



## **A Comparison of Characteristics of Patients Treated by 340B and Non-340B Providers**

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**Prepared for:**  
340B Health

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## A COMPARISON OF 340B AND NON-340B PATIENT DEMOGRAPHIC & ENROLLMENT CHARACTERISTICS

### Executive Summary

The 340B Drug Pricing Program was created to enable participating entities to stretch scarce resources to reach more eligible patients and provide more comprehensive services by allowing these entities to obtain covered outpatient drugs at reduced prices. Prior research evaluating the safety-net characteristics of hospitals has shown that 340B hospitals exhibit more of these characteristics than non-340B hospitals.<sup>1</sup> Yet, some have asked whether the benefits of the 340B program are truly supporting care for underserved populations and little research to date has examined the types of patients treated at these facilities.

Using FY2016 Medicare Part B claims data, we examined differences in the patient characteristics – including demographics and health-associated Medicare enrollment status – between those who received separately billable Medicare Part B drugs at 340B hospitals, non-340B hospitals, and physician offices.

We found that 340B hospitals treat a higher proportion of patients who are dually eligible for Medicaid and Medicare, are disabled, and are members of certain ethnic/racial minorities. These populations, in general, are associated with lower socioeconomic status, an elevated level of illness burden, and greater challenges accessing needed care. The primary findings of the study are:

- The percentage of Black/African American patients treated in 340B hospitals is 66% and 75% higher than in non-340B hospitals and physician offices, respectively.
- The percentage of patients at 340B hospitals who are disabled is 29% and 110% higher than in non-340B hospitals and physician offices, respectively
- 340B hospitals' percentage of dual-eligible patients, a proxy measure for low-income status, is 43% higher and 71% higher than in non-340B hospitals and physician offices, respectively.

These findings are in line with previous research that has shown that 340B hospitals disproportionately treat an underserved and low-income population. An analysis of Medicare hospital cost report data had documented that 340B hospitals consistently provide more uncompensated and unreimbursed care than non-340B hospitals and treat more low-income patients as a share of their overall patient load.<sup>2</sup> Recently, the Government Accountability Office (GAO) published a report comparing the characteristics of 340B and non-340B hospitals, also

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<sup>1</sup> L&M Policy Research, LLC. Analysis of 340B Disproportionate Share Hospital Services to Low-Income Patients. [https://www.340bhealth.org/files/340B\\_Report\\_03132018\\_FY2015\\_final.pdf](https://www.340bhealth.org/files/340B_Report_03132018_FY2015_final.pdf). Published March 12, 2018. Accessed January 3, 2019.

<sup>2</sup> *Ibid.*

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finding that 340B hospitals generally provided “higher amounts of uncompensated care,” and, on average, operated on lower financial margins in 2016.<sup>3</sup>

Congress implemented the 340B program to stretch federal dollars such that 340B providers can extend critical services to more patients, including those patients who are low-income and underserved. Disability-based entitlement, dual eligibility,<sup>4</sup> and certain ethnic and racial minority groups, observed in greater proportions among the 340B patient population, have been generally associated with lower socioeconomic status,<sup>5</sup> an elevated level of illness burden,<sup>6</sup> and greater challenges related to access to care.<sup>7</sup> As such, the findings of this study further contribute to the body of literature suggesting that 340B providers care for the low-income and underserved patient populations Congress targeted with the program. As policymakers continue to debate changes to the scope of the 340B program, they should consider the impact such changes could have on these underserved populations that disproportionately obtain their care from 340B hospitals.

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<sup>3</sup> The Government Accountability Office. Characteristics of Hospitals Participating and Not Participating in the 340B Program. <https://www.gao.gov/products/GAO-18-521R>. Published June 18, 2018. Accessed January 3, 2019.

<sup>4</sup> Coughlin, T., Waidmann, T., O'Malley Watts, M. Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries. The Henry J. Kaiser Family Foundation. <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7895-2.pdf>. Published April 2009. Accessed January 3, 2019.

<sup>5</sup> Mather, M. Race/Ethnic Income Gap Growing Among U.S. Working Poor Families. Population Reference Bureau. <https://www.prb.org/working-poor-families/>. Published March, 16 2015. Accessed January 3, 2019.

<sup>6</sup> Cubanski J, Neuman P. Medicare Doesn't work as Well for Younger, Disabled Beneficiaries As It Does for Older Enrollees. *Health Affairs*. 2010;29(9):1725-33. 10.1377/hlthaff.2009.0962

<sup>7</sup> The Center for Disease Control and Prevention. Finding Solutions to Health Disparities at a Glance 2016. <https://www.cdc.gov/chronicdisease/resources/publications/aag/reach.htm>. Published 2016. Accessed January 3, 2019.

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## Background

The 340B Drug Pricing Program was created to enable participating entities to stretch scarce resources to reach more eligible patients and provide more comprehensive services by allowing these entities to obtain covered outpatient drugs at reduced prices.<sup>8</sup> The program includes many types of safety-net hospitals which, based on their Medicare disproportionate share (DSH) status, treat a qualifying number of low-income Medicare and Medicaid patients. Under the program, these safety-net hospitals access reduced pricing on outpatient drugs resulting in savings to the hospital which can be used to provide more services to more low-income and other at-risk patients. These outpatient drugs include separately-billable drugs covered under the Medicare Part B program. The Medicare Part B program covers a limited number of outpatient prescription drugs under specified parameters, including drugs provided in a hospital outpatient setting or physician's office, and includes those primarily used to treat conditions such as cancer and rheumatoid arthritis.<sup>9</sup>

Some have questioned<sup>10</sup> whether the benefits from the 340B program are supporting care for low-income and underserved patients. Proponents of the program, however, maintain that 340B entities serve more low-income, high-risk, and vulnerable patients, compared to non-340B entities, suggesting that 340B entities are supporting care for low-income and underserved patient populations.

A prior analysis,<sup>11</sup> based on CMS Hospital Cost Reports, documents that 340B hospitals consistently provide more unreimbursed and uncompensated care than non-340B hospitals and have a higher low-income patient load. Recently, the Government Accountability Office (GAO) published a report<sup>12</sup> comparing the characteristics of hospitals that do and do not participate in the 340B program, finding that 340B hospitals generally provided “higher amounts of uncompensated care,” and, on average, operated on lower financial margins in 2016. While these studies have provided evidence that 340B hospitals display more safety-net characteristics than their non-340B counterparts, there is less research examining the differences in the types of patients treated at these facilities.

In this report, we examine differences in demographics and health-associated Medicare enrollment characteristics between patients of 340B hospitals and non-340B providers. Specifically, we compare characteristics of Medicare beneficiaries, including those who received

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<sup>8</sup> Health Resources & Services Administration. 340B Drug Pricing Program. <https://www.hrsa.gov/opa/index.html>. Updated February 5, 2019. Accessed January 3, 2019.

<sup>9</sup> Medicare Payment Advisory Commission. Report to the Congress: Overview of the 340B Drug Pricing Program. <http://medpac.gov/docs/default-source/reports/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program.pdf?sfvrsn=0>. Published May 2015. Accessed January 3, 2019.

<sup>10</sup> Conti, R., Nikpay, S., Gracia, G., Melinda, J., Buntin, M. Proposed Reforms to the 340B Drug Discount Program. Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20180306.70004/full/>. Published March 7, 2018. Accessed January 3, 2019.

<sup>11</sup> L&M Policy Research, LLC. Analysis of 340B Disproportionate Share Hospital Services to Low-Income Patients. [https://www.340bhealth.org/files/340B\\_Report\\_03132018\\_FY2015\\_final.pdf](https://www.340bhealth.org/files/340B_Report_03132018_FY2015_final.pdf). Published March 12, 2018. Accessed January 3, 2019.

<sup>12</sup> The Government Accountability Office. Characteristics of Hospitals Participating and Not Participating in the 340B Program. <https://www.gao.gov/products/GAO-18-521R>. Published June 18, 2018. Accessed January 3, 2019.

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Part B drugs at 340B and non-340B hospitals in 2016, as well as all beneficiaries receiving Part B drugs in non-institutional, or non-340B affiliated physician office, settings.

The following sections present the analytic approach and more detailed findings.

### **Data Construction**

Medicare reimburses hospitals under the outpatient prospective payment system (OPPS) for separately billable Part B drugs, which differ from other drugs that are bundled into payment for other services under OPPS. In order to isolate the universe of patients that received a Part B drug, we identified separately-billable drug claims by HCPCS code billed in combination with a revenue status code of “G” (drug/biological pass-through) or “K” (non-pass-through drug/biological, radiopharmaceutical agent, certain brachytherapy sources). We excluded vaccines, as they are a class of drugs excluded from the 340B program. To ensure a comparison of similar drugs, we included only Physician Part B drug claims containing the same HCPCS drug codes identified in the 340B hospital claims for separately billable Part B drugs.

### **Patient Groupings**

We used Medicare 100% Research Identifiable Files (RIF) containing Outpatient and Part B Carrier claims to identify patients who received separately billable Part B drugs in the hospital and physician office settings on an annual basis. The particular setting in which patients received all of their separately billable Part B drugs translated to the following, mutually exclusive, cohorts of patients included in this report:

1. Those who receive Part B drugs in a 340B hospital only;
2. Those who receive Part B drugs in a non-340B hospital only; and
3. Those who receive Part B drugs in a physician’s office only.

A small proportion of patients received their separately billable Part B drugs in more than one of the cohorts studied. Specifically, 0.9% of patients received Part B drugs in both a 340B and non-340B hospital in 2016, and 0.03% received Part B drugs in a non-340B hospital and in a physician’s office. These patients were excluded from this analysis to avoid inappropriately assigning costs to a particular cohort.

As we study the census of Part B patients, statistical tests are not necessary to determine the existence of differences between the included populations.

### **Study Hospitals**

We identified study hospitals using CMS’s annual IPPS Impact Files to identify the universe of acute care hospitals in the country. We then utilized the HRSA 340B OPAIS Covered Entity Daily Report to determine 340B participation status. From the HRSA Daily Report, we obtained information for all active and inactive entities in the 340B application, allowing filtering on entity participation dates with the program and selection of disproportionate share hospitals (DSH), sole community hospitals (SCH) and rural referral centers (RRC), herein collectively referred to as “340B hospitals.” Critical access hospitals were excluded from the 340B hospital cohort because they do not qualify for the 340B program based on a minimum DSH percentage

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threshold. Freestanding children's and cancer hospitals were also excluded from the 340B hospital cohort because they treat a specific population group (i.e., pediatric and cancer patients, respectively) and may skew the results. For the group of hospitals eligible as a comparison group, we selected non-340B acute care hospitals (ACH) active during this time period. Physician office claims were selected from Medicare 100% Carrier claims files, to include all non-institutional providers billing for the separately billable Part B drugs identified as stated above.

We used the Medicare Beneficiary Summary Files (MBSF) to connect the identified patient populations with relevant demographic and enrollment information.

### **Differences in Patient Demographic and Enrollment Related Characteristics**

We compare demographic characteristics for the three identified populations in Table 1. In 2016, the majority of patients received their separately billable Part B drugs in the physician office setting, with notably fewer getting Part B drugs in 340B and non-340B hospitals, in descending order. Proportionally, 340B hospitals treat more Medicare patients under the age of 65, an indicator of the proportion of disabled patients in the population as, by definition, the non-disabled population is not eligible for Medicare until they reach the age of 65. The gender distribution within each of the cohorts is very similar, with minimal differences observed between cohorts.

Prior research<sup>13</sup> has suggested that members of certain minority groups are more likely to have poorer access to care, worse health outcomes, and are more often burdened by chronic diseases such as diabetes, obesity,<sup>14</sup> and HIV/AIDS<sup>15</sup> than members of non-minority groups. Race and ethnicity classifications, as reported in the Medicare Beneficiary Summary File, show a higher proportion of 340B patients as non-white, in comparison to Part B drug patients of non-340B hospitals and physician offices. In particular, 340B hospitals have proportionally more Black/African American, Hispanic and North American Native patients. Looking specifically at Black/African American patients, the percentage of Black/African American patients treated in 340B hospitals is 66% and 75% higher than in non-340B hospitals and physician offices, respectively.

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<sup>13</sup> The Center for Disease Control and Prevention. CDC Health Disparities & Inequalities Report. <https://www.cdc.gov/minorityhealth/CHDIReport.html>. Published 2013. Accessed January 3, 2019.

<sup>14</sup> The Center for Disease Control and Prevention. Finding Solutions to Health Disparities at a Glance 2016. <https://www.cdc.gov/chronicdisease/resources/publications/aag/reach.htm>. Published 2016. Accessed January 3, 2019.

<sup>15</sup> The Center for Disease Control and Prevention. HIV and African Americans. <https://www.cdc.gov/hiv/group/raciaethnic/africanamericans/index.html>. Published 2018. Accessed January 3, 2019.

**Table 1. Comparison of Patient Demographic & Enrollment Characteristics in 2016**

	340B Hospital Patients	Non-340B Hospital Patients	Physician Office Patients
<b>Total Patients</b>	555,487	249,381	2,023,390
<b>Age</b>			
<b>Under 65</b>	19.64%	15.32%	9.27%
<b>65 and Over</b>	80.36%	84.68%	90.70%
<b>Gender</b>			
<b>Male</b>	38.69%	37.53%	38.94%
<b>Female</b>	61.31%	62.47%	61.04%
<b>Race and Ethnicity</b>			
<b>White</b>	81.52%	87.58%	87.01%
<b>Black/African American</b>	11.82%	7.10%	6.75%
<b>Other</b>	1.41%	1.24%	1.34%
<b>Asian</b>	1.60%	1.05%	1.76%
<b>Hispanic</b>	1.88%	1.47%	1.64%
<b>North American Native</b>	0.52%	0.28%	0.34%
<b>Unknown</b>	1.24%	1.28%	1.14%
<b>Current Reason for Medicare Entitlement</b>			
<b>Disability Insurance Benefits (DIB)</b>	18.75%	14.57%	8.93%
<b>ESRD</b>	0.56%	0.48%	0.23%
<b>DIB and ESRD</b>	0.32%	0.27%	0.11%
<b>Old Age and Survivor's Insurance</b>	80.36%	84.68%	90.71%
<b>Dual Eligibility</b>			
<b>Percent of Beneficiaries who are Dual Eligible</b>	24.65%	17.19%	14.41%

*Characteristics of all patients receiving Part B drugs at hospitals and physician offices in 2016. Statistical tests not performed on the census of patients.*

*Source: Medicare 100% RIFs and Medicare Beneficiary Summary Files for 2016*

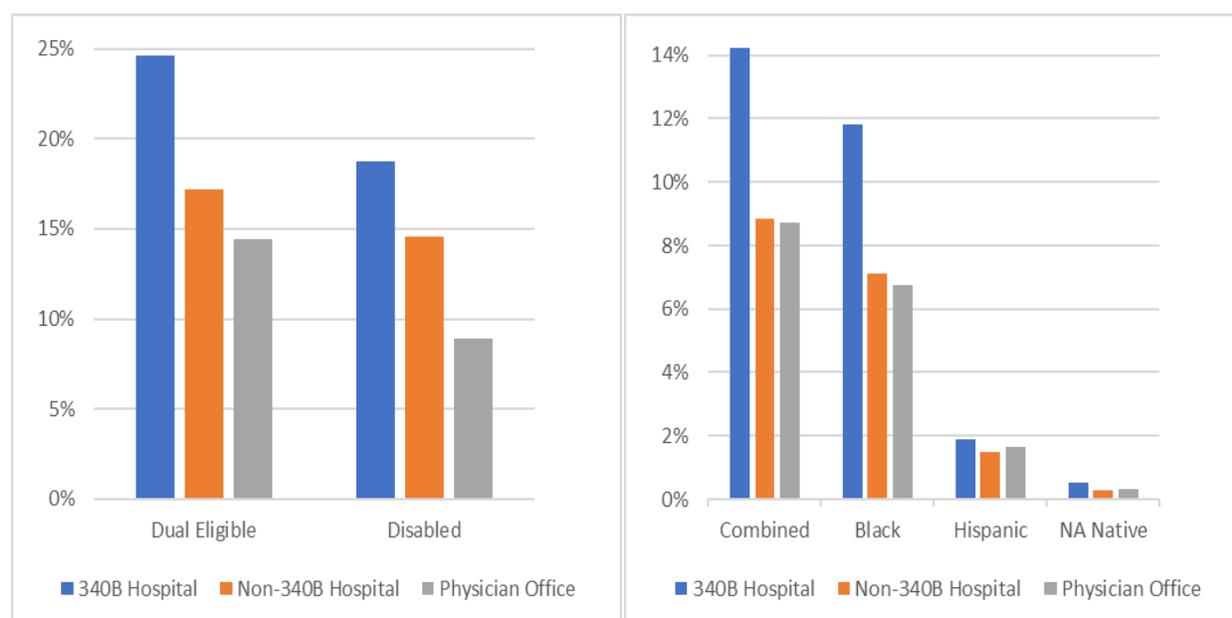
Some enrollment-related attributes also may be interpreted as indications of comparative illness burden in a population. For example, the reason for a beneficiary's Medicare entitlement may be related to a disability or end-stage renal disease (ESRD), or entitlement may be made on the basis of age, as a beneficiary turns 65. In general, a higher proportion of individuals with disability-based entitlement is associated with a higher level of illness burden in a population.<sup>16</sup> As shown in Table 1, the percentage of patients at 340B hospitals who are disabled is 29% and

<sup>16</sup> Master, R.J. and Taniguchi, C. Medicare, Medicaid, and People With Disability. *Health Care Finance Review*. 1996; 18:91-7.

110% higher than the percentage of disabled patients treated by non-340B hospitals and physician offices, respectively. In addition, 340B patients are more likely to be dually eligible for Medicare and Medicaid (24.65%) than either non-340B (17.19%) or physician office (14.41%) patients. In other words, 340B hospitals' percentage of dual-eligible patients is 43% higher than non-340B hospitals and 71% higher than physician offices. The dual-eligible patient population is often used as a proxy for low-income status and is also associated with poorer health compared with the general Medicare population.<sup>17</sup>

The findings are also summarized in Figure 1 below.

**Figure 1. Selected Characteristics of Patients Receiving Part B Drugs, 2016**



*Characteristics of all patients receiving Part B drugs at hospitals and physician offices in 2016.*

*Statistical tests not performed on the census of patients.*

*Source: Medicare 100% RIFs and Medicare Beneficiary Summary Files for 2016*

## In Summary

This research demonstrates that 340B hospitals treat more patients with demographic and other characteristics that are associated with poorer health status, lower socioeconomic status, and greater challenges related to access to care. In addition to providing more unreimbursed and uncompensated care, this research illustrates 340B hospitals provide care to proportionally more minority, dual Medicaid-Medicare, and disabled patients than other non-340B providers. These findings suggest that the program works to support care for low-income and underserved patient populations. Further research is needed to understand how the observed differences in patient characteristics between the care settings examined could contribute to differences in Part B drug

<sup>17</sup> Medicare Payment Advisory Commission. June 2016 Report to the Congress: Medicare and the Health Care Delivery System. Chapter 9: Issues affecting dual-eligible beneficiaries: CMS's financial alignment demonstration and the Medicare Savings Programs. In: Report to the Congress: Medicare and the Health Care Delivery System. <http://www.medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf?sfvrsn=0>. Published June 2016. Accessed January 3, 2019.

treatment costs and spending. As policymakers continue to debate changes to the scope of the 340B program, they should consider the impact that such changes could have on the underserved populations treated disproportionately at 340B hospitals.



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