MetroHealth

Sherrie Dixon Williams, M.D.
Past President of the Medical Staff
Pharmacy and Therapeutics (P&T) Committee, Chair
The MetroHealth System
HB 482 -Proponent Testimony
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Chairman Lipps, Ranking Member Boyd and members of the House Health Committee, on behalf of The MetroHealth System, I am pleased to offer testimony today in support of House Bill 482. I would like to thank the sponsors of this bill, Representatives Clites and Manchester, for bringing forward such important legislation to protect the 340B program, which helps serve our vulnerable patient population.

Background

MetroHealth is Northeast Ohio's safety-net hospital, caring for the most vulnerable members of our community, and we rely on our 340B savings to provide high-quality, comprehensive care for our patients. MetroHealth has a staff of over 7,800 that provides care at four hospitals, four emergency departments and more than 20 health centers and 40 additional sites throughout the region. MetroHealth is home to Cuyahoga County's most experienced Level I Adult Trauma Center, verified since 1992, and Ohio's only adult and pediatric trauma and burn center. Last year, MetroHealth served 300,000 patients at more than 1.4 million visits in its hospitals and health centers, 75 percent of them uninsured or covered by Medicare or Medicaid.

The 340B Program was created in 1992 as part of the Public Health Services Act. It is a federal program that helps safety-net healthcare providers stretch scarce federal resources as far as possible to reach more eligible patients and provide more comprehensive services[1]. The MetroHealth Medical Center has participated in the 340B Program from its inception.

This federal program requires drug manufacturers to provide discounted drugs to public and non-profit health care providers that serve a large percentage of poor and underserved patients. These discounts are provided directly from manufacturers to providers—NO federal or state tax dollars are expended to provide safety-net hospitals and clinics this critical relief from high drug costs.[2]

[1] H.R. Rep. No. 102-384(II), at 12 (1992).
[2] Minimal administration costs vis a vis federal agency oversight notwithstanding.

Over the last several years, 340B covered entities have experienced a shift in pharmacy benefit manager (PBM) contracting strategies that discriminate against 340B covered entities. These strategies are designed to exclude 340B covered entities from pharmacy networks. Rather than 340B savings accruing to organizations that provide care to a disproportionate share of low income and uninsured patients, these strategies result in 340B savings accruing to PBMs that have little-to-no involvement in patient care. Examples of such strategies include charging covered entities higher fees or reducing the reimbursed amount for drug costs, effectively driving 340B pharmacies out of the network. Every dollar of MetroHealth's 340B savings that accrue to PBMs are dollars taken from patient assistance programs, free and reduced-cost care to uninsured and underinsured patients, school-based health clinics, and our initiatives to address maternal and infant mortality and social determinants of health. This diversion was not Congress's intent when creating the 340B program.

Quality Care for Vulnerable Patient Populations

Vulnerable patient populations rely on 340B benefits to maintain access to vital treatments and quality care. Patient populations that live in communities with poor socioeconomic conditions rely on 340B covered entities to access treatments from locations that are near their chosen primary physician or practitioner. Such patients can choose their providers and pharmacists, just like patients who live in more affluent neighborhoods. Having access to providers who are in the community also reduces the need for non-health care services that are often in short supply, such as transportation, internet, and childcare. Medication therapy adherence rates and health outcomes worsen when patients are unable to access health services in their community.

Additionally, as a whole, patients in Ohio who rely on the 340B program are sicker than the average patient. Access to affordable medications for those with HIV/AIDs, tuberculosis, mental illness, or substance abuse are often a matter of life and death. For example, a Health Affairs study[3] found that antivirals were 10 times more likely and specialty drugs 20 times more likely to be dispensed through the 340B program, relative to all drugs dispensed through a pharmacy. These patients rely on close coordination between their physician and pharmacist of choice and would be subject to poorer outcomes if they had to navigate different systems to receive treatment. Access and close coordination between providers are made available by the 340B program.

Reinvestments in Vulnerable Communities

When the 340B savings accrue to health systems like MetroHealth, they are reinvested in care that benefits patients, in particular the low-income, uninsured and underinsured populations. 340B covered entities often reinvest in new or expanded models of care and broaden these offerings to different patient populations. 340B hospitals are more likely to provide a more comprehensive set of specialized and community services relative to non-

[3] https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.0833

340B hospitals.[4] Examples include community-based health initiatives, behavioral health and other vital health-related programs that serve particularly vulnerable populations, and outpatient treatment for drug and alcohol abuse, trauma care, HIV care, psychiatric emergency services, tobacco treatment programs, and health screenings. These services are available to all patients but are oftentimes most important for patients who live in communities with poor socioeconomic conditions. Without the 340B savings, these types of community benefits would be eliminated and that would have an adverse impact on poorer communities.

The 340B savings have also been vital in helping MetroHealth preserve critical healthcare capacity in the midst of the COVID 19 pandemic. In a very short period of time, and despite the uncertainties around third party reimbursement, we were able to launch a COVID-19-dedicated hotline. The hotline has allowed us to expand efforts to identify symptomatic patients and manage their care and treatment safely in their homes, without the need for a costly inpatient hospital admission. The hotline has received approximately 40,000 calls from 17 different Ohio counties since mid-March, with over 20,000 of those calls resulting in a follow-up telehealth visit. Patients are diagnosed and told how to treat their symptoms, and, in many cases, patients are referred for COVID-19 testing or told to self-quarantine based on their COVID-19-like symptoms. We believe that this hotline is critical to preventing the spread of disease and to diverting likely COVID-19 positive patients from visiting the hospital or provider's office, thereby preserving critical healthcare capacity in Northeastern Ohio. These efforts would not have been possible so quickly without 340B savings.

Preserving & Strengthening the Safety Net

The 340B program also helps safety net hospitals maintain their mission of providing care to all patients, regardless of insurance coverage. The savings offset large losses for disproportionate share or "DSH" hospitals, which provide the overwhelming amount of care to low income and uninsured populations. DSH hospitals that participate in the 340B program provide 60 percent of all uncompensated care in the United States while representing only 38 percent of acute care hospitals and has an average low-income patient load of 41.8 percent compared with 27 percent for non-340B hospitals.[5] Medicare cancer patients at 340B hospitals are 50 percent more likely to be low income and 33 percent more likely to be disabled than those at non-340B hospitals.[6] Additionally, Medicare patients at 340B hospitals are 66 percent more likely to be black, 43 percent more likely to be low income and 29 percent more likely to be disabled than those at non-340B hospitals.[7] Without savings from the 340B program, many safety net hospitals would struggle to stay open and the uninsured, and minority populations would lose access to a regular source of healthcare.

[4] https://www.340bhealth.org/files/340B_Report_03132018_FY2015_final.pdf
[5] https://www.healthaffairs.org/do/10.1377/hblog20180321.524566/full/
[6] MedPAC. Report to Congress. March 2020.
[7] https://www.340bhealth.org/files/340B_Patient_Characteristics_Report_FINAL_04-10-19.pdf

Bottomline: If these trends in PBM contracting continue and 340B savings are diverted from their intended purpose, the results will be worse health outcomes for already vulnerable populations.

In Support of HB 482

HB 482 is an important step in protecting the benefits from the 340B program. The bill would prohibit health insurers, Medicaid managed care plans, and PBMs from including any of the following provisions in a contract with a 340B covered entity[8]:

- A reimbursement rate for a prescription drug that is less than the national average drug acquisition rate for the drug, or, if that rate is not available, a reimbursement rate that is less than the wholesale acquisition cost of the drug, measured at the time the drug is administered or dispensed;
- A fee on a 340B provider that is not imposed on a non-340B provider;
- A fee on a 340B provider that exceeds the same fee imposed on a non-340B provider;
- A dispensing fee reimbursement that is less than the dispensing fee for terminal distributors of dangerous drugs the Medicaid Director establishes for the Medicaid program under current law.

We are concerned that if these contracting strategies are permitted to continue, the benefits from the 340B program will be diverted away from those for whom it was intended. Discriminatory contract terms directly undermine the intent of the 340B program and harm 340B safety-net providers and their patients. The provisions of HB 482 are an important first step in preserving the benefits for vulnerable patients and communities.

Mr. Chairman, thank you for allowing me to testify today, and for all that the Committee is doing to protect the 340B program. The MetroHealth System strongly supports HB 482.

Thank you.

[8] https://www.legislature.ohio.gov/download?key=13342&format=pdf