Minnesota Hospital Association

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Representative Tina Liebling
Chair, Health Finance and Policy Committee
Re: HF 8 and the impacts to the Federal 340B Drug Pricing Program

March 12, 2021
Sent Electronically

Please note: this letter was written prior to the HF 8 DE1 amendment being posted on Thursday afternoon. We appreciate Representative Liebling's efforts to address impacts to the 340B Program, however the newly proposed Disproportionate Share Payments in the amendment are not a substitute for 340B savings.

Madam Chair and Members of the Health Finance and Policy Committee,

We are reaching out to you today on behalf of the Minnesota Hospital Association (MHA) regarding our concerns with the impacts of HF 8 on the Federal 340B Drug Pricing Program (340B). HF 8 proposes to transfer Minnesota's managed care Medicaid pharmacy benefit to a fee-for-service (FFS) model. While it is not explicitly stated in the bill, the transfer from managed care to FFS indirectly triggers a federal rule that will eliminate millions of dollars in savings on managed care Medicaid drugs for eligible safety-net providers that participate in 340B. Although we understand the need to address unchecked pharmaceutical costs in Minnesota, HF 8 would harm patient access to discounted prescription drugs and would also significantly damage vital funding for patient care and services at safety net hospitals across Minnesota.

340B Savings and Covered Entities: Created by Congress in 1992, 340B requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at significantly discounted prices to specific health care providers that serve many uninsured and low-income patients. Such providers referred to as 340B covered entities include disproportionate share and children's hospitals, critical access hospitals, federally qualified health centers, Ryan White HIV clinics and other safety-net providers across Minnesota.

Covered entities benefit from 340B in two ways. First, when discounted drugs are dispensed to uninsured patients, covered entities bear less cost and can discount the drug price for the patient. Second, when discounted drugs are dispensed to insured patients – including managed care Medicaid enrollees – the covered entities get to use the payment differential above the discounted price of the drug to subsidize critical patient care services and costs.

Minnesota's hospitals and other covered entities use 340B savings as Congress intended – to stretch scarce federal resources to provide more comprehensive services to more eligible patients. The discounts are often extended directly to patients, but the savings are also used to provide necessary services to patients for which no reimbursement is available. Some examples of how Minnesota's hospitals use 340B savings to benefit their general patient population include but are not limited to free care for uninsured patients, free vaccinations, expanded services in mental health clinics, expanded medication management programs, and expanded community health programs.

340B Savings vs. State Medicaid Rebates: On lines 2.5-2.7, HF 8 instructs the Commissioner of Human Services to, "engage in price negotiations with prescription drug manufacturers, wholesalers, or group purchasing organizations to obtain price discounts and rebates for prescription drugs for program participants." While HF 8 could generate savings for the state, it comes at the expense of 340B covered entities. Much of the potential savings will accrue to the federal government rather than remain invested in our underserved communities. When the state Medicaid agency receives the benefits of discounts on outpatient drugs via drug rebates, these savings must be shared with the Centers for Medicare and Medicaid Services (CMS) per the federal match. At a minimum, 50% of the savings are returned to CMS. In contrast, if 340B covered entities retain the savings, 100% of the dollars stay in Minnesota and are reinvested into activities that increase access to medically underserved patients across our state.

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For example, a Critical Access Hospital in Minnesota fills a prescription for a managed care Medicaid enrollee and the total savings available on that drug is $10 via either a 340B discount to the hospital or a drug rebate to the state. If the state takes the $10 rebate, between at least $5 and $9 is reverted to the Federal government per the federal match, reducing the total savings that actually accrue to the state to between $1 and $5. However, if the $10 is retained by the hospital via 340B savings, the full $10 dollars stays in Minnesota and is used to increase access to patient care and services. Due to this, we consider 340B far superior to the drug rebate program.

HF 8 Eliminates Millions of Dollars in 340B Savings per Federal Regulation: In February 2016, CMS issued a final regulation – commonly called the "Medicaid Covered Outpatient Drug Rule" – on the Medicaid drug rebate program. This regulation stated that under Medicaid FFS, states must reimburse 340B covered entities for drugs at an amount equal to their "actual acquisition cost" (AAC) plus an "appropriate professional dispensing fee." By transferring the state's Medicaid pharmacy benefit entirely to FFS, HF 8 triggers this federal regulation and 340B covered entities are no longer able to retain any 340B savings on Medicaid FFS drugs.

Under the proposed FFS arrangement in HF 8, covered entities effectively pass the 340B discount to the Minnesota Department of Human Services when billing FFS Medicaid. However, the state must refrain from seeking a Medicaid rebate on FFS covered drugs pursuant to the Medicaid Exclusion File (MEF). Therefore, under HF 8 no 340B savings are generating or subsequently invested into patient care and the state is not able to pursue a drug rebate. This is far from ideal.

Other State Experiences with Prescription Drug Purchasing Programs and 340B: We recognize that other states such as West Virginia and South Dakota have implemented similar programs as to what is proposed in HF 8. Although these states have experienced relative success, both states had to address issues with 340B savings similar to what we discuss in this letter. Further, California and New York have both recently suspended the planned April 2021 implementation of their respective prescription drug purchasing programs due complications including the same impact to 340B savings that would occur under HF 8. Both New York and California elected to account for the impact to 340B program by each creating a $100 million supplemental state grant program to distribute funds to covered entities.

COVID-19 has stressed the importance of and need for more programs that support our most vulnerable patients and communities. 340B is an established and successful program that Minnesotans rely on to support their health care needs, especially access to significantly discounted prescriptions medications.

MHA is eager and ready to work with you and this Committee to ensure that 340B is protected, access to discounted medications is sustained, and the ability for hospitals and all 340B Covered Entities to invest in services for their patients remains secure. Thank you for your consideration.

Sincerely,

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