (carve in/carve out status)
2) Be listed on the HRSA Medicaid Exclusion File (MEF) if they are billing MA for 340B drugs
3) Ensure information on the HRSA MEF is accurate, complete, and verifiable

b. If your state allows or requires carve-in for Medicaid *fee-for-service*, has the state provided your entity with instructions on how you are to identify 340B drugs provided to Medicaid *fee-for-service* patients so they can exclude them from rebates? If so, what are those instructions, and how, if at all, do they differ among the dispensing methods?

"When submitting a claim for a 340B-purchased drug dispensed by a covered entity to a MA recipient in the FFS program, the covered entity must enter the lowest net charge a non-Medicaid 340B-eligible patient would pay for the prescription in the Usual and Customary Charge field. For example:
- The charge to a non-Medicaid 340B-eligible patient for a 30 day supply of Drug A purchased under the 340B program is $4.00.
- The entry in the Usual and Customary Charge field on a claim for the same prescription (a 30 day supply of Drug A purchased under the 340B program) for a MA recipient would be $4.00."

3. Please describe your state's policy with regard to whether covered entities can or must use 340B drugs for Medicaid *managed care* patients (i.e. carve-in 340B drugs for Medicaid managed care).

Same response as Question #2 (PA guidance applies to both MA FFS and MA MCO).

a. Please describe the state's policy as it relates to:
   i. Drugs dispensed by your in-house pharmacy
   ii. Drugs dispensed by contract pharmacies
   iii. Provider-administered drugs

b. To what extent, if at all, does this policy vary by Medicaid managed care plan?

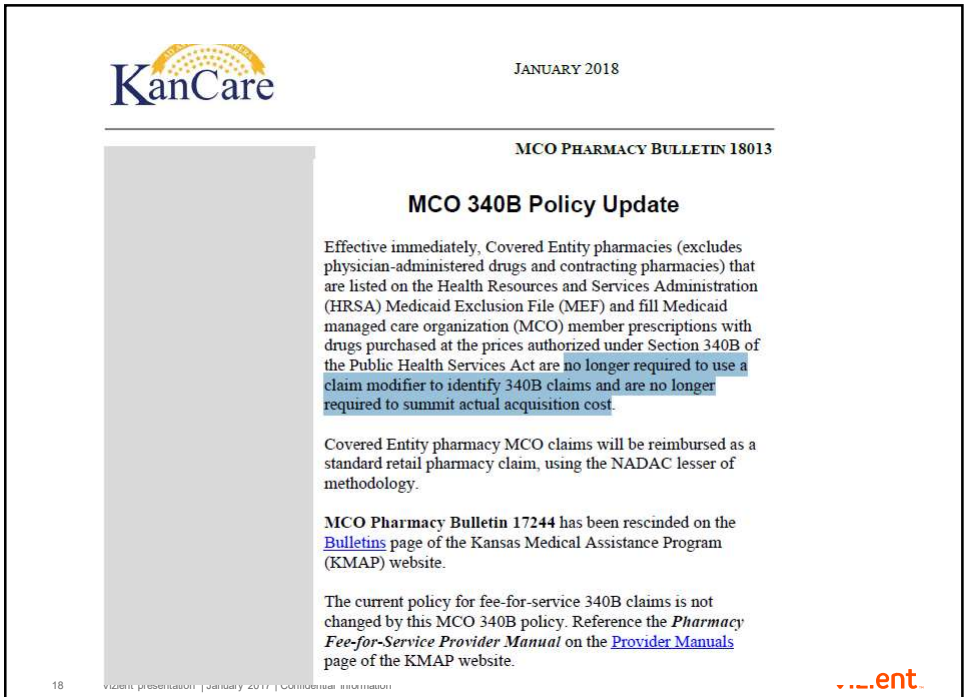
There is no difference based on MA MCO plan

c. If your state allows or requires carve-in for Medicaid *managed care*, has the state and/or managed care plans provided your entity with instructions on how you are to identify 340B drugs provided to Medicaid *managed care* patients so they can exclude them from rebates? If so, what are those instructions, and how, if at all, do they differ among the dispensing methods?

Yes (see above re: use of the MEF)

d. Do the Medicaid managed care plans in your state have unique BIN/PCN/Group combinations to distinguish Medicaid enrollees from commercial enrollees?

No – not all MCO MA plans utilize unique BIN/PCN/Group codes. Some plans utilize codes that cannot be distinguished between a MCO MA plan and an MCO commercial plan.



KanCare

JANUARY 2018

MCO PHARMACY BULLETIN 18013

MCO 340B Policy Update

Effective immediately, Covered Entity pharmacies (excludes physician-administered drugs and contracting pharmacies) that are listed on the Health Resources and Services Administration (HRSA) Medicaid Exclusion File (MEF) and fill Medicaid managed care organization (MCO) member prescriptions with drugs purchased at the prices authorized under Section 340B of the Public Health Services Act are no longer required to use a claim modifier to identify 340B claims and are no longer required to summit actual acquisition cost.

Covered Entity pharmacy MCO claims will be reimbursed as a standard retail pharmacy claim, using the NADAC lesser of methodology.

MCO Pharmacy Bulletin 17244 has been rescinded on the Bulletins page of the Kansas Medical Assistance Program (KMAP) website.

The current policy for fee-for-service 340B claims is not changed by this MCO 340B policy. Reference the ***Pharmacy Fee-for-Service Provider Manual*** on the Provider Manuals page of the KMAP website.

Kansas Medicaid Carve In Percentages

Select State/Territory from the drop down

State/Territory Kansas

Medicaid Carve In Percentages for Q2, 2019

	Current Quarter			Prior Quarter	
Kansas	**% Carve-IN**	**Number of 340B CEs**	**Change from Prior Quarter**	**% Carve-IN**	**Number of 340B CEs**
All Types	**48%**	**118**	**1%**	**48%**	**117**
All Grantees	**59%**	**98**	**1%**	**59%**	**97**
All Hospitals	**26%**	**20**	**0%**	**25%**	**20**
CAH	19%	13	8%	18%	12
DSH	67%	2	-33%	75%	3
PED	100%	1	0%	100%	1
RRC	100%	1	0%	100%	1
SCH	50%	3	0%	50%	3

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Kansas Medicaid State Details (as of 27-MAY-17)

Retail

Drug Ingredient Cost
340B AAC Invoice

Professional Dispensing Fee
10.5

Required Claim Identifiers
Unable to locate information

Professional Dispensing Fee (Max Range)

Provider or Facility Administered Drugs

Drug Ingredient Cost
ASP + 6%

Required Claim Identifiers
Unable to locate information

Can Contract Pharmacies Dispense 340B Drugs

No - explicitly prohibited by state

Comments/Notes

Kansas Medicaid Contacts

Technical Contact	Rebate Contact	Policy Contact
CINDY HEMMINGER	CINDY HEMMINGER	ANNETTE M. GRANT
KSDRUGREBATE@DXC.COM	KSDRUGREBATE@DXC.COM	ANNETTE.GRANT@KS.GOV
PO BOX 19287, 6511 SE FORBES AVE, BLDG 283	PO BOX 19287, 6511 SE FORBES AVE, BLDG 283	6511 SW FORBES AVE, BLDG 283, P.O. BOX 19287
TOPEKA, KS 66619	TOPEKA, KS 66619	TOPEKA, KS 666190287
(785) 379 2116	(800) 937 6231	(785) 296 8406

The Medicaid State Details Table Shows:

Retail Prescriptions

- **Drug Ingredient Cost** – cost to submit to Medicaid for reimbursement
- **Required Claim Identifiers** – any identifiers required by the state to accompany the claim
- **Professional Dispensing Fee (PDF)** – amount Medicaid will pay for dispensing service
- **Professional Dispensing Fee (Max Range)** – if the PDF varies, this is the max amount

Provider or Facility Administered Drugs

- **Drug Ingredient Cost** – cost to submit to Medicaid for reimbursement
- **Required Claim Identifiers** – any identifiers required by the state to accompany the claim

Can Contract Pharmacies Dispense 340B Drugs

- Does the state permit dispensing 340B drugs through contract pharmacies. NOTE: Entities who want to dispense 340B drugs through contract pharmacies must have established an arrangement among the covered entity, the contract pharmacy and the State Medicaid agency to prevent duplicate discounts, and reported this arrangement to HRSA

Compliance

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Registration

4 registration periods annually

New 340B OPAIS went live on September 18, 2017

Authorizing Official and Primary Contact must be different individuals and neither can be consultant

Both are required to create logins

2 step authentication

Only Authorizing Official can attest to changes, registrations, terminations and recertification

Government Official

340B OPAIS will house the statutorily mandated secure website to make 340B ceiling pricings available to providers

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8

Recertification

340B covered entities must annually recertify their 340B eligibility

Notifications are sent to Primary Contact and Authorizing Official

Once recertification period begins the Authorizing Official only has access via their user accounts to attest their covered entity's compliance with 340B requirements and complete recertification

Contacts listed in the 340B database must be accurate at all times to receive all notifications

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9

Diversion

Diversion

- Drugs can only be used on an outpatient basis for covered entity's patients as defined by HRSA
- Use for other individuals constitutes prohibited diversion
- Focus on defining **"patient"** & **"covered entity"**

What is **"covered entity"**?

- Where services are provided
- Physicians must be employed or under a contractual or other arrangement
- Entity should maintain a listing of approved 340B physicians

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10

Medicaid Duplicate Discounts

340B laws prohibit application of both 340B price discount on front end and payment of pharmacy rebate to state Medicaid on back end for same drug claim

General options for covered entities

Carve-out Medicaid - from 340B drug purchases

Carve-in Medicaid - requires verifying Medicaid exclusion file is accurate in 340B OPAIS

Some states have been slow to establish and communicate Medicaid billing requirements and potential modifiers

Transition to Medicaid managed care has created confusion

Covered entities should have mechanisms in place to identify Medicaid MCO patients

Contract pharmacies should not "Carve-in" Medicaid FFS or MCO

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11

Contract Pharmacy

- HRSA allows providers to enter into arrangements with multiple contract pharmacies to dispense 340B drugs to qualifying patients of providers
- Covered entity is responsible for compliance and must monitor contract pharmacies
- HRSA recommends independent audits
- Child sites, outpatient clinics
- Retail pharmacy split-billing software
- Brand vs. generic
- Do you periodically review your contract pharmacy arrangements?

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27

GPO Exclusion

The GPO Prohibition pertains to DSH, Pediatric Hospitals and Free-Standing Cancer Hospitals

Drug Purchases through GPO contracts cannot be used for outpatients covered by 340B

If covered entity is unable to track 340B and GPO use, required to purchase on WAC account

All outpatient drugs not purchased on 340B account must be purchased on WAC account

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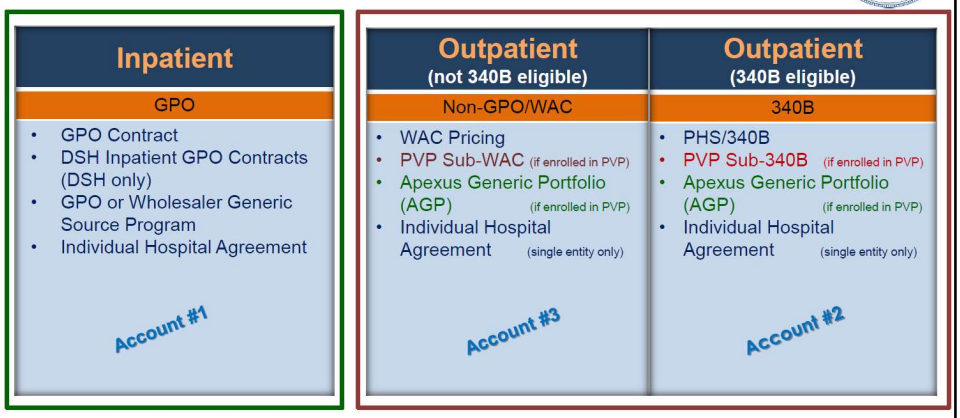
Wholesaler Account Setup -DSH/PED/CAN with GPO Prohibition



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Orphan Drugs/Voluntary Pricing

These covered entity types must purchase all orphan drugs at non-340B pricing

Critical Access Hospitals

Sole Community Hospitals

Rural Referral Centers

Free-Standing Cancer Hospitals

Manufacturers are not required to provide these covered entities orphan drugs under the 340B Program. A manufacturer may, at its sole discretion, offer discounts on orphan drugs to these hospitals.

October 14, 2015 – U.S. District Court for District of Columbia ruled on Orphan Drug Interpretation

HRSA lacks the authority to allow 340B pricing for orphan drugs used for common indications

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HRSA Audits

HRSA believes that covered entities that do not regularly review and audit contract pharmacy operations are at increased risk for compliance issues

Annual audit of each location will provide covered entities

- Regular opportunity to review and reconcile 340B patient eligibility information
- Prevent diversion

Covered entity should compare 340B prescribing records with contract pharmacy's dispensing records at least on a quarterly basis to prevent

- Diversion
- Duplicate discounts

Conducting these audits using an independent auditor will test if the pharmacy is following all 340B program requirements and provide the covered entity with ability to timely report any violations if applicable

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15

2017 Audit Results

HRSA has conducted approximately 200 audits annually since 2015

146 publically available for 2017

Audits initially had a collaborative/educational tone but the tone has changed when HRSA began instituting punitive penalties to ensure compliance

HRSA's budget will remain the same for FY 2018

340B program has grown to 22 FTEs in 2017 from 4 FTEs in 2014

HRSA will continue to focus on contract pharmacy arrangements, diversion, duplicate discounts and 340B database records

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32

Audit Finding Overview

- More than 1,000 audit results posted since 2012: 78% are of hospitals
- Majority of findings involve diversion
- Results for hospitals posted on HRSA website: 61% require repayment
- Another 200 expected in 2019

340B HEALTH 5

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HRSA Focus on DSH Hospitals

- Over half (52%) of HRSA audits have been of DSH hospitals (548 DSH audits/1052 covered entity audits)
- Two thirds of HRSA hospital audits have been of DSH hospitals (548 DSH audits/824 hospital audits), even though they account for less than half of enrolled hospitals
- Approximately 49% of all DSH hospitals in the 340B program have been audited (548 DSH audits/1,124 DSH hospitals enrolled in 340B as of 1/17/19)

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Hospital Audit Findings Over Time

	FY12	FY13	FY14	FY15	FY16	FY17	FY18*	FY19**
No Findings	42%	21%	18%	20%	27%	34%	32%	75%
Findings	58%	79%	82%	80%	73%	66%	68%	25%
Total Hospital Audits	33	72	79	158	155	160	155	12

**4 additional covered entity audits expected*
***187 additional covered entity audits expected*

340B HEALTH 7

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Specific Hospital Audit Findings

	FY12	FY13	FY14	FY15	FY16	FY17	FY18*	FY19**
Diversion	33%	58%	61%	50%	53%	51%	39%	8%
Duplicate Discount	30%	21%	23%	23%	22%	23%	28%	8%
Inaccurate Medicaid Exclusion File	-	-	-	3%	5%	5%	8%	0%
Inaccurate Database	24%	50%	48%	44%	30%	28%	29%	8%
GPO Exclusion	-	1%	12%	11%	8%	4%	1%	0%

340B HEALTH

**4 additional covered entity audit expected*
***187 additional covered entity audits expected*

9

Manufacturer Audits

Manufacturer Audit Guidelines			
May only conduct after showing of "reasonable cause"	Manufacturer inquiries to covered entity may help support "reasonable cause"	Important for covered entities to respond to manufacturer inquiries, failure to respond could result in audit	Details are not publicly available

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37

Consequences of non-compliance

Repayment of discount to manufacturer

Removal from 340B Program

Possible Civil Monetary Penalties for knowing & intentional violations

Potentially false claim liability (ripe for *qui tam* actions?)

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38

Develop a crosswalk from MCR to EMR and HRSA registration

Understanding the Medicare Cost Report

Apexus 340B Prime Vendor PROGRAM

Purpose: This tool is intended to help hospitals understand the key areas of the Medicare Cost Report that HRSA reviews when determining 340B eligibility.

Background: HRSA uses a hospital's Medicare Cost Report (MCR) when validating eligibility information for hospitals, both during registration and also during audits. This tool helps identify areas of the MCR that are important for determining:

- Eligibility type and status
- CE information (address, provider number, etc)
- Eligibility of child sites and service lines

Medicare Cost Report Worksheets

	Information used by HRSA	Conveys Parent Site Information	Conveys Child Site Information
Worksheet S	Important information about cost report filing (dates, provider number, signature)	X	X
Worksheet S-2	Parent address; control type	X	X
Worksheet E, Part A	DSH %	X	X
Worksheet A	Net expenses for eligible services/clinics	X	X
Worksheet C	Outpatient charges for eligible services/clinics	X	X

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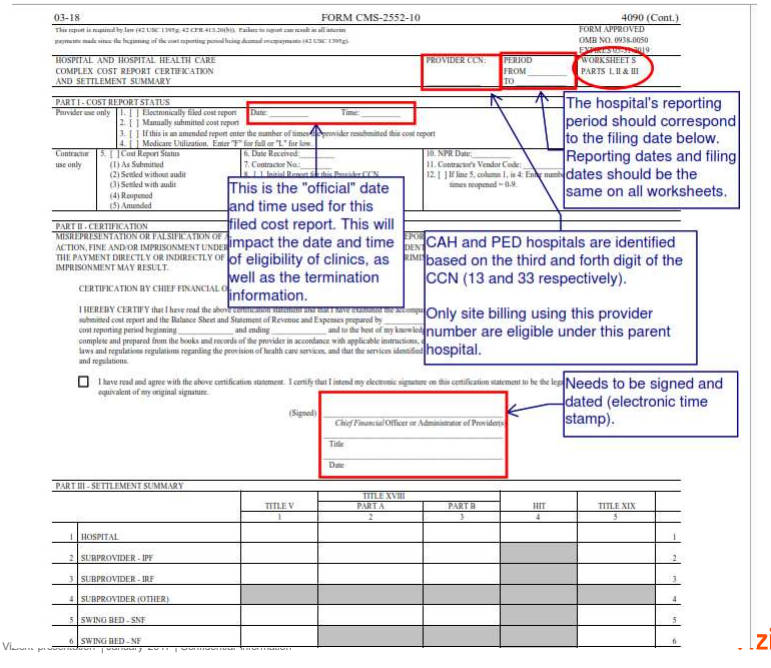

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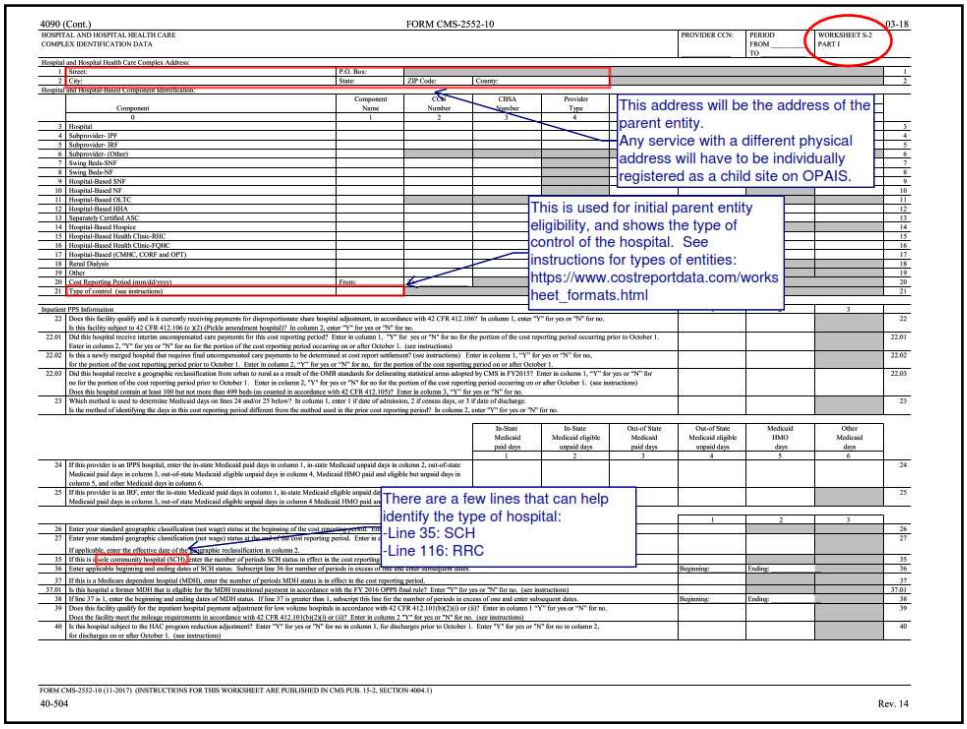


4090 (Cont.) FORM CMS-2552-10 03-18

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

PROVIDER CCN: | PERIOD FROM ____ TO ____ | WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1 Street: | P.O. Box: | 1
2 City: | State: | ZIP Code: | County: | 2

Hospital and Hospital-Based Component Identification:

	Component 0	Component Name 1	CCN Number 2	CBSA Number 3	Provider Type 4	
3	Hospital					3
4	Subprovider- IPF					4
5	Subprovider- IRF					5
6	Subprovider- (Other)					6
7	Swing Beds-SNF					7
8	Swing Beds-NF					8
9	Hospital-Based SNF					9
10	Hospital-Based NF					10
11	Hospital-Based OLTC					11
12	Hospital-Based HHA					12
13	Separately Certified ASC					13
14	Hospital-Based Hospice					14
15	Hospital-Based Health Clinic-RHC					15
16	Hospital-Based Health Clinic-FQHC					16
17	Hospital-Based (CMHC, CORF and OPT)					17
18	Renal Dialysis					18
19	Other					19
20	Cost Reporting Period (mm/dd/yyyy)	From:				20
21	Type of control (see instructions)					21

This address will be the address of the parent entity. Any service with a different physical address will have to be individually registered as a child site on OPAIS.

This is used for initial parent entity eligibility, and shows the type of control of the hospital. See instructions for types of entities: https://www.costreportdata.com/worksheet_formats.html

Inpatient PPS Information

22	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR 412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR 412.106 (c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					3	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY'2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	23

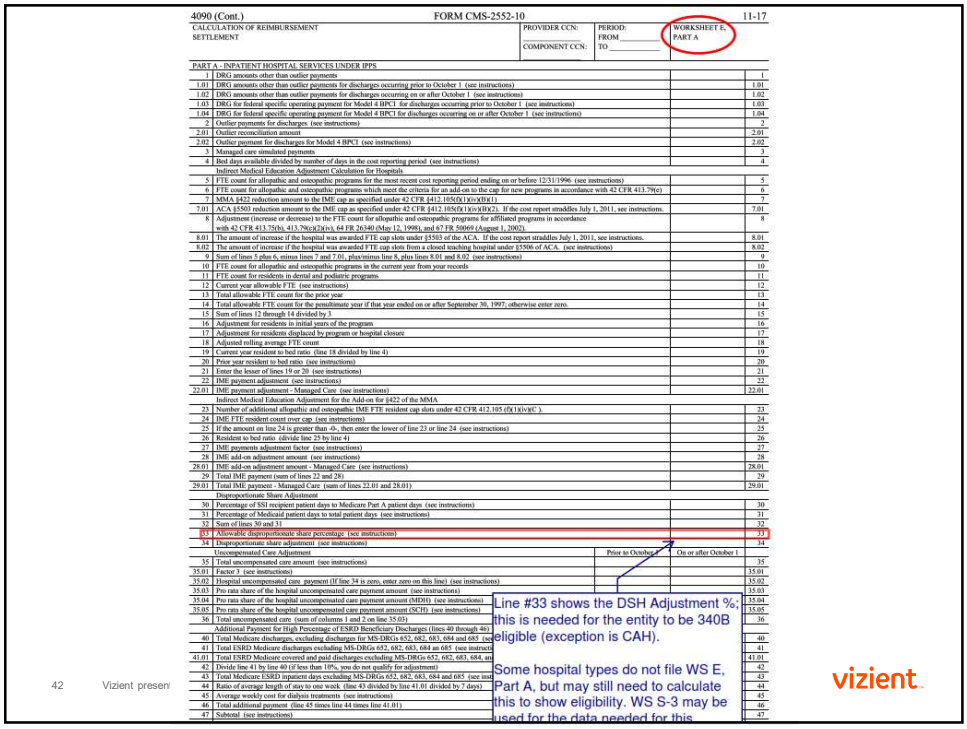
		In-State Medicaid paid days 1	In-State Medicaid eligible unpaid days 2	Out-of State Medicaid paid days 3	Out-of State Medicaid eligible unpaid days 4	Medicaid HMO days 5	Other Medicaid days 6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4 Medicaid HMO paid and							25

There are a few lines that can help identify the type of hospital:
-Line 35: SCH
-Line 116: RRC

		1	2	3	
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter in c				26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in c If applicable, enter the effective date of the geographic reclassification in column 2.				27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting				35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.				37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)				37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:		38
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				39
40	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)				40

FORM CMS-2552-10 (11-2017) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4004.1)

40-504 Rev. 14



4090 (Cont.) FORM CMS-2552-10 11-17

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER CCN: ____ COMPONENT CCN: | PERIOD: FROM ____ TO ____ | WORKSHEET E, PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS

1	DRG amounts other than outlier payments		1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1.02
1.03	DRG for federal specific operating payment for Model 4 IRPCI for discharges occurring prior to October 1 (see instructions)		1.03
1.04	DRG for federal specific operating payment for Model 4 IRPCI for discharges occurring on or after October 1 (see instructions)		1.04
2	Outlier payments for discharges (see instructions)		2
2.01	Outlier reconciliation amount		2.01
2.02	Outlier payment for discharges for Model 4 IRPCI (see instructions)		2.02
3	Managed care simulated payments		3
4	Bed days available divided by number of days in the cost reporting period (see instructions)		4
	Indirect Medical Education Adjustment Calculation for Hospitals		
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)		5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		6
7	MMA §422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2).		7
7.01	ACA §5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011, see instructions.		7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(e)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		8
8.01	The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of ACA. (see instructions)		8.02
9	Sum of lines 5 plus 6, minus lines 7 and 7.01, plus/minus line 8, plus lines 8.01 and 8.02 (see instructions)		9
10	FTE count for allopathic and osteopathic programs in the current year from your records		10
11	FTE count for residents in dental and podiatric programs		11
12	Current year allowable FTE (see instructions)		12
13	Total allowable FTE count for the prior year		13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997; otherwise enter zero.		14
15	Sum of lines 12 through 14 divided by 3		15
16	Adjustment for residents in initial years of the program		16
17	Adjustment for residents displaced by program or hospital closure		17
18	Adjusted rolling average FTE count		18
19	Current year resident to bed ratio (line 18 divided by line 4)		19
20	Prior year resident to bed ratio (see instructions)		20
21	Enter the lesser of lines 19 or 20 (see instructions)		21
22	IME payment adjustment (see instructions)		22
22.01	IME payment adjustment - Managed Care (see instructions)		22.01
	Indirect Medical Education Adjustment for the Add-on for §422 of the MMA		
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		23
24	IME FTE resident count over cap (see instructions)		24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		25
26	Resident to bed ratio (divide line 25 by line 4)		26
27	IME payments adjustment factor (see instructions)		27
28	IME add-on adjustment amount (see instructions)		28
28.01	IME add-on adjustment amount - Managed Care (see instructions)		28.01
29	Total IME payment (sum of lines 22 and 28)		29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		29.01
	Disproportionate Share Adjustment		
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		30
31	Percentage of Medicaid patient days to total patient days (see instructions)		31
32	Sum of lines 30 and 31		32
33	Allowable disproportionate share percentage (see instructions)		33
34	Disproportionate share adjustment (see instructions)		34
	Uncompensated Care Adjustment	Prior to October 1	On or after October 1	
35	Total uncompensated care amount (see instructions)			35
35.01	Factor 3 (see instructions)			35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			35.03
35.04	Pro rata share of the hospital uncompensated care payment amount (MDH) (see instructions)			35.04
35.05	Pro rata share of the hospital uncompensated care payment amount (SCH) (see instructions)			35.05
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)			
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see			40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685 (see instructi			41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684, an			41.01
42	Divide line 41 by line 40 (If less than 10%, you do not qualify for adjustment)			42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see inst			43
44	Ratio of average length of stay to one week. (line 43 divided by line 41.01 divided by 7 days)			44
45	Average weekly cost for dialysis treatments (see instructions)			45
46	Total additional payment (line 45 times line 44 times line 41.01)			46
47	Subtotal (see instructions)			47

Line #33 shows the DSH Adjustment %, this is needed for the entity to be 340B eligible (exception is CAH).

Some hospital types do not file WS E, Part A, but may still need to calculate this to show eligibility. WS S-3 may be used for the data needed for this.

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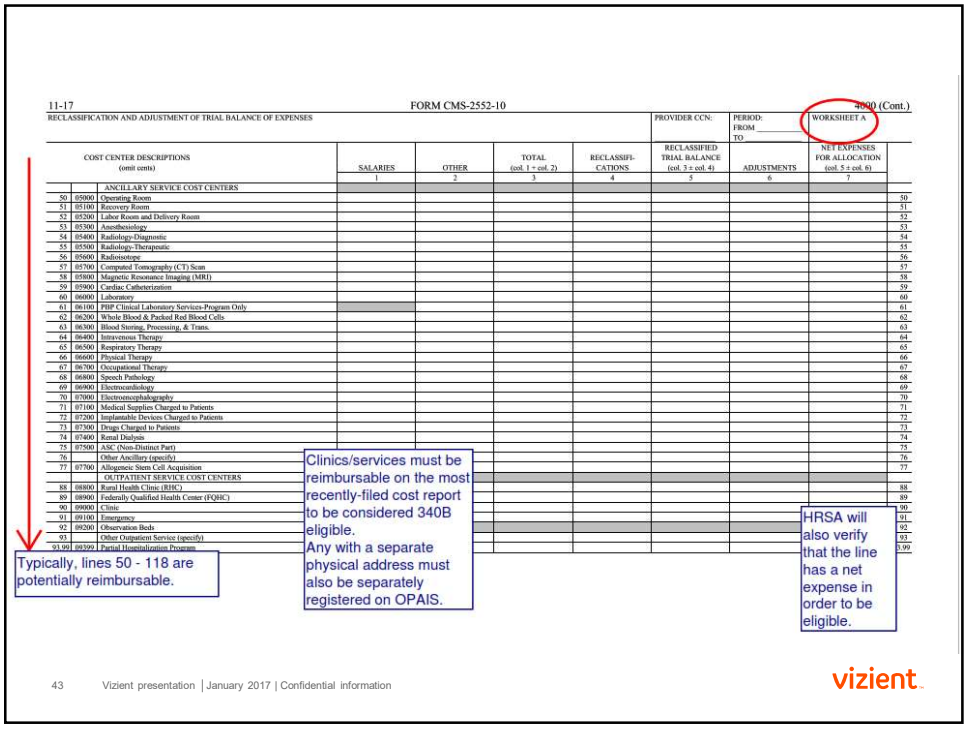

11-17 FORM CMS-2552-10 4000 (Cont.)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES — PROVIDER CCN: — PERIOD: FROM ____ TO ____ — WORKSHEET A

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI-CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6) 7	
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room								50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology								53
54	05400	Radiology-Diagnostic								54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)								58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory								60
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.								63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy								65
66	06600	Physical Therapy								66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology								69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients								72
73	07300	Drugs Charged to Patients								73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
77	07700	Allogeneic Stem Cell Acquisition								77
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic								90
91	09100	Emergency								91
92	09200	Observation Beds								92
93		Other Outpatient Service (specify)								93
93.99	09399	Partial Hospitalization Program								3.99

Typically, lines 50 - 118 are potentially reimbursable.

Clinics/services must be reimbursable on the most recently-filed cost report to be considered 340B eligible.
Any with a separate physical address must also be separately registered on OPAIS.

HRSA will also verify that the line has a net expense in order to be eligible.

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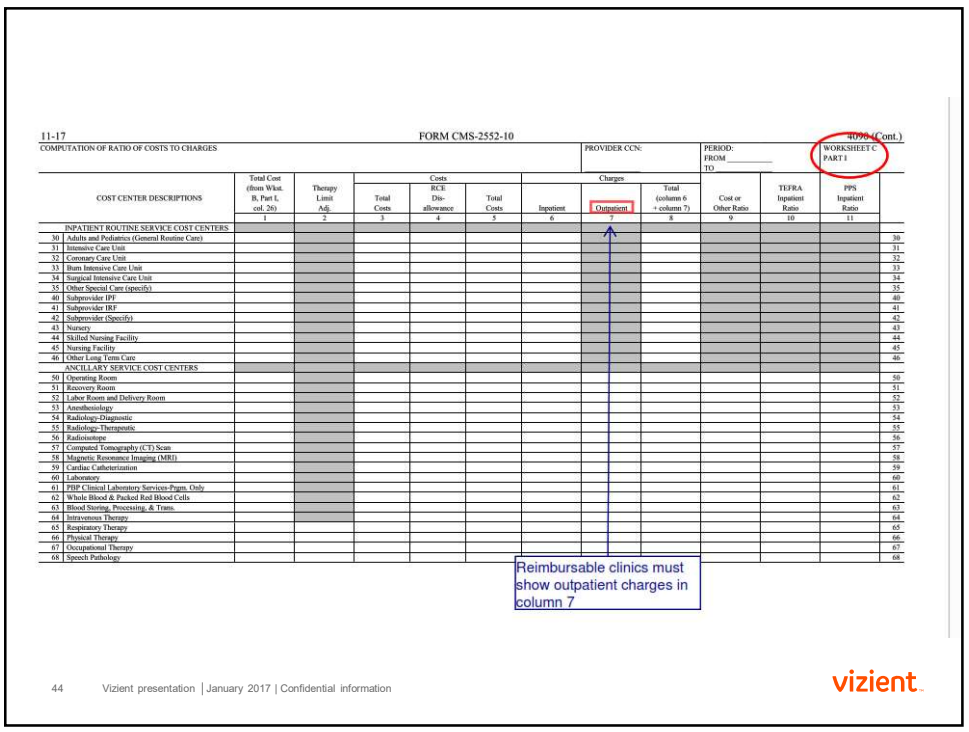

11-17 FORM CMS-2552-10 4000 (Cont.)

COMPUTATION OF RATIO OF COSTS TO CHARGES — PROVIDER CCN: — PERIOD: FROM ____ TO ____ — WORKSHEET C PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26) 1	Therapy Limit Adj. 2	Costs: Total Costs 3	Costs: RCE Dis-allowance 4	Costs: Total Costs 5	Charges: Inpatient 6	Charges: Outpatient 7	Total (column 6 + column 7) 8	Cost or Other Ratio 9	TEFRA Inpatient Ratio 10	PPS Inpatient Ratio 11	
	INPATIENT ROUTINE SERVICE COST CENTERS												
30	Adults and Pediatrics (General Routine Care)												30
31	Intensive Care Unit												31
32	Coronary Care Unit												32
33	Burn Intensive Care Unit												33
34	Surgical Intensive Care Unit												34
35	Other Special Care (specify)												35
40	Subprovider IPF												40
41	Subprovider IRF												41
42	Subprovider (Specify)												42
43	Nursery												43
44	Skilled Nursing Facility												44
45	Nursing Facility												45
46	Other Long Term Care												46
	ANCILLARY SERVICE COST CENTERS												
50	Operating Room												50
51	Recovery Room												51
52	Labor Room and Delivery Room												52
53	Anesthesiology												53
54	Radiology-Diagnostic												54
55	Radiology-Therapeutic												55
56	Radioisotope												56
57	Computed Tomography (CT) Scan												57
58	Magnetic Resonance Imaging (MRI)												58
59	Cardiac Catheterization												59
60	Laboratory												60
61	PBP Clinical Laboratory Services-Prgm. Only												61
62	Whole Blood & Packed Red Blood Cells												62
63	Blood Storing, Processing, & Trans.												63
64	Intravenous Therapy												64
65	Respiratory Therapy												65
66	Physical Therapy												66
67	Occupational Therapy												67
68	Speech Pathology												68

Reimbursable clinics must show outpatient charges in column 7

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OPA University Hospital
FY201 Trial Balance 7/1/2010-6/30/12

Dept ID	Clinic name	CR Line	Salary Expenses	Non-Salary Expenses	Total Expenses	Inpatient Rev	Outpatient Rev	Total Pat Revenue
H0122	Hand Clinic	50	$ 50.00	$ 865.00	$ 915.00	$ 452.00	$ 879.00	$ 1,331.00
H0123	Physical Therapy Clinic	50	$ 76.00	$ 367.00	$ 443.00	$ 586.00	$ 846.00	$ 1,432.00
H0124	Occupational Therapy Clinic	50	$ 23.00	$ 298.00	$ 1,358.00	$ 553.00	$ 254.00	$ 2,763.00
H0125	Outpatient Pediatric Therapy	50	$ 138.00	$ 442.00	$ 580.00	$ 125.00	$ 564.00	$ 689.00
		total	$ 287.00	$ 1,972.00	$ 2,259.00	$ 1,716.00	$ 2,543.00	$ 5,727.00
H1123	Neurology Clinic	90	$ 586.00	$ 984.00	$ 1,570.00	$ 852.00	$ 789.00	$ 1,641.00
H3021	Eye Institute	90	$ 423.00	$ 256.00	$ 679.00	$ 456.00	$ 654.00	$ 1,110.00
H2561	Dermatology Clinic	90	$ 46.00	$ 872.00	$ 2,249.00	$ 213.00	$ 321.00	$ 2,751.00
H5543	Radiology Clinic	90	$ 986.00	$ 423.00	$ 1,409.00	$ 852.00	$ 258.00	$ 1,110.00
H2614	Cardiology Clinic	90	$ 365.00	$ 5,896.00	$ 6,261.00	$ 963.00	$ 369.00	$ 1,332.00
		total	$ 2,406.00	$ 8,431.00	$ 10,837.00	$ 3,336.00	$ 2,391.00	$ 5,727.00
H1234	Pain Clinic	90	$ 231.00	$ 714.00	945			
H2345	OBGYN Associates	90	$ 462.00	$ 753.00	1215			
H34567	OPA ENT Clinic	90	$ 11.00	$ 357.00	2160			
H5678	Surgery Clinic	90.1	$ 1,852.00	$ 1,824.00	3676			

Trail Balance Sheet allows CEs to show individual clinics/services operating under a single line. It is very common to have many different clinics under line 90. In order to be eligible, each should also show expenses and outpatient revenues. Please consult the cost report instructions when adding a line to the cost center to ensure it is subscripted correctly.

Organized 340B - Advantages to System Thinking

- Understanding your 340B Program's Profitability,
- Providing meaningful program financial and community benefit through dashboards for C-Suite as a organization
- Compliance solution for the organization
- Peer to Peer Quarterly experiences / Education
- Consider the power of total spend for KHA as it relates to negotiation for greater expansion of voluntary pricing
- Create system Patient Assistance Programs to include retail and hospital participation
- Expand clinical pharmacy services to improve medication management for all patients through In-house Rx Solutions
- Contract pharmacy relationships between hospitals to provide infusions services that decreases patient travel inconvenience
- Implement Meds to Bed Program (discharge Rx)
- Improve prescription identification and capture
- Employee/dependent benefit when self insured
- Losses in Slow movers / Winners only models / Pending claims / Near misses
- Integrated Pharmacy Solutions
- Strategic focus on Specialty products

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Maintenance of Auditable Records

Maintenance of Auditable Records

Section 340B(a)(5)(C) of the PHSA requires a covered entity to permit the Secretary and certain manufacturers to audit covered entity records that pertain to the entity's compliance with 340B Program requirements. Documentation of compliance would include records of contract pharmacies used by covered entities to dispense 340B drugs. Failure to maintain the records necessary to permit such auditing is failure to meet the requirements of section 340B(a)(5) of the PHSA. A covered entity's failure to maintain auditable records is grounds for losing eligibility to participate in the 340B Program.

340B Program stakeholders have requested a standard for records retention, and HHS agrees that it is important, especially in assisting covered entities and manufacturers in preparing for audits and understanding the time and scope limitations of 340B Program audits. Therefore, HHS is proposing a record retention standard for all 340B Program records for a period of not less than 5 years, which HHS believes appropriately balances the need for a covered entity to document its compliance with 340B Program requirements and the covered entity's effort and expense required to maintain records for an extended period of time. This standard would also apply to records pertaining to all child sites and contract pharmacies. In the case of termination, a terminated covered entity or associated site is expected to maintain records pertaining to compliance with 340B statutory requirements for five years after the date of termination. If during an audit, HHS

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Documentation of auditable records

- Covered Entities should be aware of self protection by maintaining auditable records for a period of 5 year retention per federal regulations
- Covered Entities should insist on custody of all records and archive as appropriate when converting split billing or Third Party Administrators
- Standard applies to records pertaining to all child sites and contract pharmacies in the case of termination
- Manufacturers may investigate records back to CE date of eligibility

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Covered Entities should create a crosswalk from their MCR to EMR to HRSA registration

Medicare Cost Report Crosswalk to Hospital EMR (SAMPLE)

Location Code (Epic Dept ID)	Patient Class	MCR Description	MCR Line	HRSA Registration Description	Dept Code (GL Code	NPI Number	Medicare Provider Number	Address	City	340B Eligible	Net Expenses (worksheet A)	Outpatient charges (worksheet C)	Specific Service/Clinic cost (Trial Balance)
100101073	Inpatient	MMC BURN CENTER	33.00	Burn Intensive Care Unit	104203	1073576740	1111111	9876 Welcome Street	Hometown	Y	$ 6,168,817.00	$ 25,947,655.00	$ 5,831,865.98
100101074	Inpatient	MMC 4E SHORT STAY	30.00	Adults and Pediatrics (General Routine Care)	104400	1073576740	1111111	9877 Welcome Street	Hometown	Y	$ 28,290,968.60	$ 37,475,300.00	$ 1,338,359.66
100101075	Mixed	MMC BURN THERAPY	90.12	Burn Clinic	105524	1073576740	1111111	9878 Welcome Street	Hometown	Y	$ 1,651,682.43	$ 6,994,633.00	$ 1,320,489.43
100101076	Mixed	MMC BURN OT	90.12	Burn Clinic	105524	1073576740	1111111	9879 Welcome Street	Hometown	Y	$ 1,651,682.43	$ 6,994,633.00	$ 1,320,489.43
100101077	Mixed	MMC BURN PT	90.12	Burn Clinic	105524	1073576740	1111111	9880 Welcome Street	Hometown	Y	$ 1,651,682.43	$ 6,994,633.00	$ 1,320,489.43
100101080	Emergency	MMC ED ADULT	91.00	Emergency	105482	1073576740	1111111	9881 Welcome Street	Hometown	Y	$ 13,930,569.59	$ 137,900,608.00	$ 12,846,999.96
100101081	Emergency	MMC ED PEDS	91.01	Pedo ER	105484	1073576740	1111111	9882 Welcome Street	Hometown	Y	$ 4,798,812.52	$ 34,794,472.00	$ 4,798,812.52
100101082	Emergency	MMC ED BURN	91.02	Burn ER	104203	1073576740	1111111	9883 Welcome Street	Hometown	Y	$ 241,866.68	$ 9,770,538.00	$ 241,866.68
100101101	Mixed	MMC LAB	60.00	Laboratory	105420	1073576740	1111111	9884 Welcome Street	Hometown	Y	$ 14,285,843.21	$ 381,996,560.00	$ 14,285,843.21
100101102	Mixed	MMC ECHO LAB	69.00	Electrocardiology	105451	1073576740	1111111	9885 Welcome Street	Hometown	Y	$ 226,573.41	$ 9,239,622.00	$ 226,573.41
100101103	Mixed	MMC CATH LAB	54.01	Cardiac Cath	105460	1073576740	1111111	9886 Welcome Street	Hometown	Y	$ 3,037,939.40	$ 8,563,635.00	$ 3,037,939.40
100101104	Mixed	MMC MICROBIOLOGY	60.00	Laboratory	105420	1073576740	1111111	9887 Welcome Street	Hometown	Y	$ 14,285,843.21	$ 381,996,560.00	$ 14,285,843.21
100101110	Mixed	MMC RAD CT	57.00	Computed Tomography (CT) Scan	105541	1073576740	1111111	9888 Welcome Street	Hometown	Y	$ 1,373,479.41	$ 104,396,629.00	$ 1,373,479.41
100101112	Mixed	MMC RAD MRI	58.00	Magnetic Resonance Imaging (MRI)	105543	1073576740	1111111	9889 Welcome Street	Hometown	Y	$ 665,380.86	$ 20,838,190.00	$ 665,380.86
100101114	Mixed	MMC RAD NUCMED	54.05	Nuclear Medicine	105545	1073576740	1111111	9890 Welcome Street	Hometown	Y	$ 338,267.74	$ 1,876,284.00	$ 338,267.74
100101115	Mixed	MMC RAD SPECIAL	54.06	Angiography	105546	1073576740	1111111	9891 Welcome Street	Hometown	Y	$ 1,524,387.12	$ 6,349,397.00	$ 1,524,387.12
100101116	Inpatient	MMC RAD PICC	13.00	Nursing Administration	107603	1073576740	1111111	9892 Welcome Street	Hometown	N	$ 6,849,603.14	$ -	$ (3,851.81)
100101117	Mixed	MMC RAD ULTRASOUND	54.03	Ultrasound	105544	1073576740	1111111	9893 Welcome Street	Hometown	Y	$ 2,710,769.84	$ 45,782,071.00	$ 2,710,769.84
100101118	Mixed	MMC RAD DIAGNOSTIC	54.00	Radiology-Diagnostic	105542	1073576740	1111111	9894 Welcome Street	Hometown	Y	$ 2,465,237.98	$ 44,564,568.00	$ 1,590,200.74

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Thank you

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