Testimony of Jacquelyn Kilmer, CEO Harlem United[1] and Perry Junjulas, Executive Director Albany Damien Center[2] on behalf of the Save NY's Safety Net Coalition[3]

2023 Joint Legislative Public Budget Hearing on Health

Thank you for the opportunity to provide testimony on the FY2024 Executive Budget on behalf of Save NY's Safety Net ("SNYSN"). SNYSN is a statewide coalition of community health clinics, Ryan White HIV/AIDS Program services providers, and Medicaid HIV Special Needs Plans ("SNPs"), committed to serving vulnerable New Yorkers across the State.

We are providing this testimony specifically to address the pharmacy benefit carve-out from Medicaid Managed Care to a fee-for-service model that was adopted as part of the FY2021 budget, was delayed for two years by the legislature due to overwhelming community concerns and is scheduled to go into effect on April 1, 2023.

We remain firmly opposed to the carve-out, and the Governor's budget proposal is unworkable. We urge the legislature to enact the stakeholder approved compromise solution addressed below. The compromise is a sensible solution that satisfies the state's policy goals, protects patients, preserves the safety net and is more fiscally responsible.

The pharmacy carve-out will decimate New York's safety net system through its impact on the federal drug discount program known as 340B. Any threat to the safety net system will disproportionately impact Black and brown New Yorkers, New Yorkers with

[1] Harlem United is a member of the Save NY's Safety Net Coalition, and has been providing healthcare, housing, integrated harm reduction and supportive services to those most in need throughout Upper Manhattan and the Bronx for 35 years.

[2] Albany Damien Center is a member of the Save NY's Safety Net Coalition, and has been providing services designed to improve health, reduce stress and increase the quality of life in a supportive environment for individuals and families living with and affected by HIV/AIDS for 35 years.

[3] Both Ms. Kilmer and Mr. Junjulas have submitted a request to testify at the Hearing on behalf of the Coalition. As of the date of submission of this testimony, we understand that final decisions on who will be permitted to testify have not been made. In order to meet the deadline for submitting the testimony in advance of the Hearing, we have chosen to make the submission jointly.

low incomes, immigrants, the uninsured, those who already experience extreme health disparities—in other words, the very people most in need of the services provided by the safety net system.

The 340B program allows safety net providers to provide critical services such as low- and no-cost medications, housing assistance, food/nutrition programs, mental health counseling, substance use disorder treatment, transportation, school-based health programs, mobile medical and dental clinics and STI prevention programs to New York's most underserved residents. The 340B reimbursement mechanism funds critical health care for 2.3 million New Yorkers who receive care at community health centers (like Harlem United) and Ryan White HIV/AIDS program sites (like Albany Damien Center) statewide. If the carve-out is implemented, safety net providers will lose more than $316 million annually[4], forcing service cuts, staff layoffs, and some clinics—including those in already medically underserved communities—will be forced to close altogether.

Through the work of SNYSN, other advocates and the legislature, implementation of the carve-out was delayed for two years to allow the state and stakeholders to work together to find a solution that would both support the safety net providers and the SNPs and address the state's concerns. We are now only weeks away from the April 1, 2023 deadline and we are no further along in reaching a workable compromise with the state than we were two years ago.

The Executive Budget

The Executive Budget proposes moving forward with the carve-out, but despite references in the budget briefing book to "backfilling the loss of 340B revenues" and "making the [safety net providers] whole," there is no detail on how the state would implement the "reinvestment" in the safety net providers (even if the dollar amount was sufficient, which it is not).

The FY2024 Executive Budget Medicaid Scorecard includes the following with respect to the carve-out (for FY2024 and FY2025):

- Support for Ryan White Clinics (NYRx Reinvestment) $30 million each year [the loss to the Ryan White services providers is $56 million annually]
- Federally Qualified Health Centers and Diagnostic & Treatment Centers Supplemental Payments (NYRx Reinvestment) $125 million each year [the loss to the FQHCs is $260 million annually]
- Increase Hospital Reimbursement (NYRx Reinvestment) $212.5 million [the loss to HHC alone is in excess of $100 million annually].

The Executive Budget leaves many questions unanswered with respect to the pharmacy carve-out and the reinvestment in safety net providers, including:

[4] This amount does not include the losses to the hospitals that serve low-income New Yorkers.

- The amounts in the Medicaid Scorecard may reflect only the state's (50%) share, with the remaining 50% assumed to come from the federal government through the State Plan Amendment (SPA) that will have to be submitted to, and approved by, CMS in order to implement the payments; however, this is not clear. If the federal government does not pick up the remaining 50%, safety net providers would be left with the state share only, which is woefully inadequate.

- The fact that the reinvestment is not included in the Article VII legislation means that the reinvestment will be subject to the vagaries of the state's financial condition and budget negotiations on an annual basis. Safety net providers will have no assurance that they will receive any funds from year to year and therefore will be unable to rely on receiving these funds in order to plan and budget for operations year to year. In contrast, the revenue received by safety net providers from the 340B reimbursement mechanism is certain and bankable. When members of SNYSN raised this concern at a meeting with the Medicaid Director in late August, we were told that the plan was to include the mechanism for mitigating our losses in statutory language so that it would not be subject to the uncertainty of budget negotiations on a yearly basis, but that is not the case.

- There is no mechanism to address growth in the 340B program based on increased visit volume, changes in patient mix, changes in services or changes in drug mix.

- It is unclear what entities fall under the "Ryan White Clinics" that would be eligible to share in the reinvestment described in the Medicaid Scorecard. Does it include Ryan White medical clinics only? Non-medical Ryan White services providers? Both?

- There is no provision to address the disproportionate impact of the carve-out on the HIV Special Needs Plans, like Amida Care, the state's largest HIV SNP. The carve-out will severely reduce the administrative funds the SNPs utilize to coordinate access to whole person care for Medicaid recipients who are living with HIV.

- The timing of the payments proposed to be made to the safety net providers is unknown. Safety net providers operate on very thin margins as it is, and do not have the cash reserves or credit lines to cover the inevitable delay in payments, as no system for payments has yet been disclosed or determined.

- The reporting requirements, including potential cost reporting, or other deliverables for the FQHCs that receive the "reinvestment" are unknown, but are likely to create additional administrative burdens on already under-resourced community health centers.

- Although specific detail is missing, based on various discussions among the Medicaid Director and safety net providers, we understand that the "supplemental payments" for the FQHCs will not be utilization based (meaning they would not be tied to specific patient visits). While non-utilization based supplemental payments have been more common in the past, they are no longer considered to be best policy. We have consulted policy experts who stated that in general, it is considered bad policy to move away from a utilization-based reimbursement to a supplemental payment based on prior savings unrelated to current usage or even a primary care visit. In this case, according to the Medicaid Director, it would be based on 340B savings received in 2022 by the safety net providers who participated in the 340B program in 2022. This gives rise to the very real possibility that CMS will not approve the SPA.

- The methodology for allocating the reinvestment pool(s) among the safety net providers is unknown.

- The mechanism for payments to the Ryan White Program services providers is unknown. It has been suggested that those payments would be in the form of grants to be administered by NYSDOH AIDS Institute. However, in order to make certain of these agencies "whole," the grants would have to be in amounts that are outside of the norm in terms of dollar amount. In addition, we can safely assume that the administrative burden of reporting and other requirements that would be associated with such grants would be unmanageable for most if not all of such agencies.

What we do know is that the state's reinvestment plan is subject to CMS approval. No funds will flow to safety net providers prior to approval; therefore, safety net providers are still facing a fiscal cliff on April 1 and will have to take immediate drastic action to address that reality. As noted above, there is no guarantee that CMS will approve the payment mechanism. It could take 12 months or more for the approval process and implementation of the plan during which time safety net providers will not receive any payments. The damage to the safety net system, and to the health and well-being of the vulnerable New Yorkers that we serve, will already have been done.

The Compromise Bill

SNYSN partnered with the Public Health Plan Coalition to create compromise legislation that addresses the needs of the safety net and the state. The compromise achieves the state's policy objectives, averts disruption, preserves the safety net and saves the state money. The compromise achieves significant reforms to pharmacy benefit managers (PBMs). It keeps the pharmacy benefit in managed care and, in doing so, maintains the 340B reimbursement mechanism. The Chairs of the Senate and Assembly Health Committees have indicated their support for the compromise bill, as have some 35+ individual Assemblymembers.

How the compromise bill achieves the state's objectives

Objective 1- DOH justifies the carve-out by pointing out how it will improve the patient and provider experience. While we believe that the carve-out overall is not ultimately better for patients or providers, we have adopted elements that will improve their experience.

- Similar to the carve-out, the compromise bill adopts a single unified Preferred Drug List ("PDL") and a universal set of utilization management protocols. It eliminates the need to look at every plan to see if a drug is covered and under what circumstances. This provides a better patient and provider experience.

- The compromise bill protects patient choice by prohibiting PBMs from requiring that prescriptions get filled through a mail-order pharmacy. Patients should be able to fill their prescriptions at a local pharmacy of their choice.

- In the compromise bill, health plans will continue to be able to access pharmacy data in real-time to resolve issues that may hinder access to lifesaving medication, often while the member is at the pharmacy counter. The best the state can commit to in the carve–out is a one-day lag, which can delay access to critical medications and can mean the difference between life and death.

Objective 2- DOH justifies the carve-out by saying that it enhances the state's bargaining power to gain more supplemental rebates from drug manufacturers.

- By adopting a single PDL, the compromise bill enhances the state's bargaining power to the same degree as the carve-out. NYSDOH rather than PBMs will determine which drugs are favored giving them greater leverage over manufacturers.

- We project that the state will receive an additional 1% of supplemental rebates, just as the state hopes to achieve through the carve-out.

- We use the same mechanism to enhance the state's bargaining power without the disruption of the carve-out.

Objective 3 - DOH also promotes the carve-out on the basis that it will create more transparency in the drug supply chain, which is admittedly difficult to understand.

- The compromise bill creates the same degree of transparency by adopting the same approach to drug pricing.

- The compromise bill provides for drugs to be reimbursed at NADAC's pricing. NADAC is the National Average Drug Acquisition Cost. It is an objective, transparent, and readily accessible way to know how much a drug is being paid for across the country. This gets us away from the current approach where PBMs negotiate various confidential prices with different pharmacies.

- The compromise bill authorizes the state to determine and set a fair dispensing fee for pharmacists. Right now, dispensing fees in managed care are negotiated by PBMs, and the fees vary widely, often to the detriment of small community pharmacies.

Objective 4 - Curbing restrictive and anti-competitive PBM business practices.

- In the compromise bill, PBMs cannot restrict a pharmacy's access to other pharmacy networks. For instance, CVS will not be able to tell a community pharmacist that if they want a contract with them, they cannot also contract with Walgreens.

- In the compromise bill, PBMs cannot mandate the use of mail-order pharmacies. Frequently they own these pharmacies or have proprietary contracts with them.

- These PBM reforms are significant, and address concerns the policymakers have had for a significant period of time.

Objective 5 - DOH claims that the pharmacy carve-out reduces excessive fees paid to third-party middlemen.

- We believe that DOH's claims regarding these fees are exaggerated, but the compromise bill addresses these concerns and results in greater transparency.

- The role of PBMs will be reduced to what they do best: data analysis and transfer, claims processing, and encounter submissions.

- PBMs will not set drug prices, design utilization management protocols, or determine the PDL. As such, the compromise bill authorizes DOH to set PBM fees that reflect this reduced role.

- Another DOH concern is that too much of the 340B savings are going to the contract pharmacies with which community health centers partner within the 340B program. We dispute the exaggerated assertions about these fees; however, the compromise bill mandates a best contracting practice. Contracts will be fee based and not based on a much less transparent percentage of savings basis. This approach is preferred by HRSA, the federal agency overseeing the 340B program, and will create greater transparency on these contracts.

The compromise bill literally checks all the boxes on every stated policy objective of the carve-out. We have shared the compromise bill with the community pharmacists. It gives the community pharmacists what they've said they need from the carve-out: fair dispensing fees, objective pricing, and controls on anti-competitive PBM practices. It checks their boxes as well.

The compromise bill is the only actionable solution to break the log jam and must be included in the legislature's one-house budget bills.

Conclusion

The Executive Budget purports to address the chronic and systemic health inequities faced by millions of New Yorkers across the state with various investments and policy changes in the healthcare system. Yet the pharmacy carve-out will only exacerbate these inequities The proposed "reinvestment" will not mitigate the disastrous impact the carve-out will have on the safety net providers and the communities we serve. The services provided by the safety net providers using the savings from the 340B program are critical to reducing the persistent health disparities experienced by the people served by these safety net providers—New Yorkers who face barriers to effective disease prevention and treatment due to race, ethnicity, gender identity, sexual orientation, status as a drug user or sex worker, or other sources of bias, discrimination, and exclusion in health care delivery.

The compromise bill is a solution that checks all the boxes. It is imperative that the pharmacy carve-out and proposed "reinvestment" be rejected and be replaced with the compromise bill in the legislature's one-house budget bills and the final FY2024 budget. The health, safety and well-being of millions of vulnerable New Yorkers depend on it.

For questions or follow up, please feel free to contact Jacquelyn Kilmer by phone at 917-428-0049 or by email at jkilmer@harlemunited.org, or Perry Junjulas by phone at 518-961-0071 or email at PerryJ@AlbanyDamienCenter.org. Thank you.