Maine Hospital Association

MAINE'S LEADING
VOICE FOR HEALTHCARE

March 12, 2020

Meg Garratt-Reed
Senior Advisor for Coverage and Affordability
Maine Department of Health and Human Services
109 Capitol Street, 11 State House Station
Augusta, ME 04333-0011

Dear Ms. Garratt-Reed,

Please accept this Letter of Comment regarding **The State of Maine Canadian Drug Importation Program Considerations Position Paper, prepared by Horvath Health Policy.**

The Maine Hospital Association represents all 36 community-governed hospitals in the state including 33 general acute care hospitals, 2 private psychiatric hospitals, and 1 acute rehabilitation hospital. In addition to the acute hospital facilities, our hospitals represent 11 home health agencies, 18 skilled nursing facilities, 19 nursing facilities, 12 residential care facilities, and more than 300 physician practices employing thousands of medical professionals.

This position paper examines the various aspects of the state of Maine developing a system by which the State would potentially reimport prescription drugs from Canada. I attended the first two meetings of the Drug Reimportation Task Force and it is quite clear from those meetings, as well as the position paper, that establishing such a system will to be extremely complicated and will likely take many years to accomplish. An example of such complexity that was discussed at the last Task Force meeting is the need to inspect the reimported drugs immediately after they cross the border from Canada. In addition to the expense associated with this testing, it also became apparent that the testing needs to be done in a specialized facility that would require significantly renovating an existing facility or, more likely, a new building that would need to be constructed in close geographic proximity to the border.

The position paper examines multiple other complexities that would be equally as difficult to accomplish as creating a new testing facility along with the associated protocols. For this reason, we would suggest that the Department defer the important questions, such as managing supply chain price mark-ups and how 340B entities could be managed, until a later date. The 340B program is highly regulated by the federal government and extraordinarily complex. The program also works extremely well for Maine's hospitals as is so we would encourage the Department not to make any decisions or take any actions that would jeopardize hospital's participation in the 340B program.

Page 8 of the Position Paper poses the following question:

How should 340B entities and drugs be handled? 340B hospitals are required under federal rules to purchase all of their drug product from one 340B supplier. Even though it is not clear that the 340B rule would apply to non-U.S. products, these hospitals may need to continue to purchase the U.S. product depending on how the federal law is interpreted.

Option 1:

Allow 340B entities to continue to use the U.S. 340B supply chain and products but require them to bill participating payers for reimbursement not to exceed the imported price.

Option 2:

Allow 340B entities to continue to use the U.S. 340B supply chain and products and bill all payers (importation participants and others) at the market price as they do now.

If the Department chooses not to defer the questions of managing the supply chain mark up and 340B then we would recommend that the Department choose Option 2 because we believe that option would cause the least disruption to the existing and successful 340B program.

Thank you for the opportunity to comment on this position paper and please feel free to contact me with any questions.

Sincerely,

David S. Winslow
Vice President of Financial Policy