

340B DSH Hospitals Increased Uncompensated Care in 2020 Despite Significant Financial Stress

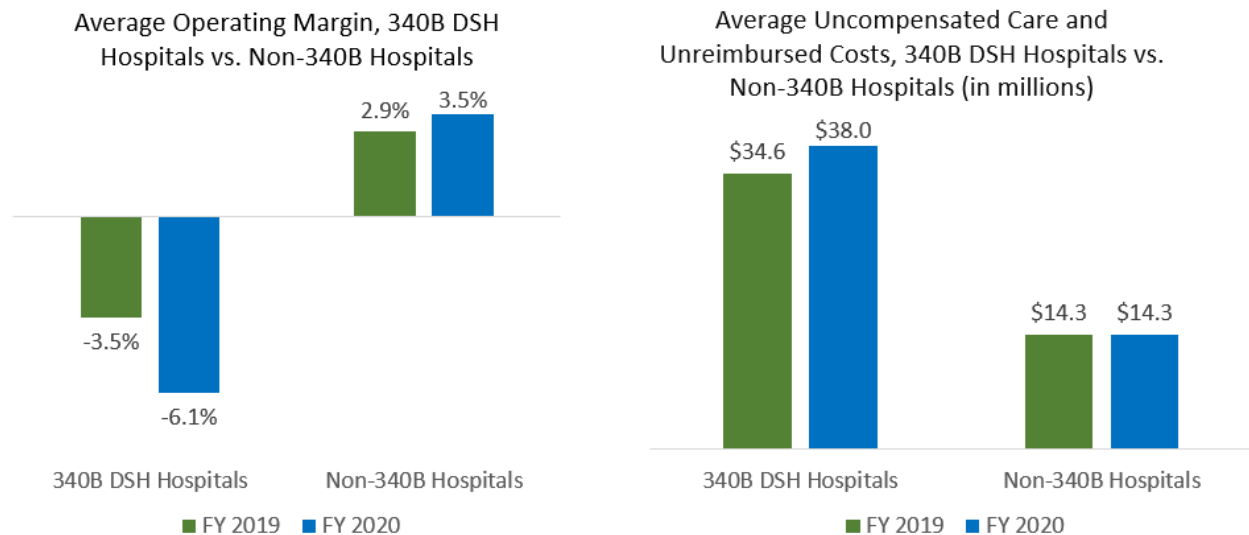
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Summary

In 2020, the COVID-19 pandemic disrupted the delivery of health care services across the U.S. Nationwide, hospitals and health systems ended the year with significant reductions in volume and outpatient revenues while expenses increased.¹ Prior research shows that 340B disproportionate share (DSH) hospitals serve larger percentages of groups that were hit hardest by COVID-19, including people of color and communities experiencing economic challenges.^{2,3,4} To understand how the events of 2020 impacted the health care safety net in which 340B DSH hospitals play a vital role, this study compares 340B DSH hospitals to non-340B hospitals on two financial metrics: operating margins and the provision of uncompensated and unreimbursed care. We found:

- 340B DSH hospitals experienced a sharp decline in their average operating margin, which already was negative, of 2.6 percentage points or 74%. In fiscal year (FY) 2019, 340B hospitals' average operating margin was -3.5%, and in FY 2020 the average was -6.1%.
- At the same time, 340B DSH hospitals increased their average provision of uncompensated and unreimbursed care by nearly 10%. In FY 2020, 340B DSH hospitals provided 67% of all such care while representing only 44% of hospitals.
- The experience of non-340B hospitals was substantially different. For these hospitals, the average operating margin increased by 21% while the average level of uncompensated and unreimbursed care remained flat.

This pattern provides important evidence that 340B DSH hospitals are continuing to fulfill the program's purpose as set out by Congress in 1992.



Source: Dobson | DaVanzo analysis of FY 2019 and FY 2020 Medicare hospital cost reports

Introduction

The 340B drug pricing program, administered by the Health Resources & Services Administration (HRSA), requires drug manufacturers to provide outpatient drugs to eligible health care organizations, or covered entities, at discounted prices.

Covered entities under 340B include providers that are critical to treating low-income and rural populations, such as federally qualified health centers (FQHCs), AIDS drug assistance programs, and certain public and nonprofit hospitals, including DSH hospitals.⁵ Congress expressly included DSH hospitals because they provide high levels of care to Medicaid patients and Medicare beneficiaries with low incomes. 340B was established to give these providers an avenue for purchasing outpatient drugs at a reduced cost. Congress intended for the savings from these discounted prices to enable covered entities “to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.”⁶

Prior research has shown that 340B DSH hospitals provide a majority of all uncompensated and unreimbursed care and Medicaid services to hospital patients.^{7,8} Compared with non-340B hospitals, 340B DSH hospitals also have a higher share of Medicare patients who have low incomes, are eligible for Medicare because of a disability, or identify as Black/African American.⁹

The pandemic put enormous strain on the health care safety net, including 340B DSH hospitals serving populations that have been disproportionately affected by COVID-19. This study examines two important financial indicators of the health of the safety net.

Methodology

In this study, the research team at Dobson | DaVanzo compared 340B DSH hospitals with acute care hospitals not participating in the 340B program on two financial metrics: operating margins and the provision of uncompensated and unreimbursed care. The research team considered two years of data to capture the initial impact of the COVID-19 public health emergency (PHE) that started in January 2020.

Hospital Groupings

The research team used the FY 2019 and FY 2020 Medicare inpatient prospective payment system (IPPS) final rules and correction notice impact files to identify the universe of eligible hospitals to include in the study.¹⁰ Critical access hospitals (CAHs) and other non-IPPS hospitals were excluded.

The team used the Covered Entity Daily Report from the HRSA Office of Pharmacy Affairs Information System (340B OPAIS) to create a list of 340B DSH hospitals in the program in FY 2019 and FY 2020.¹¹ These datasets were used to divide the universe of hospitals into 340B DSH hospitals and non-340B hospitals for the analysis in each of the fiscal years.

Financial Metrics

The data sources for the analyses of operating margins and uncompensated and unreimbursed care were the FY 2019 and FY 2020 Medicare hospital cost reports.¹²

In health care, operating margin is frequently used as a measure of a hospital's ability to generate sufficient revenues to cover expenses for its primary business of providing patient care. Simply put, an operating margin compares how many dollars of revenue are received for each dollar spent on patient care. The research team calculated operating margins as the difference between operating revenue and operating costs as a proportion of operating revenue.¹³

Uncompensated and unreimbursed care is a measure of a hospital's provision of services to individuals with low incomes. To calculate this figure, the research team summed charity care, financial assistance, bad debt, and public program shortfalls.¹⁴ Public program shortfalls are included because Medicaid pays less than the cost of caring for its beneficiaries.¹⁵ This underpayment creates financial challenges for hospitals with a large share of such patients.

Findings

Complete study findings can be found in Table 1.

Operating Margins

340B DSH hospitals saw a significant decline in operating margins from -3.5% in FY 2019 to -6.1% in FY 2020, while operating margins for non-340B hospitals increased from 2.9% to 3.5% during the same period. Operating margin differences are due in part to uncompensated care, public payer shortfalls, and the provision of typically unprofitable services.¹⁶ Hospitals cannot consistently incur financial losses and continue to provide essential services, making 340B program savings critical to the continued existence of DSH hospitals.

Financial performance in FY 2020 was significantly impacted by the COVID-19 pandemic. Health and Human Services Secretary Alex Azar declared a public health emergency (PHE) on Jan. 31, 2020. As cases increased, hospitals faced significant revenue losses due to delays in non-urgent care on top of new costs associated with COVID-19. In March 2020, Congress passed the CARES Act to provide fiscal relief to health care providers and others. Hospitals—including 340B and non-340B facilities—also received support from the Paycheck Protection Program and Health Care Enhancement Act. PHE funding was increased and distributed over time in what came to be known as the Provider Relief Fund (PRF). These distributions began in April 2020 and have continued into 2022.

The PRF dollars that hospitals received are not considered to be operating revenue on the Medicare cost report.¹⁷ While operating margins are a good indicator of the financial stress experienced by hospitals in FY 2020 as a result of the COVID-19 pandemic, the research team also looked at the extent to which PRF funding impacted financial performance by recalculating the operating margins as if the PRF funding were included in operating revenue.¹⁸

With the PRF dollars reported for FY 2020 added to operating revenue, the average operating margin for 340B hospitals overall went up by 1.7 percentage points. The operating margin for non-340B hospitals went up by 2.3 percentage points. The average difference in financial performance between 340B and non-340B hospitals in FY 2020 remained the same.

Uncompensated Care and Unreimbursed Care

We examined a more complete measure of services to populations with low incomes beyond charity care by also including bad debt and shortfalls from means-tested government programs such as Medicaid. As noted above, Medicaid has lower payment rates than commercial payers, with average payments that are below the cost of caring for Medicaid patients.

On average, uncompensated and unreimbursed care for 340B DSH hospitals grew from \$34.6 million per hospital in FY 2019 to \$38.0 million in FY 2020 and remained flat at \$14.3 million for non-340B hospitals.

Overall, 340B DSH hospitals accounted for 43.7% of hospitals.¹⁹ In total, these hospitals provided \$41.6 billion in uncompensated and unreimbursed care in FY 2020 compared to \$20.1 billion for non-340B hospitals. Overall, 340B DSH hospitals delivered 67.4% of total uncompensated and unreimbursed care.

Uncompensated and unreimbursed care represent only a part of the safety-net services provided by 340B hospitals. Services that do not generate a bill, such as transportation, translation, and other programs to address social determinants of health and wellness, are not included in this measure.

Table 1: Study Findings

	FY 2019		FY 2020	
Metric	340B DSH Hospitals	Non-340B Hospitals	340B DSH Hospitals	Non-340B Hospitals
Total and Percent of Uncompensated and Unreimbursed Care Costs	\$38,180,510,129 (64.1%)	\$21,371,832,187 (35.9%)	\$41,600,814,209 (67.4%)	\$20,141,737,430 (32.6%)
Average Uncompensated and Unreimbursed Care Costs per Hospital	\$34,646,561	\$14,266,911	\$38,026,338	\$14,264,687
Operating Margins	-3.5%	2.9%	-6.1%	3.5%

Discussion

The COVID-19 pandemic has put enormous strain on our nation's health care system, particularly on organizations such as 340B DSH hospitals that disproportionately serve the populations most affected by COVID-19. Even as 340B DSH hospital operating margins declined, 340B DSH hospitals increased their provision of uncompensated and unreimbursed care. These hospitals continued to provide a majority of uncompensated and unreimbursed hospital care.

340B recognizes the special challenges that 340B DSH hospitals face in providing care to patients with low incomes and other patient populations in need. This report provides additional evidence that 340B hospitals continue to fulfill the program's purpose as set out by Congress in 1992.

- ¹ KaufmanHall. National Hospital Flash Report. 2021 Jan. https://www.kaufmanhall.com/sites/default/files/2021-01/nationalhospitalflashreport_jan.-2021_final.pdf
- ² L&M Policy Research. A Comparison of Characteristics of Patients Treated by 340B Hospitals. 2019. https://www.340bhealth.org/files/340B_Patient_Characteristics_Report_FINAL_04-10-19.pdf
- ³ Azar KM, Shen Z, Romanelli et al. Disparities In Outcomes Among COVID-19 Patients In A Large Health Care System In California. Health Affairs. 2020; 39(7) <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00598>
- ⁴ Centers for Disease Control and Prevention. Introduction to COVID-19 Racial and Ethnic Health Disparities. <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html> Accessed 2022 Jun 17.
- ⁵ Eligible entities include federally qualified health centers (FQHCs), urban Indian organizations, family planning clinics, sexually transmitted disease grantees, Native Hawaiian Health Centers, state-operated Ryan White AIDS Drug Assistance Programs, other Ryan White grantees, hemophilia treatment centers, and black lung clinics. Eligible hospitals include certain disproportionate share (DSH) hospitals, critical access hospitals (CAHs), sole community hospitals (SCHs), rural referral centers (RRCs), freestanding cancer hospitals, and children's hospitals. Depending upon hospital type, these hospitals must meet the requirements of 42 USC 256b(a)(4)(L). Additionally, providers that meet all of the requirements for the FQHC program but do not receive federal grants—referred to as FQHC look-alikes—are eligible to participate in the 340B program.
- ⁶ 102nd Congress, Second Session. (1992). *H.R. No. 102-384, Part II*.
- ⁷ L&M Policy Research, LLC. Analysis of 340B Disproportionate Share Hospital Services to Low-Income Patients. 2018 Mar 12. https://www.340bhealth.org/files/340B_Report_03132018_FY2015_final.pdf
- ⁸ Dobson|DaVanzo. The Role of 340B DSH Hospitals in Serving Medicaid and Low-income Medicare Patients. 2020. https://www.340bhealth.org/files/340B_and_Medicaid_and_Low_Income_Medicare_Patients_Report_7.10.2020_FINAL_.pdf
- ⁹ L&M Policy Research, LLC. 2019.
- ¹⁰ Centers for Medicare and Medicaid Services. (2020). FY 2020 Final Rule and Correction Notice Data Files. Retrieved from <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page-Items/FY2020-IPPS-Final-Rule-Data-Files>
- ¹¹ Health Resources & Services Administration Office of Pharmacy Affairs. (2022 Feb 24). 340B OPAIS Reports/Files. Retrieved from <https://340bopais.hrsa.gov/Reports>
- ¹² Centers for Medicare and Medicaid Services. (2020). Hospital 2552-2010 Form. Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Hospital-2010-form>
- ¹³ Operating revenue is taken from Worksheet G3, Column 1, Line 3 and operating costs are taken from Worksheet G3, Column 1, Line 4.
- ¹⁴ Centers for Medicare and Medicaid Services, Healthcare Cost Report Information System (HCRIS). CMS-2552-10, Worksheet S-10 <https://www.cms.gov/research-statistics-data-and-systemsdownloadable-public-use-filescost-reportscost-reports-fiscal/2020>, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Cost-Reports-by-Fiscal-Year-Items/HOSPITAL10-DL-2019>
- ¹⁵ American Hospital Association. Fact Sheet: Underpayment by Medicare and Medicaid. 2022 Feb. <https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid>
- ¹⁶ Dobson|DaVanzo. The Role of 340B DSH Hospitals in Serving Medicaid and Low-income Medicare Patients. 2020. https://www.340bhealth.org/files/340B_and_Medicaid_and_Low_Income_Medicare_Patients_Report_7.10.2020_FINAL_.pdf
- ¹⁷ Centers for Medicare and Medicaid Services. COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. 28 Feb 2022. <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>
- ¹⁸ COVID-19 PHE Funding is taken from Worksheet G3 Line 24.50 in the Medicare cost report.
- ¹⁹ The analysis included 1,094 340B hospitals and 1,412 non-340B hospitals in FY 2020.