Comments of Planned Parenthood of Southern New England on
Strategies and Alternative Strategies of Bailit Health Cost Containment Proposal

November 15, 2016

Planned Parenthood of Southern New England (PPSNE) would like to thank you for the opportunity to review and respond to the Bailit Health Cost Containment proposal. We understand the need to improve care quality, to reduce health inequities while improving outcomes of underserved populations, and to reduce the total cost of health care.

PPSNE provides primary and preventive care services, including essential reproductive health services every year to nearly 60,000 women and men in Connecticut, at seventeen health centers statewide. Most of our patients are between the ages of 18 and 30, and close to three-quarters are low-income.

We provide the following comments on several of the proposed recommendations, as identified below.

1A. Provide More Coordinated, Effective and Efficient Care Through CCOs

Allowing previously unrelated entities to formally join together to change care delivery models is a welcome idea. This is particularly true for younger, and relatively healthy women whose primary health care priorities often center on their reproductive health. High-quality primary and preventive care integrates reproductive health care into the traditional primary care services that all patients should be offered.

Indeed, pregnancy intention, effective contraceptive use, and sexually-transmitted infection (STI) prevention, all services offered at our Planned Parenthood health centers, are critical to ensuring that women can maintain or improve their health status and avoid more costly chronic conditions later in life. For instance, OB/GYN providers routinely advise women on the importance of maintaining a healthy weight and using effective contraceptive methods in order to avoid unintended pregnancy that could be complicated by being overweight or obese, and may result in high risk birth outcomes.

Incremental progress needs to be made more quickly than preventive care will take to lower health care costs. To hasten this incremental progress, providers need to have access to funding supports to develop necessary infrastructure for transformation. Supports for training, care redesign and coordination, staffing, technology, and data analysis are just some examples of services needed to ensure that practices remain financially viable and can meet quality measure metrics to avoid risk.

Shared Risk

With the implementation of shared-risk over time and an expectation of better care coordination and increased accountability among providers, there absolutely needs to be additional funding resources available for the infrastructure needed to ensure health care providers like us are well prepared to enter a shared-risk arrangement.

Total Cost of Care

Total cost of care models fail to adequately take primary care services into account. This is because primary care emphasizes a preventative approach along with longitudinal care, so improved patient outcomes often do not materialize immediately and may take years, or in some cases even decades to realize. Accordingly, it is unreasonable to expect primary care to significantly impact total cost of care in the short term and the state should not develop models that require investments in primary care to be recouped by reductions in total cost of care in the short term.

1B. Build on the SIM Agenda and Current Success in the Medicaid Program

We know that a singular focus on primary care is limiting. It does not cover an entire continuum of care and has a limited impact on health care costs. This is why we are participating in SIM as a sexual reproductive health care provider offering primary care, to support the existing SIM initiatives while

remaining open to other models that the state is looking to build upon.

In addition, we provide comments on recommendations related to the pharmacy cost containment strategies highlighted in the presentation offered to the Health Care Cabinet on 11/1.

Pharmacy Cost Containment Strategies

The Health Care Cabinet's Cost Containment Study includes proposals aimed at controlling rising pharmaceutical costs, several of which focus on the federal 340B Drug Pricing Program (340B Program). Specifically, the study suggests that the State Attorney General should have the authority to investigate and report on the use of the 340B Program and "associated markups." It also proposes that State agencies and payers should "maximize the pricing structure" of the 340B Program for their own benefit. These proposals are very concerning in that they inure a benefit to payers that was intended for safety net providers and the vulnerable patients they serve.

As the legislative history of the 340B statute makes clear, the purpose of giving qualified safety net providers access to 340B discounts is to enable those providers to stretch their scarce resources so that they may "reach more patients" and furnish "more comprehensive services." This purpose cannot be achieved if 340B providers have to pass on the savings they have received through the 340B Program to third-party payers. According to the Health Resources and Services Administration, the agency that administers the Program, the 340B Program provides additional financial resources to covered entities without increasing the federal budget by lowering drug acquisition costs while maintaining revenue from health insurance reimbursements. The difference between a 340B drug's lower acquisition cost and standard non-340B reimbursement represents the very benefit that Congress intended to give qualified safety net providers when it established the 340B Program. Congress did not create the 340B Program to serve as a financial pass through from pharmaceutical manufacturers to pharmacy benefit managers and other payers. Further, the Government Accountability Office's ("GAO's)" recent report on the program, 340B covered entities use the savings from the 340B Program as Congress intended. Specifically, they leverage the program to serve more patients, offer a broader range of services and drugs, reduce the cost of services to patients, and cover the cost of providing services to Medicaid patients and patients who are uninsured or underinsured.

As the Health Care Cabinet and the State of Connecticut consider policies to contain health care costs, it is essential that the integrity of the 340B Program is not compromised. Preserving the purpose and original intent of the 340B Program—to enable safety-net providers to stretch scarce resources as far as possible to reach more eligible patients and provide more comprehensive services—is critical to ensuring the most vulnerable residents of Connecticut receive the health care they need. We respectfully request that the Cabinet and State work closely with 340B providers before promoting or moving forward with any 340B-related proposals.