



**340B HEALTH**

The affordable prescription for healthy communities

# **EVALUATING 340B HOSPITAL SAVINGS AND THEIR USE IN SERVING LOW-INCOME AND RURAL PATIENTS**

## **Results from 340B Health's 2017 Annual Survey**

Savings from participating in the 340B drug pricing program are critical for hospitals to maintain patient care services and access to care for low-income and rural patients. Restrictions to these savings would harm the ability of these hospitals to care for their low-income and rural patients, including patients who suffer from life-threatening, chronic conditions.

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**ABOUT 340B**

The 340B drug pricing program was signed into law in 1992 to ensure healthcare providers that serve large numbers of low-income, Medicaid, uninsured and under-insured populations could continue their mission to provide care to all regardless of ability to pay. Rural hospitals serving patients in remote locations also qualify for the 340B program. In order to participate in the Medicaid and Medicare Part B markets, pharmaceutical companies must agree to provide outpatient pharmaceuticals to safety-net providers at a discounted rate. 340B program participants use their savings to provide critical services to their low-income and rural patients.

**ABOUT 340B HEALTH**

340B Health is an association of more than 1,300 non-profit hospitals and systems that participate in the 340B drug pricing program. We are the leading advocate and resource for those providers who serve their communities through participation in the 340B program. For more information about us and the 340B program, visit [www.340bhealth.org](http://www.340bhealth.org).

## EXECUTIVE SUMMARY

For more than 25 years, the 340B drug pricing program has provided economic support to safety-net providers, their patients, and their communities. The 340B program requires drug manufacturers to provide discounts on outpatient drugs sold to qualified safety-net hospitals, clinics, and health centers. Savings from those discounts allow 340B providers to serve more patients and offer more services.

Earlier [research](#)<sup>1</sup> has demonstrated the high level of care 340B hospitals provide to low-income patients, and previous [surveys](#)<sup>2</sup> have evaluated how hospitals use 340B program savings to support care for low-income and rural communities. 340B Health conducted a new survey of its members as a follow up to this prior work, to better understand the scope of savings, the uses of those dollars, and the cost of compliance with current program rules and government oversight.

The survey targeted the 1,300 hospitals that are members of 340B Health. This includes disproportionate share hospitals and small rural hospitals that participate in the 340B program.<sup>3</sup> The survey instrument included 36 questions and was fielded from November to December 2017. This report summarizes the results of the survey, providing a detailed look at how hospitals use the savings from the 340B drug discount program to stretch their scarce resources to reach more patients and provide more comprehensive services. It also includes real-world examples of how 340B helps safety-net providers meet the specific needs of their patients and communities. The findings indicate that cutbacks in 340B savings will reduce hospitals' ability to carry out that important mission.

### KEY FINDINGS

- Hospitals unanimously reported using their savings to benefit low-income and rural patients. This was true for DSH and rural hospitals.
- There are, however, some key differences between DSH and rural hospitals. DSH hospitals reported using the savings from drug discounts to cover part of the losses incurred from underpayments by state Medicaid programs while many rural hospitals indicated that 340B savings are a key element of their strategies to remain open in a time of unprecedented rural hospital closures in the U.S.
- Compliance costs consume up to \$200,000 a year and require between 1 and 3 full-time employees to work solely on meeting government requirements.
- Cuts to 340B savings would force hospitals to cut back on uncompensated care and reduce services that are valuable but often under-reimbursed.

### *Quantifying Program Savings and Costs of 340B Participation*

- DSH hospitals, which tend to be larger, reported saving a median of \$5 million to \$10 million from 340B discounts in the last fiscal year, but with wide variation in their reported savings likely due to

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<sup>1</sup> L&M Policy Research. "Analysis of 340B Disproportionate Share Hospital Services to Low-Income Patients." March 12, 2018. [https://www.340bhealth.org/files/340B\\_Report\\_03132018\\_FY2015\\_final.pdf](https://www.340bhealth.org/files/340B_Report_03132018_FY2015_final.pdf)

<sup>2</sup> 340B Health. "340B Hospitals Use Their Contract Pharmacy Benefit to Treat Low-Income and Rural Patients." [https://www.340bhealth.org/files/Contract\\_Pharmacy\\_Report\\_July\\_17.pdf](https://www.340bhealth.org/files/Contract_Pharmacy_Report_July_17.pdf)

<sup>3</sup> For the purpose of this report, disproportionate share hospitals and children's hospitals are collectively referred to as "DSH hospitals" and rural referral centers, sole community hospitals, and critical access hospitals are collectively referred to as "rural hospitals."

the wide range in DSH hospital size. In fact, 23% of DSH hospitals reported less than \$ 2million in savings and 20% reported more than \$25 million in savings.

- For rural hospitals, the savings were smaller, with the median rural hospital saving between \$500,000 and \$1 million. Unlike DSH hospitals, there was little variation seen in savings as rural hospitals tend to be more similar in size. In fact, 62% of rural hospitals reported savings less than \$1 million.
- The cost of compliance and program operations – which includes maintaining staffing systems to meet program rules– average \$100,000 to \$200,000 a year for DSH hospitals. Rural hospitals spend less than \$100,000 on compliance, but can represent as much as 20% of their program savings. DSH hospitals use an average of 2.4 full-time equivalent employees (FTEs) to focus solely on compliance, while rural hospitals dedicate an average of 1.1 FTEs to such work.
- The median, or typical, DSH hospital reported that less than one-fifth of its program savings were due to its contract pharmacy arrangements, whereas the median rural hospital reported over 50 percent of its savings were due to contract pharmacy arrangements.

### ***340B Hospitals Use Program Savings to Support Care for Low-income and Rural Patients***

- Every hospital responding to the survey reported using its 340B savings to help pay for care for low-income and rural patients. Both DSH and rural hospitals reported using those savings to maintain or increase uncompensated care (95%) and increase the type of services provided (89%).
- 80 percent of DSH hospitals said they used 340B discount savings to offset low Medicaid reimbursement rates in their state.
- Three-quarters of rural hospitals (74%) said they used 340B savings to keep their doors open and preserve access to care for their patients and communities.

### ***Cuts to Payments to 340B Hospitals or Restrictions on Eligibility Would Have a Significant Negative Impact on Care and Communities<sup>4</sup>***

- All responding hospitals indicated that cuts to reimbursement or limits on eligibility for 340B would harm access to care for the low-income and rural patients and communities they serve.
- Three-fourths of hospitals (75%) reported they would have to cut back on the amount of uncompensated care they provide.
- Nearly as many (70%) reported they would have to look for ways to cut costly but often underpaid services.
- Nearly 40 percent of hospitals also reported that cuts in 340B program savings would hurt their ability to provide discounted and/or free drugs to patients in need.

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<sup>4</sup> The survey was taken before a nearly 30 percent cut in Medicare Part B payments to certain 340B hospitals went into effect on Jan. 1, 2018

## INTRODUCTION AND SURVEY PURPOSE

The 340B drug pricing program “enables covered entities to stretch scarce resources as far as possible, reaching more eligible patients and providing more comprehensive services.”<sup>5</sup> This is achieved by requiring pharmaceutical companies to provide outpatient drugs to eligible providers at a discounted rate. These eligible providers include certain public and non-profit hospitals, clinics, and federal grantee providers such as Federally Qualified Health Centers (FQHCs) and Ryan White HIV/AIDS clinics. This survey and report focus solely on hospitals enrolled in the 340B program.

Only those hospitals that serve a large volume of Medicaid and low-income Medicare patients or are located in rural areas are eligible to participate in the 340B program. To qualify for 340B, disproportionate share hospitals, free-standing children’s and cancer hospitals, rural referral centers, and sole community hospitals must maintain a minimum threshold of care to Medicaid and low-income Medicare patients.

In addition to treating high volumes of low-income patients, rural referral centers and sole community hospitals also qualify for 340B due to their status as rural providers. Critical access hospitals also participate in 340B because they serve remote, rural locations. The 340B program is especially vital for rural hospitals, which face significant financial challenges. In fact, more than 80 rural hospitals have closed since 2010.<sup>6</sup>

### SURVEY PURPOSE

340B Health conducted a survey as a follow-up to prior research demonstrating that 340B hospitals treat high volumes of low-income patients, provide a disproportionate amount of uncompensated care, and provide critical services benefiting low-income and rural patients.<sup>7</sup> This survey builds on that work by evaluating how hospitals operationalize 340B program savings to benefit their low-income and rural patients.

This survey is also a follow-up to a prior survey of 340B Health membership, in response to which hospitals unanimously reported using 340B savings to expand patient access in various ways, including enhancing their ability to serve the uninsured or underinsured, increasing their ability to provide free or discounted drugs, and maintaining their current level of care and keeping their doors open.<sup>8</sup> Respondents also unanimously reported that a loss of 340B savings would have a negative effect on their communities, with 78 percent saying drug costs would increase for uninsured and underinsured patients. The new survey discussed in this report follows up on the prior survey and comprehensively addresses the following key aspects of a hospital’s 340B program:

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<sup>5</sup> Veterans Health Care Act of 1992, Pub. L. No. 102-585, § 602, 106 Stat. 4943, codified as Section 340B of the Public Health Service Act at 42 U.S.C. § 256b

<sup>6</sup> NC Rural Health Research Program, 80 Rural Hospital Closures: January 2010 – Present, <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>.

<sup>7</sup> L&M Policy Research, Analysis of 340B Disproportionate Share Hospital Services to Low-income Patients (March 12, 2018) [https://www.340bhealth.org/files/340B\\_Report\\_03132018\\_FY2015\\_final.pdf](https://www.340bhealth.org/files/340B_Report_03132018_FY2015_final.pdf).

<sup>8</sup> 340B Program Helps Hospitals Provide Services to Vulnerable Patients: Results from a Survey of 340B Health Members (May 2016), [http://www.340bhealth.org/files/Savings\\_Survey\\_Report.pdf](http://www.340bhealth.org/files/Savings_Survey_Report.pdf).

- (1) Hospital Pharmacy Operations;
- (2) 340B Program Savings and Costs of Participation and Operations;
- (3) Use of 340B Savings;
- (4) Impact of cuts to 340B program

The “2017 340B Health Annual Survey” was administered to 340B Health member hospitals between November 7, 2017 and December 22, 2017. The survey garnered responses from disproportionate share (DSH) hospitals, critical access hospitals, children’s hospitals, sole community hospitals, and rural referral centers. We did not receive any responses from free-standing cancer hospitals. In this report, we refer collectively to DSH hospitals and children’s hospitals as “DSH hospitals” and to critical access hospitals (CAHs), rural referral centers (RRCs), and sole community hospitals (SCHs) as “rural hospitals.”

## SECTION 1: QUANTIFYING PROGRAM SAVINGS AND COSTS OF 340B PARTICIPATION AND OPERATIONS

Survey respondents were asked to estimate their program savings in their last full fiscal year.<sup>9</sup> However, results differed when looking at DSH hospitals and rural hospitals separately, due to the differences in size and resources between DSH hospitals (which tend to be larger teaching hospitals and community hospitals) and smaller rural hospitals.

The survey results also indicated that to accurately quantify a hospital's program savings, it is important to account for costs that hospitals incur in order to participate in the 340B program and maintain their 340B operations. These include costs of compliance with program rules and requirements as well as costs associated with staffing employees to manage and oversee the hospital's 340B program. The 340B program has numerous requirements with which participating hospitals must comply in order to maintain their good standing within the program. These requirements include maintaining up-to-date information in the Office of Pharmacy Affairs Information System (OPAIS), ensuring that 340B drugs are dispensed only to eligible patients, reporting on whether they bill Medicaid fee-for-service for 340B drugs to prevent manufacturers from paying duplicate discounts on a 340B drug, and annually recertifying their eligibility to participate in the program. The Health Resources and Services Administration (HRSA), the federal agency charged with overseeing the 340B program, routinely audits participating hospitals to ensure that they are complying with program requirements. Since 2012, nearly 700 hospitals have been audited to ensure compliance.<sup>10</sup>

Hospitals also often dedicate employees to manage and oversee various aspects of a hospital's 340B program, including program compliance. Organizations measure an employee's time devoted in terms of full-time equivalents (FTEs), which represent the hours worked by an employee on a full-time basis. Hospitals were also asked if there had been a change in the number of FTEs dedicated to their 340B program.

The sections below discuss the differences in program savings and the costs of 340B participation and operation for DSH hospitals and rural hospitals.

### QUANTIFYING PROGRAM SAVINGS FOR DSH HOSPITALS

DSH respondents reported a median estimated program savings of \$5-10 million per DSH hospital, indicating that half of DSH hospitals saved less and half saved more. In fact, there was wide variation in the reported savings by DSH hospitals, with 23% of DSH hospitals reporting program savings less than \$2 million and 20% of DSH hospitals reporting more than \$25 million in savings. The vast difference in responses is likely due to the variation in size of DSH hospitals, with larger DSH hospitals likely reporting greater program savings and smaller DSH hospitals reporting smaller program savings. The median DSH

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<sup>9</sup> Respondents were asked to calculate their program savings by accounting for the difference in cost of drugs that were purchased in the 340B program and the cost of the same drugs had they not been in the 340B program. This difference in cost, in addition to the benefits accrued from a hospital's contract pharmacy program, result in a hospital's total amount of 340B program. Hospitals were also asked to estimate costs associated with participating in the 340B program (e.g., compliance costs) and subtract that from the total 340B benefit to generate an estimate of net program savings.

<sup>10</sup> <https://www.hrsa.gov/opa/program-integrity/index.html>

hospital also reported operating 11-25 contract pharmacy arrangements; however, across all DSH hospitals, less than one-fifth of their program savings were due to their contract pharmacy arrangements. The financial benefit DSH hospitals access through contract pharmacy arrangements is critical to their ability to serve their low-income patients, as evidenced by prior survey results.<sup>11</sup>

### Contract Pharmacy Benefit as a Share of Total Program Savings for DSH Hospitals

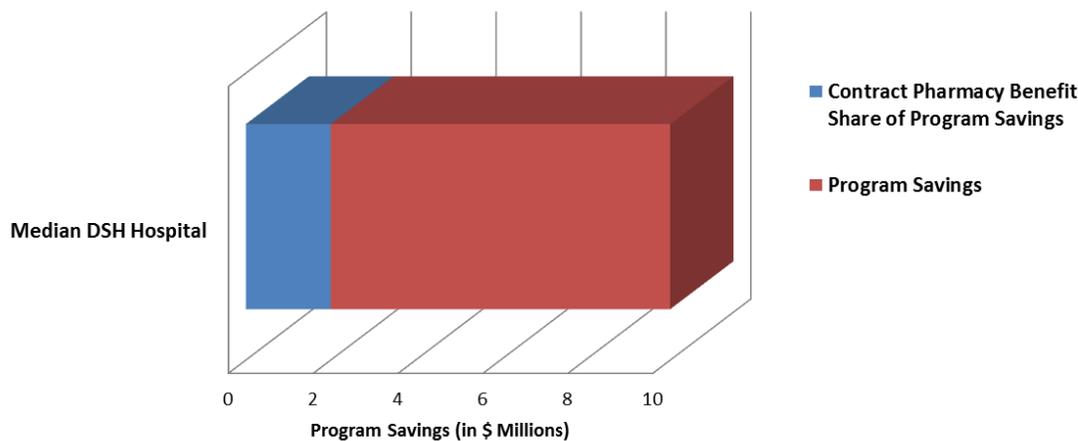


Figure 1: Estimated Program Savings and Share of Savings due to Contract Pharmacy Benefit for DSH Hospitals (Note: Savings figures shown above assume the higher end of the range reported for DSH hospitals)

### QUANTIFYING COSTS OF PARTICIPATION AND OPERATIONS FOR DSH HOSPITALS

DSH hospitals reported that annual costs of compliance, including the purchasing of expensive software programs, were between \$100,000 and \$200,000. In addition to these costs, DSH hospitals reported an average of 2.4 FTEs per hospital to manage and oversee their 340B program. Most DSH hospitals also reported an increase in FTEs in the last five years (72 percent), with a median increase of 51 to 75 percent in FTEs over that time period.

### QUANTIFYING PROGRAM SAVINGS FOR RURAL HOSPITALS

Rural hospitals reported an annual median estimated program savings of \$500,000-\$1 million, indicating that half of rural hospitals saved less and half saved more. This is lower than the median across DSH hospitals, as rural hospitals tend to be smaller in size and have lower patient and drug volumes. As shown in Figure 3 below, the results also show that rural hospitals heavily rely on their contract pharmacy programs to benefit from the 340B program, much more so than DSH hospitals. For the median, or typical, rural hospital that operated a contract pharmacy program, over 50 percent of its savings was due to their contract pharmacy arrangements.

<sup>11</sup> [http://www.340bhealth.org/files/Contract Pharmacy Report July 17.pdf](http://www.340bhealth.org/files/Contract_Pharmacy_Report_July_17.pdf)

## Contract Pharmacy Benefit as a Share of Total Program Savings for Rural Hospitals

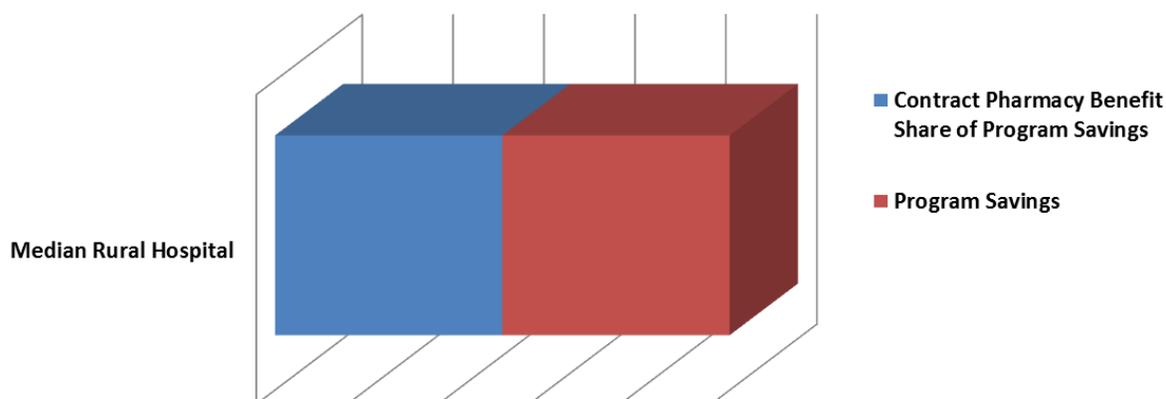


Figure 3: Estimated Program Savings and Share of Savings due to Contract Pharmacy Benefit for Rural Hospitals (Note: Savings figures shown above assume the higher end of the range reported for rural hospitals)

Most rural hospitals also reported not having their own outpatient pharmacies. This could explain why rural hospitals are more likely to rely on contract pharmacies to access a 340B benefit, as they are not able to access savings by dispensing 340B drugs in hospital-based retail pharmacies. This pattern mirrors national data, which show that smaller hospitals are much less likely to have their own in-house outpatient pharmacies compared to larger facilities.<sup>12</sup> In addition, unlike DSH hospitals, rural hospitals are subject to an orphan drug exclusion that can prevent them from accessing discounted prices on orphan drugs, which often have high prices and are commonly administered in hospital outpatient areas. As such, rural hospitals may access fewer savings through the use of 340B drugs in the hospital setting and may be more likely to rely on drugs dispensed through contract pharmacies to access a 340B benefit.

### QUANTIFYING COSTS OF 340B PARTICIPATION AND OPERATIONS FOR RURAL HOSPITALS

For rural hospitals, the costs of compliance were slightly lower than DSH hospitals, with the median rural hospital reporting compliance costs less than \$100,000. This is likely because 340B programs tend to be smaller in rural hospitals as they are smaller in hospital size and have lower patient and drug volumes. However, as a share of total program savings, compliance costs represented almost 20% of total savings (shown in Figure 4 below). In other words, compliance costs represented significant costs to rural hospitals.

Rural hospitals also reported having an average of 1.1 FTE, which was less than the average for DSH hospitals. The difference in the average number of FTEs likely corresponds to the relative size of their 340B programs. However, as a share of the overall number of FTEs in a rural hospital, the average number of FTEs dedicated to 340B operations and compliance is likely much greater in rural hospitals, given that rural hospitals employ fewer FTEs than large DSH hospitals. In addition, like DSH hospitals,

<sup>12</sup> ASHP national survey of pharmacy practice in hospital settings: Monitoring and patient education—2015, <http://www.ajhp.org/content/early/2016/07/11/ajhp160081.full?sso-checked=true>.

most rural hospitals reported increasing the number of FTEs in the last five years (69 percent) with a median increase of 51 to 75 percent in FTEs over that time period.

## Impact of Compliance Costs on Program Savings for Rural Hospitals

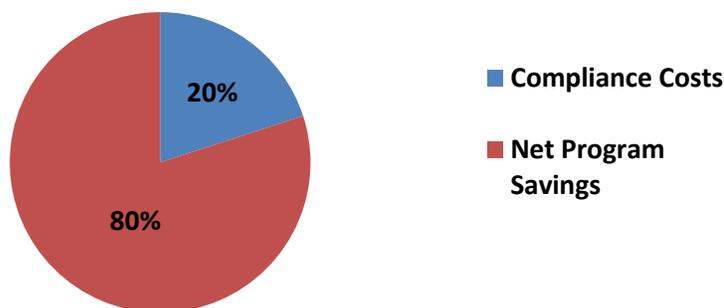


Figure 4: Illustrates the share of total program savings devoted to compliance costs as reported by rural hospitals.

## SECTION 2: ALL HOSPITALS USE PROGRAM SAVINGS TO SUPPORT CARE FOR LOW-INCOME AND RURAL PATIENTS

Hospitals unanimously reported using their program savings to benefit their low-income patients. Both DSH and rural hospitals reported that the top two ways they use their savings to benefit low-income and/or rural patients was to maintain or provide more uncompensated care (95 percent) and to maintain or provide more patient care services (89 percent). Uncompensated care includes charity care, bad debt expenses, and shortfalls from Medicaid underpayments, which represent significant financial burdens to safety-net hospitals. Patient care services include critical services such as cancer screenings, providing essential translation services, and operating a neonatal intensive care unit (NICU) to care for critically ill infants.

Hospital Use of 340B Savings to Care for Low-Income/Rural Patients	
SERVICE PROVIDED	% OF HOSPITALS
<b>Maintain or Provide More Uncompensated Care</b>	<b>95%</b>
<b>Maintain or Provide More Patient Care Services</b>	<b>89%</b>

NOTE: Percentages add up to more than 100% because hospitals were allowed to select more than one option.

## HOSPITAL SPOTLIGHT

### *Rapid City Hospital – DSH Hospital in Rapid City, South Dakota*

“Our neonatal intensive care unit costs \$5 million more to run each year than we receive for those vital services. This is in part due to the fact that although a third of our patients are American Indian, only one percent of our reimbursement comes from the Public Health Service. 340B supports the operation of our NICU and allows us to continue caring for our tiniest, most vulnerable patients.”

### **LOSS OF 340B SAVINGS WOULD HARM HOSPITALS’ ABILITY TO CARE FOR PATIENTS**

Hospitals were also asked to identify areas that would be most affected if 340B program savings were cut entirely or limited in some way. Every hospital that responded to the survey indicated that any cut in savings would significantly impact their ability to care for their low-income and rural patients. The most common area of impact reported was the ability of hospitals to continue to provide high levels of uncompensated care (75 percent). Hospitals also indicated that their ability to provide patient care services would be negatively affected by cuts in savings (70 percent). A decrease in patient care services would directly impact the ability of patients to receive the care they need. For example, one hospital reported that its savings were used to support the only detox unit in their city for patients addicted to opioids and that a cut in their savings would mean that they would likely have to close that unit down. This example is one of many that clearly demonstrate how cuts in program savings could directly impact patients, as in this example, patients addicted to opioids may not receive the care they desperately need to avoid a fatal overdose or other critical healthcare event if the detox unit at this 340B hospital were to shut down.

Nearly 40 percent of hospitals also reported that cuts in 340B program savings would impact their ability to provide discounted and/or free drugs to patients in need. This is particularly concerning as patients often rely on 340B hospitals to access expensive, yet critical medications that they cannot otherwise afford. If cuts in savings can impact a hospital's ability to provide those medications, it can likely have disastrous impacts on a patient's health status.

## HOSPITAL SPOTLIGHT

### *Mount Sinai Hospital Medical Center – DSH Hospital in Chicago, Illinois*

“Recently we had a self-pay patient diagnosed with brain parasites who needed six weeks of treatment with Albendazole. The total drug cost was \$20,000, which this patient wasn't able to afford. Thanks to the 340B program we established at our community pharmacy, we were able to extend the discounted price to this patient. Treatment ended up costing a few dollars on the 340B program and the patient was able to afford the medication.”

Hospitals were also asked to identify whether their ability to treat specific disease areas, many of which disproportionately affect low-income and rural populations, would be affected by cuts to the program. Nearly every hospital (92 percent) reported that a loss in 340B savings would harm their ability to treat at least one disease area. This particular question was one area where there was no difference found in the responses provided by DSH hospitals and rural hospitals. Hospitals indicated that the types of services most likely to be affected are provision of primary care services (73 percent), followed by

oncology (71 percent) and diabetes (52 percent). These responses support prior research that demonstrated that 340B DSH hospitals are on the frontlines of treating patients suffering from chronic, life-threatening, and undertreated diseases and conditions. For example, 340B DSH hospitals treat over 60 percent more low-income Medicare cancer drug recipients than non-340B providers, and they are more likely to provide specialized health care services that are often underpaid, such as HIV/AIDS services, alcohol/substance abuse treatment, trauma care and psychiatric care.<sup>13</sup>

### **SECTION 3: DSH HOSPITALS USE SAVINGS TO MAINTAIN SERVICES FOR LOW-INCOME PATIENTS AND OFFSET LOW MEDICAID REIMBURSEMENT**

When looking at the survey responses from DSH hospitals and rural hospitals separately, it becomes clear that DSH hospitals rely on 340B savings in unique ways that allow them to focus on treating their low-income patient populations. Although both DSH and rural hospitals rely on 340B savings to support uncompensated care, DSH hospitals reported a particular emphasis on how critical 340B is to support uncompensated and unreimbursed costs.

This focus on uncompensated care makes sense, given that 340B DSH hospitals provide the majority of the nation's uncompensated care. Research shows that 340B hospitals provided a total of \$26 billion in uncompensated care in 2015, significantly higher than the amount provided by non-340B hospitals. 340B DSH hospitals also treat significantly more low-income patients than non-340B hospitals (41.8 percent versus 27.2 percent), who often rely on 340B hospitals to obtain such services that are not readily available elsewhere in the community, such as alcohol/drug abuse treatment services and the operation of a NICU. Data show that 340B hospitals are more likely to provide these critical, specialized services, which are often underpaid by third-party payers like Medicaid.<sup>14</sup> Thus, access to 340B savings is critical for DSH hospitals to be able to provide uncompensated and unreimbursed services.

In another difference between DSH and rural hospitals, DSH hospitals were more likely to report using their program savings to offset low Medicaid reimbursement (82 percent). To qualify for 340B, DSH hospitals must meet a minimum threshold of care to Medicaid and low-income Medicare patients, and the national data show that 340B DSH hospitals treat 54 percent more of these patients than non-340B hospitals. 340B DSH hospitals are also much more likely to treat Medicare patients who are dually eligible for Medicaid than non-340B providers. This finding confirms the importance of accounting for Medicaid shortfalls in addition to charity care and bad debts, when looking at all the uncompensated and unreimbursed costs hospitals incur treating low-income patients. The Affordable Care Act (ACA) increased the number of people insured through Medicaid by approximately 16.3 million since 2013.<sup>15</sup> With this increase in enrollment, the financial burden on safety-net hospitals, like those enrolled in the 340B program, has undoubtedly increased as well. Hospitals can struggle to meet the needs of their Medicaid patients because Medicaid often underpays for services provided to these low-income patients.<sup>16</sup> The survey results demonstrate that program savings allow DSH hospitals to address this

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<sup>13</sup> L&M Policy Research, Analysis of 340B Disproportionate Share Hospital Services to Low-income Patients (March 12, 2018) [https://www.340bhealth.org/files/340B\\_Report\\_03132018\\_FY2015\\_final.pdf](https://www.340bhealth.org/files/340B_Report_03132018_FY2015_final.pdf).

<sup>14</sup> L&M Policy Research, Analysis of 340B Disproportionate Share Hospital Services to Low-income Patients (March 12, 2018) [https://www.340bhealth.org/files/340B\\_Report\\_03132018\\_FY2015\\_final.pdf](https://www.340bhealth.org/files/340B_Report_03132018_FY2015_final.pdf).

<sup>15</sup> <https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/>

<sup>16</sup> <https://www.aha.org/system/files/2018-01/medicaremedicaidunderpmt%202017.pdf>

challenge, enabling them to treat high levels of Medicaid patients despite being underpaid for many services provided to them.

## HOSPITAL SPOTLIGHT

### *Princeton Community Hospital – DSH Hospital in Princeton, West Virginia*

“Our DSH hospital uses 340B savings to provide free oncology screening clinics for the community. The clinics are conducted twice a year and feature women’s screening in the fall and men’s screening in the spring. Our outpatient infusion center provides a wide range of services, allowing residents the ability to receive treatment close to home versus traveling more than two hours to the next available center. We also use the program to hold free flu vaccine community drives. Each of those events allows us to administer 6,000 doses of vaccine to the public free of charge.”

### **LOSS OF 340B SAVINGS FOR DSH HOSPITALS WOULD LIMIT SERVICES FOR LOW-INCOME PATIENTS**

DSH hospitals reported that cuts in program savings would most impact their ability to maintain or provide more uncompensated care (75 percent). DSH hospitals also reported that cuts in savings would harm their ability to maintain or provide more patient care services (70 percent) and to provide discounted and/or free drugs (45 percent). Low-income patients treated at DSH hospitals would therefore face challenges in receiving such services as diabetes and cancer screenings as well as the critical medications that they could not otherwise afford. Collectively, the lack of both treatment and medications suggests that the health of patients would be directly jeopardized by cuts in program savings. These survey findings confirm the idea that cuts in program savings would disproportionately impact the ability of DSH hospitals to care for the high levels of low-income patients they treat.

The table below provides examples reported by DSH hospitals as to the various ways they use their program savings to support care for their low-income and rural patients.

### **DSH Hospitals reported using their 340B savings to help low-income and/or rural patients by:**

- Supporting healthcare services to the local county schools, which they cannot otherwise afford, through providing nurses, social workers, etc., all free of cost.
- Ensuring the continued provision of critical oncology care at our outpatient infusion center. Recently, we treated a melanoma patient with the 4 doses of medication that costed the hospital nearly \$30,000 per dose using 340B. This equates to \$120,000 in charity care on just one patient. Without 340B, the ability for us to offer such oncology services would be severely hindered.
- Providing infectious disease services antimicrobial stewardship services in order to decrease the rate of any hospital-acquired infections. We also use savings to provide additional staffing so that we can provide extended pharmacy hours 7 days/week to our patients.
- Supporting a flu vaccine community clinic where we provide free flu vaccines to low-income individuals in our community.
- Operating a medication assistance program for patients who cannot afford to pay for their medications.

- Providing free delivery of medications to patients, especially those in rural areas, from all of our outpatient retail pharmacies.
- Operating clinics to support treatment of heart failure, diabetes, and anticoagulation disorders.
- Providing discounted medications through an in-house voucher program.
- Supporting our ability to provide clinical services in local homeless shelters and transitional living areas.
- Providing sexual assault services to victims including medications and empiric therapy to treat for nPEP and STIs.
- Allowing us to pass back \$2.1 million in savings directly to our patients without prescription drug coverage on more than 18,000 prescriptions. On average, we reduce prescription costs by 90% for qualifying patients.
- Operating a Community Health & Wellness Clinic that services adults and children with no insurance and no primary care provider. Here they can see a physician free of charge and have prescriptions filled at one of our outpatient pharmacies.
- Allowing us to offset costs of operating two mobile clinics that serve various low-income neighborhoods in our city that have high levels of uninsured and/or undocumented patients.

## SECTION 4: RURAL HOSPITALS USE 340B SAVINGS TO SUPPORT ACCESS TO CARE IN REMOTE AREAS

Rural hospitals, like DSH hospitals, reported using their savings to maintain or provide more uncompensated care and patient care services. However, 74 percent of rural hospitals also reported using their savings to keep the doors of their facility open, a key difference from DSH hospital responses. This finding demonstrates the value of the 340B program in maintaining access to care for patients and suggests that program savings could account for the difference between a rural hospital staying open or having to close its doors. In rural areas, patients often must travel long distances to access health care resources. 340B savings allow many of these rural providers to stay in operation so that their rural patients can continue to access much-needed care. Further, rural providers face unique financial challenges that jeopardize their ability to adequately serve their communities.<sup>17</sup> As previously cited, more than 80 rural hospitals have closed since 2010, which means that patients in those communities no longer have proper access to care.

### HOSPITAL SPOTLIGHT

#### *Johnson County Hospital – Critical Access Hospital in Tecumseh, Nebraska*

“Our critical access hospital uses our 340B savings to maintain chemotherapy services in-house and to support our home health program. The nearest tertiary hospital for our patients can be up to 100 miles away, and it’s a burden on the patient and the family to drive that far to receive their treatment when they’re already not feeling well. Because of 340B, those patients can receive the care they need locally.”

<sup>17</sup> <http://www.modernhealthcare.com/article/20150516/MAGAZINE/305169959>

## LOSS OF 340B SAVINGS FOR RURAL HOSPITALS WOULD LIMIT ACCESS TO CARE IN RURAL AREAS

Rural hospitals also reported that cuts in program savings would hurt their ability to maintain or provide more uncompensated care (84 percent) and patient care services (55 percent). Over half of rural hospitals (55 percent) also reported that their ability to keep the doors of their facility open would be affected by cuts in savings. Given that rural hospitals reported using their program savings to maintain access to care, this finding indicates that cuts in savings would jeopardize the very access to care that is so important for their rural patients. One rural hospital reported that cuts in savings would mean that it would have to cut such services as a diabetes clinic and an infusion center. If these services were no longer provided, their patients would have to travel nearly 200 miles to the next nearest facility that provided the same infusion and diabetes services.

The table below provides additional examples shared by rural hospitals regarding their use of savings to support care for their low-income and rural patients.

### Rural Hospitals reported using their 340B savings to help low-income and/or rural patients by:

- Allowing our hospital to be a certified trauma center (the only one in a 60 mile radius) and employ a full-time oncologist and two orthopedic surgeons.
- Purchasing and operating a Biologic Safety Cabinet for the preparation of much-needed chemotherapy treatments for our rural patients.
- Creating community outreach and wellness programs to educate our rural community about healthcare issues and improve access to care.
- Providing screenings for blood pressure, glucose and cholesterol in the community to our underserved patient population.
- Supporting our continued ability to operate an infusion center that was under threat of closing because of chronically low reimbursement for these services.
- Providing public wellness programs such as free-of-cost lab work, cancer screenings, and blood pressure checks.
- Hiring part-time and full-time social workers, patient navigators, dieticians, physical therapy, and genetic testing and counseling for our needy cancer patients.
- Providing patient education at the pharmacy on how to use and adhere to medication regimens.
- Opening a free standing facility of the hospital that provides emergency services to a nearby community that had their hospital close down recently.
- Maintaining primary care services in off-site locations where we offer critical preventative services.
- Providing access to an infusion pharmacy for cancer patients to access much-needed cancer medications.
- Providing free or deeply discounted medications to uninsured and underinsured patients throughout the rural communities we serve.

## **CONCLUSIONS: THE 340B PROGRAM HELPS HOSPITALS SERVE THEIR LOW-INCOME AND RURAL PATIENTS**

The survey results demonstrate that the 340B program is an essential part of safety-net hospitals' ability to provide care for their low-income and rural patients. Every hospital that responded to the survey reported that program savings were being used to support care for low-income and rural patients. Subsequently, cuts in program savings would result in harmful impacts for hospitals to maintain patient care and access to care.

Key themes emerged when looking at the survey results from DSH and rural hospitals separately. While both DSH hospitals and rural hospitals reported using their savings to support uncompensated care, DSH hospitals were more likely to focus their savings on providing services to low-income patients, both by supporting uncompensated and unreimbursed services as well as offsetting low reimbursement from Medicaid. Rural hospitals were much more likely to report using their savings to remain open and maintain access to care in remote areas.

These survey results also demonstrate that cuts in 340B savings would create significant challenges for hospitals to provide care to their low-income and rural patients. This includes the provision of uncompensated care, patient care services, and the provision of free and/or discounted drugs. In addition, many rural hospitals reported that cuts in savings would directly impact their ability to continue operating, thereby weakening access to care for the patients they treat. Both DSH and rural hospitals also report that cuts in 340B savings would hurt their ability to provide primary care, diabetes, and oncology treatments to their patients.

For over 25 years, the 340B program has been a lifeline for hospitals to continue to provide care for the low-income and rural communities they serve. As policymakers evaluate the 340B drug pricing program, these survey results demonstrate the importance of considering the services hospitals are providing as a result of their 340B participation and the impact any program changes could have on access to care for low-income and rural Americans and communities.