

NEAL R. GROSS & CO., INC.

RPTS WALTER

HIF284020

EXAMINING HOW COVERED ENTITIES UTILIZE THE
340B DRUG PRICING PROGRAM

WEDNESDAY, OCTOBER 11, 2017

House of Representatives

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in
Room 2123 Rayburn House Office Building, Hon. Morgan Griffith
[vice chairman of the subcommittee] presiding.

Members present: Representatives Griffith, Burgess, Brooks,
Collins, Walberg, Walters, Costello, Carter, Walden (ex officio),
DeGette, Schakowsky, Castor, Tonko, Clarke, Ruiz, Peters, and
Pallone (ex officio).

Also present: Representative Sarbanes.

Staff present: Jennifer Barblan, Chief Counsel, Oversight
& Investigations; Adam Buckalew, Professional Staff Member,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

Health; Kelly Collins, Staff Assistant; Zachary Dareshori, Staff Assistant; Adam Fromm, Director of Outreach and Coalitions; Ali Fulling, Legislative Clerk, Oversight & Investigations, Digital Commerce and Consumer Protection; Theresa Gambo, Human Resources/Office Administrator; Brighton Haslett, Counsel, Oversight & Investigations; Brittany Havens, Professional Staff, Oversight & Investigations; Katie McKeogh, Press Assistant; Alex Miller, Video Production Aide and Press Assistant; Jennifer Sherman, Press Secretary; Sam Spector, Policy Coordinator, Oversight & Investigations; Josh Trent, Deputy Chief Health Counsel, Health; Natalie Turner, Counsel, Oversight & Investigations; Hamlin Wade, Special Advisor, External Affairs; Christina Calce, Minority Counsel; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Chris Knauer, Minority Oversight Staff Director; Miles Lichtman, Minority Policy Analyst; Kevin McAloon, Minority Professional Staff Member; Rachel Pryor, Minority Senior Health Policy Advisor; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and C.J. Young, Minority Press Secretary.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

Mr. Griffith. Welcome. Today the subcommittee is holding a hearing entitled Examining How Covered Entities Utilize the 340B Drug Pricing Program. The 340B Program was created by Congress in 1992 and mandates that drug manufacturers provide outpatient drugs to eligible entities at reduced prices in order for the manufacturers to remain eligible for reimbursements through entitle programs such as Medicaid and Medicare.

The 340B Program helps covered entities stretch scarce federal resources in order to reach more eligible patients and provide more comprehensive services to those patients. This is, undoubtedly, and important program. The dramatic growth of the program, however, couple with a dearth of information about how it is used, has led to questions about whether the program has grown beyond Congress' original intent.

The Subcommittee on Oversight and Investigations has been looking into the 340B program for several months now. Our work began with an examination of the Health Resources and Services Administration's, HRSA, role in overseeing the 340B Program. The committee requested a sample of HRSA's audits in order to understand the interactions between HRSA and covered entities and the thoroughness of HRSA's audits.

In July, the subcommittee held a hearing in which we heard from HRSA, GAO, and OIG on the challenges they face in overseeing the program. As we heard in July, the number of unique participating entities nearly quadrupled between 2011 and 2016

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

without a proportional growth in oversight and HRSA has struggled to keep up. However, our last hearing left many questions unanswered.

Because of the lack of reporting requirements in the 340B statute, HRSA is simply unable to collect data on exactly how covered entities use the program. Because HRSA is not able to report how covered entities use the program, the committee wrote to a diverse group of entities in September about their use of the program. We asked the entities to report a wide range of information, including the amount saved on drug purchases through participation in the 340B program, the level and type of charity of care provided by the entities, and how patients benefit from 340B discounts.

Over the past few months, we have heard from these entities and many others. Some entities reached out to the committee on their own, very eager to share with us the great work they are doing with the program dollars. We have heard from rural entities that started delivery services to ensure that patients in remote areas are able to receive their medications, entities that pass savings directly to their patients using a cash card program, and entities that are using their savings to combat the opioid crisis, including by examining prescribing practices and providing behavioral health services to their communities. However, I am concerned by reports that not all participating entities have devoted the program dollars to improving patient care, providing

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

access to vital services, or lowering prescription drug costs for the patients. I have seen news accounts indicating that some covered entities spend millions on salaries and bonuses for their CEOs and hundreds of millions on building expansions, even as charity care at those entities is on the decline. Perhaps even more concerning are some reports showing that patient costs are actually on the rise at some 340B entities.

In 2015, GAO found the 340B disproportionate share hospitals were either prescribing more drugs or more expensive drugs to Medicare Part B beneficiaries than their non-340B counterparts. Similarly, we have concerns that 340B hospitals are acquiring physician-owned oncology practices which can result in higher treatment costs to patients within that practice.

The 340B drug pricing program is vital to many covered entities and, by extension, to the patients that those entities serve. As such, it is crucial that Congress ensure that the program dollars used in accordance with the intent of the program to stretch scarce federal resources as far as possible to better serve uninsured and underinsured patients. We must ensure there is accountability and transparency in the program.

I am pleased that the panel we have assembled today includes three disproportionate share hospitals that serve both urban and rural populations, one Federally-Qualified Health Center, and one Ryan White Center. Each of these entities serve a different patient population and offer services that are of particular

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

121 importance to their communities.

122 I thank these witnesses for their cooperation in producing
123 data, to this committee about their use of the 340B program, and
124 their willingness to appear before us today.

125 I look forward to hearing more about the ways in which they
126 benefit and, more importantly, how their patients benefit from
127 their participation in the 340B program.

128 I do appreciate it very much. And with that, I will yield
129 to Ms. DeGette for 5 minutes.

130 Ms. DeGette. Thank you. Chairman, it is nice to see you
131 sitting there in the chair. Welcome. We are glad to have you.

132 I think that investigation like this, of programs like this,
133 really are the core job of this committee and I am pleased that
134 we are looking into the viability of the 340B Program. This
135 program, I think we will all agree on both sides of the aisle,
136 has been a lifeline for providers who care for low-income and
137 vulnerable patients. Eligible entities like DSH hospitals,
138 Federally-Qualified Health Centers and AIDS Drug Assistance
139 Program are a critical part of the communities that they serve.
140 The 340B Program helps them to make the best of their limited
141 resources.

142 When we talk about the 340B Program, we often hear about the
143 drug discounts but the program provides so much more than that.
144 When Congress established this program, we made clear that the
145 purpose was to quote stretch scarce federal resources as far as

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

146 possible, reaching more eligible patients, and providing more
147 comprehensive services.

148 Mr. Chairman, it seems like the providers are doing just
149 that. 340B recipients include large hospitals that serve urban
150 settings and rural hospitals that often provide the only care
151 available in their communities. They include Ryan White Clinics
152 and Federally-Qualified Health Centers. All of these centers
153 provide extraordinary amounts of uncompensated care and services
154 to those in need.

155 Now this investigation was initiated to see whether
156 recipients were properly using their savings and that is certainly
157 appropriate. So we received responses from most of the people
158 who received a letter from the Majority Council. As part of that
159 process, my committee staff has also conducted interviews with
160 most of them as well. While most of the recipients have reported
161 that the 340B Program is a vital source of funding that makes
162 possible to reach vulnerable populations, many have also
163 explained that these savings only cover a fraction of the care
164 that they provide.

165 For example, as a covered entity, the University of
166 Washington saved \$24 million through the 340B Program. Well,
167 that is impressive but the institution spent more than \$270
168 million covering uncompensated care costs for Medicaid and
169 Medicare recipients, as well as people who show up at the emergency
170 room with no insurance at all.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

171 Mission Health, which has a witness which will testify today,
172 saved \$38 million in 2016 by participating in the 340B program
173 but that same year, it provided \$69 million in uncompensated care,
174 as well as \$183 million in community benefits. This includes
175 services like mobile children's dental care units, a medical
176 airlift service for surrounding states.

177 In an interview with committee staff, Mission Health
178 reported that if its 340B revenues were cut, it would be forced
179 to significantly limit programs and services.

180 Parkland Hospital in Dallas provided \$431 million in charity
181 care in 2016, which was over three times the amount of their 340B
182 discounts. Parkland explained to my committee staff that when
183 all uncompensated care is taken into account, it actually provided
184 \$870 million in critical community benefits.

185 Northside Hospital in Atlanta, which also has a witness here
186 today, reported in 2016 that it generated nearly \$53 million in
187 340B savings, which does cover a lot of care, but there was nearly
188 \$370 million in charity care.

189 And UCSF saved about \$83 million but, again, that savings
190 only covered a portion of the \$331 million in charity care.

191 Last but certainly not least, the AIDS Research Center of
192 Wisconsin, which recently merged with Rocky Mountain CARES in my
193 home district. These clinics provide critical services to people
194 affected by HIV-AIDS -- medical, dental, mental health care, food
195 services, housing services, and pharmacy services. If they

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

196 didn't have 340B, they couldn't provide these services.

197 We heard this consistent message from all types of providers
198 and, from what this committee has seen, they don't seem to be
199 lining their pockets. They are using this savings to provide
200 critical care for the community and vulnerable populations.

201 Now I think we can discuss the definitions regarding what
202 is what or what is not charity care but, in the end, what should
203 not be lost is these organizations are using this compensation
204 for important community work.

205 I look forward to hearing from the witnesses about this work.
206 I think we can make improvements on transparency to the program
207 but, in doing so, we should not reduce the providers' abilities
208 to fulfill their missions and to continue their important work.

209 I yield back.

210 Mr. Griffith. I thank the gentlelady and now recognize the
211 chairman of the full committee, Mr. Walden.

212 The Chairman. And I thank you, Vice Chairman. Thank you
213 for leading this hearing today.

214 The committee has been examining the 340B Drug Pricing
215 Program for about 2 years now, as I think you all know, and the
216 Oversight Subcommittee has been particularly focused on it since
217 last spring.

218 The 340B Drug Pricing Program allows covered entities to
219 purchase certain outpatient drugs at reduced prices, in order to
220 allow those entities to stretch scarce federal resources as far

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

221 as possible to better serve their patients.

222 As you all know, the subcommittee held a hearing in July.
223 We invited Government witnesses here to testify about the program.
224 They were unable to answer many of our questions on how covered
225 entities use the 340B program, due to the lack of reporting
226 requirements in the statute. This lack of transparency and
227 coherent reporting requirements is concerning. Frankly, without
228 the data it is hard to know if this program is working as Congress
229 intended when it was created.

230 So today, we are going to hear directly from five covered
231 entities, all top-notch medical organizations that provide
232 important services to their communities. They range from of
233 smallest to some of the largest participants in the program.

234 The 340B Program enables covered entities to do some real
235 good in our communities, to extend care to underserved
236 populations, to create programs that serve specific community
237 needs, and to provide life-saving drugs at discounted prices to
238 the populations that need them the most. For some entities, this
239 program is the difference in keeping their doors open or in closing
240 shop, which could result in a loss of care to vulnerable
241 populations. So this is a very important program.

242 I have met with several hospitals in rural Oregon that are
243 using the 340B Program to improve care and reduce costs for
244 low-income patients and I have heard how vital this program is
245 to maintain their high levels of charity care. I, myself, served

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

on a nonprofit small community hospital board for about 4 years before coming to the Congress. So, I understand the importance of these programs. I am troubled, however, by the response of some stakeholders and entities who see our oversight efforts as a threat to the 340B Program and to their charity work. It is the job of this committee to ensure that the programs that Congress creates serve their intended purpose and operate with integrity and that participating entities are held accountable for how they spend the program dollars. That is our job.

Our goal in our oversight work is always to take a deliberate and fair look at all sides of the issues. We know that each entity provides unique services, serves a unique population and faces unique challenges in their communities. Because of that diversity, we want to allow entities to tell their own stories and highlight the successes they have experienced through participation in this important program. However, the lack of transparency requirements has resulted in inconsistent data and dueling reports from every side of this issue. And believe me, we hear from every side.

Much of the data that we do have is self-reported by entities that measure charity care and program savings but they do so in various ways. While I believe it is important that entities be able to share their work in a way that takes into account the specific needs of their communities, the inconsistencies here only further demonstrate that we need better data on this program.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

271 The 340B Program has grown rapidly over the years. The
272 increase in program participation has led to a dramatic increase
273 in 340B drug purchasing and savings. According to HRSA, covered
274 entities' drug savings grew from \$3.8 billion in fiscal year 2013
275 to \$6 billion dollars in fiscal year 2015. I am concerned that,
276 as the program continues to grow, participating entities are not
277 investing the necessary resources and time to oversee the program,
278 ensure accountability and transparency, and, above all, ensure
279 that they are using the program savings to improve patient care.

280 For example, some entities that we spoke with reported they
281 do not have policies to help ensure that uninsured and
282 underinsured patients directly benefit from the program by
283 receiving discounts on out-patient drugs. Most surprisingly,
284 many entities did not track their 340B savings at all and, until
285 they received our request, didn't seem to have any idea how much
286 they saved through participation in the 340B Program.

287 On the other hand, some participating entities tracked their
288 340B savings on a regular basis and provide regular training to
289 staff on federal program requirements.

290 With a program this large, it is essential that Congress
291 understands how it is being used and I hope that that is what we
292 will accomplish in this hearing. Our goal today is to develop
293 a better understanding of how much money different entities saved
294 through participation in the 340B program, how covered entities
295 tracked their savings, and how those savings are used to actually

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

296 improve patient care in various ways.

297 So I want to thank each of the witnesses for being here today
298 and I look forward to hearing more about how each of your
299 organizations provides vital care to your communities. And know
300 that I have said from day one, Mr. Chairman, we are going to look
301 from one end of the cost curve of healthcare delivery to the other.
302 It is our job and responsibility. It just happened 340B and
303 hospitals were first up but this is just the start. If we are
304 ever going to tackle high cost of health care in America, it is
305 our responsibility.

306 With that, I yield back, Mr. Chairman.

307 Mr. Griffith. Thank you, Mr. Chairman. I appreciate it
308 very much.

309 I now recognize the ranking member of the full committee,
310 Mr. Pallone.

311 Mr. Pallone. Thank you, Mr. Chairman.

312 Twenty-five years ago, Congress passed bipartisan
313 legislation establishing the 340B Program to help healthcare
314 providers expand their capacity to serve their patients. And
315 since that time, the 340B Program has played a critical role
316 ensuring that low-income Americans and most vulnerable
317 populations have access to essential healthcare services and
318 helping safety net providers expand innovative care to these
319 communities.

320 This summer, the Republican majority initiated an

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

investigation to determine how entities are using the program. From what we have heard over the last couple of weeks, it appears that 340B recipients are using their savings to reach vulnerable populations and without that money, these programs would be reduced or cut altogether.

The committee has reviewed responses from most of the healthcare facilities that the Republicans contacted. Committee staff have also interviewed representatives from most of the letters' recipients. Many entities have explained that the 340B savings often cover only a portion of the cost of their uncompensated care and services to vulnerable populations. And through these interviews and responses, we have found that covered entities rely on 340B funds to provide a diverse range of essential services to the community. Today, we will hear firsthand from our witnesses about the type of care and treatment that might be impossible to provide without the help of 340B.

For instance, 340B recipients have told the committee that they use their savings to support mobile clinics for low-income patients, or to provide free prescriptions to uninsured and underinsured patients. One provider reported that 340B savings made it possible for them to treat low-income patients with substance abuse disorders. Another said that thanks to the 340B savings, it is able to serve more vulnerable children in its neonatal intensive care unit. And this provider reported that without 340B, it might have had to cut the number of children it

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

346 can help by nearly half.

347 It is beyond question that the resources provided through
348 the 340B program directly augment patient care throughout the
349 country. We have consistently heard this message from all types
350 and sizes of 340B providers from small AIDS clinics to large urban
351 hospitals. And the 340B Program plays an integral role in
352 supporting the mission of safety net providers serving
353 low-income, uninsured, and underinsured patients.

354 Now some have suggested that we can improve the program by
355 increasing transparency and program integrity. And I certainly
356 agree good program integrity strengthens our programs not only
357 for today but for the future. But I want to be clear, however,
358 that while I am always happy to have a conversation about
359 strengthening the 340B program, it is plain from the responses
360 we have received that 340B-covered entities are using their
361 savings to serve the community and Congress should commend and
362 support those efforts.

363 So I remain dedicated to finding ways to strengthen the 340B
364 Program and ensure that it continues to fulfill its vital mission.

365 And I yield back if someone else wants time but I don't think
366 so. I yield back, Mr. Chairman.

367 Mr. Griffith. Thank you.

368 And now I ask for unanimous consent that the members' written
369 opening statements be introduced into the record. Without
370 objection, the documents will be entered into the record. I

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

371 also ask unanimous consent that members not on the Subcommittee
372 on Oversight and Investigations be permitted to participate in
373 today's hearing.

374 Without objection, I would now like to introduce our panel
375 of witnesses for today's hearing.

376 First, we have Ms. Sue Veer, who is the President and CEO
377 of Carolina Health Centers in South Carolina. Thank you for being
378 here today.

379 Next is Mr. Mike Gifford, who serves as the President and
380 CEO of the AIDS Resource Center of Wisconsin. Thank you, sir.

381 Then we have Dr. Ronald Paulus, who is the President and CEO
382 of Mission Health Systems in North Carolina.

383 Fourth is Mr. Charles Reuland, the Executive Vice President
384 and COO of Johns Hopkins Hospital in Baltimore. Thank you, sir.

385 And finally, we have Ms. Shannon Banna, who serves as the
386 Director of Finance and System Controller at Northside Hospital
387 in Georgia.

388 I thank each of you for being here today and providing
389 testimony. We look forward to the opportunity to discuss how
390 entities across the country utilize the 340B Program.

391 As you are aware, this committee is holding an investigative
392 hearing and, when doing so, as has been the practice of this
393 subcommittee, we take testimony under oath. Do any of you have
394 an objection to testifying under oath?

395 The Chair then advises that under the rules of the House and

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

396 the rules of the committee, you are entitled to be advised by
397 counsel. Do any of you desire to be advised by counsel during
398 your testimony today?

399 In that case, if you would please rise and raise your right
400 hand, and I will swear you in.

401 [Witnesses sworn.]

402 Mr. Griffith. Having heard all respond in the affirmative,
403 you all can sit. Thanks.

404 You are now under oath and subject to the penalties set forth
405 in Title 18, Section 1001 of the United States Code. You may now
406 give a 5-minute summary of your written statement and, of course,
407 we will begin with Ms. Veer.

STATEMENT OF SUE VEER, PRESIDENT AND CHIEF EXECUTIVE OFFICER,
CAROLINA HEALTH CENTERS, INC.; MICHAEL GIFFORD, PRESIDENT AND
CHIEF EXECUTIVE OFFICER, AIDS RESOURCE CENTER OF WISCONSIN;
RONALD A. PAULUS, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER,
MISSION HEALTH; CHARLES REULAND, EXECUTIVE VICE PRESIDENT AND
CHIEF OPERATING OFFICER, THE JOHNS HOPKINS HOSPITAL; AND SHANNON
BANNA, DIRECTOR OF FINANCE AND SYSTEM CONTROLLER, NORTHSIDE
HOSPITAL, INC.

STATEMENT OF SUE VEER

Ms. Veer. Thank you, Chairman Griffith, Ranking Member
DeGette, and members of the subcommittee.

My name is Sue Veer and I am the President and CEO of Carolina
Health Centers, a Federally-Qualified Health Center that serves
as the primary care medical home for 26,952 patients in the west
central portion of South Carolina known as the Lakelands. We
operate 13 primary care sites and two community pharmacies serving
patients within an HHS-designated medically underserved area of
over 3,700 square miles.

I appreciate the opportunity to serve as a witness before
the subcommittee today and to speak to the importance of the 340B
Program for Carolina Health Centers. If there are two key things
that I hope you will take away from my testimony they are, first,
that the 340B Program is a critically important tool for FQHCs
as we work to provide the highest quality of care to underserved

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

433 patients and the communities in which our sites are located.

434 Second, each category of 340B-covered entity has unique
435 aspects that must be considered in any potential reforms. In the
436 case of FQHCs, we are already subject to HRSA oversight and
437 specific health center requirements that guide many aspects of
438 our participation in the 340B Drug Pricing Program. Consistent
439 with these specific FQHC requirements, we never turn a patient
440 away due to inability to pay or due to demographic, geographic,
441 and socioeconomic barriers. Patients with incomes before the
442 poverty level pay no more than a nominal fee for the full range
443 of services that we provide. And patients whose incomes are
444 between 101 and 200 percent of the poverty level pay a discounted
445 rate according to a sliding fee scale that's based on their ability
446 to pay.

447 We are also governed by a community-based Board of Directors,
448 a majority of whose members are patients of the health center.
449 This structure ensures that we remain directly responsive to the
450 unique needs of our patients and the community.

451 And finally, all health centers are subject to intensive and
452 ongoing oversight from the Department of Health and Human Services
453 Health Resources and Services Administration. The HRSA
454 requirements with which we must comply are spelled out in a 92-page
455 manual and grouped into 18 major categories, which include but
456 are not limited to, clinical quality, financial management,
457 ensuring access, and our collaboration with other local

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

458 healthcare providers.

459 At Carolina Health Centers, we make every effort to ensure
460 that uninsured and low-income patients are able to afford their
461 prescriptions. While every health center may use their 340B
462 savings differently, these savings enable my health center to
463 provide deeply discounted pharmacy services to those patients
464 eligible for the income-based sliding fee program. Those
465 pharmacy services include clinical programs, such as medication
466 therapy management, which promote clinical outcomes and
467 cost-effective care. We are also about to launch a new
468 multi-disciplinary program for the reduction of the use of
469 controlled substances.

470 We also use our 340B savings to support the following
471 services that are designed to expand access to essential primary
472 care services for patients throughout our rural service area.
473 Daily delivery of health center patient prescriptions to Carolina
474 Health Centers' medical practices that in our outlying rural
475 communities, communities where patients have little or no access
476 to affordable pharmacy services. That delivery service makes
477 over 20,000 affordable prescriptions accessible to low-income and
478 uninsured patients every year.

479 Oral health service, both preventive and restorative
480 provided through uninsured -- provided to uninsured and sliding
481 fee-eligible patients through a network of contract dentists and
482 behavioral health counseling, which is provided on-site for

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

483 patients who would either not qualify or have incredibly long
484 delays in accessing care from the local mental health agency.

485 In addition the 340B savings contribute to my health center's
486 ability to ensure continued access to primary care and preventive
487 care at certain of our primary care delivery sites in communities,
488 which due to their particularly rural location would not likely
489 be sustainable otherwise.

490 The health center statute requires FQHCs to use all their
491 340B savings for purposes that advance their HRSA-approved scope
492 of project. In other words, for activities that increase access
493 to high-quality affordable care for medically-underserved
494 populations.

495 As my testimony demonstrates, the 340B Program is vital to
496 my health center and to our ability to provide patients with access
497 to affordable prescriptions, as well as needed services for our
498 low-income and underserved patients.

499 Thank you for the opportunity to testify before you today
500 and for recognizing the importance of this program for the health
501 centers and all the patients we serve.

502 [The prepared statement of Ms. Veer follows:]

503 *****INSERT 1*****

504 Mr. Griffith. Thank you.

505 I now recognize Mr. Gifford for 5 minutes for an opening

506 statement.

STATEMENT OF MICHAEL GIFFORD

Mr. Gifford. Good morning, Chairman Griffith, Ranking Member DeGette, and members of the subcommittee. Thank you for inviting me to provide testimony today.

As we gather here today, we can talk credibly about the end of the HIV epidemic in our lifetime. The 340B Program is vital to attaining that goal.

My name is Mike Gifford. I serve as the President and Chief Executive Officer of the AIDS Resource Center of Wisconsin. Earlier this year, ARCW expanded our services into Denver, Colorado and the unique model of care that we offer. In total, we serve more than 4,000 people with HIV.

The 340B Program costs the Federal Government nothing, yet generates hundreds of millions of dollars in care for HIV patients. For HIV patients, the purpose of the 340B program, to stretch scarce federal resources, to serve more patients, and to provide more comprehensive services, is met every single day. We assure unfettered access to medical care, dental care, mental health therapy, drug treatment, and pharmacy services tightly integrated with social services like case management, food assistance, and housing.

More than 90 percent of our patients are low-income and one-third of all of our medical visits care for uninsured patients.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

Our patients achieve some of the finest clinical outcomes in the country, 89 percent of whom achieve the gold standard in HIV health care and undetectable viral load. That is a rate far above the national average. Governor Scott Walker's administration has found that our patients are so healthy they cost of the State of Wisconsin 30 percent less than HIV patients cared for elsewhere.

Further, DHHS data shows HIV patients in Wisconsin have the lowest HIV mortality rate in the country. Our HIV medical home buoyed by 340B savings result in people with HIV living in Wisconsin longer than anywhere else in the country.

At ARCW, 340B savings are used consistent with legal and regulatory requirements. Savings have supported opening an opioid treatment program in Green Bay, expanding mental health services throughout Wisconsin, launching clinical pharmacy care in Denver, and increasing the number of patients we care for throughout all of our services by more than one-third.

Last year, ARCW generated \$7,429,666 in savings, the exact use of which is included in my written testimony. To track 340B medications and savings, we have developed specialized software that monitors compliance related to patient eligibility, diversion, and duplicate discount. We audit ourselves on a monthly basis and have an annual third-party external audit. Last year, it showed 99.57 percent compliance. This year our compliance rate is at 99.9996 percent.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

557 As the subcommittee reviews the 340B program, there are
558 critically important policies necessary to achieve that goal I
559 mentioned earlier, a world without AIDS. The current patient
560 definition used for Ryan White grantees must be maintained to
561 support the integrated care necessary in achieving substantially
562 better clinical outcomes. Without it, there will be fewer
563 resources, worse outcomes, and increased healthcare costs, not
564 to mention the substantial difficulties for the people we serve.

565 Separately, the use of 340B savings for Ryan White grantees
566 has been limited, prohibiting their use to extend access to: 1)
567 lifesaving prep services; 2) expand the number of locations we
568 can offer our care; and 3) assure the financial sustainability
569 of our providers. These regulations create significant barriers
570 to ending AIDS.

571 Statistics and advocacy tell only part of the story.
572 Briefly, let me tell you about one of our patients, Kathy. She
573 came to us newly diagnosed with HIV 20 years ago, struggling with
574 substance abuse. Through our drug treatment program, she entered
575 a life of sobriety. Kathy then accessed medical care, housing,
576 food services, and mental health therapy to achieve that gold
577 standard in care in undetectable viral load.

578 She proceeded to meet her boyfriend and relocate to another
579 town. Just weeks later, we received a call from Ms. Kathy. Her
580 boyfriend turned out to be a domestic abuser. We rushed to her
581 aid, removed her from harm's way, and provided her a safe home.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

582 She is no longer being beaten. Sadly, she was no longer
583 undetectable.

584 Today, she is accessing many of our services and is back on
585 the way to that gold standard. Throughout it all, our services
586 were always there for Kathy, even if she couldn't pay, each one
587 of them supported by 340B savings -- savings that saved her life.

588 Thank you for this opportunity to testify before the
589 committee. I look forward to responding to any questions you may
590 have.

591 [The prepared statement of Mr. Gifford follows:]

592
593 *****INSERT 2*****

594 Mr. Griffith. Thank you.

595 Now, I yield to Dr. Paulus for 5 minutes for an opening

596 statement.

STATEMENT OF RONALD PAULUS, M.D.

Dr. Paulus. Vice Chair Griffith, Ranking Member DeGette, and members of the subcommittee, on behalf of the nearly one million patients and 12,000 Mission Health Care Givers in western North Carolina, I would like to thank you for inviting me to discuss our participation in the 340B Drug Program.

I simply cannot overstate the importance of this program in enabling what we do. Mission Health is an independent community-governed integrated health system providing services to the 18 mostly rural and mountainous counties of western North Carolina. We've earned numerous awards and achieve national recognition, including being named one of the nation's top 15 health systems in the 5 of the past 6 years by IBM Watson. Mission Health is a significant provider of medical education and training, serving as a branch campus of the UNC Chapel Hill School of Medicine and as a clinical training site for the numerous primary care residencies like family practice, OB/GYN, general surgery, and psychiatry.

Our community board members, clinicians, and staff focus each and every day on the delivery of compassionate high-quality care to everyone, without regard to their ability to pay. The weight of our safety net responsibility is sometimes heavy but it is always real. Our patients are disproportionately older, poorer, sicker, and less likely to be insured than state and

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

national averages, with nearly 70 percent covered by Medicare, Medicaid, or having no insurance at all.

Communities in our southern Appalachian Mountains are beautiful but they have real challenges. Globalization of manufacturing, particularly for furniture, decimated many communities. Opioid abuse is an absolute epidemic. Our infrastructure is stretched and the rugged terrain of our mountainous region adds complexity for patients in getting the care that they need. We make difficult decisions every single day to keep our regional safety net system viable. The 340B Program directly enables those crucial efforts by providing savings that we use, yes, to stretch scarce federal resources as far as we possibly can. Six Mission Health hospitals qualified for the 340B Program, based on either DSH or Critical Access Hospital status. Our use of 340B Program savings directly reflects the intent of the program. We operate the region's only tertiary-quaternary referral center. Mission is the sole provider of numerous essential services, including being the only Level II trauma center, the only Level III NICU, the only open heart program, the only children's hospital, the only medevac helicopters, and the list goes on.

For un- and underinsured patients, Mission Health provides robust financial assistance, including completely free care for those earning up to twice the federal poverty guidelines on a sliding scale up to 300 percent of the federal poverty guidelines.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

647 We have also implemented a novel community investment
648 program that identifies and funds external programs that are not
649 Mission Health to address the most urgent, underserved health
650 needs that serve the uninsured or are either not covered by
651 insurance or are not reimbursed at a financially viable level.
652 We require for those investments a real business plan, metrics,
653 and forecasts as if it were a real investment and we are seeing
654 real results.

655 In 2016, Mission Health's total value of charity and
656 unreimbursed care was nearly \$105 million and our total community
657 investments exceeded \$180 million. In that same year, Mission
658 Health generated \$37.4 million in 340B savings and this year we
659 expect to generate a little more than \$38 million. Our total
660 charity care, up 20 percent this year over last, and bad debt alone
661 is more than double the value of our 340B savings and those savings
662 only represent one-fifth of our total community benefit provided
663 in the most recent year.

664 Now what are some examples? C3@356. This is a walk-in
665 urgent care center for those with behavioral health needs that
666 we helped fund and create on behalf of the community.

667 The Mountain Child Advocacy Center, which supports and
668 treats child abuse victims and their families.

669 The Dale Fell Health Center, a Federally-Qualified Health
670 Center that provides primary care to the most vulnerable in our
671 community with a particular focus on homeless families and

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

672 individuals.

673 The Family Justice Center, which provides wraparound
674 services for victims of domestic and sexual violence in a
675 trauma-informed setting.

676 Other services include our Children's Hospital ToothBus
677 Program, 40-foot-long buses that go to schools to provide dental
678 care for children and our Medication Assistance Program, which
679 is a centralized service for all system hospitals, offering
680 patients help with both short- and long-term, and discounted
681 medications, one-on-one pharmacist education, and help with
682 chronic medical conditions. That program is not limited to 340B
683 discounted outpatient drugs and includes a Meds-to-Beds Program
684 so people go home with their medications.

685 These programs, like many others that we work so hard to
686 support are the heart of what safety providers do. So we
687 appreciate this opportunity to participate in the dialogue, share
688 how the 340B Program impacts our patients and we are eager to help
689 you make this important program even better.

690 [The prepared statement of Dr. Paulus follows:]

691

692 *****COMMITTEE INSERT 3*****

693

Mr. Griffith. Thank you very much.

694

Mr. Reuland now for a 5-minute opening.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

STATEMENT OF CHARLES REAULAND

Mr. Reuland. Chairman Griffith, Ranking Member DeGette, and members of the subcommittee, my name is Charlie Reuland and I am the Executive Vice President and Chief Operating Officer of The Johns Hopkins Hospital.

I began my career at Johns Hopkins in 1990 and have served in a variety of roles over the past 3 decades. I have the privilege to be the hospital's representative on the panel here today to share with you JHH's proud legacy of care and service to the vulnerable individuals and families made possible, in part, by its participation in the 340B Drug Pricing Program.

For many, the Johns Hopkins Hospital is synonymous with world-class research and care for patients from around the nation and world but what sometimes gets lost behind the headlines is that we were founded as and continue to be first and foremost the local community hospital for the people of East Baltimore. For 127 years, the hospital has been rooted in Baltimore, still occupying the same square block as the original historic hospital which opened in 1889.

Our history as a participant in the 340B Program is much more recent, only since 2002 but the value of the program is just as inherent, just as vital to our mission.

Dr. William Osler, one of the four founding physicians of The Johns Hopkins Hospital once said it is much important to know

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

what sort of a person has a disease than it is to know what sort of a disease a person has. To us, that means that the care can be provided best when we understand the life circumstances of a patient and adjust our care to optimize the results in that overall context. The great strength of the 340B Program is the discretion it affords eligible hospitals in tailoring the use of program savings to address the unique needs of our communities.

Our ability to invest in interventions both at the patient level, as well as the community level is critical to our success and improving the health of our patients in our community. And here is why: In Baltimore, nearly one in four residents live at or below the poverty level and the unemployment rate is above the national average. Jobs that pay a family's sustaining wage are scarce and one in four residents in Baltimore City lives in a food desert. JHH tailors the use of its 340B savings with these grim realities in mind.

As a safety-net hospital, we respond to emerging crises, provide ongoing care, and disease prevention for the most vulnerable patients in Baltimore and invest in improvements in our city, all made possible in no small part by the savings afforded to us by the 340B program. We have many examples of those programs, which I will be glad to tell you more about but, in general, they fall into two basic categories of action.

The first category is providing wraparound support for patients when the normal processes of diagnosis and treatment may

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

745 not be enough. Patients returning to homes without running water
746 may have greater difficulty following through on instructions to
747 keep wound dressings clean and sterile. Children with asthma may
748 not be able to avoid secondhand smoke that exacerbates their
749 breathing challenges. And a senior will have difficulty taking
750 the correct dosage of medication, if they can't read the label
751 because of the tiny print.

752 Providing wraparound services, such as in-house pharmacy
753 visits to assure safe and appropriate use of medications means
754 the patient has a greater likelihood of adhering to the treatment
755 plan and having a better outcome.

756 The second is designing and implementing prevention
757 strategy. Picture that proverbial cliff with people sometimes
758 falling off. There are ambulances picking up the patients at the
759 bottom but people continue to fall. The 340B Program allows a
760 hospital to help install a fence at the top of the cliff to prevent
761 further falls and, importantly, to tackle the causes of disease
762 and disability in our community.

763 With 340B savings, Johns Hopkins developed programs for
764 expectant mothers in surrounding community, for instance, to
765 increase the likelihood of healthy on-time deliveries, rather
766 than wait for a low birth weight baby to require a NICU stay.

767 These activities are not reimbursed under the traditional
768 hospital payment structure, yet they are inherent to our mission
769 and are all made possible with the savings of the 340B Program.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

770 The 340B Program has been a success in our community,
771 allowing JHH to operate a variety of programs and provide services
772 for vulnerable patients that improve their health and well-being
773 that otherwise would not be possible. These efforts help avoid
774 other, more expensive medical interventions, the cost of which
775 would be borne in large part by Federal and State governments if
776 funds were not -- funds, if not for the 340B Program.

777 Now is the time for the Federal Government to recommit to
778 the 340B Program. The program is as relevant and vital today as
779 it was when first enacted. The legacy of the 340B program is that
780 today JHH, along with the national network of other
781 Disproportionate Share Hospitals and other 340B-covered entities
782 are the bedrock of the national safety net dedicated to saving
783 lives and improving the health of our most vulnerable neighbors.

784 Thank you for the opportunity to provide these comments and
785 I look forward to your questions.

786 [The prepared statement of Mr. Reuland follows:]

787 *****COMMITTEE INSERT 4*****

788

Mr. Griffith. Thank you, very much.

789

And now for a 5-minute opening, Ms. Banna.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

790 STATEMENT OF SHANNON BANNA

791

792 Ms. Banna. Good morning, Chairman Griffith, Ranking Member
793 DeGette, and members of the subcommittee. My name is Shannon
794 Banna and I am here in my capacity as Director of Finance and
795 Systems Controller for Northside Hospital. We thank you for the
796 opportunity to demonstrate to the subcommittee how Northside
797 utilizes the 340B Drug Pricing Program to serve Georgia
798 communities.

799 The 340B Program is critical in assisting Northside with its
800 mission of providing high-quality health care for the entire
801 community, regardless of anyone's ability to pay. As background,
802 Northside is a nonprofit corporation that owns and operates and
803 extensive network of healthcare facilities in Georgia. This
804 includes three acute care hospitals, more than 150 ancillary and
805 physician service site, and supportive services and facilities
806 located throughout Georgia. As one of the State's largest and
807 most respected healthcare delivery systems, Northside offers a
808 full range of services through over 2.5 million patient encounters
809 each year.

810 As the undisputed national leader in maternity services,
811 Northside Hospital Atlanta delivers more babies than any other
812 single hospital in the nation. Our neonatal intensive care unit
813 treats as many 100 premature and high-level special care babies
814 each day.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

815 Northside Center for Perinatal Medicine offers
816 nationally-recognized expertise and innovation in maternal fetal
817 medicine and diagnostic radiology.

818 We are also one of the largest and most respected providers
819 of cancer care in Georgia, diagnosing and treating more
820 gynecologic and prostate cancer cases than any hospital in Georgia
821 and more breast cancer cases than any hospital in the southeast.

822 The Northside Blood and Marrow Transplant Program has among
823 the highest survival rates in the nation and is recognized as a
824 premiere program throughout the southeast.

825 The Northside Hospital Cancer Institute is one of only 21
826 community cancer programs nationwide selected by the National
827 Cancer Institute for participation in the National Cancer
828 Institute's Community Oncology Research Program. Selection
829 criteria included scope of patient reach and overall
830 comprehensive delivery of high-quality patient care.

831 Northside treats all patients the same, regardless of
832 insurance and regardless of their ability to pay. No patient is
833 ever turned away due to the inability to pay for their healthcare.
834 In the past 5 years, we have provided almost \$1.4 billion in free
835 or discounted care. In 2016 alone, the system provided \$370
836 million in free or discounted care into our patient community.

837 From 2012 'til 2016, Northside Atlanta's provision of
838 charity and indigent care grew at a rate 63 percent greater than
839 our increase in hospital adjusted gross revenue. During the same

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

840 period, the number of distinct patients receiving charity care
841 at Northside Atlanta increased 350 percent.

842 This free and discounted care encompasses a wide range of
843 service for those in need and makes comprehensive care available
844 to a greater number of patients. For example, Northside offers
845 free and low-cost educational courses on topics related to
846 maternal and infant health, with over 700 available classes. In
847 2016, 18,500 individuals accessed Northside's free breastfeeding
848 eLearning program. More than 31,000 women used our free
849 Lactation Support telephone hotline.

850 In addition to providing audiology screening for all
851 newborns and hearing screenings for many school children, we
852 provide numerous free preventative health screenings to adults
853 as well, including prostate cancer screening, skin cancer
854 screening, and stroke screening.

855 Northside also operates a Financial Access Surgery Program
856 to provide radiology, cancer, and related surgical services to
857 the uninsured and underinsured who are not otherwise able to
858 afford medically-necessary outpatient care.

859 In recent years, Northside has worked hard to make
860 state-of-the-art cancer care accessible to more patients in more
861 locations. We offer cutting edge oncology drugs to all patients,
862 regardless of their ability to pay. We have expanded and enhanced
863 oncology care by adding more than 250 full-time positions in and
864 in support of our oncology clinics. These positions provide

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

865 services such as financial assistance, wellness counseling,
866 nutrition, navigation, clinical research, and much more.

867 Northside Atlanta qualifies for participation in the 340B
868 Program because of our disproportionate share of indigent and
869 low-income inpatient days, currently running at approximately 16
870 percent of total inpatient days.

871 Northside started our 340B Program in 2013 under the guidance
872 and oversight of our 340B Steering Committee and then independent
873 third-party consultant. In addition to constant oversight by the
874 Steering Committee, which encompasses individuals from several
875 departments of the hospital, our 340B Program undergoes frequent
876 and rigorous internal and external auditing and monitoring.

877 In 2016, Northside underwent an audit by HRSA, which
878 confirmed Northside's compliance with 340B Program requirements.
879 Following a thorough review of the 340B Program, HRSA found a
880 single instance of inadvertent diversion, representing less than
881 \$7.

882 Northside is proud of our commitment to charity and the
883 services we provide to our community, the extent of which is made
884 possible through 340B savings. We appreciate the opportunity to
885 provide this information and we look forward to answering your
886 questions.

887 [The prepared statement of Shannon Banna follows:]

888

889 *****COMMITTEE INSERT 5*****

890 Mr. Griffith. Thank you very much to all of our witnesses.
891 At this point, I ask unanimous consent that the contents of the
892 document binder be introduced into the record and to authorize
893 staff to make any appropriate redactions.

894 Without objection, the documents will be entered into the
895 record with any redactions that staff determines are appropriate.

896 [The information follows:]

897

898 *****COMMITTEE INSERT 6*****

899 Mr. Griffith. And with that, we will go to questions. I
900 recognize myself for 5 minutes.

901 And I would ask each of the witnesses how did you calculate
902 your 340B savings. Is it an estimate or a precise amount? And
903 if it is an estimate, what information do you need that you do
904 not have in order to accurately calculate your savings?

905 And as position has it, we will start of this end of the table
906 with Ms. Veer.

907 Ms. Veer. Thank you, Mr. Chair, for the question.

908 Our savings for 2016 were \$561,620 and if my CFO were here,
909 he would probably give you the change. But I will say that there
910 may be other ways to calculate 340B savings but for my health
911 center it has been that margin remaining after the sale of the
912 drug. We manage all of our programs using profit and loss
913 statement specific to that program or to that site. And so it
914 is an exact number based on the net margin after the sale of all
915 drugs.

916 Mr. Griffith. All right, thank you very much.

917 Mr. Gifford.

918 Mr. Gifford. Thank you, Mr. Chairman.

919 We calculate our 340B savings in a very direct and simple
920 way, the cost of the medication at a non-340B rate less the cost
921 of the 340B medications. It is the difference between the two
922 costs that we use.

923 Mr. Griffith. Thank you, sir.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

924 Dr. Paulus.

925 Dr. Paulus. Thank you.

926 We calculate our savings in two ways. One, with respect to
927 drugs that we get through our wholesaler, we calculate those based
928 upon the difference between the discounted price and what our GPO
929 price is. And for contract pharmacies, our 340B vendor
930 calculates them based upon the discount.

931 Mr. Griffith. All right.

932 Mr. Reuland.

933 Mr. Reuland. Thank you, Mr. Chairman.

934 Yes, we calculate the GPO price versus the 340B price and
935 use that differential as our savings.

936 Mr. Griffith. All right.

937 Ms. Banna.

938 Ms. Banna. We also calculate the 340B price per unit of drug
939 and compare that to the price in the non-340B locations.

940 Mr. Griffith. Are those savings earmarked for specific
941 programs or are they channeled to a general fund?

942 And we will start on this end this time so that we try to
943 be more fair. Ms. Banna.

944 Ms. Banna. We monitor our savings first and foremost and
945 then, separately, we focus on growth and expansion of charity and
946 indigent care, and additionally expansion of oncology services,
947 and other services that our community is looking for.

948 Mr. Griffith. But I guess the question is is it earmarked

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

949 for those programs or does it go into a general fund and then those
950 are the things that, as a part of your institutional mission you
951 go forward with?

952 Ms. Banna. They aren't earmarked. They are tracked and
953 monitored and then our growth is tracked and monitored. And we
954 do ensure that our growth far exceeds the savings.

955 Mr. Griffith. Thank you.

956 Mr. Reuland.

957 Mr. Reuland. We invest in a variety of different programs
958 that are for community benefit using our savings. And they vary
959 in size and range and for different kinds of patient types.

960 Mr. Griffith. But are they earmarked or does it go into a
961 general fund and then that is part of your general mission? That
962 is what I am trying to sort out.

963 Mr. Reuland. One way maybe to think about it, perhaps, is
964 that there is not really a check that comes back, if you will.
965 This is a lower price paid. So there isn't a check that comes
966 back that then you have the opportunity to say where it goes. This
967 is a reflection of paying less for a drug than you otherwise would
968 pay.

969 So there is not really a budgeted amount that you could say
970 that is what you are going to put in each of these buckets.

971 Mr. Griffith. All right.

972 Dr. Paulus.

973 Dr. Paulus. To directly answer the question, there is not

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

974 a dollar-for-dollar tracking no more than there would be an
975 earmark for a tax dollar that I might pay in income tax.

976 But on the other hand, we track very closely our savings.
977 We know those savings and when we are preparing our budget for
978 each year, we include those dollars in the charity care
979 allocations in all of these programs.

980 So I would say that yes, they are targeted but not literally
981 dollar-for-dollar.

982 Mr. Griffith. Okay and when you say that, so when you are
983 doing your budget, you actually have a line in your budget that
984 says 340B savings and then they go out in these different
985 directions.

986 Dr. Paulus. Yes, we do.

987 Mr. Griffith. All right, thank you.

988 Mr. Gifford.

989 Mr. Gifford. In our budgeting process, we identify the
990 savings that we anticipate in the coming year and we direct it
991 to the pharmacy, health, and social services that I discussed in
992 my testimony.

993 Mr. Griffith. Thank you.

994 And Ms. Veer.

995 Ms. Veer. I would have to echo my colleagues to some degree.
996 It is not an exact line item transfer dollar-for-dollar from one
997 cost center to another cost center, but at the beginning of the
998 year, as part of both the budgeting and the strategic planning

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

999 process, we estimate what we anticipate those savings to be and
1000 then look at what programs they can fund, what otherwise unfunded
1001 programs they can fund.

1002 Then at the end of the year, we do an annual report to our
1003 Board of Directors linking those two together.

1004 Mr. Griffith. I appreciate that. I like the concepts that
1005 both Dr. Paulus and Ms. Veer -- that doesn't mean the others are
1006 not doing it right -- but I kind of like those because then somebody
1007 can actually take a look at it and see what you are doing with
1008 it directly.

1009 But I appreciate that and now I yield 5 minutes to Ms. DeGette
1010 for her questions.

1011 Ms. DeGette. Thank you very much, Mr. Chairman.

1012 I will just skip around. Dr. Paulus, I would like to ask
1013 you, yes or no, Mission Health reported to the committee that it
1014 saved about \$37 million through 340B in 2016. Is that correct?

1015 Dr. Paulus. I believe that is correct.

1016 Ms. DeGette. Thank you. And Mission Health spent more than
1017 \$183 million providing community benefits, including \$105 million
1018 in uncompensated care. Is that correct?

1019 Dr. Paulus. That is correct.

1020 Ms. DeGette. Now, Dr. Reuland, a similar question. In
1021 2016, Johns Hopkins generated about \$109 million in 340B savings.
1022 Is that correct?

1023 Mr. Reuland. Yes.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1024 Ms. DeGette. And Johns Hopkins provided nearly \$220 million
1025 in charitable care for vulnerable populations and other vital
1026 community benefits. Is that correct?

1027 Mr. Reuland. Yes.

1028 Ms. DeGette. No, Ms. Banna, your hospital, Northside,
1029 reported that it generated nearly \$53 million in 340B savings.
1030 Is that correct?

1031 Ms. Banna. That is correct.

1032 Ms. DeGette. And yet Northside reported to the committee
1033 that it spent nearly \$370 million in charity care. Is that right?

1034 Ms. Banna. That is right.

1035 Ms. DeGette. Now, let me just say the 340B Program doesn't
1036 seem to be some windfall that subsidizes bonuses for senior
1037 management but, as you all testified both in your written
1038 testimony and in your verbal testimony today, you are using this
1039 money to help provide essential benefits that the community needs.

1040 So I want to ask each of you if you can briefly describe what
1041 would happen if Congress eliminated the 340B money. I will start
1042 with you, Ms. Veer.

1043 Ms. Veer. Thank you because that is a wonderful question.
1044 It really gets to the heart of what we are all concerned about
1045 and our need for Congress to have confidence in the integrity and
1046 --

1047 Ms. DeGette. If you could just briefly --

1048 Ms. Veer. Sure.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1049 Ms. DeGette. -- describe some of those services. We,
1050 unfortunately, only have 5 minutes and I would like to hear from
1051 everybody.

1052 Ms. Veer. Absolutely. The delivery service that I
1053 mentioned that is delivering over 20,000 prescriptions to
1054 outlying rural areas would have to be eliminated because those
1055 costs are directly covered by the 340B savings, as would our
1056 in-house behavioral health counseling for people who don't
1057 receive care, or would not qualify for care, or experience delays
1058 in the mental health agency.

1059 Ms. DeGette. Thank you.

1060 Mr. Gifford, can you give me some examples?

1061 Mr. Gifford. Elimination of the 340B Program would
1062 substantially undermine the fight against AIDS. It would mean
1063 fewer resources, fewer services. Our patients would become more
1064 ill. They would not have an undetectable viral load. There
1065 would be new and more HIV infections and, sadly, far bigger health
1066 care costs.

1067 Ms. DeGette. All right, let me ask you why that is. What
1068 are the services that you provide that you would not be able to
1069 provide without this savings?

1070 Mr. Gifford. Certainly, we would not be able to provide as
1071 much medical care for uninsured patients, dental care, mental
1072 health therapy and drug treatment.

1073 Ms. DeGette. Dr. Paulus?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1074 Dr. Paulus. Yes, I would go back to Vice Chair Griffith's
1075 question, which is how we approach our budgeting. So we are going
1076 to expect to earn about \$38 million this year. As we look out
1077 into next year, we would have to cut \$38 million worth of programs.
1078 Those programs would be prioritized but might include -- for
1079 example, 10 to 12 percent of our NICU babies are opioid addicted.
1080 We developed a novel detox program so that those babies can be
1081 detoxed at home. That costs us over \$3 million a year to detox
1082 them at home and that might be something but we would sure as heck
1083 be cutting some very needed programs.

1084 Ms. DeGette. Mr. Reuland?

1085 Mr. Reuland. Thank you. An example of a program that we
1086 might not be able to offer would be something our Broadway Center,
1087 we call it, provides. It is substance abuse recovery treatment.
1088 And we provide supportive housing for patients who are enrolled
1089 in that program because if you send patients back to the same
1090 environment from which they came, even really great daily care
1091 isn't going to help them escape --

1092 Ms. DeGette. What do they do in this Broadway program?

1093 Mr. Reuland. So there is counseling. There is medication
1094 treatment, typical kinds of treatment for substance abuse
1095 treatment and recovery. And the supporting housing is a good
1096 example of the wraparound project that we provide so that we don't
1097 send folks back to the environment from which they came initially
1098 while they are trying to recover. That is the kind of thing --

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1099 that is a half a million dollars plus for us that we would have
1100 to take out that is an investment we make.

1101 Ms. DeGette. And Ms. Banna.

1102 Ms. Banna. You know immediately our organization's
1103 resources would be directed to offsetting the substantial drug
1104 price increases that we all experience annually. In doing so,
1105 the reduction of resources would slow our ability to provide
1106 additional services. So in our case, the 250 positions that we
1107 put in our oncology clinics that were not there before, either
1108 social workers, nurses, supervisors, research staff, care
1109 navigators, nutrition, genetic counselors, that pace would slow
1110 down. Those positions might not be funded, in addition to
1111 financial assistance directed directly to patients.

1112 Ms. DeGette. Thank you so much, Mr. Chairman.

1113 Mr. Griffith. The gentlelady yields back.

1114 I now recognize the chairman of the full committee, Mr.
1115 Walden of Oregon.

1116 The Chairman. I appreciate it.

1117 I served on a hospital board for 4 and 1/2, 5 years. Nobody,
1118 first of all, if talking about eliminating 340B Program. So,
1119 everybody breathe.

1120 Second, I have got to tell you I think when the average
1121 American hears what you would cut, not a one of you said any
1122 overhead, capital construction, salary bonus. It was infants
1123 trying to recover from opioids is the first thing. Really?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1124 I mean I have owned and operated a business -- I will leave
1125 it.

1126 We have had a lot of different ways we have heard about how
1127 the money you get out of this program is tracked to do charity
1128 care. Carolina Health Centers reported spending \$4.8 million in
1129 charity care in 2016. That represented 21 percent of the total
1130 patient revenue. Johns Hopkins Hospital reported \$28 million in
1131 charity care and nearly \$200 million on community benefit
1132 activities in 2016.

1133 Northside Hospital reported that from 2015 to 2016,
1134 September to August, it served over 32,000 distinct indigent and
1135 charity care patients, and reported spending \$350 million on
1136 charity care in 2016, putting its charity care at about seven
1137 percent. Yet, a 2017 Atlanta Journal Constitution article
1138 estimated Northside's charity care at 1.7 percent of total
1139 expenses for 2016, based on Northside's cost reports filed with
1140 the Federal Government. This makes it a little hard to do apples
1141 to apples comparison of whether covered entities are truly using
1142 340B savings to improve patient care.

1143 So to each of you, what do you think is the best measure to
1144 estimate an entity's commitment to serving low-income and
1145 uninsured individuals? Do community benefit programs serve only
1146 low-income and uninsured patients or the entire community,
1147 including those with commercial insurance? Would a patient
1148 receive one element of care for free, at a reduced cost, be counted

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1149 as one of those patients? I mean how do we track this? That is
1150 what we are trying to figure out here.

1151 The Government Accountability Office I think or the IG told
1152 us there is no clear definition what a patient is. There is no
1153 requirement to track. This program has expanded dramatically
1154 around the country.

1155 We are trying to figure out are the people who are supposed
1156 to get the help actually getting the help. So can you help us
1157 understand what the best measure is to estimate an entity's
1158 commitment to serving low-income and uninsured individuals?

1159 Ms. Banna, we will just start with you.

1160 Ms. Banna. Absolutely. I do think industry standard is not
1161 to reflect the provision of care to the vulnerable population of
1162 the percent of just operating expenses, which is what was done
1163 in the AJC article. I would say that is inaccurate or at least
1164 incomplete. When comparing to expenses, you are including things
1165 like overhead, and telephone, and depreciation on your buildings.

1166 So we would emphasize other more commonly quoted mechanisms,
1167 which would be the provision of charity and indigent in terms of
1168 total patient revenues or distinct patient served and those are
1169 the ways that we quoted in our submissions.

1170 Mr. Reuland. Mr. Walden, one of the things I might mention
1171 is when we set up programs, we tend to set them up from a clinical
1172 perspective to manage a disease state or a population with a
1173 disease. And so an example might be sickle cell anemia and sickle

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1174 cell disease is a disease that you may know disproportionately
1175 affects African Americans. And we have set up a very
1176 comprehensive program, the only one in the region to manage those
1177 kinds of patients.

1178 We can't really set it up with different sort of swim lanes
1179 for payer capability. People move in and out of insured status
1180 throughout their life, as you might imagine. And so what we set
1181 up is a clinical program to care for them in whatever state of
1182 care they need and then try to support around that whatever the
1183 insurance needs are.

1184 Dr. Paulus. First with respect to your comment, which I
1185 respect you have perspective on that, I did not say that we would
1186 not detox babies. What I said was we developed a program that
1187 saved the Medicaid program \$3 million by detoxing them at home
1188 and we would probably have to revert back to inpatient care.

1189 Second, we do every single day, or we would already be closed,
1190 the overhead, capital projects, et cetera. So, that is a routine
1191 part of our business.

1192 I would point you, perhaps, to the idea behind Schedule H
1193 for the IRS filing and the community benefit. I think there might
1194 be opportunities there to define and identify a specific
1195 reporting. I would think about total unreimbursed care because
1196 that is really what we are talking about here.

1197 And those are my thoughts.

1198 Mr. Gifford. Ryan White grantees may have a slightly less

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1199 complex financial world that we operate in. We welcome the
1200 opportunity to report the savings and how they are directed to
1201 specific costs for the delivery of care.

1202 Ms. Veer. I think the term or concept of charity care is
1203 one that is not terribly familiar for community health centers
1204 or in the community health center world, not because we don't
1205 understand that concept but because we operate under a set of
1206 statutory requirements that essentially mean we are on the hook
1207 for taking care of everyone, regardless of their ability to pay,
1208 and for providing a full range of services, regardless of their
1209 ability to pay, and have been for decades.

1210 So my health center, the \$4.2 million that is listed as
1211 charity care really represents the cost of all care provided to
1212 patients for which we receive no compensation.

1213 And I will give you an example. If a patient qualifies for
1214 our nominal fee, it is \$10 for a visit, which might encompass a
1215 99205 visit, so a complex visit, plus radiology, plus lab work.
1216 And for that, we are receiving \$10.

1217 So the health centers do have a very concrete way of measuring
1218 that.

1219 The Chairman. I appreciate that and I thought your initial
1220 answer in the beginning about how much you account for was spot
1221 on. So, thank you.

1222 Mr. Griffith. Thank you very much for yielding back, Mr.
1223 Chairman.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1224 I now recognize the ranking member, Mr. Pallone of New
1225 Jersey.

1226 Mr. Pallone. Thank you, Mr. Chairman.

1227 I have been impressed with the responses the committee has
1228 received with its inquiries about how covered entities use the
1229 340B Program and it appears that recipients rely on program
1230 savings to provide important services to vulnerable patient
1231 populations.

1232 But I just want to briefly go with each of you, if I could,
1233 if you can just answer my question in 30 seconds.

1234 Mr. Gifford, your testimony states that the AIDS Resource
1235 Center of Wisconsin received \$7.4 million in 340B discounts last
1236 year and that these savings played a crucial role in providing
1237 service to your patients. Can you explain in 30 seconds how the
1238 340B Program helps you provide services?

1239 Mr. Gifford. Certainly. They support the cost that Ms.
1240 Veer was discussing in terms of the professional time providing
1241 medical care, the laboratory costs, the medications that
1242 uninsured patients receive.

1243 And then for our physicians, they often talk about health
1244 care needed is overcoming the social barriers to care. So, making
1245 sure that mental health illnesses and drug addictions are
1246 addressed before they can get into the medical exam room.

1247 Mr. Pallone. Thank you.

1248 Now to Mission Health. Dr. Paulus, you reported that

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1249 Mission Health provided \$105 million in charity and unreimbursed
1250 care. You also reported that Mission Health's community benefits
1251 were worth \$183 million that year.

1252 In 30 seconds or less, how does the 340B Program help you
1253 provide services?

1254 Dr. Paulus. Well, we are faced with a tsunami of illness
1255 and of need in our community. And as I described, we take our
1256 anticipated savings on 340B and specifically look to allocate
1257 those to funds to programs that we could otherwise not afford to
1258 provide.

1259 So there is a great amount of detail in our testimony in the
1260 written document about each of those program.

1261 Mr. Pallone. All right, next, Johns Hopkins. Dr. Reuland,
1262 you reported that Johns Hopkins provided \$28 million in charity
1263 care and community benefits worth \$191 million. Briefly, how
1264 does the 340B Program help Johns Hopkins provide services to the
1265 community?

1266 Mr. Reuland. So I will give you just two very quick
1267 examples, one that is in our community benefit report and one that
1268 isn't.

1269 In the community benefit report, the Health Leads Program
1270 is an opportunity for us to prescribe basic things like food,
1271 shelter, clothing, utility support for patients who need it. And
1272 that can be for any disease state. That is a general concept that
1273 we use in a lot of our outpatient areas.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1274 More broadly, we have done a development exercise in the
1275 region right north of our campus that is a partnership with the
1276 city and some developers to basically take an old burned out part
1277 of the city and redevelop it in a way that we would be happy to
1278 tell you more about. But it is those kinds of city building and
1279 infrastructure-building activity that are on the broader scale.

1280 Mr. Pallone. Well, thank you.

1281 And then moving on to Carolina Health Centers, Ms. Veer, you
1282 state in your testimony the 340B savings enable Carolina Health
1283 to provide services that would otherwise go unfunded.

1284 In a minute or less, how does that work?

1285 Ms. Veer. Well first and foremost, I will read a quote out
1286 of my written statement that was from one of my most senior medical
1287 providers. To diagnose when the patient has not access to
1288 affordable medication is always an exercise in futility and, in
1289 some cases, it is an announcement of a death sentence.

1290 So first and foremost, it allows us to make essential
1291 prescription medications available to low-income patients who
1292 otherwise would not have any access to their medication.

1293 Mr. Pallone. All right, thank you.

1294 And then last, Ms. Banna, Northside Hospital reported that
1295 it provided nearly \$370 million in charity care, as well as
1296 community benefits such as oncology, patient assistance,
1297 maternity education, surgical services for the uninsured. Do you
1298 want to explain to us how 340B helps you provide those services?

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1299 Ms. Banna. Absolutely. I think in its most simplest form,
1300 340B reduces our costs. And as a nonprofit hospital, that is what
1301 we strive for each and every day. Reducing our costs fuels our
1302 ability to expand our mission into our communities. And you are
1303 hearing from each of us that our missions are different but we
1304 use that savings to empower growth out into the communities that
1305 we serve.

1306 Mr. Pallone. All right, thanks.

1307 I wanted to ask anyone how you make sure the savings actually
1308 go to help patients. I know 30 seconds, maybe I will go back to
1309 Mr. Reuland.

1310 Mr. Reuland. Well, there are plenty of very direct
1311 assistance programs, including a Pharmacy Assistance Program, for
1312 example. Patients who show up and if you walk to one of our
1313 clinics and they say I cannot pay for my medications or a copayment
1314 for them, we have the discretion through a Pharmacy Assistance
1315 Program on the spot to make sure that the patient can leave with
1316 the medications that they needed. And then we can help them after
1317 that to perhaps connect them to some other form of payment going
1318 on over time or, sometimes, we continue supporting that right
1319 through these dollars.

1320 Mr. Pallone. That is a good example.

1321 Thank you, Mr. Chairman. Thank you all.

1322 Mr. Griffith. The gentleman yields back.

1323 I now recognize Mr. Walberg of Michigan.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

1324 Mr. Walberg. Thank you, Mr. Chairman and thanks to the
1325 witnesses for taking the time to be here with us today.

1326 I want to get to the concerns about the savings that you have
1327 had that you have talked about today. I also want to ask some
1328 questions relative to how you train and evaluate the success of
1329 the program, the costs, et cetera, how you administer it. But
1330 I think our chairman brought up some points I would like to go
1331 into first and meddle a little bit, I guess, at this point, kind
1332 of get personal.

1333 I pulled the 990s of each of your organizations for the most
1334 recent years that we are able to get to, 2015. So let me ask you
1335 just to respond yes or no, correct or false to these questions.

1336 Ms. Veer, Carolina Health Centers indicated that the salary
1337 for the CEO was \$198,000. Is that correct?

1338 Ms. Veer. That is correct.

1339 Mr. Walberg. Mr. Gifford, for the AIDS Resource Center, it
1340 was indicated that the salary for the CEO was \$350,000. Is that
1341 correct?

1342 Mr. Gifford. That is cash compensation, yes.

1343 Mr. Walberg. Okay, cash compensation. Okay.

1344 Let me ask Mr. Paulus, Mission listed at \$1.6 million,
1345 approximately.

1346 Dr. Paulus. I assume that is correct.

1347 Mr. Walberg. Okay. Mr. Reuland, Johns Hopkins lists for
1348 that year \$2.6 million.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1349 Mr. Reuland. I also have to assume that is correct.

1350 Mr. Walberg. Okay and then Ms. Banna, it is listed for
1351 Northside at \$2.8 million that year.

1352 Ms. Banna. That is correct.

1353 Mr. Walberg. Okay. Let me plumb a little bit more here.
1354 Going back to the net assets for each of your organizations at
1355 the end of 2015.

1356 Northside, Ms. Banna, \$1 billion net asset; net income \$157
1357 million.

1358 Ms. Banna. That is correct.

1359 Mr. Walberg. Is that correct?

1360 Mr. Reuland, Johns Hopkins listed at \$1.3 billion; net income
1361 \$80 million, almost \$81 million.

1362 Mr. Reuland. That is correct, about a 3.6 percent operating
1363 margin.

1364 Mr. Walberg. Okay. Mr. Paulus, Mission is listed at \$1.4
1365 billion; net income \$101-102 million.

1366 Dr. Paulus. Sounds right.

1367 Mr. Walberg. Okay. Mr. Gifford, your AIDS Resource Center
1368 \$12.7 million.

1369 Mr. Gifford. That sounds correct and it is just a fraction
1370 of what our financial advisors are suggesting necessary to assure
1371 longevity.

1372 Mr. Walberg. The net assets of \$12.7 million.

1373 Mr. Gifford. Correct.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1374 Mr. Walberg. Ms. Veer, Carolina Health Centers, \$7.7
1375 million net assets?

1376 Ms. Veer. That sounds correct, yes.

1377 Mr. Walberg. Okay. I just wanted that for the record.
1378 Again, there are certainly explanations, and extenuating
1379 circumstances, and other things that I am sure you can share with
1380 us on those issues but it is good to have those factors in,
1381 especially when we are talking about entities listing saving over
1382 \$100 million annually through the program.

1383 The program has grown rapidly in the last decade and it seems
1384 it will continue to grow. So, those figures are important.

1385 In the area of education, let me ask you each to respond.
1386 First of all for the sake of context, how many full-time employees
1387 do you have total? And secondly, how many employees of those
1388 full-time employees do you have devoted fully to 340B
1389 administration and compliance?

1390 Ms. Veer?

1391 Ms. Veer. In our most recent Universal Data System report
1392 to HRSA, we reported 231.20 full-time employee equivalent. Of
1393 that, 45.40 are pharmacy employees. And since approximately 50
1394 percent of our business in the pharmacy is 340B, I would estimate
1395 that our pharmacy staff devoted to 340B is approximately 25.

1396 Mr. Walberg. Twenty-five, okay.

1397 Mr. Gifford?

1398 Mr. Gifford. ARCW has 240 employees, about 25 of them who

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1399 work in our pharmacy. 340B is the largest part of our pharmacy
1400 operations so, they are all devoted to it. Additionally, we have
1401 a compliance department that includes two full-time employees and
1402 parts of six other employees.

1403 Mr. Walberg. Mr. Paulus?

1404 Dr. Paulus. We have two dedicated full-time people who do
1405 nothing but 340B and 76 others that have 340B as part of their
1406 job description, including five people who have gone through a
1407 complete 340B university training.

1408 Mr. Walberg. Total employees how many?

1409 Dr. Paulus. Twelve thousand.

1410 Mr. Walberg. Twelve thousand total employees.

1411 Mr. Reuland?

1412 Mr. Reuland. Johns Hopkins Hospital employs about 10,000
1413 FTEs directly, not counting our physicians. And we have about
1414 nine to ten whose effort is primarily dedicated toward the
1415 program, significantly toward the compliance of the program.

1416 Mr. Walberg. Okay and Ms. Banna?

1417 Ms. Banna. We have over 14,000 employees. We have an
1418 integrated approach. There are people in multiple departments
1419 across our hospital that have been educated and we consider
1420 content experts. Fifty to seventy-five people are educated in
1421 content experts. I would say the pharmacists are most directly
1422 full-time 340B-responsible. So that is probably 25 to 25.

1423 Mr. Walberg. Thank you. I yield back.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1424 Mr. Griffith. The gentleman yields back. I now recognize
1425 Ms. Castro of Florida for 5 minutes for questions.

1426 Ms. Castor. Thank you, Mr. Chairman. Based upon what I
1427 have seen from my hospitals, and providers back home, and the
1428 testimony today, I think it is clear that the 340B Program is
1429 critical to America's healthcare safety net. And according to
1430 HRSA, 340B savings represent less than two percent of total drug
1431 spending in this country but the benefits here under 340B are so
1432 broad where you are able to expand health services, you are able
1433 to see more patients, offset losses from uncompensated care.

1434 And at a time when drug prices are skyrocketing across the
1435 board for consumers, here is one bright light for our neighbors
1436 back home. And I have seen it at Saint Joseph's Hospital. It
1437 is part of the BayCare Health System. They provide over \$100
1438 million in charity care per year, about, and 340B has helped them
1439 save about \$17 million.

1440 They run the Children's Hospital there, a complex clinic for
1441 the medically fragile. And what they are able to do with
1442 wraparound services, as has been mentioned, is remarkable.

1443 They have had to expand substantially behavioral health and
1444 substance abuse services and that is where part of the savings
1445 go. And we are all grappling with that.

1446 And they have a care clinic that stretches the federal Ryan
1447 White funding to support a continuum of care to maintain a higher
1448 retention rate for HIV patients achieving viral suppression,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1449 which is vital for the future.

1450 And Tampa General Hospital is our teaching hospital for the
1451 University of South Florida. It is our Level I trauma center.
1452 They provide about \$78 million in uncompensated care. 340B has
1453 helped them save about \$35 million. And I have seen what they
1454 have been able to do as the Congress has said we are going penalize
1455 the hospital if patients are readmitted after discharge. I have
1456 seen what they have been able to do on an innovative basis to really
1457 make sure patients at discharge have the prescriptions they need
1458 and it has largely been through the 340B savings that they have
1459 been able to achieve that.

1460 So, Dr. Reuland, Johns Hopkins recently expanded to the All
1461 Children's Hospital in the Tampa Bay area. We are grateful for
1462 that, as you raise the standard of care there.

1463 In your written response to the committee's letter, you
1464 suggest that the total amount of free and discounted care provided
1465 you can't just look at pure charity care but also at the services
1466 provided to the community to help vulnerable populations. I have
1467 seen this working. I have seen providers become more innovative.
1468 Is that a fair understanding of how Johns Hopkins measures its
1469 commitment to the community?

1470 Mr. Reuland. Yes, I appreciate you pointing that out. And
1471 I also appreciate you pointing out that the growth in savings is
1472 really a reflection of the growth in our spend of drugs.

1473 And so to give you our experience, our drug spend grows

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1474 between eight to ten percent a year over the past 5 years,
1475 oncologics, new therapies, immunotherapies, and in some cases
1476 just explained drug inflation that we can't explain. We had seven
1477 very common drugs, the price of which went up 312 percent with
1478 volume going up 12 percent. And one of those drugs is commonly
1479 found on a crash cart, a cart that we use to resuscitate patients.

1480 So the drug spend growth is what leads the savings growth
1481 for us and that is a big part of it.

1482 Ms. Castor. And there is an important qualifier. If
1483 someone just tuned into this hearing, they would say wow, what
1484 is happening here but HRSA and the parameters that the Congress
1485 has put into law over time says these covered entities are a real
1486 subset of providers across the country. Can you explain that a
1487 little further? What is the covered entity gateway to qualify
1488 for 340B?

1489 Mr. Reuland. If I understand the question, we qualify by
1490 virtue of being a DSH hospital. Our percentage DSH is about 19
1491 percent.

1492 Ms. Castor. DSH hospital for someone that is tuning in --

1493 Mr. Reuland. Disproportionate share of our patients come
1494 from an underserved and have a social security disability
1495 eligibility.

1496 Ms. Castor. You are saying a disproportionate share of our
1497 neighbors back home who don't have health insurance coverage or
1498 they are underinsured.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1499 Mr. Reuland. Yes.

1500 Ms. Castor. And Ms. Banna, in Georgia, you are kind of in
1501 the same boat as the State of Florida. Georgia did not expand
1502 Medicaid coverage, like Florida. Our uninsured rate is about 13
1503 percent. I think it is about that in Georgia. Is that right?

1504 Ms. Banna. I believe it was nine percent most recently.

1505 Ms. Castor. Most recently nine percent. So you know these
1506 disproportionate share providers and our community health centers
1507 are seeing so many folks who just do not have the ability to pay.
1508 And what you are able to do with these savings is pretty
1509 remarkable.

1510 But let me ask you this, Ms. Banna. There are all sorts of
1511 -- this goes back to what Dr. Paulus said, the tsunami of need.
1512 Should we be looking at purely charity care provided to uninsured
1513 individuals or the total uncompensated care borne by hospitals,
1514 including bad debt and losses on Medicaid? In Florida we are
1515 looking at a governor that wants to slash the reimbursement rate
1516 yet again. That is going to make it even more difficult to provide
1517 the care that our neighbors need.

1518 Ms. Banna. I agree. Dr. Paulus brought this up earlier.
1519 Uncompensated care is measured on the IRS 990, which is the
1520 Schedule H is used as a reliable method for quoting the complete
1521 view of the uncompensated care that a healthcare entity is
1522 providing to its community.

1523 In responding today, Northside chose conservatively to

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1524 respond to only the indigent and charity care that we provide,
1525 simply because --

1526 Ms. Castor. You didn't include bad debt?

1527 Ms. Banna. We didn't include bad debt and we didn't include
1528 other elements of uncompensated care, which includes the care that
1529 is not covered that is provided to Medicare and Medicaid
1530 beneficiaries.

1531 There are entire other populations of care that is provided
1532 effectively free to the community.

1533 Ms. Castor. Thank you very much.

1534 Mr. Griffith. The gentlelady yields back.

1535 I now recognize Mr. Costello of Pennsylvania for 5 minutes
1536 for questions.

1537 Mr. Costello. Thank you, Mr. Chairman.

1538 To each witness, the 340B Program provides covered entities
1539 with discounts on prescription drugs. Does your entity provide
1540 all 340B patients with discounted prices on prescription drugs?

1541 Ms. Veer. Starting on this end, I am assuming. Yes, we do,
1542 according to the rules, HRSA rules, around our sliding fee scale.
1543 Sliding fee is required. A sliding fee program is required for
1544 all services that we provide.

1545 So in my organization, the price to a patient under 200
1546 percent of poverty is based on the 340B discount price plus a
1547 deeply discounted dispensing fee.

1548 Mr. Costello. Does your entity provide uninsured or

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1549 self-pay 340B patients with discounted prices on prescription
1550 drugs?

1551 Ms. Veer. Yes.

1552 Mr. Costello. Mr. Gifford.

1553 Mr. Gifford. Yes, we do. We operate under a comparable
1554 sliding fee scale that FQHCs --

1555 Mr. Costello. Yes to both those questions?

1556 Mr. Gifford. Yes.

1557 Mr. Costello. Dr. Paulus?

1558 Dr. Paulus. Yes, we don't always know who is 340B-eligible
1559 at the time of service but we provide, as I said, free care up
1560 to 200 percent of the federal poverty guidelines. And we have
1561 the Medication Assistance Program that provides free or
1562 discounted drugs to all of those patients.

1563 Mr. Costello. Okay, Mr. Reuland.

1564 Mr. Reuland. Yes, our Pharmacy Assistance Program applies
1565 to any patient, whether uninsured, underinsured. If they can't
1566 afford their coinsurance and their copayments, we use our Pharmacy
1567 Assistance and Charity Care policies to help cover them.

1568 Mr. Costello. Yes to both questions?

1569 Mr. Gifford. Yes.

1570 Mr. Costello. Ms. Banna?

1571 Ms. Banna. Yes to both questions. If you qualify for
1572 indigent or charity care, then we are looking for opportunities
1573 to provide that.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1574 Mr. Costello. Okay, back to Ms. Veer. Does your
1575 organization use patient assistance programs offered by
1576 biopharmaceutical companies or other entities to help lower the
1577 cost of prescription medicines for patients?

1578 Ms. Veer. Yes, we do.

1579 Mr. Costello. What percentage of your patients have free
1580 -- receive free medicine from a patient assistance program that
1581 is offered by a biopharmaceutical company or other entity? What
1582 percentage?

1583 Ms. Veer. I don't have that exact percentage at my
1584 fingertips.

1585 Mr. Costello. Do you have that, though, the answer to that,
1586 in terms of the percentage?

1587 Ms. Veer. I could obtain that but I don't have it in my
1588 documents.

1589 Mr. Costello. Mr. Gifford?

1590 Mr. Gifford. Yes, we use financial pharmacy assistance
1591 programs and I could obtain the percentage of patients that
1592 utilize them for you also.

1593 Mr. Costello. Dr. Paulus?

1594 Dr. Paulus. We do, from time to time, use that. I do not
1595 know what the percentage is. I could try to find out.

1596 Mr. Costello. Mr. Reuland?

1597 Mr. Reuland. Yes, we do use those programs. I don't have
1598 that percentage here. And we also use foundations and other

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1599 not-for-profits.

1600 Mr. Costello. Ms. Banna?

1601 Ms. Banna. We do have an Oncology Patient Assistance
1602 Program. Forty-nine million of care was identified specifically
1603 to oncology patients that is completely separate from charity and
1604 indigent care. So needs beyond say means tested, \$31 million of
1605 that represented free drugs that were supplied by vendors. So
1606 some of the full-time equivalent of people that I mentioned that
1607 we have hired work to contact vendors directly and identify
1608 programs to supply drugs free to these patients.

1609 Mr. Costello. Okay. So another line of inquiry here.

1610 I served on the hospital board for a little while. I also
1611 served as a county commissioner. The best thing was flexible
1612 funding. When you had a funding stream that you were able to sort
1613 of figure out where to fill in the gaps that didn't have a lot
1614 of reporting requirements, that wasn't subject to an audit that
1615 sort of froze where or when you could use the money, that was always
1616 preferable to a funding stream that had attachments to it that
1617 required an audit.

1618 And I think the concern here, everybody supports 340B.
1619 Okay? I look at all of you. You are in it for the right reasons.
1620 You want to do good. You are helping people. Totally onboard.

1621 I think the concern, as I read through the materials is that
1622 with the 340B funding does not necessarily come the type of
1623 accounting accountability that enables us to audit, to ensure that

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1624 the money is being spent in those programs and in the ways with
1625 which it was intended. And so when we read that while we weren't
1626 able to unearth through an audit whether compliance was in fact
1627 successful or not as a consequence of us not being able to audit,
1628 it causes a great deal of frustration and we want to fix that.

1629 Mr. Gifford, as I understand it, you have -- let me make sure
1630 I have this right, have you developed software to monitor
1631 compliance?

1632 Mr. Gifford. Yes, we have.

1633 Mr. Costello. Okay. Are all of you familiar with the
1634 software that he has developed to monitor compliance?

1635 Do any of you object to creating an accounting mechanism so
1636 that as you get this funding, it is able to be audited in a way
1637 which comports with us being able to ensure that you have 340B
1638 compliance? I think that that is the gist of it, as I --

1639 Do you have concerns? Ms. Veer.

1640 Ms. Veer. Yes, I was just going to say I do think, at least
1641 for -- I can only speak from the perspective of a HRSA grantee
1642 but from that perspective, one of our grant conditions is that
1643 we are required to use all program income, including what is
1644 generated outside of the grant, for the purposes of advancing our
1645 HRSA scope of projects. So we do have a reporting mechanism for
1646 accountability.

1647 And in terms of our pharmacy, from the compliance standpoint,
1648 we audit daily to ensure that the program is being used

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1649 specifically for 340B patients.

1650 Mr. Reuland. Yes, I would add it sounds like there may be
1651 two issues, is the compliance with meeting the requirements and
1652 I think the software program. I am not sure which one you are
1653 referring to there but we use one as well to assure that we only
1654 avail ourselves of a discount for the appropriate patients. And
1655 that is an important part of the program.

1656 Anything that would curtail the flexibility, as you said,
1657 of our ability to invest in that entire patient would be a
1658 challenge I think. So we would look at a policy proposal but the
1659 flexibility remains the most important thing, as you pointed out.

1660 Mr. Costello. I yield back. Thank you, Mr. Chairman.

1661 Mr. Griffith. I thank the gentleman. The gentleman yields
1662 back.

1663 I know recognize Ms. Schakowsky -- Ms. Clarke has just walked
1664 in. Are you ready to go, Ms. Clarke?

1665 Ms. Clarke. Yes, I am.

1666 Mr. Griffith. All right, then Ms. Clarke of New York.

1667 Ms. Clarke. Thank you very much, Mr. Chairman and I thank
1668 our Ranking Member DeGette. I thank our expert panelists for
1669 their testimony here today.

1670 I understand that a lot of the questions my colleagues about
1671 this program relate to whether providers are using their 340B
1672 benefit to stretch scarce federal resources as far as possible
1673 to help low-income patients.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1674 As I understand the purpose of the 340B Program, Congress
1675 intended to provide a financial benefit to qualifying providers
1676 who treat high volume of low-income, Medicaid, uninsured, and
1677 underinsured patients so they are able to provide services to
1678 these populations.

1679 I hear frequently from hospitals in my district about how
1680 they are able to provide services to low-income patients in my
1681 district because of the 340B Program. For example, NYU Langone
1682 Health has invested 340B funds in several areas in my district,
1683 in particular, at the Family Health Center and four school-based
1684 health centers. 340B funds were used to implement at the Family
1685 Health Center and the school-based health centers the same
1686 electronic health system that is used at NYU Langone Health for
1687 all its hospitals' and physicians' offices so that when one of
1688 their patients goes to the NYU Langone Hospital-Brooklyn, after
1689 being seen at the Family Health Center, there is a full record
1690 of the treatment that patient received at the Family Health Center
1691 or school-based health center, avoiding duplication of tests and
1692 giving the treating physician a full view of the patient's history
1693 prior to care.

1694 I also hear frequently from hospitals that there would be
1695 an impact on their ability to treat low-income and rural patients
1696 if access to 340B savings was limited.

1697 So my question to you is can you tell me about that. Without
1698 340B, what would be the impact on patient care? And feel free,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1699 whoever.

1700 Ms. Veer. I think the most immediate impact on patient care
1701 is without the 340B Drug Pricing Program, the prescriptions
1702 themselves would be unaffordable for many of our patients.

1703 On the medical side of our health center, we serve
1704 approximately 22 percent of uninsured patients of our 26,000. So
1705 for that 22 percent of our patients, I am not sure that they would
1706 have access to affordable medication. Affordable medication
1707 drives -- it is the greatest driver of improved clinical outcomes.
1708 So it would have a dramatic impact on our clinical outcomes.

1709 Dr. Paulus. I would just add to that. For us, if you look
1710 back to 2016, we had about \$37 million in 340B savings and we had
1711 a \$53 million operating margin. So 70 percent of our entire
1712 operating margin, which is not for largess but for maintaining
1713 programs, and replacing buildings that are deteriorated, and so
1714 forth, and so on, that would be gone.

1715 In addition to that, as Ms. Veer just noted, when you look
1716 at the long-term impact of appropriate pharmaceuticals, it is one
1717 of the few places where we can make secondary prevention. By
1718 that, I mean we can treat a disease like hypercholesterolemia or
1719 other kinds of things and avoid much more expensive, much more
1720 debilitating programs downstream.

1721 So unless people perceive that there is free money laying
1722 around or we are sort of just grossly inefficient and incompetent,
1723 you can't remove that kind of benefit. And again, in our case,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1724 the entire benefit for 340B is less than just our charity care.

1725 Lastly, you can't look at this without also looking at bad
1726 debt. As high deductible plans have gotten ever higher, the
1727 patients have no ability to pay those amounts. They then become
1728 part of the charity care, which is one of the reasons why our
1729 charity care is up 20 percent in 2017 over 2016 because those
1730 people have no capacity to pay those deductibles.

1731 Mr. Reuland. Thank you for the question. And I think an
1732 example, I will build on that sickle cell disease program I
1733 mentioned earlier.

1734 One of the things that Dr. Lanzkron and her team do is
1735 actually reach out to patients to make sure -- because high and
1736 low temperature exposure can actually bring on a sickle cell
1737 crisis, they work hard to make sure that they in fact have
1738 appropriate air conditioning option or heating option so that they
1739 can avoid having a crisis in the first place. Those are the kind
1740 of things that you could imagine would suffer.

1741 On a larger scale, we have invested in a program, a bundle
1742 of case management services that has been shown to reduce
1743 readmissions and inappropriate use of our hospitals and EDs on
1744 a broad scale. If we can't fund those kind of interventions, we
1745 could drive utilization back up in an unintended way.

1746 Ms. Clarke. I thank all of you for your response and I yield
1747 back, Mr. Chairman. Thank you.

1748 Mr. Griffith. Thank you for yielding back.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1749 I now recognize the gentleman, Mr. Carter of Georgia.

1750 Mr. Carter. Thank you, Mr. Chairman and thank all of you
1751 for being here today.

1752 As the only pharmacist currently serving in Congress, I am
1753 very familiar with the 340B Program. I have seen the benefits.
1754 I have also seen where it can be abused.

1755 As the chairman said earlier, the chairman of the full
1756 committee, the reason we are here is because one of the initiatives
1757 of this committee, hence, Oversight and Investigations, is to look
1758 into programs and see how we can improve those programs.

1759 I will remind you that we had a hearing in July. And for
1760 my colleagues, I want to remind them, if you can play the clip
1761 now, of what we heard in that hearing.

1762 Well, it looks like we are not going to get it. But what
1763 we heard over and over was the statute is silent. The statute
1764 is silent. It was irresponsible, as Members of Congress, that
1765 we did not specify exactly what we heard.

1766 Have you got it now?

1767 [Video shown.]

1768 Mr. Carter. That is what we heard. That is why we are here
1769 today. That is why we need your help because it is irresponsible
1770 of us. That is our responsibility in Congress.

1771 You know I take offense and I am resentful of my colleagues
1772 on the other side of the dais to insinuate that we have somehow
1773 said we wanted to cut out this program. I have never heard anyone

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1774 say we wanted to cut out this program but we have a responsibility,
1775 as Members of Congress, to make sure this program is running
1776 correctly and it is not being abused.

1777 I want to ask some very quick questions here. Ms. Vanna,
1778 I am very familiar with Northside Hospital and I have worked with
1779 you in the State Legislature. You enjoy a great reputation in
1780 the State of Georgia. I am sure it is hard-earned. I am sure
1781 it is well-deserved.

1782 However, I need to ask you some questions, particularly as
1783 it relates to consolidation. One of the things that I have
1784 discovered as a Member of Congress is just what an impact our
1785 actions here in Congress can have on the private sector and have
1786 on the free market. Have you, in recent years since you have
1787 started this program, has there been an increase in the number
1788 of clinics that Northside Hospital has acquired, specifically
1789 oncology clinics?

1790 Ms. Banna. I think that we are, as a hospital system, are
1791 being encouraged to expand our clinically-integrated outpatient
1792 care model, yes.

1793 Mr. Carter. That is not what I asked and you are under oath.
1794 Okay, Ms. Banna? Have you increased the number of oncology
1795 clinics that you have bought since the 340B Program has come into
1796 effect?

1797 Ms. Banna. Well in our case, we did acquire oncology clinics
1798 in 2011 and 2012, yes.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1799 Mr. Carter. Does the 340B Program have anything to do with
1800 that or are you acquiring the oncology clinics because you have
1801 a chance to make more money through the 340B Program, hence, what
1802 we have done in Congress is leading to a consolidation in health
1803 care inadvertently on our part?

1804 Ms. Banna. No and forgive me, that goes back to my prior
1805 answer. We are being encouraged to expand our
1806 clinically-integrated model past the hospital --

1807 Mr. Carter. Ms. Banna, can you get me in writing how many
1808 oncology clinics Northside Hospital has acquired since 1992?
1809 Will you do that for me? I would appreciate that very much.

1810 I want to go now to Mr. Reuland and Johns Hopkins and I want
1811 to ask you how many 340B drugs were distributed to Part B
1812 beneficiaries last year. Do you know that?

1813 Mr. Reuland. I don't know that.

1814 Mr. Carter. Can you get me that in writing?

1815 Mr. Reuland. I think so. So what is the question?

1816 Mr. Carter. The question is how many 340B drugs were
1817 distributed to Part B recipients last year through Johns Hopkins?

1818 Mr. Reuland. It might be good to work offline to make sure
1819 we know what you mean by how many drugs.

1820 Mr. Carter. How many drugs, obviously 340B drugs that you
1821 got through that.

1822 Mr. Reuland. But we would be happy to work with you.

1823 Mr. Carter. Okay you all are familiar with CMS and their

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1824 recent proposal to cut the reimbursement for Part B reimbursement
1825 on these drugs from APS plus six to APS minus 22 and a half. Are
1826 all of you familiar with that proposal?

1827 Mr. Gifford, you said earlier in your testimony, in your
1828 opening testimony that it doesn't cost the government any money
1829 whatsoever. And I would refute that point. In fact, I would tell
1830 you that the CMS has said that by changing this formula that it
1831 could save over \$900 million. So it does cost taxpayers money
1832 and it costs taxpayers money not only in the Part B program but
1833 also in the programs with Part D, when it pushes people out of
1834 the donut hole into the catastrophic. Then, the Federal
1835 Government has to pay more and that is something that costs us
1836 as well.

1837 One question for you, Mr. Gifford, and that is as I understand
1838 it the requirements for the Ryan White patients for the AIDS
1839 patients are actually more stringent than they are for anywhere
1840 else. You seem to be a strong advocate of the program and very
1841 supportive of the program.

1842 If we were to tighten it up for the other areas, do you think
1843 that it would impact them that much?

1844 Mr. Gifford. I would hope that the community would look at
1845 expanding the use of the dollars that we save through 340B and
1846 I included that in the written testimony. The current
1847 constriction on Ryan White programs are actually inhibiting our
1848 ability to --

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1849 Mr. Carter. So your answer to me is that this is actually
1850 restricting you. You could actually, if we were to loosen it up
1851 instead of tightening it up, that you could actually do more as
1852 these other hospitals have done.

1853 Mr. Gifford. If we could loosen this up for Ryan White --

1854 Mr. Carter. But my question to you was since you have got
1855 more stringent requirements, you still benefitted from the
1856 program. You spoke very highly of the program.

1857 Mr. Gifford. The program does support the fight against
1858 AIDS in many ways and we would hope that the committee would expand
1859 our ability to offer life savings --

1860 Mr. Carter. Again, let me explain to all of you that no one
1861 has said they want to do away with this program. All we have said
1862 is that we understand we have a responsibility to tighten this
1863 up, to make sure it is being used like it was.

1864 And Ms. Veer, you have made some very good points and I want
1865 to thank you for what you are doing over there.

1866 Thank you very much, Mr. Chairman.

1867 Mr. Griffith. The gentleman yields back.

1868 I now recognize Mr. Tonko of New York for 5 minutes for
1869 questioning.

1870 Mr. Tonko. Thank you, Mr. Chair.

1871 Before I begin my questioning, I will echo my colleagues'
1872 expressions of strong support for the 340B Program. While it is
1873 always appropriate to conduct oversight and review that the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

implementation of a 25-year-old law, the testimony we have heard from our witnesses today about the ways in which they are using 340B savings to reinvest in their communities and serve needy populations shows us that the program is working well across our country.

In my district, the 340B program is also paying dividends, benefiting community health centers, Ryan White clinics, and safety net hospitals.

Ellis Hospital in Schenectady used 340B savings to treat a patient suffering from an acute porphyria attack. As you know, porphyria is a very rare disease that causes cycles of extreme abdominal pain, vomiting, high blood pressure, increased heart rate and anxiety. The patient had previously been unable to obtain treatment, which costs upwards of \$50,000, due to the cost. As a direct result of the 340B Program, Ellis was able to provide the initial treatment and also to develop a procurement and administration plan for future attacks.

These types of human success stories help to illuminate the value that the 340B Program provides and should also serve as a note of caution to policy makers as we evaluate the program.

As with other efforts to address health care in this body, our goal when considering changes to 340B must always be first do no harm.

I want to go back to the questioning of our witness from Northside Hospital. To you, Ms. Banna, I am understanding that

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1899 Northside reported to the committee that most of its 340B child
1900 site were sites already associated with Northside prior to 2012
1901 but were registered between 2012 and 2017 because of changes to
1902 the HRSA guidance.

1903 Northside did, however, acquire two oncology practices in
1904 2013, did it not?

1905 Ms. Banna. Those discussions began in 2011 and completed
1906 in 2012.

1907 Mr. Tonko. Okay. So Ms. Banna, can you explain why
1908 Northside acquired these sites?

1909 Ms. Banna. Absolutely. We were approached by a large
1910 oncology practice that was seeking integration with the hospital
1911 system, as were several other hospital systems in the Atlanta
1912 area. We worked with them throughout 2011 and 2012 to determine
1913 the model that would provide the right kind of
1914 clinically-integrated care that both parties were looking for and
1915 completed that transaction in 2012.

1916 Mr. Tonko. And Ms. Banna, to your knowledge, has any patient
1917 been denied service at these oncology sites due to inability to
1918 pay since you acquired them?

1919 Ms. Banna. Since we acquired them, no. As a nonprofit
1920 hospital, that is a service that we extend to meet the need no
1921 matter the ability to pay.

1922 And typically, that is a service that is not in place prior
1923 to a nonprofit hospital's entrance.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1924 Mr. Tonko. Thank you, Ms. Banna. And would it be accurate
1925 then to say that since Northside does not deny services to
1926 Medicare-eligible, Medicaid-eligible, or uninsured patients, it
1927 is likely that these oncology sites now provide services to more
1928 patients than when the sites were privately owned?

1929 Ms. Banna. Absolutely.

1930 Mr. Tonko. And one last question, Ms. Banna. Does
1931 Northside place oncology patients into any type of queue through
1932 which commercially-insured patients are treated before Medicaid
1933 and Medicare patients?

1934 Ms. Banna. No.

1935 Mr. Tonko. Thank you.

1936 I would like to also go over to address the Mission Health
1937 program. So, Dr. Paulus, I understand that the 340B savings
1938 cannot be directly attributed to individual services. However,
1939 generally speaking, if Mission Health could not rely on savings
1940 from the 340B program, how would that affect your ability to
1941 provide these community benefits?

1942 Dr. Paulus. Well, as I mentioned, it would have a major
1943 impact. We had about \$37.4 million worth of 340B savings last
1944 year and our entire operating margin was \$53 million. So, that
1945 is 70 percent of the total. We need that operating margin to be
1946 able to maintain services, replace outdated buildings and
1947 equipment and so forth. And so we would have to go through and
1948 figure out how to cut our budget. And by definition, some of the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1949 outreach and charity that we do today would have to be curtailed.

1950 Mr. Tonko. Thank you. And Dr. Reuland, Johns Hopkins
1951 reported \$109 million, I believe, in 340B savings in 2016. If
1952 you could not rely on those savings, what impact would that have
1953 on your ability to provide services in your given community?

1954 Mr. Reuland. Well thank you for the question. And
1955 certainly, as I think we have been elaborating on, the wraparound
1956 services and the preventive services that we try to put in place
1957 in addition to the standard services is really what it is to serve
1958 an underserved community. And our inability, if we had to
1959 increase our drug prices by \$109 million, that would cause a
1960 significant amount of cost pressure and cause us to have to cut
1961 back on some other programs, just like the ones we have mentioned.

1962 So I think, I will give you an example that there is a program
1963 called the CAPABLE Program, where we send a nurse, an occupational
1964 therapist, and a handyman or handywoman to a person's house. And
1965 they will typically install a second bannister for somebody who
1966 can get up and down the stairs now and get to a doctor's appointment
1967 more easily. It is that kind of hands-on community work that we
1968 would simply not be able to support.

1969 Mr. Tonko. Thank you. And Ms. Veer, how would losing 340B
1970 savings impact Carolina Health's ability to provide services in
1971 your given community?

1972 Ms. Veer. Well I have spoken to two or three specific
1973 programs that are funded by the 340B savings. Our delivery of

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1974 prescriptions into very rural outlying areas that would be very
1975 difficult to sustain. We also provide behavioral health
1976 counseling in our sites for people who would experience long
1977 delays in accessing the local mental health agency. Both of those
1978 areas would be significantly impacted.

1979 Beyond that, we have sites in -- we have medical sites in
1980 rural areas that, because of the nature of the population there
1981 and how rural the area is, they operate at a loss. And so total
1982 out of our 13 sites, those operating losses are around \$1.8
1983 million. We would definitely need to look at how we redistributed
1984 care to those areas, possibly combining some of those sites or
1985 reducing hours at those sites.

1986 Mr. Tonko. Thank you. I appreciate the quality services
1987 you all provide with these savings.

1988 And with that, Mr. Chair, I yield back.

1989 Mr. Griffith. The gentleman yields back.

1990 I now recognize the gentleman from New York, Mr. Collins.

1991 Mr. Collins. Thank you. And I want to thank the panelists
1992 for being here and maybe reset the stage just a bit.

1993 All of us stipulate the great benefits the 340B -- the
1994 pharmaceutical companies stipulate that. I mean it has been
1995 around a long time. I think what we are starting to look into,
1996 though, and I won't use the word abuse because if something is
1997 legal, it is not an abuse, but I will use the word loophole. We
1998 have seen a huge increase in the number of oncology practices which

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

1999 deliver the most expensive drugs to America being bought up by
2000 hospitals, whether it is Johns Hopkins or others. Right in my
2001 area, the largest oncology practice was recently purchased by a
2002 DSH hospital and, I would say, for only one reason and that is
2003 the 340B profit.

2004 You know they are buying up oncology practices where
2005 basically, when you are out in the suburbs, the vast majority of
2006 those patients are fully insured. Those practices have never
2007 gotten 340B discounts on the \$100,000 kind of drugs. The minute
2008 a DSH hospital acquires that practice, all of a sudden these 25
2009 to 50 percent discounts flow to the bottom line of the hospital,
2010 plain and simple. A business decision. I can't blame you for
2011 it. It is legal.

2012 But I call that a loophole and here is why. If I look at
2013 the requirements to be a DSH hospital, you have to have a certain
2014 percent of Medicare and Medicaid patients -- inpatients not
2015 outpatients. It is defined and calculated by inpatient stays in
2016 the hospital. But yet when you get to a clinic in the suburbs,
2017 those are outpatient.

2018 So these DSH hospitals which qualify based on inpatient
2019 hospital stays are able to acquire outpatient oncology practices,
2020 without that impacting that calculation. That is a loophole.

2021 Number two, the whole idea that what you call a child site
2022 is one of these oncology practices, nothing changes. The
2023 patients go to, in many cases, like a shopping center. They park

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

there. They see their same doctors except the doctors now work for the hospital. And the monies, the discount paid by the pharmaceutical company now goes to the bottom line of the hospital and we have no idea what it is going for. You tell us you are using it for outpatient work.

The Ryan White clinics, they tell us exactly where they go. The hospitals tell us that is too much administrative overhead to tell us but, trust us, we are providing more services. Maybe you are. And if you are, you should be held accountable for it.

Because here is the bottom line. I know this isn't government money and this is the problem. The discount the pharmaceutical companies are giving and people go whoa, the big pharmaceutical companies, they make too much money, yadda, yadda, yadda but let us face it, that is where the new discoveries are coming from that is improving health care in the United States.

And here is my worry. The business model used to be let's call it a 25-30 percent discount over a certain number of groups, including your hospitals but you didn't own these oncology practices. And I would put forth you are buying them for only one reason and that is the bottom line of the discount.

At some point, the prices for these pharmaceuticals are going to go up for everyone. Pharmaceutical companies that used to have to discount, I don't know, half my drugs, now I am discounting 90 percent of my drugs. Guess what? The list price goes up. There is no free lunch. And that is my problem.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2049 It is not that we don't understand the importance of 340B.
2050 It is that the definition of the DSH hospital doesn't even take
2051 into account the outpatient work in these clinics. These are
2052 people that were fully reimbursed.

2053 The other thing I am a little troubled by and you can tell
2054 me if I am right or wrong but many cases, \$100,000 procedure might
2055 be discounted to \$40,000. Is that reasonable? For a fully
2056 insured patient you see it. \$100,000, oops, discount down to
2057 \$40,000. But when you write it off as charity care or bad debt,
2058 don't you put it in as \$100,000 and not \$40,000?

2059 Mr. Reuland?

2060 Mr. Reuland. Well, what I was going to say is a couple of
2061 comments. The State of Maryland is a little bit different in that
2062 regard. And the State of Maryland's hospital rates are regulated
2063 by the entity called the Health Services Cost Review Commission.
2064 And the charges are actually governed to a level that is very close
2065 to the cost and so there is no opportunity that you are describing
2066 there.

2067 I would also point out that as a comprehensive cancer center,
2068 our growth has not been because of the purchase of any practices.
2069 Johns Hopkins Hospital has purchased no oncology practices. We
2070 grow because there is sort of a limitless demand based on
2071 demographics for the treatments that we offer. And so our growth
2072 in oncology is a growth in our drug spend that outpaces our revenue
2073 growth. And that is why our operating margin has actually been

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2074 declining in the past couple of years down to --

2075 Mr. Collins. Yes, my time has expired. I was going to get
2076 into, though, with Johns Hopkins the last 2 years of your diversion
2077 of pricing through the contract pharmacies but that will have to
2078 wait for another hearing.

2079 Mr. Griffith. The gentleman yields back.

2080 I now recognize Ms. Schakowsky of Illinois for 5 minutes for
2081 questioning.

2082 Ms. Schakowsky. Thank you. First of all, I want to thank
2083 the witnesses for their testimony.

2084 I know 340B is essential to people in my district with
2085 skyrocketing drug prices or, as the President would say, price
2086 gouging prices. 340B is literally a lifesaver and not one of us
2087 opposes transparency. I am certainly not for waste, or fraud,
2088 or abuse. I am for transparency. But it does raise questions
2089 when it is the pharmaceutical companies that are the loudest
2090 complainers about the 340B Program.

2091 And it is interesting to me that while the pharmaceutical
2092 companies have argued for transparency for the 340B Program, PhRMA
2093 has spent millions of dollars to prevent laws that require
2094 transparency in their own drug pricing. And this leaves us blind
2095 as we work to lift the burden of crushing drug prices and it is
2096 well past time that this committee talk about how we are going
2097 to lower drug prices.

2098 You know we have no clue when they tell us that all this money

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2099 is going to develop new drugs and for research and development,
2100 what that is really about. We know about your CEO, how much they
2101 make. We don't know about theirs. And we need to concentrate
2102 more on that.

2103 And I think it is really a dereliction of duty that we allow
2104 these prices to get so out of control that they do imperil the
2105 health of people across this country.

2106 In my district, Advocate Health has used its 340B savings
2107 to provide support for low-income patients through child
2108 vaccination programs and the Medication Assistance Program that
2109 helps people who are uninsured and underinsured, as some of you
2110 do as well.

2111 So let me just ask a couple of questions. Each of you
2112 mentioned very -- oh, no, no. I wanted to go to these questions.

2113 Dr. Paulus, I see that Mission Health used a large number
2114 of contract pharmacies to dispense 340B drugs. Can you explain
2115 the benefits of using these pharmacies?

2116 Dr. Paulus. Yes. So first I think with respect to contract
2117 pharmacies, we only have arrangements that include dispensing
2118 fees. That is an important part of our criteria. Mission
2119 Health, as an entity, has 62 contract pharmacies but that is for
2120 six separate covered entities. Mission Hospital, which is the
2121 largest hospital, by far, has 31 but of those, 16 are mail order
2122 or specialty pharmacies that haven't had a dollar's worth of
2123 revenue. So it is an inflated number.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2124 Two, our distribution entities and there is no revenue
2125 associated with those; two we own.

2126 And the total value of Mission Health's contracted
2127 pharmacies is \$7.6 million but the value of that is that, for
2128 example, at Angel Medical Center, which is one of our rural
2129 Critical Access Hospitals, patients are provided with vouchers
2130 to go to those contract pharmacies and receive free medication.

2131 So the contract pharmacies we view as an extension of our
2132 own work. Our goal is, either through our own medication
2133 assistance program or through those contracted pharmacies, that
2134 no patient goes without free or discounted medications, if they
2135 need that medication.

2136 Ms. Schakowsky. Thank you. I am just wondering if any of
2137 you have witnessed dramatic increases in the cost of a particular
2138 drug that your patients need that you might want to tell us about.
2139 I have heard those horror stories from a number of doctors in the
2140 Chicago area.

2141 Yes, Dr. Reuland.

2142 Mr. Reuland. Thank you for the question. I mentioned
2143 earlier that we have seen a couple of -- seven very common
2144 medications. We noticed that our spend on them increased 312
2145 percent with a volume growth of 12 percent.

2146 So it was clearly a price increase that we could not explain
2147 and these were not medications that were easily substitutable with
2148 something else.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2149 Dr. Paulus. If I could just add, you know there is a variety
2150 of reasons for the quote growth in the programs, one of which is
2151 prices. And I think the data are a third of the savings is due
2152 to price changes alone.

2153 But let me bring up another issue, which is a thank you to
2154 the pharmaceutical manufacturers. When we compare our 2014 to
2155 2017 data, there are six drugs that are new that didn't exist that
2156 comprised over \$5 million of spend in 2017.

2157 So the growth of the program is a multifactorial attribute
2158 and it is important to look into the detail.

2159 Ms. Schakowsky. Thank you and I yield back.

2160 Mr. Griffith. Thank for yielding back.

2161 I now recognize Mrs. Brooks of Indiana for 5 minutes for
2162 questioning.

2163 Mrs. Brooks. Thank you, Mr. Chairman.

2164 Ms. Banna, we heard about the acquisition by Northside of
2165 the oncology practices in 2012. Are those two practices 340B
2166 child sites?

2167 Ms. Banna. The locations operating as hospital outpatient
2168 departments are.

2169 Mrs. Brooks. And when did you register those oncology
2170 practices for the 340B Program?

2171 Ms. Banna. I believe it was spring of 2014.

2172 Mrs. Brooks. And can you talk about the registration
2173 process? So that is the date that the registration process

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2174 concluded, is that correct, in 2014?

2175 Ms. Banna. It was April 2014.

2176 Mrs. Brooks. And about how long does that process take?

2177 Ms. Banna. To register them?

2178 Mrs. Brooks. Uh-huh.

2179 Ms. Banna. You must demonstrate that you are operating them
2180 as a hospital outpatient department. So if you own a location
2181 and it appears on your hospital cost report as a hospital
2182 department, then you request. You bring it in as a child site
2183 and about a quarter later, you can begin operating it as a 340B.

2184 Mrs. Brooks. And are patients that are treated at these
2185 centers, oncology centers, charged a facility fee?

2186 Ms. Banna. If it is a hospital location, they are billed
2187 in accordance with hospital standards.

2188 Mrs. Brooks. And those are billed as hospital sites, then?

2189 Ms. Banna. Correct.

2190 Mrs. Brooks. So they would be charged a facility fee.

2191 Ms. Banna. Correct.

2192 Mrs. Brooks. And how much is that fee?

2193 Ms. Banna. I can't quote that.

2194 Mrs. Brooks. Can you get that for us?

2195 Ms. Banna. I can, sure.

2196 Mrs. Brooks. And what other fees are patients charged that
2197 maybe those patients didn't pay prior to them becoming hospital
2198 sites? Are there other fees that patients are charged once they

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2199 become hospital sites that they weren't charged previously,
2200 oncology patients, for example?

2201 Ms. Banna. I think you know I can't speak to charges that
2202 are not hospital-based. They are charged commensurate with any
2203 hospital service area.

2204 Mrs. Brooks. So are you aware as to whether or not patients
2205 -- what a patient's bill might have looked like prior to them being
2206 acquired by the hospital versus what they are after the
2207 acquisition, a comparison of the costs?

2208 Ms. Banna. I mean I understand what hospital charges are,
2209 yes. I think it is important, though, to state that charges are
2210 not directly related really to what people pay. People pay based
2211 on what kind of insurance coverage they have or don't have.

2212 Mrs. Brooks. And so on the hospital fees and whether there
2213 are any other fees, are they all included in the one bill or might
2214 there be an additional separate bill to the patient?

2215 Ms. Banna. Patients may receive bills for non-hospital
2216 services.

2217 Mrs. Brooks. I want to ask each of the panelists what is
2218 the DSH percentage of your entities and is that for the parent
2219 entity or the DSH percentage compared to the child sites?

2220 And I will just start with you, Ms. Banna. What is your DSH
2221 percentage for your parent entity and how does that compare to
2222 your child sites?

2223 Ms. Banna. The DSH percentage is a representation of

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2224 inpatient days, as was mentioned a moment ago. So the child sites
2225 don't have that percentage but our parent has a 16 percent ratio.

2226 Mrs. Brooks. And how about you, Mr. Reuland?

2227 Mr. Reuland. Johns Hopkins Hospital is 18.97 percent.

2228 Mrs. Brooks. Okay, Dr. Paulus.

2229 Dr. Paulus. We are between 15 and 16 percent across all
2230 sites.

2231 Mrs. Brooks. Mr. Gifford.

2232 Mr. Gifford. That is a requirement that we are not required
2233 to adhere to.

2234 Mrs. Brooks. Okay.

2235 Mr. Gifford. That is not a part of the Ryan White --

2236 Mrs. Brooks. Okay, thank you.

2237 Ms. Veer.

2238 Ms. Veer. Similar to Mr. Gifford, our eligibility is based
2239 on our approved scope of project under HRSA.

2240 Mrs. Brooks. And so for those of you that maintain the
2241 percentages, has that percentage fluctuated over the years? And
2242 if so, what kind of fluctuation have you seen?

2243 Dr. Paulus.

2244 Dr. Paulus. I couldn't quote that off the top of my head.
2245 It has been relatively consistent.

2246 If I might add two comments about the oncology practices,
2247 our integration in our market has largely been driven by two
2248 things. You know one is physicians who, because of the same

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2249 demographic challenges that we face, find it hard to exist in that
2250 marketplace. And by becoming part of a system and being able to
2251 be paid a salary, as an example, are able to do that.

2252 One of the additional benefits -- you raised fair points,
2253 but one of the additional benefits is all of those patients in
2254 that new setting are eligible for all of our charity policies,
2255 which did not exist in those practices previously.

2256 The other point is you know we are being pressured by
2257 everyone, including the Federal Government and others, to form
2258 integrated systems to coordinate care across that network.

2259 Mrs. Brooks. Right, of course.

2260 Mr. Reuland?

2261 Mr. Reuland. I don't know the history of our roughly 19
2262 percent number. We could, I am sure, provide that.

2263 Our oncology, as I mentioned, is not a growth based on
2264 acquisition of any practices. It is as a comprehensive cancer
2265 center. As new therapies come along, as Dr. Paulus pointed out,
2266 they often bring some very nice promise but they certainly bring
2267 a heavy cost with them and that is part of our reality.

2268 Mrs. Brooks. Thank you. My time is up. I yield back.

2269 Mr. Griffith. Thank you. I appreciate that very much.

2270 I now recognize Dr. Ruiz from California for 5 minutes for
2271 questioning.

2272 Mr. Ruiz. Thank you very much, Mr. Chairman.

2273 As you know, I have spent a lifetime trying to figure out

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2274 how to provide care for underserved communities and I just want
2275 to remind everybody of the big picture. It is easy to get lost
2276 in the details but let's just keep the big picture in mind. We
2277 are talking about populations with severe barriers to accessing
2278 the healthcare services they need to live healthy and fulfilling
2279 lives.

2280 We are talking about communities that exist with one doctor
2281 per 9,000 residents, like in certain areas in my district. We
2282 are talking about catchment areas, where even though you may be
2283 in a big tertiary care academic institution, they are still hard
2284 to read for whatever reason. So just the mere existence of these
2285 clinics or programs in these communities is a benefit, a very vital
2286 important benefit. And on top of their existence, whether they
2287 have to pay the electricity bill or whether they pay their multiple
2288 salaries to keep their doors open, they also do outreach, and
2289 public health education, and programs, and prevention programs,
2290 and education, and all these benefits that the underserved
2291 communities exist.

2292 There is a community clinic Desert AIDS Project in my
2293 district, you might be familiar with them, Mr. Gifford, who do
2294 amazing work but they provide critical wraparound services and
2295 lifesaving treatment programs. They exist in narrow margins and
2296 the money they have been able to save with 340B Programs allows
2297 them to provide hepatitis C medications, which we know is very
2298 expensive.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2299 But in addition to that, the cost savings allows them to
2300 provide the nutrition that augments the support that the patients
2301 need, allows them to providing housing that we know is a critical
2302 factor in a patient's ability to recover from the AIDS or having
2303 the HIV infection.

2304 So these are very important that oftentimes gets missed in
2305 these conversations. So I think the real question here is how
2306 do we measure value of the cost savings of the 340B system. And
2307 it has been very misleading to hear that the only way that we
2308 measure this is charity care. And since you know that charity
2309 care is going down, meaning that that was an active choice by
2310 hospitals to make, while their profits is going up is very
2311 misleading because we know that uncompensated care has gone down
2312 because the number of insured has gone up by 20 million in this
2313 country thanks to the Affordable Care Act.

2314 But that doesn't mean that families are still struggling.
2315 That doesn't mean that there is more uncompensated -- residual
2316 uncompensated care out there that we need to hassle -- I mean we
2317 need to handle.

2318 So the fact that clinics and hospitals are expanding to more
2319 communities is a good thing. The fact that you are bringing in
2320 patients that otherwise, or oncology clinics, for example, that
2321 otherwise would be inaccessible through other healthcare systems
2322 into your mission-driven hospital is a good thing. So now your
2323 patients have access to oncology care. For example, the poor and

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2324 struggling working families also get cancer. They also need the
2325 medications. They also need care.

2326 And I think it is misleading to insinuate that you decided
2327 to purchase a clinic so that you can dive into the 340B Programs
2328 to acquire more money to then line the pockets of CEOs and
2329 leadership.

2330 So let me just ask you point blank. Did you do that? What
2331 was the reason for you purchasing some of these oncology clinics,
2332 Dr. Paulus?

2333 Dr. Paulus. Yes, as I mentioned just a bit ago, for us it
2334 was a matter of maintaining oncology services in the region and
2335 getting those clinics available in the 18 diverse and mountainous
2336 counties.

2337 Mr. Ruiz. So keeping oncology services for the patients in
2338 your catchment area that you want to serve.

2339 Ms. Veer?

2340 Ms. Veer. We don't operate oncology services. However, I
2341 will say the next to the last site that we opened was opened at
2342 the request of a local hospital that 75 percent of their emergency
2343 visits were ambulatory care-sensitive. And since we have -- I
2344 can give the example of one patient who had 11 visits down to none.

2345 Mr. Ruiz. Well, yes, I mean how do you measure the ability
2346 to use some of the cost savings to go into the community to provide
2347 nutrition classes, exercise classes, prevention, education for
2348 diabetics knowing, that by them participating in these programs,

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2349 they will prevent going blind, they will prevent leg amputations,
2350 they will prevent costly renal insufficiency and hemodialysis?
2351 So how do we measure the true value of these cost-saving programs
2352 that allow you to do more outreach into underserved communities?
2353 And that is where the real problem lies. If we are just narrowly
2354 focused on uncompensated care, then we are missing the big picture
2355 here.

2356 So you know I think we need to expand services. We need to
2357 empower the clinics and hospitals to do more outreach into more
2358 underserved areas to provide more lifesaving care that will help
2359 prevent rising costs for the emergency care that they are going
2360 to need if they don't get those services to begin with.

2361 Thank you very much.

2362 Mr. Griffith. The gentleman yields back. I appreciate.

2363 I now recognize Mr. Sarbanes of Maryland.

2364 Mr. Sarbanes. Thank you, Mr. Chairman, and thank you for
2365 allowing me to participate in the hearing today.

2366 I want to thank the panel. Your testimony is, obviously,
2367 very critical and you have, I think, seen that there is broad and
2368 deep support for the 340B Program on both sides of the aisle. And
2369 I want to thank all of your institutions for the contributions
2370 you are making at the community level to address the situation
2371 of vulnerable populations and sort of change the underserved
2372 vulnerable populations and to serve vulnerable populations.

2373 I come with a very biased, in the positive direction, view

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2374 of Johns Hopkins and the role that it has played in Baltimore City,
2375 having watched that my whole life.

2376 Dr. Reuland, I think you said you started in 1990 at Johns
2377 Hopkins. So in 1989, when I returned to Baltimore from school,
2378 I became involved in a program in East Baltimore, a
2379 community-based education and health initiative. And one of the
2380 reasons the health component was so critical to that -- and we
2381 were working with Dunbar High School and Lombard and Dunbar Middle
2382 Schools and other schools that you are familiar with -- one of
2383 the reasons the health piece was so critical is the impact on
2384 education of children in that community from asthma, from lead
2385 paint poisoning was significant. And we didn't think we could
2386 bring a kind of holistic response in needs of those children
2387 without having the health piece right in the center of it.
2388 Hopkins has always stood up and was a full partner in that effort.

2389 So I am going to ask you to maybe go over again in a little
2390 more detail some of the services that the 340B Program savings
2391 have allowed Hopkins to provide in the community. Why don't you
2392 start by talking about what you have been able to do to address
2393 the issues of asthma and lead paint poisoning? I know you have
2394 the Johns Hopkins Children's Center. There has been a lot of
2395 innovation there. If you could speak to that, I would appreciate
2396 it.

2397 Mr. Reuland. Thank you for joining us and thank you for the
2398 question, Mr. Sarbanes.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2399 The presence in the schools is something that is, as you have
2400 pointed out, very important. I was talking with Dr. Connor the
2401 other day, one of our pediatricians who works in one of the schools
2402 in Baltimore. And about 1500 elementary and middle school kids
2403 in the school and she estimates that 30 percent of them may have
2404 asthma. And so the steady presence there is immediate
2405 diagnostics, sometimes nebulizer treatments right there on the
2406 spot to treat them, rather than sending them to an emergency
2407 department. She thinks in the first year she prevented 75
2408 emergency visits just with that program alone. And so that is
2409 an example of a kind of thing that we are very proud of.

2410 And you are right, pairing the health with the education,
2411 she thinks we prevented 167 absences from school as a result of
2412 asthmatic complications. So, a very strong contribution.

2413 The other school I will mention is -- you are familiar, but
2414 others may not be, with the development work to the immediate north
2415 of our campus a very troubled area that has been rebuilt. The
2416 Henderson-Hopkins School is something we helped establish as a
2417 part of that redevelopment initiative. And it has been an
2418 extraordinary success so far. If you were to see that area back
2419 in 1989, when you referred to, and look at it today, it is a
2420 startlingly better story.

2421 Mr. Sarbanes. Let me ask you to speak as well -- I have got
2422 about a minute left but, obviously, every community across the
2423 country and certainly every congressional district is experience

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2424 this opioid crisis. Baltimore has very special challenges with
2425 respect to heroin and opioid addiction crisis. And maybe you
2426 could speak on behalf of hospitals across the country of who
2427 benefit from the 340B Program in terms of their ability to respond
2428 to that crisis in those communities, which is absolutely critical
2429 right now.

2430 Mr. Reuland. And I am happy to respond and others may want
2431 to contribute. But we are absolutely seeing an increase in opioid
2432 dependence. It is an estimate of about 45,000 residents in
2433 Baltimore have a dependence. And in an emergency department, as
2434 Dr. Ruiz knows, patients will present often having overdosed and
2435 will be reversing that with naloxone and trying to bring them back.
2436 And as more powerful substances are available on the streets, we
2437 are doing more and more of that.

2438 The aftercare, the recovery and management of addiction, I
2439 mentioned earlier some of the wraparound services we provide, so
2440 that not only can we treat the patient with standard therapies
2441 but provide them with supportive housing on the outside so they
2442 don't go back quite to that same neighborhood. It is that kind
2443 of thing that I suspect all of us do at some level.

2444 Mr. Sarbanes. I appreciate your testimony. I thank all of
2445 you for what you are doing in your various communities.

2446 I yield back.

2447 Mr. Griffith. I thank the gentleman for yielding back and
2448 if you all can bear with us a few more minutes, I have a couple

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2449 of additional questions.

2450 So I am going to recognize myself for an additional 5 minutes.

2451 And Ms. DeGette may wish to but she is going to play that by ear.

2452 So I am going to feed off of what Mr. Sarbanes was just asking
2453 about and this committee has important bipartisan work underway
2454 to see how we can leverage federal resources and authorities to
2455 better combat the opioid crisis.

2456 As part of our work, it is important to understand how all
2457 federal programs intersect and what their interest is with the
2458 crisis that has left virtually no American family or community
2459 untouched. That being said, can each of you identify what
2460 percentage of the 340B prescription opioids represents as a
2461 percentage of your program and can you detail for us what steps
2462 might be in place to prevent diversion or misuse of these drugs,
2463 once they are dispensed to the patients?

2464 I will start with you again, Ms. Veer. And if we could be
2465 quick.

2466 Ms. Veer. Sure. I don't have the exact percentage but I
2467 could provide that in writing.

2468 Mr. Griffith. Okay.

2469 Ms. Veer. I can tell you that we use medication management
2470 contracts with our patients. We do standard drug testing to make
2471 sure that it is not being diverted.

2472 Mr. Griffith. I appreciate it.

2473 Mr. Gifford.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2474 Mr. Gifford. I also can provide the data on the percentage
2475 of prescriptions. We do provide medication management therapy
2476 and we do a lot of counseling with our patients and clients about
2477 it.

2478 But on this issue of opioids and fighting the opioid
2479 epidemic, this is one of the problems with the Ryan White
2480 constricting language. We cannot use 340B savings to provide
2481 Narcan to somebody to save them from an overdose and a clear death.
2482 And that is one of the examples that I would hope this committee
2483 would look to expanding our ability to fight both the HIV epidemic
2484 and the opioid epidemic. It is a federal regulation that is
2485 inhibiting our ability to fight the opioid epidemic.

2486 Mr. Griffith. That is interesting information. I asked
2487 Ms. DeGette and she didn't know that either. I was not aware of
2488 that. So thank you for bringing that to our attention.

2489 Dr. Paulus?

2490 Dr. Paulus. I don't know the exact numbers. I know that
2491 it is less than one percent of our revenue.

2492 What we have done is we have done academic detailing for each
2493 of our practices to reeducate them about the prescription
2494 evidence-based best practices for opioids. We have supported
2495 providing free Narcan for our community. And on any given day,
2496 we have between 37 and 60 behavioral health patients being brought
2497 into our emergency department that are uncompensated that relate
2498 to the tragedy that is occurring.

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2499 If I could ask one other thing like that, we also provide
2500 support to a free clinic that provides medication assistance and
2501 education but free clinics don't qualify for 340B either. So that
2502 is a parallel.

2503 Mr. Griffith. I appreciate that.

2504 Mr. Reuland. I also don't know our precise percentage but
2505 we certainly have plenty of programs in place to prevent
2506 diversion.

2507 Mr. Griffith. And if you all could just get us that
2508 information, as some others have offered, that would be great.

2509 Ms. Banna. Agreed and I would argue or articulate for us
2510 the opioid epidemic is striking all patient populations. In our
2511 case, you see it affecting the extension of behavioral health
2512 services dramatically and, certainly, our babies. I mentioned
2513 we have a really high amount -- a high population of special care
2514 babies in our nursery. The opioid epidemic has increased their
2515 length of stay. Many of those babies are Medicaid babies. That
2516 is part of what contributes to our DSH percentage.

2517 Mr. Griffith. And another subject that we will probably
2518 have to touch on another day because, in my area, Bristol,
2519 Virginia-Tennessee -- think of the GEICO gecko -- the newspaper
2520 ran a series of articles on the problems that we are having in
2521 our region with those infants born already addicted.

2522 As a follow-up to my first round of questions, I want to
2523 discuss again how each of you calculate your savings. Ms. Veer

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2524 and Mr. Gifford, I believe I understand the answers you gave. I
2525 understand Mission and Johns Hopkins use of the GPO price to
2526 calculate their savings, which you get by comparing a wholesale
2527 manufacturer price. You get that GPO from them.

2528 Following up on Northside, it appears, from what I have been
2529 able to read and discern, that you all have chosen not to use the
2530 GPO price or you use some other mechanism. Can you explain it
2531 to me and then explain why?

2532 Ms. Banna. We are actually comparing the GPO price. We are
2533 comparing the average unit paid on drugs in 340B oncology clinics
2534 to those paid in non-340B clinics where GPO is applicable.

2535 So it is, effectively, 340B pricing to GPO pricing.

2536 Mr. Griffith. But you all are taking an average. I think
2537 what everybody else is doing is they are saying we are buying Drug
2538 A and Drug A costs \$10 and under 340B we save that \$10. And you
2539 all are doing an average across the board. Is that correct?

2540 Ms. Banna. That is correct. What we do is monitor the
2541 program's effect in totality. Each individual drug, there are
2542 some that see bigger savings than others on a per unit but the
2543 units that you purchase move day by day, depending on the patients
2544 that appear and the drug sizing and such that are sold.

2545 Mr. Griffith. I am just curious why you all think that is
2546 a better method.

2547 Ms. Banna. Right. Oh, so I guess we consider it to be less
2548 noisy. We are monitoring the total program impact across the

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com

2549 board.

2550 Mr. Griffith. My additional 5 minutes is up.

2551 Ms. DeGette, I am happy to yield to you. Did you have any
2552 additional questions?

2553 Ms. DeGette. No.

2554 Mr. Griffith. All right. Oh, okay. Apparently Dr.
2555 Burgess is attempting to come down. Do we know how close he is?
2556 You don't. Okay.

2557 Well my follow-up material is here that I have to do.

2558 I do appreciate all of you all being here today. If Dr.
2559 Burgess walks in, I will yield some time to him but I do appreciate
2560 you all being here today. I know it takes a lot of time both to
2561 get here, get back, and to spend your time answering questions
2562 of a lot of different folks with slightly different opinions.

2563 Okay, in conclusion, having thanked you all, I do remind the
2564 members that they have 10 business days to submit questions for
2565 the record and then I would ask all the witnesses to agree to
2566 respond promptly to the questions that members ask.

2567 [The information follows:]

2568

2569 *****COMMITTEE INSERT 7*****

2570 Mr. Griffith. And with that being said, any additional --
2571 okay. That being said, this committee is adjourned.
2572 [Whereupon, at 12:24 p.m., the subcommittee was adjourned.]

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433

www.nealrgross.com