



340B AND CANCER HEALTH EQUITY

CANCER EQUITY RESOURCE GUIDE

RESOURCES

340B HOSPITALS AND CANCER CARE

340B ONCOLOGY DEMOGRAPHICS ISSUE

340B HOSPITALS: WHAT THE RESEARCH SAYS

COMING SOON: 340B HEALTH EQUITY REPORT
(WEEK OF 2/1/21)

AMERICAN CANCER SOCIETY: CANCER ACTION NETWORK RESOURCES

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340B Hospitals and Cancer Care

340B hospitals are a significant source of care for patients with cancer. The majority of National Cancer Institute (NCI)-designated cancer centers (75%) are affiliated with 340B hospitals. These centers are recognized for their scientific leadership, resources, and commitment to cancer prevention, diagnosis, and treatment.

340B hospitals provide an important access point for underserved cancer patients.

- MedPAC found 340B hospitals serve a Medicare cancer patient population that is more likely to be low-income and/or disabled.¹

	340B DSH Hospitals	Non-340B Hospitals	Physician Offices
LIS Recipients	30%	20%	19%
Disabled	24%	18%	15%

340B hospitals rely on 340B savings to treat low-income and rural cancer patients. 79 percent of 340B DSH hospitals report loss of 340B funding would negatively impact cancer care.²

- University of Rochester Medicine has expanded access to cancer care across the Finger Lakes Region and within the city of Rochester, which has the third highest concentration of poverty in the country. Due to 340B savings, UR Medicine can support 12 oncology clinics – including eight in rural areas – so that patients do not have to travel 30 miles or more to Rochester for treatment.
- Southern Ohio Medical Center, in Portsmouth, OH serves an Appalachian community with a high rate of lung cancer. To meet this community need, SOMC launched a patient navigator program for individuals with or at high risk for lung cancer. The program offers screening to promote early detection as well as support for diagnosed patients throughout treatment. SOMC’s rate of positive screenings is five times the national average. Early detection leads to better patient outcomes. For its work, SOMC has earned G02 Foundation for Lung Cancer Center of Excellence status. 340B savings makes this program possible.

340B hospitals are on the frontlines of providing cutting-edge treatments for cancer.

- MedStar Franklin Square Medical Center in Baltimore, MD provides the latest cancer technologies, including the daVinci® robotic surgical system and CyberKnife®, which aid in the precise treatment of cancerous tumors. These services are available in a county that is nearly 30 percent black or African American, a population that is traditionally underserved.
- University of California San Francisco (UCSF), a 340B hospital in San Francisco, CA, is on the cutting edge of providing new cancer immunotherapies while maintaining patient-centered care. Researchers at UCSF have recently made progress on a platform using CRISPR gene-targeting technology and a newly developed breakthrough technique to evaluate multiple cell therapies simultaneously, enabling different types of cancer to be targeted more effectively for patients.³

¹ Medicare Payment Advisory Commission. [Report](#) to Congress. 2020 Mar.

² 340B Health. [2019 340B Health Annual Survey](#). 2020. Mar.

³ <https://www.ucsf.edu/news/2020/04/417201/crispr-based-discovery-engine-new-cell-therapies-advance-cancer-treatments>

Issue Brief: Characteristics of Cancer Patients Receiving Drugs at 340B DSH Hospitals, Non-340B Hospitals, and Physician Offices

Kennan Murray, M.P.H., Al Dobson, Ph.D., and Joan E. DaVanzo, Ph.D., M.S.W.

The Issue

The 340B Drug Pricing Program, administered by the Health Resources & Services Administration, requires drug manufacturers to provide outpatient drugs to eligible health care organizations at reduced prices. These organizations comprise providers that are critical to treating low-income and vulnerable populations, including disproportionate share (DSH) hospitals.

When Congress first enacted the 340B program in 1992, it targeted DSH hospitals that provide high levels of care to Medicaid and low-income Medicare beneficiaries. Congress intended for the savings from discounted drug prices to enable covered entities “to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services” (102nd Congress, Second Session, 1992).

Prior studies have found that 340B hospitals overall serve higher proportions of low-income, minority, and disabled patients (L&M Policy Research, 2019). The goal of this study was to similarly evaluate whether 340B DSH hospitals treat a higher proportion of low-income oncology patients than do non-340B providers. Dobson | DaVanzo had earlier analyzed 2013 and 2014 hospital outpatient department and physician office claims from the Medicare Standard Analytic File Limited Datasets (SAF LDS) and found that 340B hospitals treated a higher proportion of low-income, dually eligible cancer patients than did non-340B hospitals or physician offices (DaVanzo, Murray, El-Gamil, & Dobson, 2017). This study uses 2018 Medicare claims data to determine if the utilization pattern continues to demonstrate that 340B hospitals treat a higher proportion of patients receiving cancer drugs representing low-income or minority populations than do non-340B hospitals or physician offices.

KEY FINDINGS

Analyses of 2018 Medicare hospital outpatient department and physician office claims confirm that 340B DSH hospitals served a disproportionate percentage of cancer patients from low-income and other vulnerable populations.

- 340B DSH hospitals treated a higher proportion of low-income and disabled patients receiving cancer drugs than did non-340B hospitals or physician offices.
- 340B DSH hospitals treated proportionally more Black/African-American and Hispanic beneficiaries than did non-340B providers.

Study Population

Eligible beneficiaries who received at least one separately billable oncology Part B drug from a 340B DSH hospital or a non-340B provider in 2018 were assigned to three cohorts:

Cohort 1: Beneficiaries who received all of their separately billable oncology drugs at 340B hospitals and no separately billable oncology drugs at non-340B providers.

Cohort 2: Beneficiaries who received separately billable oncology drugs at non-340B hospitals and no separately billable oncology drugs at 340B hospitals.

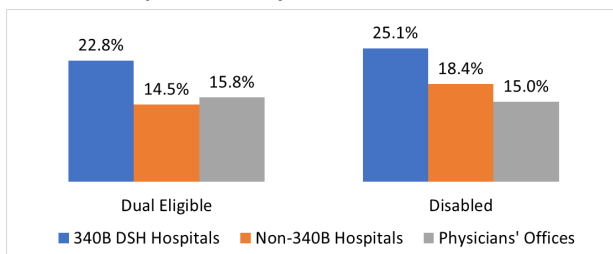
Cohort 3: Beneficiaries who received separately billable oncology drugs in physician offices and no separately billable oncology drugs at 340B hospitals.

Cohort 1, which includes beneficiaries who received all of their oncology drugs at 340B DSH hospitals, is mutually exclusive from both Cohort 2 and Cohort 3. However, Cohorts 2 and 3 may overlap.

Results

In 2018, 340B DSH hospitals treated a higher proportion of low-income and disabled patients receiving cancer drugs than did non-340B hospitals or physician offices. As illustrated by Figure 1, beneficiaries treated with oncology drugs at 340B DSH hospitals were 57 percent more likely to be dually eligible for Medicare and Medicaid, a standard proxy for low-income status, than were beneficiaries at non-340B hospitals, and 44 percent more likely than beneficiaries at physician offices.¹ Additionally, the percentage of beneficiaries who were originally entitled to Medicare for disability insurance benefits was 36 percent higher at 340B DSH hospitals than at non-340B hospitals and 67 percent higher than at physician offices.²

Figure 1: Distribution of Dual Eligibility and Disability among Beneficiaries Receiving Oncology Drugs at 340B DSH Hospitals, Non-340B Hospitals, and Physician Offices, 2018



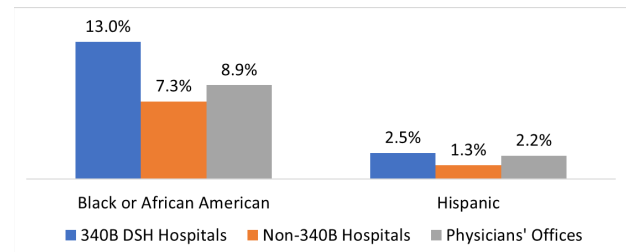
Source: Dobson | DaVanzo analysis of the 2018 five percent SAF LDS

These results are consistent with those of our 2013/2014 analyses, and with a recent analysis by the Medicare Payment Advisory Commission (MedPAC). The MedPAC analysis determined that 340B hospitals treat a higher proportion of low-income (30 percent vs. 20 percent) and disabled (24 percent vs. 18 percent) beneficiaries than non-340B hospitals (Medicare Payment Advisory Commission, 2020).⁴

In addition to income and disability status, the racial and ethnic composition of patient populations served by 340B DSH hospitals differed sharply from those served by non-340B hospitals and physician offices. Figure 2 illustrates that 340B DSH hospitals treated a

proportion of Black or African-American beneficiaries that was 78 percent higher than that of non-340B hospitals and 46 percent higher than that of physician offices. The proportion of Hispanic beneficiaries receiving care was also higher in 340B hospitals.

Figure 2: Racial and Ethnic Composition of Beneficiaries Receiving Oncology Drugs at 340B DSH Hospitals, Non-340B Hospitals, and Physician Offices, 2018



Source: Dobson | DaVanzo analysis of the 2018 five percent SAF LDS

The results of these analyses demonstrate that the eligibility criteria for 340B DSH hospitals continue to properly target hospitals that treat low-income, vulnerable patients. The data support the assertion that the program has maintained its commitment to serving underserved populations.

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¹ 340B DSH hospitals vs. non-340B hospitals: $(22.8\% - 14.5\%) \div 14.5\% = 57\%$; 340B DSH hospitals vs. physician offices: $(22.8\% - 15.8\%) \div 15.8\% = 44\%$

² 340B DSH hospitals vs. non-340B hospitals: $(25.1\% - 18.4\%) \div 18.4\% = 36\%$; 340B DSH hospitals vs. physician offices: $(25.1\% - 15.0\%) \div 15.0\% = 67\%$



340B HEALTH

340B Hospitals: What the Research Says

340B hospitals are a critical element of America’s health care safety net. 340B hospitals that serve a disproportionate share of Medicaid and Supplemental Security Income (SSI) patients (DSHs) serve patients that are more likely to be low income, disabled, or part of minority groups. These hospitals are more likely to offer services that must be subsidized to breakeven but are critical to these populations. Rural 340B hospitals may be the only source of care in a wide geographic area. The patients served by these hospitals in general face greater health challenges and barriers accessing health care, a product of the inequities within the nation’s health care system. The 340B program is quite small relative to total U.S. drug spending but 340B savings play a tremendous role in supporting the safety net, maintaining and improving access to care for underserved populations, and helping to bridge the health equity divide.

Supports Safety Net at No Cost to Taxpayers

The 340B Drug Pricing Program, established with strong bipartisan support in 1992, provides relief from high drug costs to safety-net providers. Specifically, the program requires drug manufacturers to sell covered outpatient drugs to enrolled providers, called “covered entities,” at discounted prices. The discount structure is similar to the Medicaid drug rebate program,

but instead of rebates, it requires upfront discounts. Drug manufacturers must participate in the 340B program in order for their drugs to be covered by Medicaid and Medicare Part B.

To enroll in the program hospitals must meet criteria based on hospital type, ownership, contractual relationship to government,

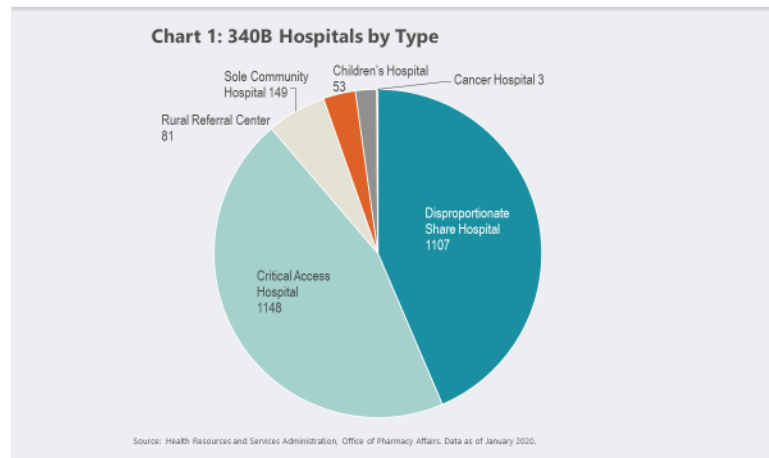
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Taxpayer dollars required to fund 340B Program discounts

and/or payer mix. There are also 10 categories of non-hospital covered entities that are eligible based on the federal funding they receive.

According to Congress, the purpose of the 340B program is to enable covered entities to stretch scarce resources as far as possible, reaching more eligible patients and providing more comprehensive services.¹ It is noteworthy that this program provides drug discounts for the safety net at no cost to taxpayers. Rather, drug manufacturers provide the discounts.

340B supports safety-net services and/or care for rural populations at six types of hospitals.



340B Hospitals are the Backbone of America’s Health Care Safety Net

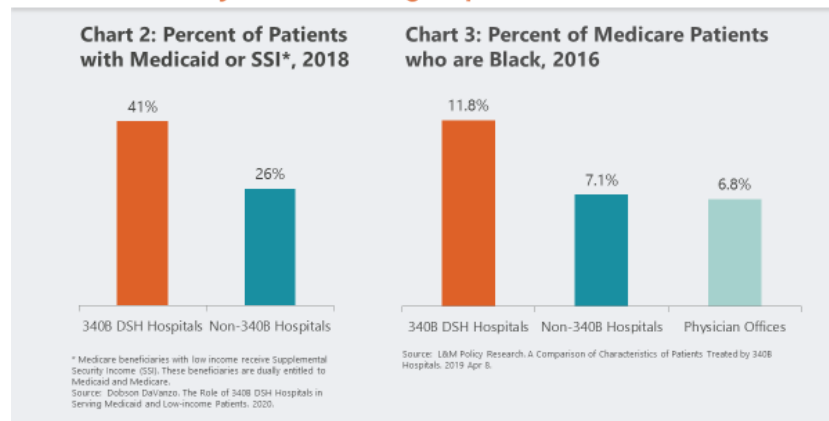
The role of 340B hospitals in America’s health care safety net shows in their substantial contribution to caring for traditionally underserved populations who face challenges in accessing care and have higher rates of chronic disease, such as racial and ethnic minority groups and those with low incomes. 340B

DSH hospitals that qualify for the program based on their service to low-income patients represent 43 percent of hospitals but provide 75 percent of Medicaid hospital services as measured by net revenue.² Service to Medicaid patients creates financial challenges. Medicaid pays about 89 cents for every dollar spent caring for

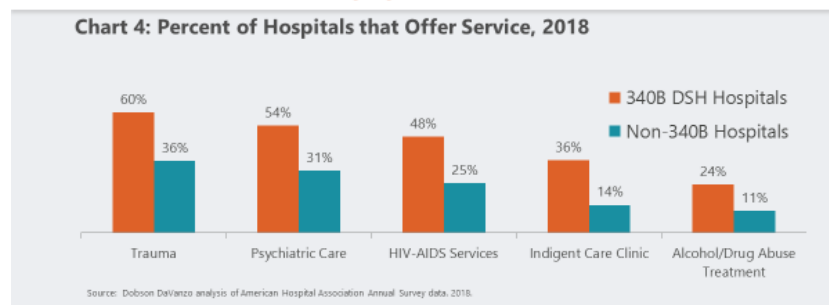
75%

Percent of Medicaid net hospital revenues accounted for by 340B DSH hospitals

Patients of 340B DSH hospitals are more likely to be from traditionally underserved groups.



340B DSH hospitals are more likely to offer services critical to low-income populations.



Medicaid beneficiaries, and that shortfall is growing.³

The proportion of Medicaid or low-income Medicare patients is nearly 60 percent higher at 340B DSH hospitals compared with non-340B hospitals.⁴ 340B DSH hospitals also are more likely to offer services that must be subsidized to break even. Examples include: trauma care, which has very high fixed costs because of the specialty physicians and support staff that must be standing by in the event their services are needed; indigent care clinics, offered by about a third of 340B DSH hospitals; psychiatric care, which is chronically under-reimbursed; and HIV/AIDS and addiction services, including alcohol and drug disorder care, which disproportionately affect patients with low incomes who are often on Medicaid or uninsured.⁵

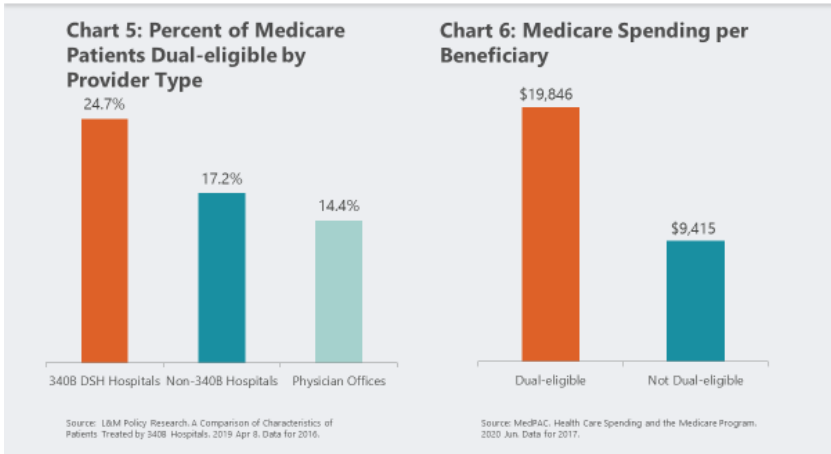
“There were times when my blood sugar was so low that I’d pass out at the dinner table for about 10 minutes until my blood sugar recovered. That’s how dangerous it was. But syringes and insulin and regular medical treatments were unaffordable. The 340B program allows me to buy insulin at prices I can afford.” Paul Haskins, Patient of San Mateo County Medical Center (CA), Faces of 340B

340B Hospitals Serve Sicker and More Costly Patients

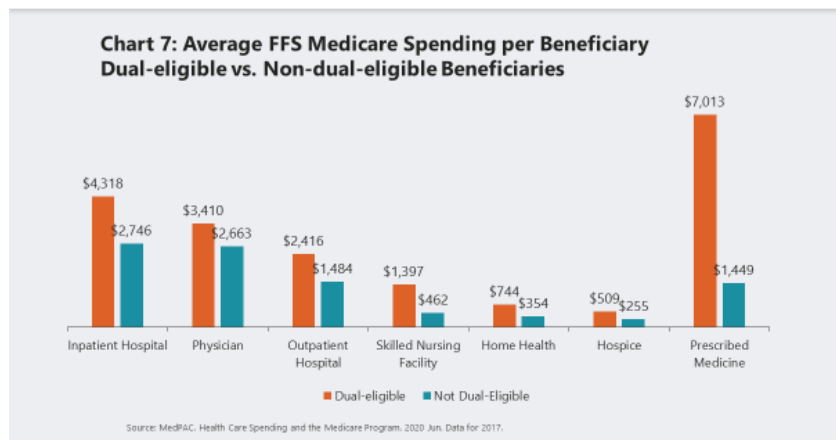
Research has confirmed that 340B hospitals incur financial challenges due to the nature of the patients they treat. Inequities in the health care system mean their patients tend to be sicker, lower income, disabled, and more likely to suffer from chronic conditions. Nearly one-in-four Medicare patients of 340B DSH hospitals is dual-eligible meaning that their income is low enough that they qualify for Medicaid in addition to Medicare. This proportion is over 40 percent higher than for non-340B hospitals.⁶ Dual-eligible individuals are more than three times as likely to report that they are in poor health and more than half need support to perform activities of daily living.⁷ Not surprisingly, these patients are twice as costly overall than the non-dually-eligible population.⁸ This cost difference is amplified for drugs prescribed to Medicare beneficiaries.

Providers face other challenges in serving the under-65 Medicaid population. Medicaid beneficiaries are nearly three times as likely to report being in poor health, have higher rates of obesity and other chronic conditions, and are more likely to have had trouble finding a doctor or to have delayed care due to lack of transportation.⁹

340B hospitals serve a much higher proportion of dual-eligible beneficiaries who are twice as costly.



Spending differences for dual-eligible individuals are most pronounced for prescribed drugs.



The higher mix of low-income patients means 340B DSH hospitals provide high levels of uncompensated and unreimbursed care. While the coverage expansion under the Affordable Care Act caused an

initial reduction in uncompensated care, uncompensated care is on the rise again.¹⁰ Further, the proportion of patients on Medicaid is going up creating a growing payment shortfall.¹¹

The 340B program "...has been a lifeline to providers who care for low-income and vulnerable patients. When we talk about the 340B program, we often hear about the drug discounts, but the program provides so much more than that. 340B recipients include large hospitals that serve urban settings, and rural hospitals that often provide the only care available in their communities." *Rep. Diana DeGette (D-Colorado)*

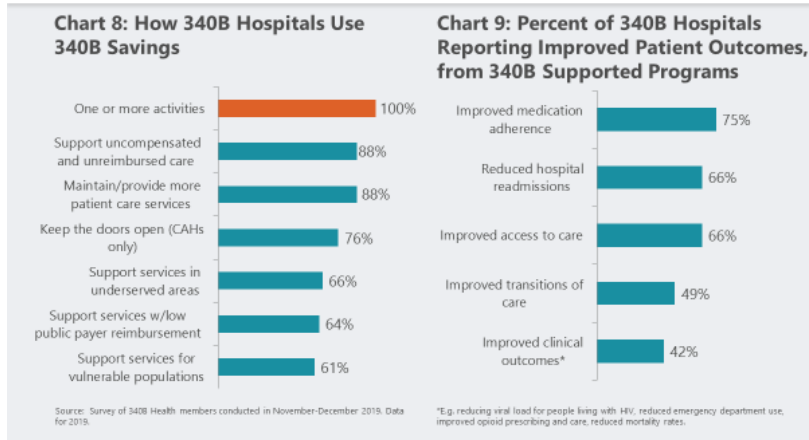
340B is Small but Plays a Huge Role in Supporting the Safety Net

340B savings reduce drug manufacturer revenues by only a small percentage overall but play a critical role in ensuring access to care for low-income and rural populations treated by 340B hospitals.¹² National data show that all 340B hospitals use savings to support programs and services for low-income and rural patients.¹³ These include uncompensated care, services in underserved areas, and access to low-cost medication.

340B savings are used in the pharmacy to defray the cost of expensive drugs for both the provider and the patient and to ensure the pharmacy is both well-stocked and well-staffed. 340B savings also help fund other lines of care that hospitals and pharmacies provide ensuring there are as few gaps in care as possible. Patient



All 340B hospitals used their savings to support care and improve outcomes for low-income and rural patients.



counseling and financial assistance, hospital readmission prevention, medication therapy management, and discharge planning are among the many integrated services that are possible due to 340B. The program also enables hospitals to provide mobile clinics and

transit vouchers, infusion and cancer care centers, HIV/AIDS and mental health clinics, and more to reach patients who otherwise have limited access to care. Ultimately, the savings from 340B help improve health care outcomes and keep the entire safety net intact.¹⁴

340B Urban Safety-net Hospitals Share Their Stories

Children’s Hospital of Orange County, California, uses its 340B savings in many ways including to support its inpatient mental health unit, provide bedside discharge prescriptions, subsidize chemotherapy and other specialty medications for low-income patients, and underwrite the cost of promising new therapies such as gene therapies and CAR-T cell treatments.

Einstein Medical Center in Philadelphia, Pennsylvania, uses 340B savings to help patients overcome cost barriers to cancer treatment. Cheryl, a breast cancer patient, was never presented a bill for any of her chemotherapy treatments. The center is using some of the savings from the discounts it receives on medications to help fill in the gap between what her Medicare and Medicaid coverage pays and the full cost of providing her care.

Eskenazi Health in Indianapolis, Indiana, uses its 340B savings to expand its HIV/AIDS pharmacy team to work with vulnerable patients to ensure medication access and support adherence.

Community Regional Medical Center in Fresno, California, serves a population that is 55 percent Hispanic and has a high rate of diabetes. Using 340B savings, it created a team-based Diabetes and Chronic Disease Medical Home. The multi-disciplinary team includes a medical director, nurse practitioners, registered nurses, social workers, medical assistants, and an outreach specialist. Patients receive training on self-management including use of insulin, how to operate medical equipment, what foods to eat, and the role of exercise in disease management.

The 340B Program is a Lifeline for Rural Hospitals and Their Communities

46 million Americans live in rural America.¹⁵ Rural Americans tend to be older, sicker, and poorer than their urban counterparts, which makes this population especially vulnerable and in need of equitable health care.¹⁶ Despite these needs, more than 130 rural hospitals have closed since 2010, and nearly half of those that remain are operating at a financial loss.¹⁷

Since Congress expanded the 340B program to rural providers in 2010, over 1,000 rural hospitals now participate.¹⁸ 76 percent of rural 340B hospitals

report using savings from the program to keep the doors of their facility open. More than half surveyed note that if they lost all or a portion of their 340B savings, they would likely have to close entirely or make cutbacks in services.¹⁹

340B savings help rural hospitals care for more patients by expanding their level of uncompensated and unreimbursed care. Most rural hospitals also use savings to offer free or discounted drugs to their patients, many of whom are unable to afford their medications. By providing

76%

Percent of rural hospitals use 340B savings to keep their doors open

certain drugs for free or at steep discounts, rural hospitals better ensure patients are accessing the medications they need in order to improve their overall health.²⁰

340B Rural Hospitals Share Their Stories

Johnson County Hospital, a critical access hospital in Tecumseh, Nebraska, uses its 340B savings to support essential health care services in its rural community. Johnson County Hospital holds an annual breast cancer awareness event to teach patients about risk factors and the importance of screening. It also offers free blood pressure clinics and toenail care for patients with diabetes to prevent infections.

Fosteria Community Hospital, a critical access hospital in rural Ohio, uses its 340B savings to support dialysis services which otherwise would require a drive of 45-50 miles. Fosteria recently added capacity and modernized its equipment to better accommodate the community's need. With increased access to services, patients can receive treatment on schedule and stay healthier longer.

Pella Regional Health Center in Pella, Iowa, reports that without 340B, the hospital likely would need to reduce access to care in its rural community, including its hospice and home care services, which allow terminally ill patients to access compassionate care closer to home.

Madison Memorial Hospital in Rexburg, Idaho, has used 340B savings to invest in costly care improvements needed by patients in the community, such as an oncology program, smart-pump technology, and medication bar coding at the bedside. Without the \$3 million in savings the hospital receives every year, it would be operating at a \$2.5 million loss, meaning cuts to the 340B program would necessitate reductions in services, technology, and/or staff.

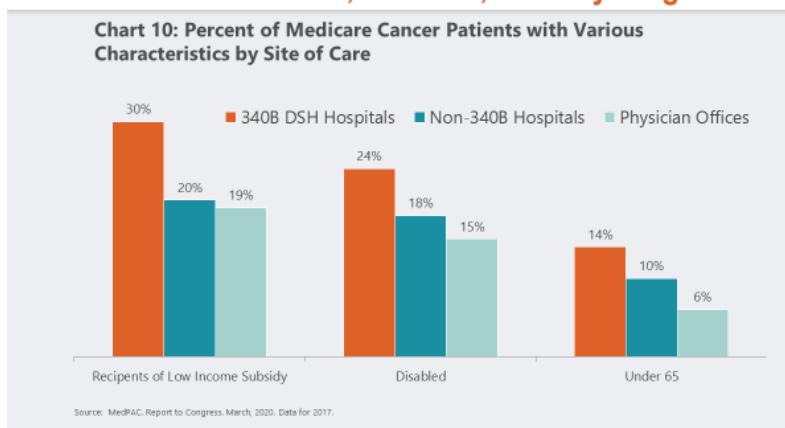
340B Hospitals Serve as the Safety Net for Patients with Cancer

Cancer drugs are among the most expensive physician-administered outpatient drugs in use. Disparities in income and insurance status and inequities in diagnosis and treatment mean that some people are underserved, contributing to higher mortality for cancer. ²¹ A recent study found that death rates for cancer were 24 percent higher in low-income counties compared to high-income counties. ²²

340B program discounts allow 340B hospitals to play a special role in the provision of cancer care for medically underserved patients. 340B DSH hospitals are 38 percent more likely to offer oncology care than non-340B hospitals. ²³

A recent report by the Medicare Payment Advisory Commission ([MedPAC](#)), a group that advises Congress on Medicare payment policy, found that 340B hospitals serve a substantially higher proportion of Medicare patients who are disabled, under 65, and/or receive a low-income subsidy (LIS) to purchase Medicare Part D coverage. ²⁴ A recent [issue brief](#) sponsored by 340B Health confirmed these findings. This report also found the proportion of Black or African American beneficiaries receiving cancer care at 340B hospitals

340B hospital cancer patients are more likely to be low-income, disabled, and/or young.



was 78 percent higher than at non-340B hospitals. For Hispanic beneficiaries, it was 92 percent higher. ²⁵

A 2015 report from the Government Accountability Office (GAO) raised concerns that 340B hospitals may be spending more than non-340B hospitals and physician offices on drugs for cancer and other conditions.

MedPAC found there was little evidence to support this claim. Straight comparisons of cancer drug spending across 340B hospitals, non-340B hospitals, and physician practices for five types of cancer found no consistent pattern of higher or lower drug spending. An examination of newly enrolled 340B hospitals found no evidence of increased drug spending per patient. Finally,

markets with a higher penetration of spending in 340B hospitals had spending differences that were not statistically significant for three of five cancers. In general, any difference associated with 340B status was overwhelmed by the magnitude of manufacturer price increases over the study period.

MedPAC did find that the patients disproportionately served at 340B hospitals – young, disabled, and/or low-income – tend to have higher costs for cancer care. Younger patients often require more aggressive treatment. Also, research findings demonstrate that low-income patients are more likely to be diagnosed at a later stage which also necessitates more aggressive and costly treatment. ²⁶

“...those 340B effects [on drug spending], however, were much smaller than the effects of the general increase in oncology spending which reflects both the effect of rising prices and shifts in the mix of drugs, including the launch of new products with higher prices.” *MedPAC Report to Congress, March 2020*

Preserving 340B Protects Safety-net Hospitals and the Patients They Serve

Over the past several years, some lawmakers have debated making changes to the 340B program that could limit its scope and use. Such changes would present significant challenges to urban safety-net and rural hospitals and the patients they serve. Changes to 340B that limit program savings would be on top of drastic cuts in Medicare Part B drug payments first imposed on certain 340B hospitals in 2018 and still in effect. These cuts continue to limit the value of the 340B discount for hospitals and could even be expanded in future years. Further changes could have devastating consequences for patient care programs supported by 340B savings. Limits on use of 340B drugs and hospital access to 340B savings also could reduce the number of drugs that manufacturers must sell safety-net providers at discounted prices, ultimately transferring resources from safety-net providers to pharmaceutical companies.

If 340B savings were cut, hospitals report that they would need to cut back on patient care services, reduce the provision of free and/or reduced cost drugs, provide less uncompensated care, and/or even close their doors. The clinical areas that would be most affected include oncology, diabetes, and mental health and substance abuse.²⁷

When 340B is permitted to work as intended, it is a major health care delivery system success story. Hospitals across the country use their 340B savings in invaluable ways to advance health equity and to meet the unique needs of their communities by providing patients with access to needed treatments and services. The benefits of program discounts accrue to a broad cross-section of underserved populations, all at no cost to taxpayers.

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