340B HEALTH
The affordable prescription for healthy communities

340B HOSPITALS USE THEIR CONTRACT PHARMACY BENEFIT TO TREAT LOW-INCOME AND RURAL PATIENTS

Results from a survey of 340B Health Members

The contract pharmacy program is critical for 340B hospitals to maintain and expand access to care for low-income and rural patients. Without their contract pharmacy benefit, hospitals would face difficulties maintaining the same level of care for patients in need, particularly Medicaid patients, rural populations, and patients who suffer from chronic and life-threatening conditions.

JULY 2017

CONTENTS

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 hospitals 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.

EXECUTIVE SUMMARY

Since it was signed into law by President George H.W. Bush in 1992, the 340B drug pricing program has served as a lifeline for safety-net providers and, by extension, the patients they serve. Previous surveys of 340B Health members have focused on the full scope of the program and have shown that the 340B program is critical for hospitals to treat their low-income and rural patients. This survey focuses on hospital use of contract pharmacies to dispense 340B drugs to eligible patients.

340B Health conducted a survey of its members to better understand the value of contract pharmacies to 340B hospitals and their patients. The survey targeted the 1,301 hospitals that are members of 340B Health. The survey instrument was 15 questions in length and hospitals were given three weeks to respond. The survey results demonstrate that 340B hospitals rely on their contract pharmacy benefit to treat their low-income and rural patients. The findings also indicate that eliminating or reducing the contract pharmacy program could reduce the level of services 340B hospitals are able to provide to patients in need.

KEY FINDINGS

Overall Findings

- The contract pharmacy benefit is critical for hospitals to serve their low-income and rural patients.
- DSH hospitals reported a greater focus on using their contract pharmacy benefit to support uncompensated care and provide direct services to low-income patients, whereas rural hospitals were more likely to report using their benefit to support access to care, namely by maintaining operations and keeping their doors open.
- Hospitals unanimously reported that a reduction in their contract pharmacy benefit would negatively impact their ability to provide services to their low-income and rural patients.

DSH Hospitals Use Their Contract Pharmacy Benefit to Support Uncompensated Care and Provide Services to Their Low-Income Patients

- *Summary:*
    - DSH hospitals rely on their contract pharmacy benefit to fund care to their low-income patients, such as by supporting uncompensated care, reducing the price of drugs to low-income patients, offsetting low Medicaid reimbursement and providing specific services to low-income patients suffering from chronic, life-threatening, and undertreated diseases and conditions.
    - 340B DSH hospitals are able to support this level of care to low-income patients, in part, because of their contract pharmacy benefit, and a loss in contract pharmacy benefit would prevent DSH hospitals from maintaining services for patients in financial need.
- *By the numbers:*
    - 89 percent of DSH hospitals use their contract pharmacy benefit to provide or maintain uncompensated care.
    - 74 percent use their contract pharmacy benefit to provide more services despite low Medicaid payments.
    - 71 percent use their contract pharmacy benefit to provide discounted and/or free drugs to low-income and/or rural patients.

- 95 percent use their contract pharmacy benefit to support services for low-income and rural patients to treat at least one chronic, life-threatening, or undertreated disease, including oncology (77 percent), diabetes (77 percent), and cardiac diseases (68 percent).

Contract Pharmacies are Vital for Rural Hospitals to Maintain Operations and Provide Access to Care in Remote Areas

- *Summary:*
  - Contract pharmacies are especially important to rural hospitals, given that they face unique challenges and operate differently than other hospitals. Rural hospitals are less likely to maintain in-house outpatient pharmacies, and more likely to heavily rely on their contract pharmacy benefit as a share of their overall 340B benefit.
  - Like DSH hospitals, rural hospitals use their contract pharmacy benefit to support uncompensated care, but they are also more likely to rely on their benefit to maintain their operations and keep their doors open.
  - Rural hospitals also reported providing remote communities with access to care for a number of life-threatening diseases and conditions.
- *By the numbers:*
  - 65 percent of rural respondents did not operate their own outpatient pharmacy.
  - 60 percent rely on their contract pharmacy benefit for more than half of their overall 340B benefit.
  - 87 percent use their contract pharmacy benefit to maintain their operations and keep their doors open.
  - Rural hospitals use their contract pharmacy benefit to support services in rural areas to treat a number of chronic and life-threatening conditions, including diabetes (78 percent), oncology (57 percent), cardiac diseases (54 percent), and pulmonary diseases (50 percent).

Contract Pharmacies Support Access to Specialty Drugs and Improve Patient Care

- *Summary:*
  - Contract pharmacy arrangements provide particular benefits to hospitals and their patients when the arrangements are with specialty pharmacies. Through arrangements with specialty pharmacies, hospitals are able to support care to low-income and rural patients as well as address actions in the specialty market that limit hospital and patient access to specialty drugs.
- *By the numbers*:
  - 52 percent of hospitals with at least one contract pharmacy arrangement reported that one or more of those arrangements were with a specialty pharmacy.
  - 72 percent of hospitals with specialty pharmacy arrangements indicated that they entered into these arrangements to increase resources to help their hospital meet the needs of their low-income and rural patients.
  - 69 percent indicated they entered into arrangements with specialty pharmacies to access specialty drugs that had been placed in a preferred pharmacy/closed network or otherwise restricted by a payer.
  - 67 percent indicated the reason was to access specialty drugs that manufacturers placed in limited distribution networks.
  - 63 percent reported the reason was to expand coordination of care and medical documentation for patients to ultimately improve their clinical conditions.

INTRODUCTION AND STUDY PURPOSE

The 340B drug pricing program helps hospitals maintain and expand access to care for their low-income and rural patients by requiring pharmaceutical companies to provide outpatient drugs to safety-net providers at a discounted rate. Hospitals use their program savings to provide services to their patients in need. In a prior survey of the 340B Health membership, hospitals unanimously reported using 340B savings to expand patient access in various ways, including by 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. 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.[1]

340B HOSPITALS TREAT HIGH LEVELS OF LOW-INCOME AND RURAL PATIENTS

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 and cancer hospitals, rural referral centers, and sole community hospitals must maintain a minimum threshold of care to Medicaid and low-income Medicare patients. Studies have documented that 340B DSH hospitals provide significantly more care to low-income patients compared to non-340B hospitals. 340B DSH hospitals treat 64 percent more Medicaid and low-income Medicare patients than non-340B hospitals.[2] Although 340B DSH hospitals account for only 36 percent of all Medicare acute care hospitals, they provide nearly 60 percent of all uncompensated care.[3] 340B DSH hospitals are also significantly more likely than non-340B hospitals to offer vital health care services that are often unreimbursed or under-reimbursed, which include trauma centers, HIV-AIDS services and immunizations.[4] In addition, compared to non-340B providers, 340B DSH hospitals treat significantly more Medicare Part B patients who are dually eligible for Medicaid, disabled, have end stage renal disease, or are a racial or ethnic minority.[5] 340B DSH hospitals also treat over 60 percent more low-income Medicare cancer drug patients than non-340B hospitals and physician offices.

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

[1] 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.
[2] Dobson Davanzo & Associates, Update to a 2012 Analysis of 340B Disproportionate Share Hospital Services Delivered to Vulnerable Patient Populations Eligibility Criteria for 340B DSH Hospitals Continue to Appropriately Target Safety Net Hospitals, Nov. 15, 2016, available at http://www.340bhealth.org/files/Update_Report_FINAL_11.15.16.pdf.
[3] *Id.*
[4] *Id.*
[5] Dobson DaVanzo, Analysis of Patient Characteristics among Medicare Recipients of Separately Billable Part B Drugs from 340B DSH Hospitals and Non-340B Hospitals and Physician Offices, Nov. 15, 2016, http://www.340bhealth.org/files/Demographics_Report_FINAL_11.15.2016.pdf.

rural hospitals, which face significant financial challenges. In fact, eighty rural hospitals have closed since 2010.[6]

CONTRACT PHARMACIES ARE AN INVALUABLE PART OF THE 340B PROGRAM

Contract pharmacies have been a vital component of the 340B program since the early years of the program. In 1996, the Health Resources and Services Administration (HRSA), which oversees 340B, recognized that providers can dispense 340B drugs to eligible patients through contractual agreements with outside pharmacies.[7] Under these arrangements, an outside pharmacy under contract with a 340B provider dispenses 340B drugs purchased by the 340B provider to eligible patients of that provider. HRSA initially limited providers to one contractual arrangement per provider but later issued guidance recognizing that 340B providers may contract with multiple contract pharmacy locations.[8]

STUDY PURPOSE

We conducted a survey of 340B Health's membership to evaluate how hospitals use the financial benefit they obtain through contract pharmacy arrangements to help their low-income and rural patients. 340B Health administered a "2017 Contract Pharmacy Benefit Survey" to member hospitals between May 25, 2017 and June 16, 2017.

[6] NC Rural Health Research Program, 80 Rural Hospital Closures: January 2010 – Present, http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
[7] Final Notice, Notice Regarding Section 602 of the Veterans Health Care Act of 1992; Contract Pharmacy Services, 61 Fed. Reg. 43549 (Aug. 23, 1996), http://www.hrsa.gov/opa/programrequirements/federalregisternotices/contractpharmacyservices082396.pdf.
[8] Final Notice, Notice Regarding 340B Drug Pricing Program—Contract Pharmacy Services, 75 Fed. Reg. 10272 (March 5, 2010), https://www.gpo.gov/fdsys/pkg/FR-2010-03-05/pdf/2010-4755.pdf.

SECTION 1: OVERALL FINDINGS

In looking at the survey results across 340B hospitals of all types, it is clear that the contract pharmacy benefit is critical to helping low-income and rural patients. Hospital respondents that operated at least one contract pharmacy arrangement unanimously reported that a loss in their contract pharmacy benefit would hamper their ability to provide services to their patients in need. Upon further analysis of the results, it became clear that hospitals of different types rely on their contract pharmacy benefit in different ways. DSH hospitals reported a greater focus on using their contract pharmacy benefit to support uncompensated care and provide direct services to low-income patients. Rural hospitals were more likely to report using their benefit to maintain access to care, namely by maintaining operations and keeping their doors open. In the following sections, we will break down the findings for both DSH and rural hospitals.

SECTION 2: DSH HOSPITALS USE THEIR CONTRACT PHARMACY BENEFIT TO SUPPORT UNCOMPENSATED CARE AND PROVIDE SERVICES TO THEIR LOW-INCOME PATIENTS

The survey results show that DSH hospitals rely on their contract pharmacy benefit to support uncompensated care and provide specific services to low-income patients. It would be fitting that DSH hospitals would use such a financial benefit to support services to their low-income patients, given that the research shows 340B DSH hospitals provide such a high level of care to patients in financial need. The survey results show that 340B DSH hospitals are able to support this level of care to low-income patients, in part, because of their contract pharmacy benefit. Moreover, a loss in contract pharmacy benefit would prevent DSH hospitals from maintaining their services for patients in financial need.

MAINTAIN OR PROVIDE UNCOMPENSATED CARE

The most common answer among DSH hospitals as to how they use their contract pharmacy benefit to help low-income and/or rural patients was to provide or maintain uncompensated care (89 percent). Uncompensated care includes charity care, bad debt expenses, and shortfalls from Medicaid underpayments. Given that data show 340B DSH hospitals provide 60 percent of all hospital uncompensated care, the survey findings indicate that contract pharmacies are a key force behind uncompensated care across the country and a reduction to the contract pharmacy benefit could diminish the level of care DSH hospitals are able to provide to low-income patients.

OFFSET LOW MEDICAID REIMBURSEMENT

Seventy-four percent of DSH respondents reported using their contract pharmacy benefit to provide more services despite low Medicaid payments. This finding is meaningful, given that 340B DSH hospitals treat so many Medicaid patients. 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 64 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.

Hospitals can struggle to meet the needs of their Medicaid patients because Medicaid often underpays for services provided to these low-income patients.[9] The survey results show that the contract pharmacy benefit helps 340B DSH hospitals address this challenge, allowing them to treat their Medicaid patients even though they are underpaid for services provided to them. Moreover, any reductions to the contract pharmacy benefit could jeopardize the ability of hospitals to maintain the same level of care and could diminish access to care for Medicaid patients.

PROVIDE FREE OR DISCOUNTED DRUGS

Seventy-one percent of DSH hospitals reported using their contract pharmacy benefit to provide discounted and/or free drugs to low-income and/or rural patients. The share of DSH hospitals using their benefit to provide discounted or free drugs was 45 percent higher than the share of all other hospital respondents (49 percent), showing how DSH hospitals use their contract pharmacy benefit differently than other hospitals. DSH hospitals were also much more likely to report that a loss of their contract pharmacy benefit would affect their ability to provide free or discounted drugs, with 51 percent reporting this service in their top three areas that would be affected by a loss of contract pharmacy, compared to 39 percent of all other hospital respondents.

HOSPITAL SPOTLIGHT

Mercy Health Saint Mary's – DSH Hospital in Grand Rapids, Michigan

"We operate a pharmacy access program with screening and entry points at 7 locations serving many medically indigent clients. Clients are screened for 200% of [the federal poverty level] with either no insurance or with unaffordable co-payments after insurance. […] The patient receives these medications at no cost. During fiscal year 2017 (July 2016 – June 2017) we have provided 20,200 prescriptions, to an average of 550 patients a month. Our health system supports the program by paying for drug cost or co-payment cost plus pharmacy labor expense."

The ability to discount drug prices for low-income patients is especially critical as hospitals and patients continue to struggle with the high cost of drugs. Between 2013 and 2015, average annual inpatient drug spending in community hospitals increased by 23.4%, with spending increasing by 38.7% on a per admission basis, primarily driven by increases in drug prices.[10]

[9] AHA, Underpayment by Medicare and Medicaid Fact Sheet, 2017 Update (Dec. 2016), http://www.aha.org/content/16/medicaremedicaidunderpmt.pdf.
[10] NORC, Final Report, Trends in Hospital Inpatient Drug Costs: Issues and Challenges (Oct. 11, 2016), http://www.aha.org/content/16/aha-fah-rx-report.pdf.

DSH Hospitals Use Their Contract Pharmacy Benefit to Help Low-Income Patients

SERVICE PROVIDED	% OF HOSPITALS
Maintain or Provide More Uncompensated Care	89%
Offset Low Medicaid Reimbursement	74%
Provide Discounted and/or Free Drugs	71%

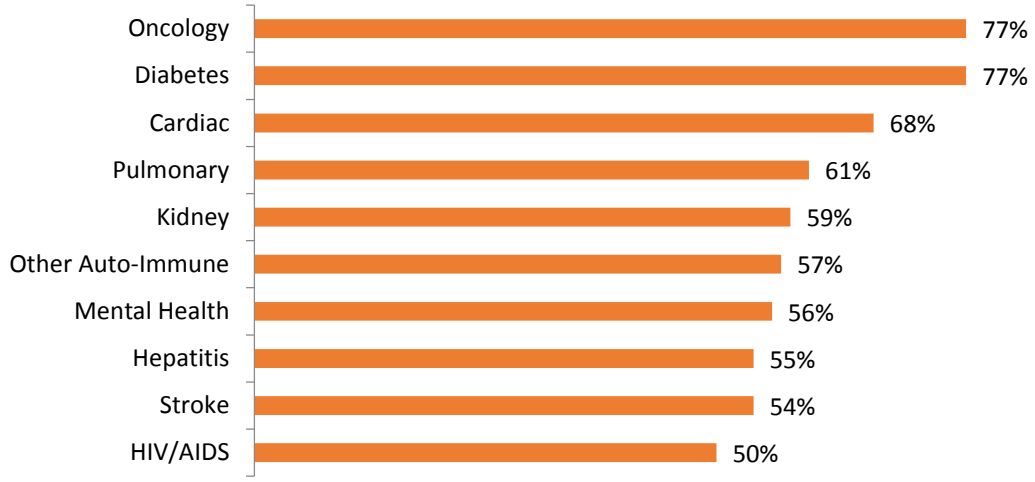
NOTE: Percentages add up to more than 100% because hospitals selected more than one option.

TREAT CHRONIC, LIFE-THREATENING, AND UNDERTREATED DISEASES AND CONDITIONS

The survey asked respondents whether they used their contract pharmacy benefit to treat a number of specific diseases that often disproportionately affect low-income patients. Nearly all DSH hospitals with contract pharmacies (95 percent) reported using their contract pharmacy benefit to treat at least one of the diseases or conditions listed, with oncology and diabetes being the two most commonly chosen (77 percent each), followed by cardiac diseases at 68 percent.

These responses support research that shows 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 and psychiatric care. DSH hospitals rely on their contract pharmacy benefit to support low-income and rural patients suffering from these conditions.

DSH Hospitals Using Their Contract Pharmacy Benefit to Support Low-Income and/or Rural Patients by Disease Type



NOTE: Percentages add up to more than 100% because hospitals selected more than one option.

DSH Hospitals reported using their contract pharmacy benefit to help low-income and/or rural patients by:

- Maintaining pharmacy and medicine reconciliation counselors to help low-income patients adhere to their medications
- Maintaining an anticoagulation clinic to help patients who suffer from cardiac diseases
- Providing clinical services and education for transplant and Hepatitis C patients, who otherwise would not be successful with treatment
- Providing clinical pharmacy services that lead to a great quality of care through a diabetes clinic, HIV clinic, and pharmacotherapy clinic
- Maintaining a pulmonary clinic that provides respiratory medications and an anticoagulation clinic that provides Coumadin both at minimal out-of-pocket expense to low-income and rural patients
- Maintaining a community clinic for low-income and uninsured patients as well as provide medications to homeless patients
- Maintaining a mental health clinic that provides services to low-income inner-city patients
- Operating a financial assistance program that gave away over $855,000 worth of medicines to indigent patients between April 1, 2016 and March 31,2017

SECTION 3: CONTRACT PHARMACIES ARE VITAL FOR RURAL HOSPITALS TO MAINTAIN OPERATIONS AND PROVIDE ACCESS TO CARE IN REMOTE AREAS

Contract pharmacies are especially important to rural hospitals, which face unique challenges and operate differently than other hospitals. In recent years, rural hospitals have struggled to continue operating and serving their remote, isolated communities. Eighty rural hospitals have closed since 2010 and many more are squeezed by reduced reimbursements and rising healthcare costs.[11] Survey responses show that rural hospitals use their contract pharmacy benefit to support access to care in remote locations, namely by maintaining operations and keeping their doors open.

LESS LIKELY TO HAVE THEIR OWN OUTPATIENT PHARMACY

The survey results indicate that 340B rural hospitals are less likely to have their own outpatient pharmacy. Of the rural hospital respondents with a contract pharmacy, 65 percent did not operate their own outpatient pharmacy. In contrast, only 24 percent of other hospital types with a contract pharmacy indicated not having their own outpatient pharmacy. This mirrors national data, which show that smaller hospitals are much less likely to have their own in-house outpatient pharmacies compared to larger facilities.[12] The majority of rural hospitals in 340B are critical access hospitals that have 25 beds or less. Without their own outpatient pharmacies to dispense drugs, these smaller rural hospitals have fewer options to access 340B savings. Therefore, rural hospitals may be especially reliant on the contract pharmacy portion of their overall 340B benefit.

MORE HEAVILY RELY ON THEIR CONTRACT PHARMACY BENEFIT

The survey results verify that rural hospitals are more heavily reliant on their contract pharmacy benefit as a share of their overall 340B benefit. Sixty percent of rural hospitals reported relying on their contract pharmacy benefit for more than half of their overall 340B benefit. Rural hospitals may be more likely to report such a heavy reliance on their contract pharmacy benefit for several reasons. First, as discussed above, they are less likely to have their own outpatient pharmacy and therefore have fewer options for dispensing 340B drugs and accessing savings. Second, unlike DSH hospitals, rural hospitals are subject to an orphan drug exclusion that can prevent them from accessing discounted prices on orphan drugs. These are expensive products that 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.

KEEP THEIR DOORS OPEN

Because rural hospitals face such considerable financial challenges and rely on their contract pharmacy benefit for a large portion of their overall 340B benefit, it follows that they would be especially reliant on their contract pharmacy benefit to stay in operation. Like DSH hospitals, rural hospitals use their contract pharmacy benefit to support uncompensated care, but compared to other hospitals, rural

[11] NC Rural Health Research Program, 80 Rural Hospital Closures: January 2010 – Present, http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/.
[12] 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.

hospitals reported being much more likely to rely on their contract pharmacy benefit to maintain their operations and keep their doors open. The number one way rural hospitals reported relying on their contract pharmacy benefit was to keep their doors open (87 percent), whereas across all hospitals, maintaining and providing uncompensated care was the most reported response.

Rural Hospitals Use Their Contract Pharmacy Benefit to Maintain Access to Care

SERVICE PROVIDED	% OF HOSPITALS
Maintain Operations/Keep the Doors Open	**87%**
Does Not Have an Outpatient Pharmacy	**66%**
Contract Pharmacy Benefit Makes Up Majority of Overall 340B Benefit	**60%**

NOTE: Percentages add up to more than 100% because hospitals selected more than one option.

HOSPITAL SPOTLIGHT

Avera Holy Family Hospital – Critical Access Hospital in Estherville, Iowa

"[We use our contract pharmacy benefit to] stay open and viable as a healthcare provider in our small, mostly rural area, which means patients have close access to care. We are able to currently assist with staffing and operations of the local free clinic for low-income, underinsured and noninsured patients."

SUPPORT ACCESS TO KEY SERVICES IN REMOTE LOCATIONS

Respondents were asked whether they used their contract pharmacy benefit to treat a number of specific diseases and conditions. As discussed above, DSH hospitals were more likely than the other hospital respondents to report using their contract pharmacy benefit to support many of these services. However, rural hospitals commonly reported using their contract pharmacy benefit to treat several key diseases or conditions, including diabetes (78 percent), oncology (57 percent), cardiac diseases (54 percent), and pulmonary diseases (50 percent). A number of the testimonials from respondents demonstrate the importance of the contract pharmacy benefit to ensuring that rural patients have access to treatments for these diseases and do not have to travel great distances to receive care.

HOSPITAL SPOTLIGHT

Cobre Valley Community Hospital – Critical Access Hospital in Globe, AZ

"[We use our contract pharmacy benefit to] expand our pharmacy services to rural communities we serve in our region. These communities are 25-40 miles away from any healthcare services and range in population from 2,500 to 5,500 residents. In one community our hospital was able to build a new rural health clinic that is staffed 5 days a week with a medical provider. We have also been able to bring specialists (Orthopedics, Cardiology, Surgery, and Physical therapy) to the clinic. Additionally, contract pharmacy benefits allowed us to implement a delivery service for medications to the healthcare clinic. We were also able to invest in technology that allows for residents in the community to pick up prescriptions from a ScriptCenter kiosk that was purchased with funds derived from the 340B program. As of today, we serve over 550 patients and fill 1800 prescriptions a month for patients at the clinic. We offer many of them reduced or free prescriptions if they do not have insurance or cannot afford copays."

Rural Hospitals Using Their Contract Pharmacy Benefit to Support Low-Income and/or Rural Patients by Disease Type

NOTE: Percentages add up to more than 100% because hospitals selected more than one option.

Rural hospitals reported using their contract pharmacy benefit to support access to care in their rural communities by:

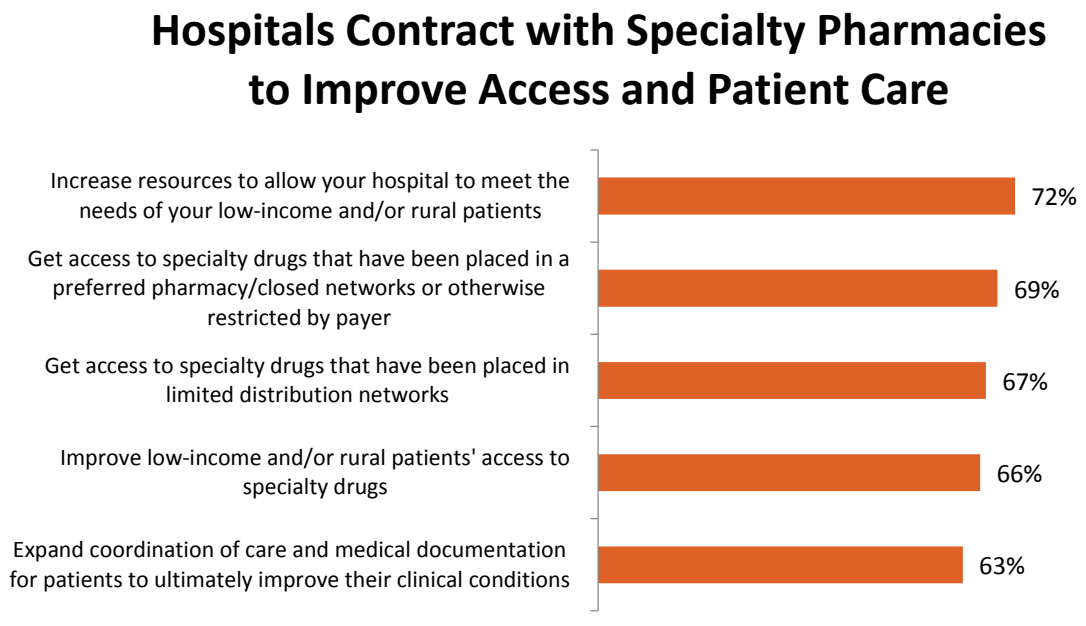
- Keeping the doors of their local pharmacy open
- Maintaining a diabetes clinic and supply indigent and uninsured diabetics with medications for either a $1.00 or $3.00 copay per month
- Keeping the doors open of two oncology outreach clinics where patients can receive oncology treatments closer to where they live so patients do not have to commute 20 or more miles for treatment
- Providing community health screenings for diabetes, hypertension, and cholesterol
- Providing discounts for self-administer drugs for Medicare patients while they are under observation
- Investing in hiring a pharmacist that can do transition of care visits to patients home, if home bound, or clinic on hospital follow-up to assure accurate and safe use of medications

SECTION 4: CONTRACT PHARMACIES SUPPORT ACCESS TO SPECIALTY DRUGS AND IMPROVE PATIENT CARE

The survey also demonstrated that contract pharmacy arrangements provide particular benefits to hospitals and their patients when the arrangements are with specialty pharmacies. Fifty-two percent of hospitals with at least one contract pharmacy arrangement reported that one or more of those arrangements were with a specialty pharmacy.

Several of the reasons for why hospitals reported they entered into arrangements with specialty pharmacies related to supporting care for low-income and rural patients. For example, 72 percent reported entering into the arrangements to access additional resources to support care for low-income and rural patients, and 66 percent reported entering into the arrangements to improve low-income and/or rural patients' access to specialty drugs. These arrangements can also help improve clinical care to patients, with 63 percent of respondents reporting they entered into the arrangements to expand coordination of care and medical documentation for patients to ultimately improve their clinical conditions. One DSH hospital reported that "as a result of our contract pharmacy agreements, we have closer relationships with other specialty pharmacies, which allows us to track our patients' medication utilization and improve clinical outcomes through closer follow-up."

In addition, hospitals reported entering into arrangements with specialty pharmacies in response to actions in the specialty market that limited hospital and patient access to specialty drugs. Sixty-nine percent of respondents with specialty pharmacy arrangements reported contracting with specialty pharmacies to access specialty drugs that had been placed in a preferred pharmacy/closed network or otherwise restricted by a payer. Similarly, 67 percent contracted with specialty pharmacies to access specialty drugs that manufacturers had placed in limited distribution networks, thereby preventing access to drugs through normal distribution channels.



NOTE: Percentages add up to more than 100% because hospitals selected more than one option.

These responses are consistent with hospital reports made in recent years to 340B Health of difficulties accessing 340B pricing on specialty drugs. Hospitals indicate that they seek out contract pharmacy arrangements with specialty pharmacies in many cases only because manufacturers place network restrictions on specialty products, making them unavailable to hospital pharmacies. Therefore, the only way for hospitals to access 340B pricing for specialty drugs and provide discounted pricing on those products to low-income patients is through contract pharmacy arrangements.

Manufacturer notices posted on HRSA's website highlight instances when a drug is placed into limited distribution.[13] These notices do not necessarily reflect every limit on drug distribution, as manufacturers are not required to submit limited distribution plans to HRSA. However, at least one notice about a drug placed in limited distribution specifically states that if a 340B covered entity is not part of the distribution network and cannot access the drug at the 340B price, it would be able to access the 340B price if it has a contract pharmacy arrangement with a specialty pharmacy in the manufacturer's network.[14]

[13] HRSA, Manufacturer Notices to Covered Entities, https://www.hrsa.gov/opa/manufacturernotices/index.html.
[14] Notice Regarding Pfizer Defined Oncology Distribution Network, https://www.hrsa.gov/opa/files/340bnoticeregardingpfizerdefinedoncology.pdf

CONCLUSION: CONTRACT PHARMACIES HELP 340B HOSPITALS SERVE THEIR LOW-INCOME AND RURAL PATIENTS

The 340B program is essential to hospitals and their ability to provide care for low-income and rural patients. The results of 340B Health's survey of member hospitals show that use of contract pharmacies is an important component of the overall 340B program. In response to the survey, every hospital with at least one contract pharmacy arrangement reported that a loss of its contract pharmacy benefit would negatively impact the services it provides to its low-income and rural patients.

A more-detailed breakdown of the responses by hospital type shows that DSH hospitals heavily rely on their contract pharmacy benefit to support their low-income patients. DSH hospitals most commonly use their contract pharmacy benefit to maintain or provide more uncompensated care, and they also rely on the benefit to provide free or discounted drugs to low-income or rural patients, offset low-Medicaid reimbursement, and provide services to treat chronic and life-threatening diseases to low-income and rural patients.

Rural hospitals rely on the contract pharmacy benefit in equally important but different ways. Although these hospitals also reported using their benefit to support uncompensated care, they were more reliant on their contract pharmacy benefit to support access to care in their remote locations, namely by maintaining their operations and keeping their doors open. The responses were not surprising, given the financial challenges rural hospitals face and the fact that they are less likely to have their own outpatient pharmacies, which the survey also confirmed.

Hospitals also reported particular benefits from maintaining contract pharmacy arrangements with specialty pharmacies. These arrangements allow hospitals to support care to low-income patients as well as improve access to specialty drugs. This is especially important, given the challenges that 340B hospitals report trying to access 340B pricing on specialty drugs when manufacturers limit their distribution. Many hospitals may not have contracted with a specialty pharmacy if not for the fact that a manufacturer limited access to specialty products through a limited distribution network.

Regardless of the hospital type, 340B Health's survey of member hospitals verifies the critical role that 340B contract pharmacies play in supporting safety net hospitals and their ability to treat low-income and rural patients. A loss of or reduction to the contract pharmacy benefit would significantly hamper the ability of 340B hospitals to treat their patients in need.