Hello Senator Lyons,

My name is Dawn Cogger, and I have been following the progress of H-266 from the beginning. Gifford has both a Critical Access Hospital (CAH) as well as a Federally Qualified Health Center (FQHC) and I manage the 340B operations of both entities every day.

Twelve years ago, I started working as a retail pharmacy technician. After earning my national certification, I went into hospital pharmacy, pharmacy purchasing, and finally 340B.

Reporting Requirements at Section 2

As a 340B Hospital, Gifford is all for transparency. We can tell you how much financial assistance was provided as per our contract with the State of Vermont, one of the requirements of our eligibility for the 340B program - $2.23 million total services in 2024. It would require further data analysis (and time away from patients) to pull just the drug charges out of this number though.

However, it would be impossible for Gifford to break down the exact amount of drug payment by payor. The Vermont House removed that language for some valid reasons. They wanted data to be accurate, actionable, and non-burdensome. To attempt to report this information would cause an extremely costly administrative burden for less than accurate data.

You see, some insurances pay an upfront negotiated "bundled" price for a whole procedure, which includes the drugs. How much of this bundled payment is allocated for just the drug is unknown. Some insurances negotiate lower prices to settle the patient bills they receive. How does this affect the amount paid for the drug(s) used? Another unknown. Pharmaceuticals that are part of an outpatient visit are not even billed separately to Medicare due to their reimbursement policies.

Also, most smaller hospitals like Gifford do not have software systems in place for this. In-house 340B pharmacy numbers are managed by one or more people on Excel sheets. The patient record associated with each drug would have to be accessed manually to see who paid what, if that information was available. This would take an exorbitant amount of time considering the hundreds of drugs dispensed each month.

Witnesses have pointed to Minnesota reporting requirements. While Minnesota received a 90% response rate, the data was not complete. The report states:

- "MDH considers this first-year reporting successful with more than 90% of Covered Entities reporting data. However, nearly every submission had data quality issues requiring MDH to conduct extensive follow-up efforts with reporting entities. MDH identified three major

data challenges with the most important being the failure by most entities to report data for office-administered drugs (dispensed to a provider and administered in an outpatient setting)."

Minnesota's proposed fix does not appear to fix the problem at all:

- "Step 1: Retrieve the payment received amounts ($) of all J-codes that have service line payment amounts for the drugs (i.e. separately payable). ▪ Note: This step excludes any drugs paid through a bundled payment, including inpatient Diagnosis-Related Groups (DRGs) or bundled outpatient procedures.

Bundled payments are excluded in Minnesota because they include the prescription drug and we are unable to separate the drug out from the payment, which is why we can't report on it."

Recommendation:

Pass the bill as read in the Senate and consider how non-burdensome, accurate and actionable data could be reported in the future and by whom—either through wholesalers or manufacturers.