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Health + Hospitals receives discounts on 2 drugs for city's inmate population

By Dan Goldberg

New York City public hospitals are getting a 35-percent discount on Zepatier, the expensive Hepatitis C drug, and a 60-percent discount on Proventil, a bronchodilator, to treat patients inside the city's correctional facilities.

The deal means New York City Health + Hospitals will spend $35,490 for a 12-week course of treatment of Zepatier. The list price is $54,600. Health + Hospitals will pay $28.46 for Proventil, an inhaler. The list price is $71.16 per inhaler.

Both drugs are made by Merck.

In exchange, Health + Hospitals will use Zepatier exclusively, foregoing similar, more expensive drugs made by Gilead Sciences and AbbVie. The city also will ensure that Proventil reaches at least 70 percent of the jail population that needs an albuterol inhaler.

The prices and terms of the agreement are laid out in a contract that was signed Aug. 26, and obtained Dec. 23 through a Freedom of Information request. The request was at first denied by Health + Hospitals, then granted after a letter from an attorney for POLITICO.

Taken together, these deals will save the city only a few million dollars per year but open a pathway for inmates, who do not receive Medicaid benefits, to obtain life-altering medications.

Roughly 12 percent of inmates have hepatitis C, according to the city's health department, and Health + Hospitals estimates the discount will enable the city to triple the number of patients who receive the drug.

Health + Hospitals estimates 23 percent of inmates suffer from asthma.

"We greatly appreciate the opportunity to expand the availability of hepatitis C and asthma medications to some of the most vulnerable individuals in the city," said Patsy Yang, senior vice president for correctional health services. "As one of the largest providers of correctional health services in the nation, we have an ethical obligation to ensure that our patients have access to the care they need."

Hepatitis C medications have made national headlines because of how effective they are at curing the virus — which, if left untreated, can cause liver failure — and for their price, which has blown a hole in state Medicaid budgets across the country. Gilead, first to the market, charges more than $94,000 for Harvoni before accounting for rebates. Zepatier, which was brought to market one year ago, was listed at $54,600 to undercut its rivals.

Merck, which is based in Kenilworth, New Jersey, did not respond to a request for comment.

Cuomo's veto sets up Medicaid budget fight

By Dan Goldberg

Gov. Andrew Cuomo vetoed legislation on New Year's Eve that would have created a new class of safety net hospitals and required the state to provide increased Medicaid reimbursement to those facilities that meet the new definition.

The governor's decision did not come as a great surprise because Cuomo prefers to handle spending bills through the budget. But it paves the way for an all-out lobbying effort from activists and labor unions such as DC-37 and the New York State Nurses Association, which argue that the current definition of safety net is overly broad and that dozens of hospitals, which serve the state's poorest residents, are unable to survive on the current Medicaid rates.

The battle for increased reimbursement will play out over the next 90 days as the budget is negotiated, and against the backdrop of a state-imposed Medicaid cap, uncertainty over the future of federal Medicaid funding and cries from long-term care facilities and home health care providers, which are also pleading for higher reimbursements.

The bill, which passed unanimously in both chambers last June, would have narrowed the definition of a safety net to include: a public hospital, with the exception of SUNY; a federally designated critical access or sole community hospital; or a hospital that has at least 50 percent of its patients uninsured or on Medicaid, 40 percent of its inpatient population covered by Medicaid, not more than 25 percent of its discharges using commercial insurance, and at least 3 percent of its patients uninsured.

The legislation did not provide a dollar amount that this new class of hospitals would receive or provide any direction on where the increased funding would come from.

Shortly after the bill was passed, state Sen. Kemp Hannon, a Republican from Long Island and the measure's sponsor, said the legislation was meant to tell the governor that the current system of financing hospitals is broken and needs to be addressed.

That may prove difficult given the uncertainty around the future of Medicaid under a Donald Trump administration and the uncertainty surrounding efforts to replace the Affordable Care Act, which has cut the state's uninsured rate in half.

Still, legislators, advocates as well as some union members and hospital executives have long said the state needs to change its charity care formula to better serve those hospitals that treat the most uninsured and underinsured patients.

For more than 30 years, the state allowed hospitals to be reimbursed for bad debt from patients who were insured but didn't pay their share of the bill, as well as those from patients who had no insurance at all. That allowed some of the state's more financially secure hospitals, with a high percentage of commercially insured patients, to claim more charity care dollars.

The Affordable Care Act, passed in 2010, attempted to change how charity care dollars were allocated, punishing states that allowed hospitals to count bad debt. The idea is that Disproportionate Share Hospital dollars, a pool of federal money, would flow toward hospitals that treat more uninsured and Medicaid patients.

New York, worried it might lose federal funding, changed its formula.

In an effort to mitigate the loss of funding to some private hospitals, the state said no hospital would lose more than 2.5 percent of its funding each year.

That means if a hospital under the new rules is entitled to half the charity care funding it received in 2012, it will take until 2032 for the dollar amount to match what the Affordable Care Act intended.

Because there is a finite amount of money to give, this floor also acts a ceiling for those hospitals entitled to more money under the new formula.

"While this cushions the impact for hospitals losing funds, it also perpetuates a system that has historically short-changed [public hospitals]," city Comptroller Scott Stringer wrote in a 2015 report examining safety net hospitals in New York City.

Other safety net hospitals are "shortchanged" as well and the state is making up for that difference through direct and indirect subsidies, which the Cuomo administration is using to push these hospitals toward value-based purchasing.

Judy Wessler, former director of the Commission on the Public's Health System, said it would be much simpler to carve out a group of hospitals and increase the Medicaid reimbursement rate, rather than change the formulas or worry over which Affordable Care Act rules survive the next four years.

Legally, that would look a lot like a direct subsidy but it would be required by statute as opposed to being at the whim of the governor's office.

"We need a better definition for the safety net that recognizes the tremendous service that these hospitals provide," Wessler said in an email. "Increasing the Medicaid reimbursement rate for the safety net means earning the revenue [and] not relying totally on hand-outs that don't always come [when] needed."

The Cuomo administration has opted for a different strategy. In addition to the subsidies given to financially struggling hospitals, the Department of Health uses public money as a carrot for large health systems to acquire smaller hospitals. The administration's theory is that larger systems have the scale and expertise necessary to operate an efficient health care facility, as well as negotiate value-based contracts with insurers.

The problem, Wessler and others have said, is that bigger isn't always better. Studies have shown that consolidation can lead to higher costs and the shifting of services from one area to another. Wessler pointed to Mount Sinai's takeover of Beth Israel and its decision to reduce the number of beds and relocate many services, including OBGYN.

"New York does not target dollars to those most in need, rather seeming to reward those that already have enough but get more to get larger and buy more," she said.