

## 340B HOSPITALS VS. NON-340B HOSPITALS: GROWTH AND DISTRIBUTION OF PHYSICIAN-ADMINISTERED DRUG REIMBURSEMENT ACROSS TEN THERAPEUTIC AREAS

The 340B program has undergone significant changes in recent years coinciding with a period of dramatic program growth. This growth has been driven by a number of factors including expanded eligibility of hospitals, the acquisition of physician practices by participating hospitals, the use of multiple-contract pharmacy arrangements, as well as other legal and policy changes.<sup>i</sup> Studies have shown how the financial incentives involved in the 340B program have created market distortions that have affected physician and hospital business practices, negatively affecting community physician clinics, and leading to unintended consequences in billing patterns, particularly in the therapeutic area of oncology.<sup>ii,iii</sup> The Government Accountability Office (GAO) has also studied the 340B program and found that higher per beneficiary Part B spending at 340B disproportionate share hospitals (DSH) raises concerns about the program’s financial incentives and the potential for increased costs for patients.<sup>iv</sup>

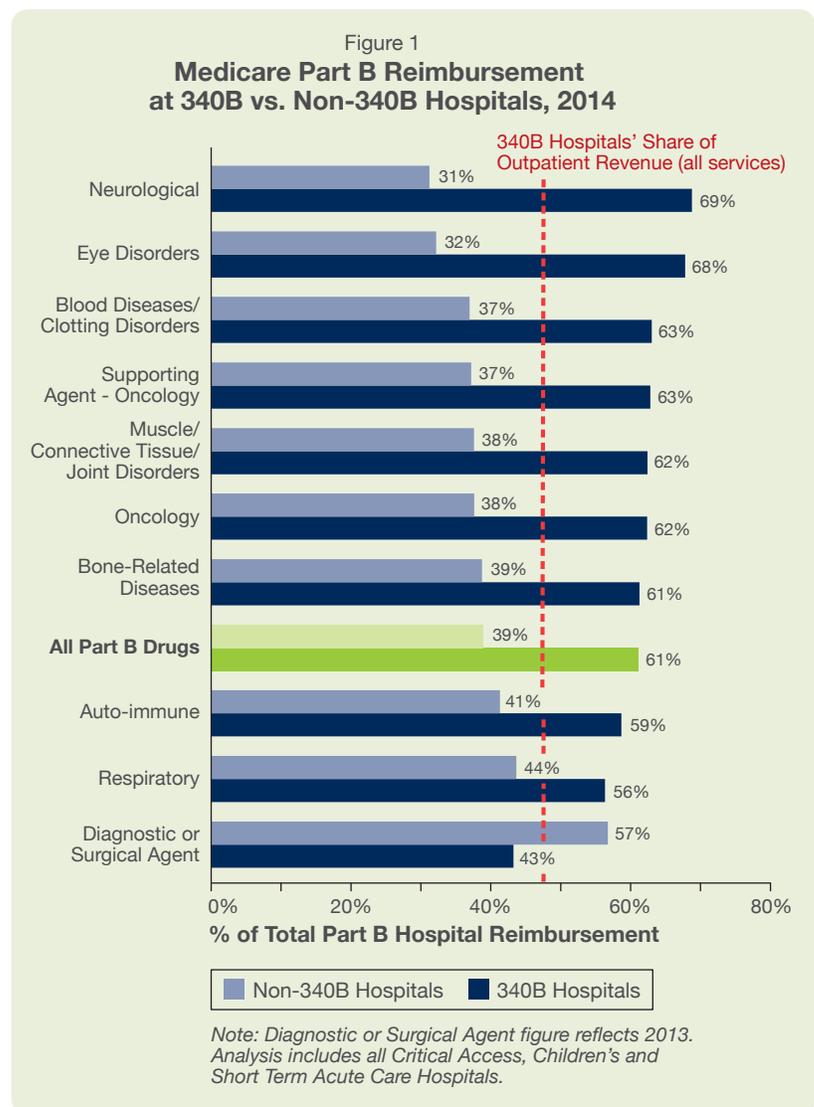
New data from the Berkeley Research Group (BRG) adds to the existing body of research by analyzing trends across several therapeutic categories and highlights additional areas where the 340B program has created market distortions in physician-administered drugs. BRG used a combination of Medicare claims and Office of Pharmacy Affairs (“OPA”) data to examine the distribution of Medicare Part B reimbursement for physician-administered drugs to 340B and non-340B hospital outpatient departments from 2008 through 2014.<sup>v</sup> These data were then benchmarked against hospital outpatient revenues found in Medicare hospital cost reports. The analysis focused on the top ten therapeutic categories based on total Medicare Part B reimbursement.<sup>vi</sup>

### DISTRIBUTION OF REIMBURSEMENT IN 2014

In 2014, 340B hospitals accounted for 61 percent of total Part B drug reimbursement, even though these hospitals represented just under half (49.7%) of total Medicare hospital outpatient revenue.<sup>vii</sup> These data demonstrate that 340B hospitals account for a disproportionate share of Medicare reimbursement for physician-administered drugs as compared to Medicare revenues (Figure 1).

Moreover, while the percentage of Medicare Part B drug reimbursement to 340B hospitals varies markedly when broken out by therapeutic category, in nine of the top ten therapeutic categories, 340B hospitals accounted for substantially more than half of Medicare Part B hospital outpatient reimbursement.

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## TRENDS IN REIMBURSEMENT

When looking at Medicare Part B drug reimbursement in the hospital outpatient setting over time, it is clear that the share of reimbursement attributed to 340B hospitals has increased substantially between 2008 and 2014. As illustrated in Figure 2, all ten therapeutic categories examined saw increases in Part B drug reimbursement at 340B hospitals. The largest increases were seen for auto-immune and respiratory drugs, at 97.7 percent and 87.3 percent respectively. Meanwhile, non-340B hospitals saw decreases in their share of Part B drug reimbursement across all ten therapeutic areas.

## CONCLUSION

Growth in the 340B program has been well documented and these new data provide additional details regarding the impact of this growth and the market distortions created by the program. This analysis demonstrates that growth in the share of Medicare Part B reimbursement attributable to 340B utilization has not been uniform across therapeutic categories, but instead has disproportionately affected certain therapeutic areas. As GAO has noted, the current structure of the 340B program raises concerns that the program may be increasing costs for patients.<sup>viii</sup> The outsized role 340B plays in some therapeutic categories raises additional questions about how the program's financial incentives may create distortions in specific markets. These distortions potentially undermine the sustainability of the program as the utilization-based incentives for 340B providers may not be in the best interests of patients.

Figure 2  
**% Change in Share of Part B Hospital Reimbursement  
 2008–2014**

| Top 10 Part B Therapeutic Categories     | 340B  | Non-340B |
|--|-------|----------|
| Auto-immune                              | 97.7% | -41.2%   |
| Respiratory                              | 87.3% | -37.6%   |
| Supporting Agent - Oncology              | 84.1% | -43.6%   |
| Bone-Related Diseases                    | 78.6% | -41.0%   |
| Oncology                                 | 56.5% | -37.4%   |
| Muscle/Connective Tissue/Joint Disorders | 49.1% | -35.4%   |
| Diagnostic or Surgical Agent             | 29.7% | -14.8%   |
| Blood Diseases/Clotting Disorders        | 27.7% | -27.0%   |
| Neurological                             | 27.5% | -32.2%   |
| Eye Disorders                            | 5.7%  | -10.2%   |

*Note(s):*

[1] Analysis of all Critical Access, Children's, and Short Term Acute Care Hospitals.  
 [2] Diagnostic or Surgical Agent figure reflects 2013

<sup>i</sup>Avalere Health, *Hospital Acquisitions of Physician Practices and the 340B Program*, June 2015. Available at <http://340breform.org/userfiles/Avalere%20Acquisition.pdf>; GAO, *Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals*, June 2015. Available at <http://www.gao.gov/products/GAO-15-442>; MedPAC, *Report to the Congress, Overview of the 340B Drug Pricing Program*, May 2015. Available at <http://www.medpac.gov/documents/reports/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program.pdf?sfvrsn=0>; BRG Healthcare, *Growth of the 340B Program: Past Trends, Future Projections*, November 2014, Available at [http://www.thinkbrg.com/media/publication/524\\_Vanderveelde\\_340B\\_GrowthDrivers\\_WhitePaper\\_20141202\\_FINAL.pdf](http://www.thinkbrg.com/media/publication/524_Vanderveelde_340B_GrowthDrivers_WhitePaper_20141202_FINAL.pdf)

<sup>ii</sup>BRG Healthcare, *Growth of the 340B Program: Past Trends, Future Projections*, November 2014.

<sup>iii</sup>BRG Healthcare, *340B Growth and the Impact on the Oncology Marketplace*, September 2015, Available at [http://www.communityoncology.org/pdfs/BRG\\_COA\\_340B-Report\\_9-15.pdf](http://www.communityoncology.org/pdfs/BRG_COA_340B-Report_9-15.pdf)

<sup>iv</sup>GAO, *Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals*, June 2015.

<sup>v</sup>These data does not include grantees, contract pharmacies, or Part B reimbursement to physician offices.

<sup>vi</sup>IVIG was excluded as a category as these drugs are not typically purchased at 340B prices. Full methodology available upon request.

<sup>vii</sup>The analysis did not examine the underlying health conditions of the patients served, however, the June 2015 GAO report examining Part B drug spending at 340B DSH hospitals as compared to non-340B hospitals found that the differences in reimbursement were not explained by hospital characteristics or patients' health status.

<sup>viii</sup>GAO, *Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals*, June 2015.