

BENEFITING HOSPITALS, NOT PATIENTS:

An Analysis of Charity Care Provided by Hospitals
Enrolled in the 340B Discount Program

AIR_x340B
Alliance for **x** Integrity and Reform

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Executive Summary

Three years after first analyzing the amount of charity care provided by 340B hospitals, the Alliance for Integrity and Reform of 340B (AIR 340B) has updated the analysis to include 2014 data that reflects the first year of the Affordable Care Act's (ACA) coverage expansions.

The ACA has succeeded in dramatically lowering the uninsured rate from 18.0% in 2013 to 11.0% in early 2016.¹ Despite this significant change, eligibility criteria for discounted medicines under the 340B program have remained largely the same for hospitals. In fact, the increase in Medicaid coverage under the ACA likely has led to more hospitals becoming eligible for 340B—a counterintuitive result for a program designed to support access to prescription drugs for vulnerable or uninsured patient populations.

Under the 340B program, pharmaceutical manufacturers provide steep discounts on outpatient prescription drugs to certain qualifying facilities; however, the program guidance currently does not require those facilities to extend the discounts to needy patients.² There is an important distinction between different types of 340B facilities in this regard. 340B eligibility is open to certain clinics that receive federal grants, known as grantees, and certain types of hospitals. Grantees such as federally qualified health centers and hemophilia treatment centers typically must demonstrate that they serve a specified vulnerable population, typically on an income-based, sliding-fee scale. Grantees are also largely required to reinvest any additional resources into services for those populations. In contrast, hospitals typically are not subject to this requirement and typically do not have charters requiring that revenue derived from the 340B program be reinvested in care for the uninsured or vulnerable.

For this report, AIR 340B engaged with Avalere Health to update their analysis from the previous AIR 340B report on charity care levels at 340B disproportionate share

hospitals (DSH).³ Based on that data analysis, this report raises questions regarding whether the qualification criteria for DSH hospitals are appropriately aligned with Congress' goal of supporting access to prescription drugs for uninsured or vulnerable populations.



More than one-third (37%) of 340B DSH hospitals provide charity care that represents less than 1% of their total patient costs.

SOURCE: Avalere Health analysis of FY 2014 Medicare cost report data

Analysis of charity care data reported by hospitals in fiscal year (FY) 2014 Medicare cost reports reveals that many of the hospitals enrolled in the 340B program are not fulfilling Congress' expectation. While there are some 340B hospitals that provide considerable charity care, for greater than one-third (37%) of 340B DSH hospitals, charity care represents less than 1% of total patient costs. This is an increase in the share of 340B hospitals providing charity care that is less than 1% of their total patient costs. Specifically, in 2011, 24% of 340B DSH hospitals provided charity care that was below 1% of total patient costs.⁴ For 64% of 340B DSH hospitals in 2014, charity care as a percent of total patient costs is less than the national average of 2.2% for all short-term acute care hospitals (STACHs).

The new data also shows that that the charity care burden for all STACHs (340B and non-340B) declined in 2014 as more individuals gained coverage through the Affordable Care Act. In 2011, charity care represented 3.3% of total patient costs, on average. That percentage dropped to 2.2% in 2014.

Similar to the results from Avalere’s previous analysis, data from the FY 2014 cost reports find that a small number of 340B DSH hospitals account for the bulk off overall charity care. Approximately one-quarter (24%) of 340B DSH hospitals provide 80% of all charity care delivered by 340B DSH hospitals, even though these hospitals account for less than half (45%) of all 340B DSH hospital beds.

The 340B program has grown substantially since its inception in 1992, and it is clear that today the program lacks an adequate structure for accountability and transparency. Despite continuing widespread support for the program’s original intent, 340B is out of sync

with its mission. Changes in how the program operates, concerns about whether and how it is fulfilling its mission, major shifts in the overall health system, evidence that the program may be leading to market distortions, and the program’s continuing rapid growth all raise questions about its design and sustainability in the form that has emerged.⁵ Based on these recurring questions and this analysis of charity care, this paper concludes that Congress should consider revising the eligibility criteria for hospitals to ensure that the eligibility criteria align with the program’s original intent, which was to offer targeted assistance to providers that serve safety-net populations.

Background

Congress created the 340B program in 1992 to reinstate the deep discounts that manufacturers had voluntarily provided to many safety-net facilities before the 1990 enactment of the Medicaid drug rebate statute.⁶ This 1990 statute established a nationwide drug rebate for state Medicaid programs, and the rebate formula took into account the “best price” a manufacturer gave to any customer. Congress failed to exempt voluntary discounts to safety-net providers from Medicaid “best price,” which inadvertently penalized the manufacturers that provided such discounts. Later in 1992, Congress responded by amending the Medicaid rebate statute to exempt these discounts from “best price” and creating the 340B program, which establishes discounted prices for eligible safety net providers based on a specific formula.⁷ These providers, also known as “covered entities,” include select federal grantees and certain hospitals.⁸

Hospital Eligibility for the 340B Program

Eligibility for the 340B program is defined in the 340B statute. Non-hospital 340B entities typically are eligible if they receive one of ten types of federal grants that provide resources for health care services for low-income, uninsured individuals.⁹ Grant-approval processes typically require clinics to demonstrate that they provide services to certain specified vulnerable populations and that the entities reinvest resources into services for those populations.¹⁰ Any funds that these entities derive from 340B are therefore reinvested into services for the populations these grantees serve.

In contrast, hospitals are not typically required to demonstrate that they provide services to uninsured patients or reinvest resources into services on their behalf under the 340B program. Instead, hospitals qualify for the 340B program based, in part, on their

disproportionate share hospital (DSH) percentage,¹¹ a measure relating to the number of Medicaid and low-income Medicare patients treated in a hospital’s inpatient unit. As demonstrated by the data summarized in this paper, a high disproportionate share adjustment percentage does not automatically correlate with high levels of charity care. In fact, declines in charity care due to uninsured patients becoming eligible for Medicaid through the eligibility expansions under the Patient Protection and Affordable Care Act (ACA) are projected to make more hospitals eligible for 340B as their DSH percentages increase.¹²



The current eligibility criteria have allowed many hospitals to qualify even though they may not serve significant numbers of vulnerable and uninsured patients and may not provide significant amounts of charity care.

When the 340B program began, Congress anticipated that only a small number of hospitals would qualify. The legislative history explains that certain private nonprofit hospitals that served many “low-income individuals who are not eligible for Medicaid or Medicare” (and met additional requirements) could participate in the 340B program; however, a private nonprofit hospital that had “a minor contract to provide indigent care which represents an insignificant portion of its operating revenues” could not.¹³

The DSH metric was a proxy intended to target hospitals serving a disproportionate share of needy patients. However, developments that are discussed below and

could not have been anticipated by the law’s drafters, combined with the lack of sufficient guidance from the Department of Health and Human Services, have shown the program’s current hospital eligibility criteria to be a wholly inappropriate metric. These eligibility criteria have allowed many hospitals to qualify that do not serve significant proportions of the populations the law intended to help.

The DSH Metric

The DSH percentage used for the purposes of determining 340B eligibility was designed for use within Medicare, and determines whether hospitals receive enhanced Medicare payments.¹⁴ The DSH percentage is calculated based on: (1) the share of low-income patients *insured* by Medicare (*i.e.*, patients entitled to both Medicare Part A and Supplemental Security Income benefits) compared to the total Medicare population treated by the hospital, plus (2) the share of Medicaid patients without Medicare compared to the total patients treated by the hospital.¹⁵ The DSH percentage, therefore, is a reflection of care provided to low-income *insured* patients and does *not* reflect the share of uninsured patients or the amount of charity care provided at a hospital. Additionally, the DSH metric is based solely on *inpatient* utilization, which makes it a poor proxy for a program such as 340B that is limited to outpatient drugs.

Another criterion is that all 340B-eligible hospitals must be: (1) owned or operated by a unit of state or local government; (2) a public or private nonprofit hospital formally granted governmental powers by a state or local government; or (3) a private nonprofit hospital with a contract with a state or local government to provide health care services to low-income individuals who are not Medicare or Medicaid eligible.

Importantly, under current HRSA guidance private nonprofit hospitals that qualify for 340B through such formally granted governmental powers or through contracts with state or local governments for health

care services targeted at specific populations may use 340B discounted drugs for *all* outpatient services at the hospitals, not merely those related to such powers or contracts. By contrast, non-hospital grantees that qualify for the 340B program have more limited missions that focus on the needy or vulnerable populations they serve. The Health Resources and Services Administration (HRSA) published draft guidance for notice and comment in August 2015 that did not make any significant changes to hospital eligibility for 340B.¹⁶ The draft guidance would allow hospitals to qualify for 340B on the basis of being formally granted governmental powers if (among other things) granted power to “act on behalf of the government.” However, the draft guidance does not specify what that power would entail. The guidance also would require that government contracts that confer 340B eligibility have “enforceable expectations” for the provision of health care services to low-income individuals ineligible for Medicare and Medicaid but the guidance does not include any requirements on, for example, the size or scope of the contract. Additionally, HRSA would continue its current policy of not reviewing these contracts to verify that the applicant is eligible to participate in the 340B program.

It is therefore possible that some hospitals may have interpreted this criterion to allow a hospital to qualify for 340B based on a contract that is very limited in scope and provides nominal care to a small number of individuals, such as providing limited health screenings for a school district. Such a contract also could be completely unrelated to providing outpatient drugs.

The Role Hospital Eligibility Plays in Program Growth

In a recent report, the Medicare Payment Advisory Commission (MedPAC) noted that the number of hospitals participating in 340B grew from 583 in 2005 to 1,365 in 2010, and then further increased to 2,140 hospitals by 2014.¹⁷ MedPAC also noted that by 2014, about 45% of all Medicare acute care hospitals participated in the 340B program.¹⁸

Post-1992 Medicaid Expansions

One reason for this growth is likely an increase in the share of the population covered by Medicaid. Higher Medicaid enrollment contributes to a larger share of hospitals qualifying for 340B based on their DSH percentage, because the DSH percentage used for 340B eligibility measures hospital use by Medicaid and low-income Medicare beneficiaries, not by uninsured persons. In 1996 (the earliest year for which consistent data are available), 13% of the population had Medicaid coverage at some point during the year. By 2013, that percentage had increased to 19%.¹⁹ That percentage likely has continued to rise due to the Medicaid expansion in the ACA, which began in 2014 in many states. According to the government's enrollment data, Medicaid enrollment was up 19% from 2013 to January 2015.²⁰ Previous analysis by the U.S. Government Accountability Office (GAO) noted that state Medicaid expansions preceding the ACA may have contributed to the rise in hospitals participating in 340B.²¹ The expanded Medicaid eligibility included in the ACA likely will increase further the number of hospitals eligible for 340B based on their DSH percentage.

Relationship Between DSH and Hospital Share of High-Cost Patients and Charity Care

Since 1992, the DSH metric itself has been the subject of careful analyses that have shed light on what it does and does not measure. These analyses call into question the DSH metric's use in helping determine 340B hospital eligibility.

As noted previously, the DSH metric was not specifically designed for 340B eligibility purposes and does not measure the percentage of uninsured patients a hospital serves or the level of charity or uncompensated care it provides. MedPAC has analyzed the DSH adjustment percentage to determine whether hospitals with higher DSH payments had patients who were more costly to treat and/or were providing higher levels of uncompensated care. In 2007, MedPAC reported that

it had found little correlation between hospitals' DSH adjustment percentages and whether they had either high-cost patients or a high percentage of uninsured patients.²² In 2015, a GAO analysis of Medicare cost report data for 340B DSH hospitals found that there were "notable numbers of 340B hospitals that provided low amounts of [charity and uncompensated] care."²³

The 340B program has transformed from a well-intentioned program targeted at true safety-net providers in 1992 to one including an unanticipated large number of hospitals today. This growth has continued despite recent declines in the uninsured rate.²⁴ That trend, combined with analyses demonstrating DSHs' lack of relationship to the amount of uncompensated care hospitals deliver, raises questions about whether the program is being appropriately targeted to only those facilities that spend significant resources providing care to disadvantaged populations. Notably, in the ACA, Congress set a precedent for revisiting the use of DSH as a policy metric for aiding hospitals that provide uncompensated care through its decision to reduce DSH payments to hospitals due to expected declines in the uninsured.²⁵

Hospital Charity Care

The charity care data analyzed in this paper reflects the cost of providing free or discounted care to low-income individuals who qualify for a hospital's charity care program. The analysis presented here focuses solely on charity care and not the broader category of uncompensated care, which includes bad debt from non-indigent and insured patient accounts. This paper's focus on charity care is consistent, therefore, with the 340B program's intent, which is to sustain care for the vulnerable or uninsured.

Many hospitals provide charity care to patients who meet certain income and asset requirements. The specific nature of charity care can vary by hospital, as individual hospitals develop their own policies regarding the criteria individuals must meet to qualify. The American Hospital Association's (AHA) voluntary policies and guidelines for hospitals suggest that care should be provided free of charge to uninsured patients with incomes below 100% of the Federal Poverty Level (FPL) and at reduced rates for uninsured patients with incomes between 100% and 200% of the FPL.²⁶ The ACA placed some limits on how much nonprofit tax-exempt hospitals can charge qualifying individuals; these limits are enforced through Internal Revenue Service (IRS) regulations.²⁷ These rules require that hospitals have publicly available charity care policies, and also prohibit hospitals from charging inflated prices to those who qualify for these programs. However, neither the regulations nor the 340B program have any requirements on who must be eligible for free or reduced price care. In a recent *New England Journal of Medicine* article,²⁸ researchers noted that many hospitals were not meeting the standards set forth in the ACA prior to the requirements taking effect. The Berkeley Research Group replicated the methodology of the *New England Journal of Medicine* article, and separately analyzed 340B and non-340B hospitals.²⁹ The Berkeley Research Group study found that there were not meaningful

METHODOLOGY:

The analysis presented in this paper is based on data obtained from FY 2014 Medicare cost reports analyzed by Avalere Health LLC (Avalere) to determine the share of total hospital costs attributable to charity care, as reported by the hospital (see Appendix A for more information on charity care and data methods).

The paper leverages data from the Medicare cost reports, which are filed annually by hospitals and were redesigned in 2010 to more accurately capture the cost of the charity care that hospitals provide. This Medicare cost report data on charity care also was used by the GAO for a June 2015 report on 340B, in which the GAO stated that it "confirmed with CMS that the agency did not have any concerns about our use of the data." The GAO also stated that it performed a "data reliability assessment and concluded that the cost report data were sufficiently reliable."

The analysis in this paper analysis excludes Critical Access Hospitals because those rural hospitals have very different cost structures than other hospitals and qualify for 340B based on different metrics (see Appendix B for more information on Critical Access Hospitals). Additionally, Free-Standing Cancer Hospitals, Rural Referral Centers, Children's Hospitals and Sole Community Hospitals were excluded from this analysis so that the paper could focus on DSH hospitals, which account for 81% of total 340B sales according to 2015 data from Apexus.

differences between 340B and non-340B hospitals in terms of how likely they were to comply with the new ACA requirements. For example, in 2013 only 37.1% of 340B hospitals reported that they complied with the ACA requirement to limit charges for those who qualify for financial assistance to no more than rates for patients insured through Commercial coverage or Medicare. The share of non-340B hospitals complying with that requirement was roughly the same (36.6%), despite the fact that these hospitals do not benefit from 340B discounts.

Even if the IRS rules are fully enforced, hospitals still will be able to set their own eligibility standards for charity care programs. Given this flexibility, the IRS guidelines do not appear sufficient to ensure that the nonprofit hospitals that qualify for 340B fulfill Congressional expectations for the safety net program. This paper analyzes whether 340B hospital eligibility criteria target hospitals that provide relatively high levels of free or reduced price care to vulnerable or uninsured patients.

Results of Charity Care Analysis

The data analyzed for this paper show that the 340B program includes many hospitals that provide a minimal amount of charity care. In fact, for more than one-third (37%) of the 340B hospitals studied, charity care represents less than 1% of hospital patient costs (Figure 1). These hospitals provide a level of charity care that is far below the 2.2% national average for all short-term acute care hospitals (STACHs), regardless of 340B status. An additional 27% of the 340B hospitals studied provide charity care that represents between 1% and 2.2% of patient costs. In total, 64% of 340B hospitals provide less charity care than the national average for *all* hospitals, including for-profit hospitals. A recent MedPAC report that analyzed uncompensated care also found that a sizable share of 340B hospitals provides relatively little

charity care. That study used the same Medicare data analyzed by Avalere for this paper and found that 40% of 340B hospitals provide less than the median (midpoint) level of uncompensated care for all hospitals.³⁰

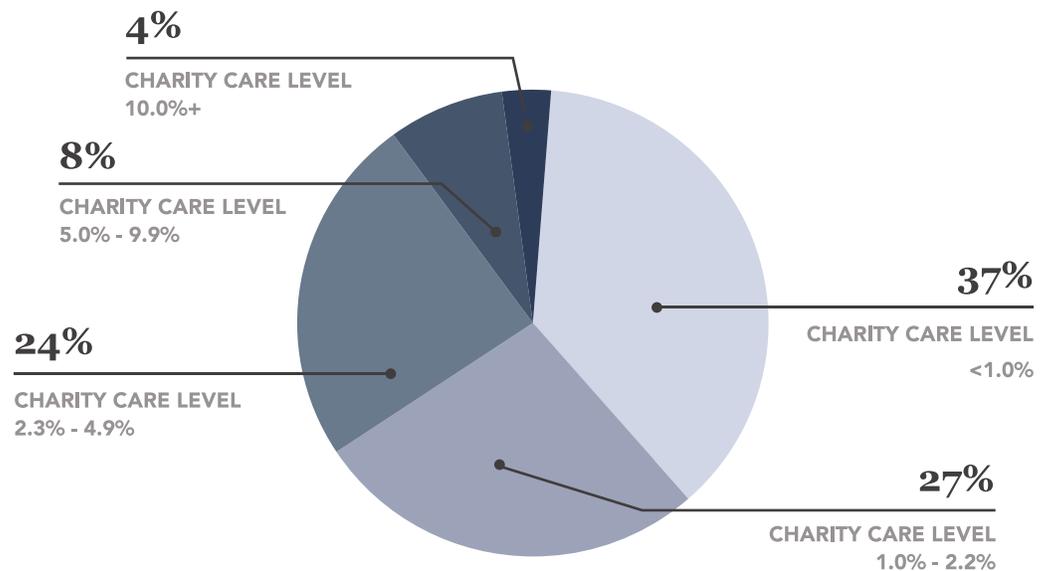
In total, 64% of 340B hospitals provide less charity care than the national average for *all* short-term acute care hospitals, including for-profit hospitals.

SOURCE: Avalere Health analysis of FY 2014 Medicare cost report data

FIGURE 1: CHARITY CARE AS A PERCENT OF PATIENT COSTS FOR 340B HOSPITALS COMPARED TO NATIONAL AVERAGE FOR ALL HOSPITALS

64%

OF 340B HOSPITALS HAVE CHARITY CARE RATES BELOW THE 2.2% NATIONAL AVERAGE FOR ALL HOSPITALS



NOTE: National average is calculated for all short-term acute care hospitals (STACHs), 340B hospitals include only 340B disproportionate share hospitals (DSH).
SOURCE: Avalere analysis of FY2014 Medicare cost reports submitted by 2,672 STACHs. Of those, 866 hospitals were participating in 340B as a DSH entity for a full or a portion of their cost reporting period based on the enrollment and termination dates in the Office of Pharmacy Affairs (OPA) 340B Database.

Charity care, as well as uncompensated care, has declined substantially since the coverage expansions in the ACA were enacted in 2014. Table 1 shows that for all hospitals (340B and non-340B) charity care costs as a percent of all patient costs ranged from 3.3% to 2.9% between 2011 and 2013. In 2014, this percentage declined to 2.2%. The share of 340B hospitals that provide a below average level of charity care has remained relatively steady, and was 69.0% in 2011; the percentage fell slightly to 64.4% in 2014. The share of 340B hospitals that provide charity care that represents less than 1% of their patient

costs increased from 24% in 2011 to 37% in 2014. Data reported by the American Hospital Association, a trade group that represents hospitals, showed a similar trend. That data also showed the value of all uncompensated care provide by hospitals—including both bad debt and charity care—declined by \$4 billion from 2013 to 2014.³¹ These declines in charity care and uncompensated care show that the coverage expansions in the Affordable Care Act are reducing the burden on hospitals to provide free and reduced cost care to low-income uninsured and underinsured patients.

TABLE 1: CHARITY CARE AS A PERCENT OF TOTAL PATIENT COSTS, 2011-2014

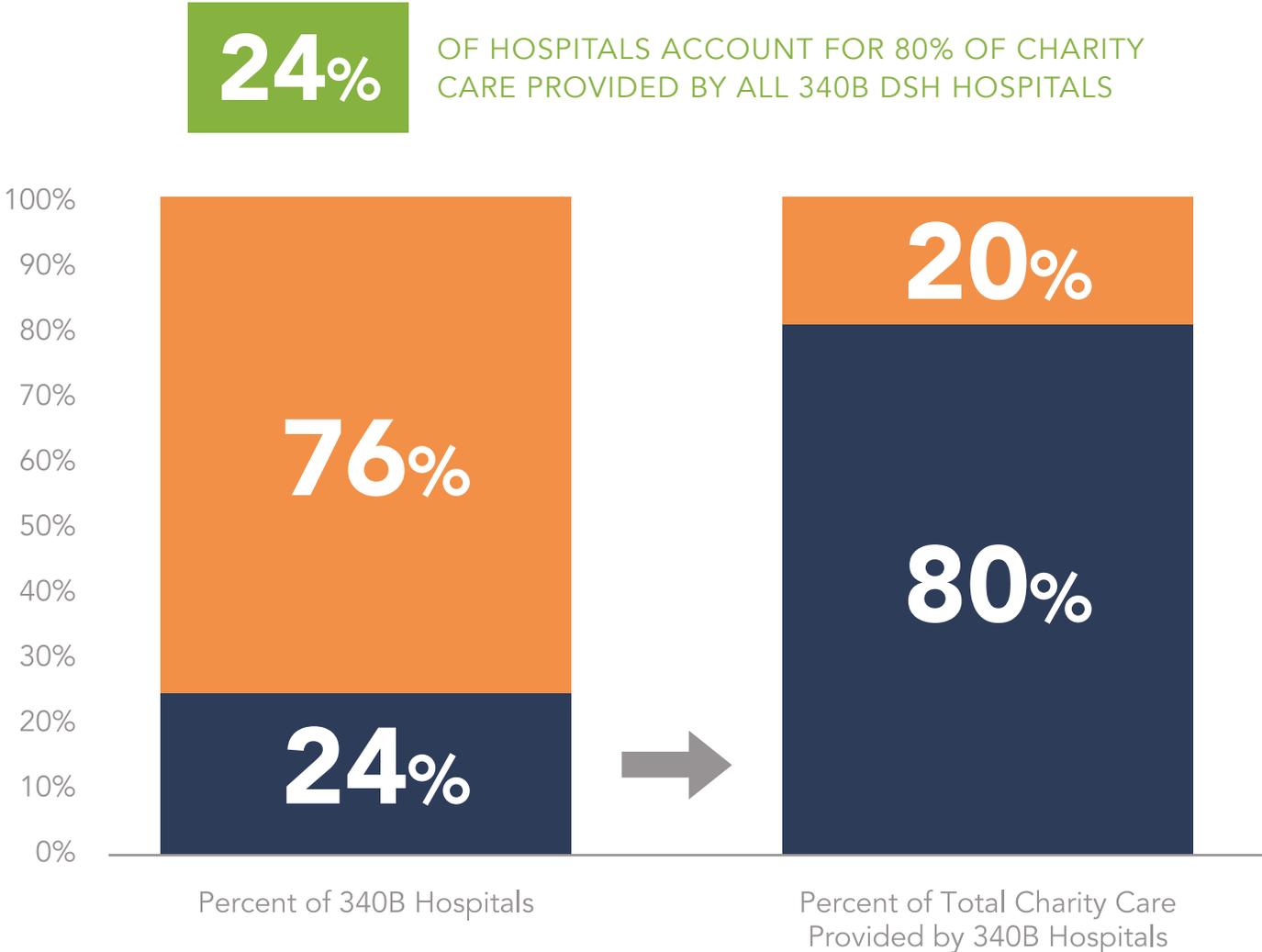
	2011	2012	2013	2014
National Average Charity Care Level	3.3%	2.9%	2.8%	2.2%
Percent of 340B Hospitals Below National Average	69.0%	61.9%	59.5%	64.4%

SOURCE: Avalere analysis of FY 2011-2014 Medicare cost reports for all short-term acute care hospitals (STACHs), 340B hospitals include only 340B disproportionate share hospitals (DSH). 340B participation based on being listed as a DSH entity for a full or a portion of their cost reporting period based on the enrollment and termination dates in the Office of Pharmacy Affairs (OPA) 340B database.

Similar to our previous report, analysis of the Medicare cost report data found that in 2014 a small minority of 340B hospitals provided the vast majority of all charity care provided by hospitals that receive 340B discounts. About one-quarter (24%) of all 340B hospitals provide 80% of the total charity care provided by all 340B hospitals (Figure 2). These same hospitals represent only 50% of total patient costs and 45% of total hospital beds in all 340B facilities, meaning that they are providing

a disproportionately high level of charity care relative to their size. Conversely, the remaining 76% of 340B hospitals provide just 20% of the total charity care, even though they represent about half of all 340B hospital beds and hospital costs. This finding is consistent with an IRS study that found just 9% of surveyed nonprofit hospitals were responsible for 60% of the community benefit expenditures provided by all of the nonprofit hospitals in the survey.³²

FIGURE 2: CHARITY CARE DISTRIBUTION (IN DOLLARS) AMONG 340B DSH HOSPITALS



SOURCE: Avalere analysis of FY2014 Medicare cost reports submitted by 866 hospitals that were participating in 340B as a DSH entity for a full or a portion of their cost reporting period based on the enrollment and termination dates in the Office of Pharmacy Affairs (OPA) 340B Database.

Given that charity care represents a substantial share of costs for only a small minority of 340B hospitals, the data also shows that some non-340B hospitals—including some that are for-profit hospitals—provide more

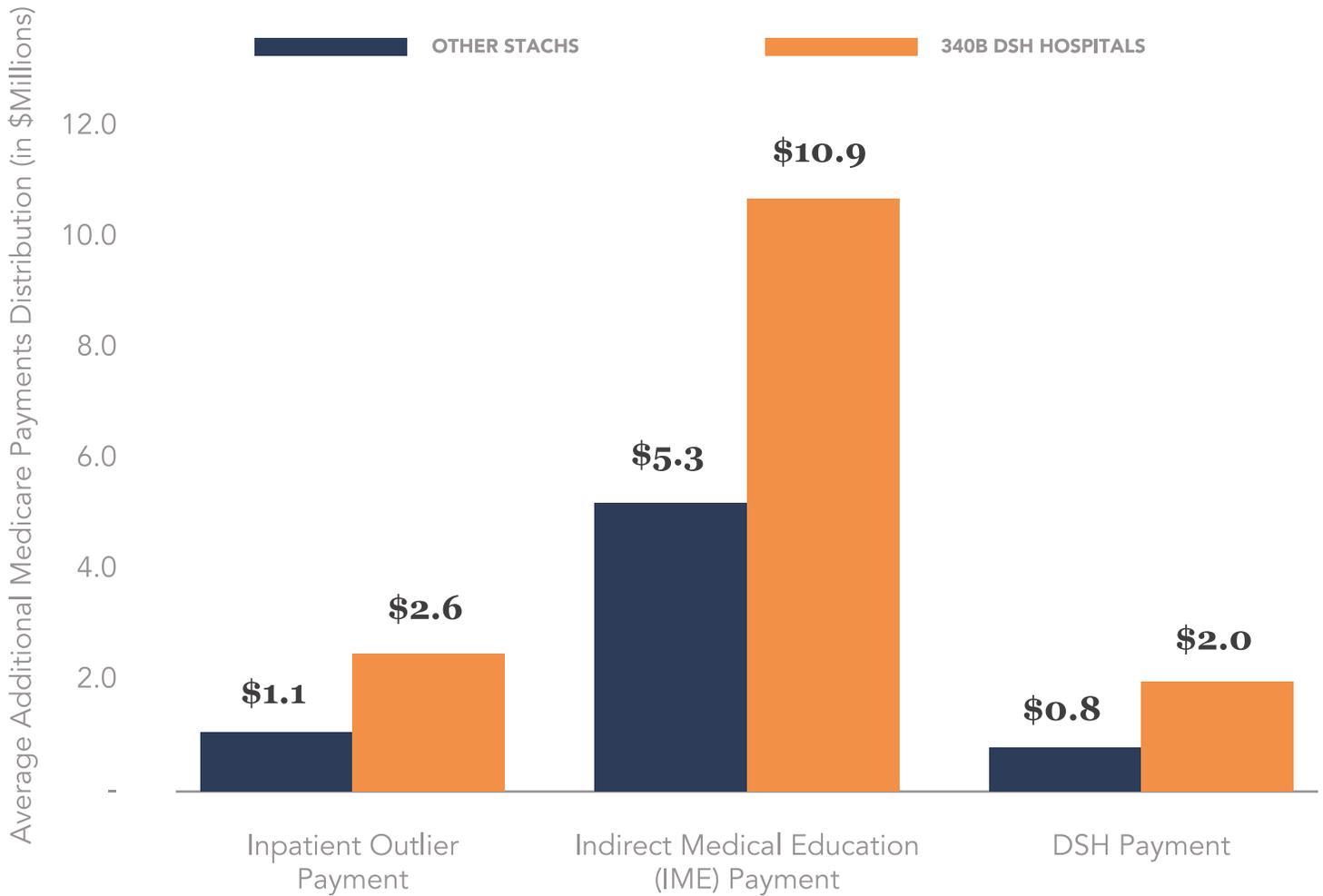
charity care than the vast majority of 340B hospitals. Specifically, almost one in fourteen (7%) non-340B hospitals provide charity care that represents 5% or more of the hospital's costs.

Additional Sources of Government Funding for Hospitals

Despite the fact that many hospitals provide very little charity care, hospitals currently receive government funding from numerous sources to compensate them for the cost of providing charity care and to help them absorb the cost of bad debt. Additionally, all hospitals that qualify for 340B are nonprofit, meaning that they benefit from being exempt from federal, state and local taxes. The tax benefits for nonprofit hospitals were valued at \$24.6 billion in 2011.³³

Some sources of government funding are reported in the Medicare cost reports. Avalere's analysis of FY 2014 data found that the total value of inpatient outlier payments, indirect medical education (IME) payments and Medicare DSH payments totaled \$8.5 billion for 340B DSH hospitals in 2014. As compared to non-340B short-term acute care hospitals, 340B DSH hospitals receive payments that are more than twice as large (Figure 3) on average. This is despite the fact that the average number of beds for the 340B hospitals is only 61% larger compared to the non-340B hospitals (280 compared to 174).

FIGURE 3: THE AVERAGE ADDITIONAL MEDICARE PAYMENT, 340B DSH HOSPITALS VS. OTHER SHORT-TERM ACUTE CARE HOSPITALS, 2014



SOURCE: Avalere analysis of FY2014 Medicare cost reports submitted by 2,672 STACHs. Of those, 866 hospitals were participating in 340B as a DSH entity for a full or a portion of their cost reporting period based on the enrollment and termination dates in the Office of Pharmacy Affairs (OPA) 340B Database.

Conclusion

The 340B program was intended to support access to outpatient drugs for uninsured or vulnerable patients. The program's design allows eligible providers to benefit from steeply discounted prices in return for their support of uninsured or vulnerable patient populations. The analysis presented in this paper demonstrates that current eligibility criteria for hospitals has resulted in the majority of hospitals participating in the 340B program despite the fact that an increasing share of those hospitals are providing minimal levels of charity care. To promote a well-functioning 340B program designed to support access for needy patients and underpinned by sound policy, Congress should reconsider the eligibility criteria for hospitals.

Appendix A: Additional Information on Charity Care

Charity Care Background

Acute-care hospitals will often provide charity care to patients who meet certain income requirements. The specific nature of charity care can vary by hospital. The ACA added section 501(r) to the Internal Revenue Code, which requires nonprofit hospitals to meet four key requirements to qualify for federal tax exemption. These four requirements include:

- Establish written financial assistance and emergency medical care policies;
- Limit the amounts charged for medically necessary care to individuals eligible for assistance under the hospital's financial assistance policy;
- Make reasonable efforts to determine whether an individual is eligible for assistance before engaging in extraordinary collection actions against the individual; and
- Conduct a community health needs assessment and adopt an implementation strategy at least once every three years.³⁴

Each individual hospital develops its own policy regarding the specific financial criteria that must be met for an individual treated in the hospital to qualify for charity care. The American Hospital Association (AHA) has developed a set of policies and guidelines hospitals may follow that suggests care should be provided free of charge to uninsured patients with incomes below 100% of the Federal Poverty Level (FPL) and at reduced rates for uninsured patients with incomes between 100% and 200% of the FPL.³⁵

Charity Care Data

The charity care data analyzed in this report is taken from FY 2012-2014 Medicare cost reports. While the IRS 990 Schedule H forms also include data on charity care, the Medicare cost report forms were used because they include all hospitals, while the IRS forms are only available for nonprofit hospitals. Specifically, this analysis used the CMS-2552-10 form, line 23 from worksheet S-10. This line represents the estimated cost of care that was provided to patients approved for charity care. To calculate this amount, hospitals first enter the total charges for care provided to patients approved for charity care on line 20 of the same worksheet. On that line of the form hospitals are asked to:

“Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital’s charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility. For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient’s total charges. For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), these are the deductible and coinsurance payments required by the payer. Include charity care for all services except physician and

other professional services. Do not include charges for either uninsured patients given discounts without meeting the hospital’s charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital’s charity care policy and the patient meets the hospital’s charity care criteria.”

After entering this amount, hospitals are then instructed to multiply this amount by the hospital-wide cost-to-charge ratio. This is the same ratio that the Medicare program uses to convert Medicare charges into estimated costs when determining the payment rates under the Medicare Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS).

Finally, hospitals are instructed to subtract any payment they have received from patients who were approved for partial charity care services. This final step is reflected in the amount listed on line 23 of the worksheet, which is the amount used in this report.

Table 2 provides an overview of the number and type of hospitals that were included in the charity care analysis.

TABLE 2: NUMBER OF HOSPITALS INCLUDED IN THE ANALYSIS

Type of Hospital	340B Hospitals in Analysis	Total Hospitals (340B and non-340B) in Analysis
Short-Term Acute Care Hospitals	866	2,672
Nonprofit	635	1,570
Government	214	366
Proprietary	17	736
Urban	656	2,240
Rural	210	432

Appendix B: Critical Access Hospitals

For the bulk of the analyses in this report, the data for Critical Access Hospitals (CAH) are excluded or presented separately than the data for Short-term Acute Care Hospitals (STACH). CAHs have a different operating structure than most STACHs given the statutory requirements for CAH approval. Under current law, a CAH must, according to the original requirements set out in the Balanced Budget Act of 1997, have no more than 25 beds, be at least 15 miles by secondary road and 35 miles by primary road from the nearest hospital or be declared a “necessary provider” by the state (although the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated a state’s ability to declare a hospital as a necessary provider). Once qualified as a CAH, the Medicare program reimburses the facility on a cost-plus basis rather than under the Inpatient Prospective Payment System (IPPS) that is used for all STACHs.³⁶

In addition to meeting the statutory requirements, most CAHs are located in rural areas where the mix of patients is likely to be quite different than it is for STACHs. For example, a recent report from the Department of Health and Human Services Office of

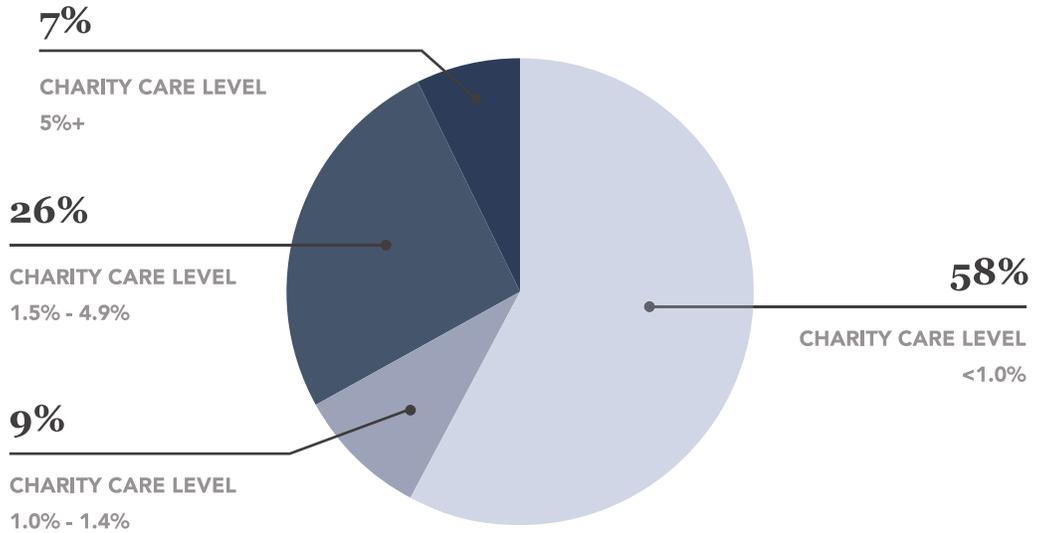
the Inspector General found that the average CAH had an inpatient utilization rate of only 21%, whereas STACHs ranged from 37% to 65% inpatient utilization rates, depending on their size.³⁷ Likewise, the OIG found that Medicare beneficiaries represented over 60% of all inpatient utilization for CAHs, while the STACH rates ranged from approximately 35% to 45%.³⁸ CAH admissions were also less likely to come from the emergency room (ER): less than 40% of all CAH admissions came from the ER, while the STACH rate ranged from approximately 55% to 65%.³⁹

Due to these differences in size, location, patient mix, and other factors, co-mingling the operating statistics between CAHs and STACHs tends to inappropriately skew the results. Instead, the operating statistics for STACHs were compared only to other STACHs, while the operating statistics for CAHs were compared only to other CAHs. Analysis of the provision of charity care by CAHs is shown below in figure 4. Notably, the same pattern for 340B DSH hospitals also holds for 340B CAHs—about two-thirds of the 340B CAHs provide less charity care than the average for all CAHs.

FIGURE 4: CHARITY CARE AS A PERCENT OF PATIENT COSTS FOR 340B CRITICAL ACCESS HOSPITALS COMPARED TO NATIONAL AVERAGE FOR ALL 340B CRITICAL ACCESS HOSPITALS

67%

OF 340B CAHS HAVE CHARITY CARE RATE BELOW THE 1.4% AVERAGE FOR ALL CAHS



CAH: Critical Access Hospital

SOURCE: Avalere analysis of FY2014 Medicare cost reports submitted by 1,264 CAHs. Of those, 895 hospitals were participating in 340B as a CAH entity for a full or a portion of their cost reporting period based on the enrollment and termination dates in the Office of Pharmacy Affairs (OPA) 340B Database.

Footnotes

¹ S. Marken, "U.S. Uninsured Rate at 11.0%, Lowest in Eight-Year Trend," *Gallup*, April 7, 2019.

² See 42 U.S.C. § 256b (the "340B statute").

³ AIR 340B, "Unfulfilled Expectations: An analysis of charity care provided by 340B hospitals," Spring 2014.

⁴ Alliance for Integrity and Reform of 340B (AIR 340B), "Unfulfilled Expectations: An analysis of charity care provided by 340B hospitals," Spring 2014.

⁵ Government Accountability Office, "Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement," September 2011; A. Alexander and K. Garloch, "Hospitals probed on use of drug discounts," *Charlotte Observer*, October 3, 2012, <http://www.charlotteobserver.com/2012/09/29/3566421/hospitals-probed-on-use-of-drug.html>; R. Conti and P. Bach, "Cost Consequences of the 340B Drug Discount Program," *JAMA* 2013; 309(19): 1995-1996; GAO, "Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals," June 2015.

⁶ See, e.g., "Hearing Before the Committee on Labor and Human Resources," *U.S. Senate*, October 16, 1991; "Statement of the Pharmaceutical Manufacturers Association (PMA)" at 54 ("We understand that the introduction of the bill is a reaction to the price increases to the covered entities caused by the best-price provisions of the Medicaid Rebate Program. That could be addressed by adopting the same approach that is contained in the Department of Veterans Affairs Appropriation Act; namely, to exempt the prices to the covered entities from the Medicaid rebate best price calculations.")

⁷ See Veterans Health Care Act of 1992, Pub. L. 102-585, § 601 (exempting prices charged to 340B covered entities from the Medicaid "best price" calculation) and § 602 (creating the 340B program).

⁸ See 42 U.S.C. § 256b(a)(4)(e).

⁹ See 42 U.S.C. § 256b(a)(4)(A)-(K); HRSA, "Eligibility & Registration," <http://www.hrsa.gov/opa/eligibilityandregistration/index.html> (listing the types of clinics that qualify for the 340B program with links to websites providing an overview of the types of grants that those entities must qualify for in order to enroll in the 340B program).

¹⁰ See, e.g., HRSA, "Black Lung Clinics Program," <http://www.hrsa.gov/gethealthcare/conditions/blacklung> ("[Black Lung Clinic] [s]ervices are available to patients and their families regardless of their ability to pay."); HRSA, "Federally Qualified Health Centers," <http://www.hrsa.gov/opa/eligibilityandregistration/healthcenters/fqhc/index.html> ("[Federally Qualified Health Centers] must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients.")

¹¹ See 42 U.S.C. § 256b(a)(4)(L)-(O).

¹² A. Vandervelde, "Growth of the 340b Program: Past Trends, Future Projections," Berkeley Research Group, December 2014.

¹³ U.S. House of Representatives Report accompanying H.R. Rep. 102-384 (II) (1992).

¹⁴ See 42 U.S.C. § 1395ww(d)(5)(F).

¹⁵ See Department of Health and Human Services, "Medicare Disproportionate Share Hospital," ICN 006741 January 2013, <http://www.hrsa.gov/opa/eligibilityandregistration/hospitals/disproportionatesharehospitals/index.html>.

¹⁶ 80 Fed. Reg. 52300 (Aug. 28, 2015).

- ¹⁷ MedPAC, "Report to Congress: Overview of the 340B Drug Pricing Program," May 2015.
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- ¹⁹ AIR 340B Analysis of MEPS net data for entire U.S. population. Data accessed February 25, 2016.
- ²⁰ S. Artiga, et al., "Recent Trends in Medicaid and CHIP Enrollment as of January 2015: Early Findings from the CMS Performance Indicator Project," *Kaiser Family Foundation*, March 31, 2015.
- ²¹ Government Accountability Office, "Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement," September 23, 2011.
- ²² Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2007.
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- ²⁶ American Hospital Association, "AHA Policies & Guidelines on Billing, Collections, Tax-Exempt Status, and Community Health," <http://www.aha.org/content/00-10/07nov-billingpolicyguidelines.pdf>.
- ²⁷ Patient Protection and Affordable Care Act, Disproportionate Share Hospital, Pub. L. No. 111-148, § 9007 (2011); Fed. Reg. Vol. 79, No. 250 at 78954.
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- ²⁹ A. Vandervelde and A. Oliphant, "Compliance Trends with Hospital Charity Care Requirements," Berkeley Research Group, April 2015.
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- ³⁴ IRS, "Request for Comments Regarding Additional Requirements for Tax-Exempt Hospitals," *Notice 2010-39*, <http://www.irs.gov/pub/irs-drop/n-10-39.pdf>.
- ³⁵ American Hospital Association, "AHA Policies & Guidelines on Billing, Collections, Tax-Exempt Status, and Community Health," <http://www.aha.org/content/00-10/07nov-billingpolicyguidelines.pdf>.
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- ³⁷ Department of Health and Human Services Office of the Inspector General, "Services Provided by Critical Access Hospitals in 2011," December 2013, <http://oig.hhs.gov/oei/reports/oei-05-12-00081.pdf>.
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