Analysis of the Proportion of 340B DSH Hospital Services Delivered to Low-Income Oncology Drug Recipients Compared to Non-340B Providers

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Synopsis of Key Findings

- The goal of this study was to evaluate whether 340B disproportionate share (DSH) hospitals[1] treat a higher proportion of low-income oncology drug recipients than do non-340B providers. Dual eligibility for Medicare and Medicaid was used as a proxy for low-income status.
- Based on Medicare claims data for patients treated at 340B hospitals and non-340B providers (including non-340B hospitals and physician offices) from 2013-2014, we sought to compare the proportion of patients receiving separately billable Part B oncology drugs who were dual eligible.
- **We found that 340B DSH hospitals treated a higher proportion of low-income, dual eligible oncology drug recipients than did non-340B providers. In 2014, almost one-quarter (22.8 percent) of oncology drug users at 340B DSH hospitals were dual eligible, compared to 13.8 percent in non-340B hospitals and 14.0 percent in physician offices. Similar results were found for 2013, with the proportion of dual eligible beneficiaries in 340B DSH hospitals rising slightly from 22.4 percent in 2013 to 22.8 percent in 2014.**

Table 1. Percent of Oncology Drug Users Dually Eligible for Medicare and Medicaid

Year	340B DSH Hospitals	Non-340B Hospitals	Physician Offices
2014	22.8%	13.8%	14.0%
2013	22.4%	14.8%	13.9%

About the Analysis

- 340B Health commissioned Dobson DaVanzo & Associates, LLC to analyze hospital outpatient department and carrier (physician office) claims data from the 2013 and 2014 Medicare Standard Analytic File Limited Datasets.
- Dual eligibility was used as a proxy for low-income status because only those Medicare beneficiaries with low incomes and limited assets are eligible to enroll in Medicaid. These beneficiaries tend to be the poorest and the sickest beneficiaries covered by either program.[2]
- Research has suggested that newly-registered 340B clinics serve more affluent areas compared to previously-registered hospitals and clinics, particularly with regard to oncology clinics.[3] Some suggest that these findings indicate that the 340B program is no longer helping low-income patients.[4] Furthermore, other research has looked at whether rural hospitals made eligible for 340B by the Affordable Care Act (ACA) are more likely to acquire oncology practices compared to other hospitals and found this was not the case.[5] However, this research did not evaluate 340B DSH hospitals.
- Therefore, this research compares the proportion of low-income oncology drug users in 340B DSH hospitals to non-340B providers. Non-340B providers include hospitals not in the 340B program and physician offices. Physician offices were included in the analysis in order to capture the majority of Part B drug spending, since in 2013, 55.5 percent of Part B drug spending was in physician offices that do not qualify for 340B.[6]
- 340B Health identified separately payable Part B oncology drugs to be analyzed by Healthcare Common Procedure Coding System (HCPCS) code, including the J series J8500 through J9999, as well as temporary oncology drug codes that CMS reimbursed under Part B during applicable years. Only drugs labeled with a "drug" price code and labeled as separately paid with a status indicator of "G" or "K" were included.[7] Vaccines, supplies, and surgical dressings were not included as they are not covered under the 340B program.
- Beneficiaries who received oncology drugs in 340B DSH hospitals, non-340B hospitals, and physician offices were identified and dual eligibility was compared across settings.

[1] In this analysis, "340B DSH hospitals" refers to hospitals enrolled in the 340B program as DSH-eligible and paid under the Inpatient Prospective Payment System (IPPS), as reflected in the IPPS Impact File from the Centers for Medicare & Medicaid Services CMS.
[2] Kaiser Commission on Medicaid Facts. (May 2011). Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries. Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/4091-08.pdf.
[3] Rena M. Conti and Peter B. Bach. The 340B Drug Discount Program: Hospitals Generate Profits by Expanding to Reach More Affluent Communities, HEALTH AFFAIRS 33, NO. 10 (2014): 1786–1792; Berkeley Research Group, 340B Covered Entity Acquisitions of Physician-based Oncology Practices (April 22, 2014).
[4] Rena M. Conti and Peter B. Bach. The 340B Drug Discount Program: Hospitals Generate Profits by Expanding to Reach More Affluent Communities, HEALTH AFFAIRS 33, NO. 10 (2014): 1786–1792.
[5] Abby Alpert, Helen Hsi and Mireille Jacobson. Evaluating the Role of Payment Policy in Driving Vertical Integration in The Oncology Market, HEALTH AFFAIRS 36, no.4 (2017):680-688.
[6] OIG. Part B Payments for 340B-Purchased Drugs. November 2015.
[7] Status indicator "G" indicates pass-through drugs and biologicals and "K" indicates non pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals, brachytherapy, and blood and blood products. Status indicators were contained in the Hospital Outpatient Prospective Payment System Final Rule Addendum B for the relevant year.