



# EVALUATING 340B HOSPITAL SAVINGS AND THEIR USE IN SUPPORTING CARE FOR RURAL AND LOW-INCOME PATIENTS

## Results from 340B Health's 2018 Annual Survey

*The 340B drug pricing program is critical for safety-net hospitals to support care for their low-income and rural patients and to improve their health and well-being. Limiting savings from the program can have devastating impacts on maintaining vital patient services and access to care, especially for the nation's most underserved populations.*

JUNE 2019

# CONTENTS

**EXECUTIVE SUMMARY ..... 4**

**INTRODUCTION AND SURVEY PURPOSE ..... 7**

**SECTION 1: QUANTIFYING PROGRAM SAVINGS AND COSTS OF 340B OPERATIONS AND COMPLIANCE..... 9**

**SECTION 2: 340B HOSPITALS USE PROGRAM SAVINGS TO SUPPORT CARE FOR RURAL AND LOW-INCOME PATIENTS ..... 11**

**SECTION 3: 340B SAVINGS HELP HOSPITALS IMPROVE PATIENT HEALTH OUTCOMES AND HOSPITAL QUALITY OUTCOMES..... 16**

**CONCLUSION: 340B IS A VITAL PROGRAM THAT HELPS SAFETY-NET HOSPITALS CARE FOR PATIENTS WITH LOW INCOMES AND LIVING IN RURAL COMMUNITIES..... 17**

**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

The purpose of the “2018 340B Health Annual Survey” was to evaluate the relative size of savings 340B hospitals secure through their participation in the 340B drug pricing program and how those savings are used to stretch their scarce resources to reach more patients with low incomes and those living in underserved rural communities and to provide more comprehensive services. The 340B program is an important mechanism for safety-net hospitals to support the care they provide to underserved populations and to keep their doors open in the face of financial pressures. The 340B program requires drug manufacturers to provide discounts on certain outpatient drugs sold to qualifying safety-net hospitals, clinics, and health centers. Savings from those discounts allow 340B providers to serve more patients, and to offer more services and more comprehensive services at no additional cost to American taxpayers.

This survey was fielded from November – December 2018 and targeted the more than 1,300 hospitals that are members of 340B Health. This report summarizes the results of the survey and highlights examples of 340B hospitals using their savings to meet the specific needs of their patients and communities.

### KEY FINDINGS

- All hospitals reported using their savings to benefit low-income and rural patients.
- Hospitals reported that the top two areas for use of 340B savings were to support uncompensated and unreimbursed care and to support patient care services (including clinical services, pharmacy services, and patient auxiliary services).
- In addition to these areas, there are key differences between disproportionate share (DSH) hospitals and rural hospitals use of 340B savings:
  - DSH hospitals reported using their 340B savings to offset low reimbursement from Medicaid.
  - Rural hospitals indicated that 340B savings were critical to keeping the doors of their facilities open and operational and that a loss of those savings would likely force them to close.
- All hospitals reported that cuts to 340B savings would force them to scale back key programs, including services focused on caring for patients with cancer and diabetes and, more broadly, the provision of uncompensated and unreimbursed care.

### ***Quantifying 340B Savings and Costs of 340B Operations and Compliance***

- The average annual 340B savings across all hospitals was \$11.8 million.
- 340B savings range widely across hospitals, based primarily on the size of the facility.
- Hospitals reported an average of \$100,000-\$200,000 in 340B compliance costs and an average of two full-time employees overseeing and maintaining a hospital’s 340B program.

### ***340B hospitals are using savings to support care for low-income and rural patients***

- 95 percent of hospitals are using 340B savings to support the provision of uncompensated care

- 90 percent of hospitals are using savings to support patient care services, including critical clinical and pharmacy services and auxiliary services such as transportation, translation, and social services.
- 70 percent of hospitals report using savings to provide discounted and/or free drugs to their low-income and/or rural patients, thereby improving access to potentially life-saving medications.
- 72 percent of DSH hospitals report using savings to offset low reimbursement from Medicaid
- 93 percent of rural hospitals said they use their savings to keep the doors of their facilities open and maintain access to care for the rural communities they serve.

### ***340B savings are helping to improve the health and well-being of patients at 340B hospitals***

- Nearly 9 out of 10 hospitals reported that they had started programs or services with their 340B savings that have improved patient outcomes including:
  - Improving medication adherence (81 percent)
  - Reducing preventable readmissions (78 percent)
  - Improving clinical outcomes for patients (60 percent) including reducing viral load for people living with HIV, reducing emergency room use, improving opioid prescribing and care, and reducing mortality rates.

### ***Cuts to the 340B Program would hurt hospitals and their patients***

- Hospitals unanimously reported that limiting or completely losing their 340B savings would harm their ability to care for patients with low incomes and those living in rural communities.
  - 82 percent of hospitals reported that it would hurt their ability to provide more patient care services
  - Nearly two-thirds of hospitals said that a loss of 340B savings would reduce their ability to provide uncompensated care.
  - Many DSH hospitals (71 percent) reported that a loss in savings would reduce their ability to provide free and/or discounted drugs
  - Over half of rural hospitals (57 percent) reported that a loss in program savings would affect their ability to stay open at a time of record rural hospital closures.
  - The clinical areas that would be most affected include oncology (67 percent) and diabetes (59 percent).



## INTRODUCTION AND SURVEY PURPOSE

The 340B drug pricing program “enables covered entities to stretch scarce Federal resources as far as possible, reaching more eligible and providing more comprehensive services.”<sup>1</sup> This is achieved by requiring pharmaceutical companies to provide certain outpatient drugs to eligible providers at a discounted price. 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 (DSH) hospitals, free-standing children’s (PED) and cancer hospitals (CAN), rural referral centers (RRC), and sole community hospitals (SCH) 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 discounts due to their status as rural providers. Critical access hospitals (CAH) 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, according to the North Carolina Rural Health Research Program which tracks nationwide rural hospital closures, 106 rural hospitals have closed since 2010.<sup>2</sup>

### SURVEY PURPOSE

The purpose of the “2018 340B Health Annual Survey” was to evaluate hospitals’ savings from the 340B program and how those savings are used to support care for patients with low incomes and those living in underserved rural communities. Questions on the survey focused in the following key areas:

- I. 340B Savings and Costs of 340B Operations and Compliance;
- II. Use of 340B Savings; and
- III. Impact of Cuts to the 340B Program.

As an update to last year’s annual survey<sup>3</sup>, we added questions to better understand 340B operations and compliance measures as well as how 340B savings are being used to improve patient health outcomes and hospital quality outcomes.

The survey was administered to over 1,300 340B member hospitals between November – December 2018 and received responses from disproportionate share hospitals, critical access hospitals, children’s hospitals, sole community hospitals, and rural referral centers. No responses were received from free-standing cancer hospitals.

---

<sup>1</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>2</sup> NC Rural Health Research Program, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

<sup>3</sup> Evaluating 340B Hospital Savings and Their Use in Serving Low-Income and Rural Patients (June 2018) [https://www.340bhealth.org/files/2017\\_Annual\\_Survey\\_Report\\_final.pdf](https://www.340bhealth.org/files/2017_Annual_Survey_Report_final.pdf)

For the purpose of this survey, we refer collectively to DSH hospitals and children’s hospitals as “DSH hospitals” and to critical access hospitals, rural referral centers, and sole community hospitals as “rural hospitals.” This distinction helps to highlight the differences in responses between hospitals that primarily serve urban populations versus hospitals that serve rural populations. However, we highlight nine “DSH hospitals” that responded to our survey that are located in rural areas and do serve a primarily rural patient population.

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

Survey respondents were asked to estimate their 340B savings in their last full fiscal year. Hospitals were given the option to calculate their 340B savings using whichever methodology was convenient for them as hospitals often have different resource capacities for such calculations use different systems to calculate this figure. Most hospitals reported that they used their billing software systems to calculate the difference between what they paid for their 340B drugs and what they would have paid for those same drugs had they not participated in the 340B program.

The average savings across all respondents was \$11.8 million per hospital, with 34 percent of hospitals reporting less than \$1 million in savings and 26 percent of hospitals reporting more than \$10 million in savings. There were key differences between DSH hospitals and rural hospitals. Rural hospitals reported average savings of \$2.2 million per hospital, with more than 60 percent reporting less than \$1 million in savings. On the other hand, DSH hospitals reported average savings of \$19.2 million, with approximately 50 percent reporting less than \$5 million in savings. The difference observed in average 340B savings between rural hospitals and DSH hospitals is likely due to differences in the number of patients treated, general size of facilities and resource capacities – in general, DSH hospitals tend to be larger, treat more patients and have greater resource capacities, while rural hospitals tend to be smaller and have more limited resources.

### **340B SAVINGS CORRELATE WITH SIZE OF HOSPITAL**

We observed wide variation in 340B savings figures across all 340B hospitals. The same trend was seen when we looked within the DSH and rural hospital groups. This wide variation is further evidenced by the significant difference between the average and median 340B savings – \$11.8 million in average 340B savings compared with approximately \$2 million to \$5 million in median 340B savings.

To better understand potential underlying factors for the observed variation in 340B savings, we mapped 340B savings against the size of the hospital. To estimate the size of hospital, we used number of hospital beds as a proxy measure, using data from the 2018 CMS Inpatient Prospective Payment System (IPPS) Impact File. For hospitals not included in the IPPS Impact file, which include many of our rural hospital respondents, we used data from FY2016 Medicare Cost Reports to ascertain data on the number of hospital beds. We excluded from the analysis any hospitals for which we could not access data on the number of hospital beds.

We found that larger 340B hospitals tended to report higher program savings, while smaller 340B hospitals tended to report lower savings. We would expect this positive correlation as larger hospitals tend to have a more patients and therefore are more likely to use more 340B drugs. We found a similar correlation when we plotted 340B savings against a hospital's average daily census, which is another measure of hospital size and represents the average daily number of beds that are occupied by patients. Ultimately, this finding suggests that 340B savings are generally tied to the size of the hospital.

## **340B COSTS OF OPERATION AND COMPLIANCE ARE SIGNIFICANT, ESPECIALLY FOR SMALLER HOSPITALS**

340B hospitals incur significant costs in order to maintain their program operations and stay compliant with program rules and requirements. In particular, hospitals must ensure that 340B drugs are dispensed only to eligible outpatients and DSH hospitals must ensure that they do not purchase covered drugs through a group purchasing organization. Compliance with these requirements often requires the use of expensive 340B-specific inventory management systems to track purchasing and dispensing of inpatient and outpatient drugs. Hospitals must also comply with state Medicaid billing rules and other federal rules specific to 340B, including annual recertification their eligibility to participate in the program and regular maintenance of hospital information in the Office of Pharmacy Affairs Information System (OPAIS). 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 1000 hospitals have been audited to ensure compliance.

Hospitals reported a median of \$100,000 to \$200,000 in 340B compliance costs, meaning that half of respondents reported less than that amount, and half of respondents reported more. For smaller hospitals with lower savings amounts, these compliance costs can represent a significant share of their savings. For example, for a small hospital that saves \$500,000 annually through 340B and incurs compliance costs of \$100,000, those costs represent one-fifth of their total 340B savings. Unlike the positive correlation we observed with 340B savings and the size of a hospital, we do not observe a similar correlation between the 340B costs of operation and size of hospital. In other words, smaller hospitals do not, necessarily have lower compliance costs.

## **340B HOSPITALS ARE INVESTING IN RESOURCES FOR BETTER COMPLIANCE**

Hospitals often dedicate employees to manage and oversee various aspects of a hospital's 340B program, including program compliance. Organizations measure an employee's time in terms of full-time equivalents (FTEs), which represent the hours worked by an employee on a full-time basis. Hospitals reported an average of two FTEs for 340B oversight, compliance, and operations, with DSH hospitals reporting a slightly higher average number of FTEs (2.2 FTE) and rural hospitals reporting only an average of one FTE per hospital.

Hospitals were asked if there had been a change in the number of FTEs dedicated to their 340B program, and more than one-third of hospitals reported an increase in their 340B-dedicated FTEs in the past two years. This represents an increased investment on the part of 340B hospitals to ensure better compliance with program rules and requirements. For example, one DSH hospital reported that they used part of their 340B savings to hire staff to collect data and conduct ongoing internal audits of their 340B program. The hiring of staff to conduct these audits allowed them to ensure that they were staying compliant with program requirements.

Most hospitals (94 percent) reported having a 340B work group or committee charged with overseeing their 340B operations to ensure compliance. Hospitals reported that several departments were involved in the daily operations of their 340B program, also illustrating the important investments hospitals are making to ensure compliance. In addition to the pharmacy department, hospitals reported that their finance, information technology (IT) and legal departments were involved to ensure 340B compliance.

Many smaller hospitals, especially rural hospitals, reported that only their pharmacy departments were involved in the operation, maintenance, and compliance of their 340B program. This is largely due to the fact that many smaller hospitals generally do not have multiple departments, including an in-house legal department.

## SECTION 2: 340B HOSPITALS USE PROGRAM SAVINGS TO SUPPORT CARE FOR RURAL AND LOW-INCOME PATIENTS

Savings from 340B support a broad array of programs and services within hospitals and are not limited to pharmacy programs. Hospitals unanimously reported using their program savings to benefit their patients with low incomes and those living in rural communities. Both DSH and rural hospitals reported that the top two ways they use their savings to benefit low-income and/or rural patients were to maintain or provide more uncompensated care (95 percent) and to maintain or provide more patient care services (90 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 such critical services as cancer screenings, trauma care, and translation services.

<b>Hospital Use of 340B Savings to Care for Low-Income/Rural Patients</b>	
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>90%</b>

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

A significant number of hospitals (70 percent) reported using 340B savings to provide discounted and/or free prescription drugs to their low-income patients, thereby improving their access to life-saving medications. In addition to caring for more low-income patients and providing critical services, hospitals report using their 340B savings to help offset the high costs of medications, which is an important mechanism to ensure that patients adhere to their prescribed treatments and improve their health.

## HOSPITAL SPOTLIGHT

### *University of California San Diego Medical Center – DSH Hospital in San Diego, California*

“One of the many ways in which we use 340B to help patients is through financial assistance to patients who cannot afford the medications they need. One such patient had lost his employer-sponsored health coverage and no longer could pay for his immunosuppressant and anticoagulant medication. By offering the drugs to this patient at the discounted price, we were able to cut his out-of-pocket costs by \$750. That meant that he maintained access to the medication he needed to stay healthy during the time he was uninsured.”

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

In addition to providing uncompensated and unreimbursed care and critical services, DSH hospitals reported a particular emphasis on using their savings to offset low reimbursement from Medicaid. To qualify for 340B, DSH hospitals provide significant services to Medicaid and low-income Medicare patients, and the national data show that 340B DSH hospitals provide 54 percent more care to these patients than non-340B hospitals.<sup>4</sup> 340B DSH hospitals are also much more likely to treat Medicare patients who are dually eligible for Medicaid than non-340B providers.<sup>5</sup> This survey finding highlights how 340B helps hospitals absorb the unreimbursed costs they incur treating Medicaid patients and demonstrates 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>6</sup> With this increase in enrollment, the financial burden from Medicaid underpayments on safety-net hospitals has also increased as evidenced by the growth in Medicaid underpayments to nearly \$76.8 billion in 2017 alone.<sup>7</sup> Hospitals can struggle to meet the needs of their Medicaid patients because Medicaid often underpays for services provided to these low-income patients.<sup>8</sup> The survey results demonstrate that program savings allow DSH hospitals to address this challenge, enabling them to treat high levels of Medicaid patients despite being underpaid for many services provided to them.

---

<sup>4</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>5</sup> L&M Policy Research, A Comparison of Characteristics of Patients Treated by 340B and Non-340B Providers (April 8, 2019) [https://www.340bhealth.org/files/340B\\_Patient\\_Characteristics\\_Report\\_FINAL\\_04-10-19.pdf](https://www.340bhealth.org/files/340B_Patient_Characteristics_Report_FINAL_04-10-19.pdf)

<sup>6</sup> Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid Enrollment Changes Following the ACA (July 2018) <https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/>

<sup>7</sup> American Hospital Association (AHA). AHA: Medicare, Medicaid underpaid by \$76.8 billion in 2017 (January 3, 2019) <https://www.aha.org/news/headline/2019-01-03-aha-medicare-medicare-underpaid-hospitals-768-billion-2017>

<sup>8</sup> *Id.*

DSH hospitals also reported other ways they use their program savings to support care for their patients with low incomes beyond offsetting low Medicaid reimbursement. The table below provides examples:

### DSH hospitals reported using their 340B savings to help their patients by:

- supporting indigent care patients and offering discounted services for low-income and rural patients.
- subsidizing free one-time outpatient-dispensed drugs used by case management to promote safe discharge of low-income patients.
- funding community health improvement services and community benefit operations such as a “Good Samaritan Clinic”, a health center targeted to low-income and minority patients, and a mental health program.
- providing free influenza vaccines to the community annually and free medications and supplies to indigent diabetic patients.
- providing free naloxone to emergency department patients at risk for opiate overdose.
- supporting treatment for diabetes, HIV/AIDS and sexually transmitted diseases, family planning services, transplant services, and infusion clinics that offer discounted services and drugs for our low-income and under-insured patients.
- providing off-site services for our pediatric patients in the region. The high DSH percentage at our children’s hospital depends on 340B to offset decreasing reimbursement and allows us to care for children.

### RURAL HOSPITALS USE SAVINGS TO SUPPORT ACCESS TO CARE

More 46 million U.S. residents live in rural areas and rely on rural hospitals for their care.<sup>9</sup> 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.

In addition to supporting uncompensated and unreimbursed care along with critical patient services, 93 percent of rural hospitals reported they need their 340B savings to keep the doors of their facility open. More than half (57 percent) of rural hospitals said they would be forced to close if their 340B savings were diminished or eliminated.

Further, rural providers face unique financial challenges that jeopardize their ability to adequately serve their communities. Since 2010, 106 rural hospitals have closed, and an additional 46 percent of currently active rural hospitals are operating at a financial loss.<sup>10</sup> 340B savings allow these hospitals to mitigate their financial losses and maintain access to care for their patients.

<sup>9</sup> U.S. Congress Joint Economic Committee. KRWG – The State of Rural Communities: A Report (June 29, 2018) <https://www.jec.senate.gov/public/index.cfm/democrats/in-the-news?ID=06ADA76B-59C7-4E44-B9C9-DA936141D1AA>

<sup>10</sup> NC Rural Health Research Program <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

## HOSPITAL SPOTLIGHT

### *Bonner General Hospital – Critical Access Hospital in Sandpoint, Idaho*

“Chronically ill patients rely on our infusion clinic to receive vital maintenance medications. As drug costs continue to rise, reimbursements from health plans increasingly fall short of covering the full amount of providing the care. Without the ability to receive these drugs at a discounted price through 340B, our clinic would be forced to close, and those patients would be forced to travel hours to obtain treatments they cannot live without.”

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

### Rural hospitals reported using their 340B savings to help their patients by:

- keeping the doors of the hospital open to provide inpatient, emergency room, and clinic services to our community.
- maintaining remote after-hours pharmacist order review to increase patient safety.
- supporting a clinic pharmacist going to a rural clinic with no pharmacy services to provide medication therapy management visits.
- operating our county’s only ambulance service and provide home health services to our rural patients.
- supporting an outpatient infusion service to provide care to our patients who would otherwise have to travel great distances for the same level of care.
- expanding mental health services in our clinic and ongoing support for mental health patients that is critically needed in our rural community, where many of our patients suffer from one or more mental illnesses.
- expanding pharmacy counselling services to improve medication adherence as well as to fund a much-needed charity care program.

## DSH HOSPITALS LOCATED IN RURAL AREAS HELP MAINTAIN ACCESS TO CARE FOR THEIR RURAL PATIENTS

While DSH hospitals tend to represent larger and urban-situated institutions, such as many academic medical centers and large public hospitals, there are some DSH hospitals that are comparatively smaller and are in primarily rural areas. Using the CMS definition of a “rural” hospital<sup>11</sup>, we estimate that

---

<sup>11</sup> The CMS definition of a rural hospital is based on a definition from the Office of Management and Budget (OMB) that defines “rural” as any counties not part of a Metropolitan Statistical Area (MSA). Therefore, any hospital located in a county that is not part of an MSA is considered a rural hospital. (<https://www.hrsa.gov/rural-health/about-us/definition/index.html>)

approximately 20 percent of the approximately 1,100 DSH hospitals participating in 340B can also be classified as “rural” hospitals.

Nine of these hospitals responded to our survey. they look more like the “rural hospitals” we refer to in this report and face similar challenges in patient care. These rural DSH hospitals unanimously reported using their savings to support care for low-income patients and noted that they were using their savings to “keep their doors open” and maintain access to care for their rural patients.

### **LOSS OF 340B SAVINGS WOULD LIMIT PATIENT SERVICES AND HARM ACCESS TO CARE**

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 indicated that cuts in savings would significantly impact their ability to care for their low-income or rural patients. The top two areas of impact reported was the ability of hospitals to continue to provide critical patient services such as trauma care, HIV/AIDS services, and mental health services (82 percent) and to provide uncompensated and unreimbursed care (64 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 with opioid use disorders (OUDs) and that a cut in their savings would mean that they would likely have to close that unit. Another hospital reported that its savings support a fully staffed medication access program that ensures patients get the drugs they need at little to no cost to the patient and continuous follow-up to ensure that the patient is adhering to their medications. This hospital reported that cuts to its 340B savings would likely mean cutting this program which would directly hurt their patients. These examples are just a couple of many that clearly demonstrate how cuts in program savings could directly impact patients, as in the first example, patients with OUDs 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.

We also observed important differences between DSH and rural respondents in response to this question. In addition to the expected effects on patient care services and the provision of uncompensated and unreimbursed care, 71 percent of DSH hospitals reported that 340B program cuts would harm their ability to provide discounted and/or free prescription drugs to patients in need. This is particularly concerning as patients often rely on 340B hospitals to access costly, yet critical medications that they cannot otherwise afford. If cuts in savings can impact a hospital’s ability to provide those medications, they could result in potential negative effects on patients’ health and well-being. On the other hand, more than half of rural hospitals (57 percent) reported that 340B savings cuts would force them to close their doors. Given that rural hospitals reported using their program savings to maintain access to care, this finding indicates that cuts in savings would jeopardize access to care for rural patients.

## HOSPITAL SPOTLIGHT

### *Dickinson County Hospital – Sole Community Hospital in Iron Mountain, Michigan*

“Thanks to 340B savings, we provide diabetes treatments, wound care, and oncology services locally to members of our rural community, many of whom are uninsured or underinsured. Without 340B, it’s likely we would not be able to offer this care. That means some of our patients would be forced to travel up to 85 miles one way just to find the next nearest hospital that could give them the care they need.”

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. Hospitals unanimously reported that a loss in 340B savings would harm their ability to treat at least one disease area. Hospitals indicated that the types of services most likely to be affected are provision of primary care services (80 percent), oncology (67 percent) and diabetes (59 percent). Research has shown that 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>12</sup>

## SECTION 3: 340B SAVINGS HELP HOSPITALS IMPROVE PATIENT HEALTH OUTCOMES AND HOSPITAL QUALITY OUTCOMES

Hospitals were asked if they were operating programs and/or services that were supported entirely or in-part by 340B savings that have improved patient health outcomes and/or hospital quality outcomes. These outcomes are important markers for assessing the impact of the program on the health and well-being of 340B hospital patients. Ninety percent of hospitals reported having a program that improved patient health outcomes and/or hospital quality outcomes. 340B hospitals reported the following as the top three areas where patient outcomes were improved:

Patient Health Outcomes and Hospital Quality Outcomes Improved with 340B Program Support	
PATIENT/HOSPITAL OUTCOMES	% OF HOSPITALS
Improved Medication Adherence	81%
Reduced Hospital Readmissions	78%

<sup>12</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).

## Improved Patient Clinical Outcomes

60%

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

In addition to these outcomes, hospitals reported reducing emergency department patient visits and patient mortality rates, as well as improving opioid prescribing and patient care. For example, one DSH hospital noted that they operate a program in coordination with the pharmacy department to provide free diabetes medications with support from their 340B savings. These medications often have price tags in the thousands of dollars and represent a significant financial burden for patients. As a result of patients receiving their diabetic medications for free through this 340B-supported program, the hospital was able to observe that their diabetic patients have improved their adherence to these medications and seen a marked improvement in the hemoglobin A1C levels of their patients.

### HOSPITAL SPOTLIGHT

#### *Strong Memorial Hospital – DSH in Rochester, New York*

“Patients have better health outcomes and reduced hospital admissions when pharmacy staff work closely with other health care providers on comprehensive patient care. That’s why we have achieved success with installing pharmacists and technicians in clinical roles at our hospital as well as implementing a meds-to-beds program that gives discharged patients the maintenance drugs they need to stay healthy. These programs would not be able to exist if 340B savings did not help pay for the costs of running them.”

## CONCLUSION: 340B IS A VITAL PROGRAM THAT HELPS SAFETY-NET HOSPITALS CARE FOR PATIENTS WITH LOW INCOMES AND LIVING IN RURAL COMMUNITIES

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.

Key themes emerged when comparing the survey results between hospitals that serve primarily urban patients and hospitals that serve primarily rural patients. While both types of 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 illustrate how 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, vital patient care services like cancer and diabetes care and the provision of free

and/or discounted drugs. In addition, many rural hospitals reported that cuts in savings would directly affect their ability to continue operating, thereby jeopardizing access to care for the communities they serve.

Finally, both types of hospitals overwhelmingly reported that they were using their 340B savings to establish programs and services that have improved patient and/or hospital quality outcomes such as improved clinical outcomes, reduced readmissions and reduced mortality. These data demonstrate the continued importance of 340B in the overall health and well-being of the patients served by these safety-net hospitals.

The 340B program is a lifeline for hospitals to care for patients in need, both in the urban and rural communities they serve. These results indicate hospitals are fulfilling the stated intent of 340B – to care for more patients and offer more comprehensive services.