TO: Health Care Clients

FROM: Alston & Bird LLP

DATE: January 22, 2020

RE: A&B MedPAC Session Summary—Does the 340B Program Create Incentives for Participating Hospitals to Use More Expensive Drugs?

On January 17, 2020 the Medicare Payment Advisory Commission (MedPAC) held a session entitled, Congressional Request on Health Care Provider Consolidation: Does the 340B Program Create Incentives for Participating Hospitals to Use More Expensive Drugs. Staff members Kim Neuman, Nancy Ray, and Shinobu Suzuki presented an analysis of whether the 340B Drug Pricing Program creates incentives for hospitals to choose more expensive drugs. The Commissioners discussed the staff’s findings and provided guidance for finalizing the report.

Staff explained that in August of 2018, the Chairman of the House Committee on Energy and Commerce asked MedPAC to report on a series of questions on the effects of hospital mergers, physician-hospital consolidation, and the 340B Drug Pricing Program. Specifically, Congress expressed interest in whether 340B drug discounts create financial incentives for participating hospitals to choose more expensive products in some cases. Staff explored this question and analyzed what the resulting impact might be on Medicare patients’ cost-share for such drugs.

Staff provided some background information on the 340B Drug Pricing Program, explaining that it was created so eligible hospitals could purchase outpatient drugs at substantial discounts. The 340B ceiling price is calculated by subtracting a basic rebate and an inflation rebate from the average manufacturer price (AMP).

- The basic rebate for brand drugs is the greater of 23.1 percent AMP or AMP minus Best Price; for generic drugs, 13 percent of AMP.
- The inflation rebate is the difference between the actual AMP and what the AMP would have been if it grew at a rate of CPI-U between a base year and a current year.

Staff explained that the 340B Program could influence drug spending in two primary ways:

1. It could create potential incentives for selection of higher-priced drugs. If higher-priced products offer higher margins than lower-priced therapeutic alternatives, then 340B could create incentives for selection of higher-priced products,
2. It could create incentives to furnish more drugs. The general profitability of drugs for 340B providers might encourage use of more drugs.

Empirical evidence about 340B effects on drug selection is limited. Staff said 340B prices are generally confidential. However, some studies have found higher cancer drug spending at 340B hospitals versus their counterparts. For example, the Government Accountability Office (GAO) found per-beneficiary Medicare spending in 2012 for cancer drugs was 12 percent greater at 340B Disproportionate Share Hospitals (DSHs). However, stakeholders have critiqued such studies for not sufficiently controlling for differences in mix of patients.
Staff explained that their analysis of the effects of the 340B Program sought to answer whether 340B status is associated with higher cancer drug spending. They looked at average cancer drug spending per month for five types of cancer (breast, colorectal, prostate, lung, leukemia, and lymphoma) and included beneficiaries treated by 340B hospitals, non-340B hospitals, and physician offices. Staff noted that they analyzed data from before the 2018 340B payment change. Staff also noted that type of cancer and location of care can both affect cancer drug spending. Compared to non-340B hospitals, average spending by cancer type at 340B hospitals is about 2 percent to 5 percent higher. Compared to physician offices, average spending by cancer type at 340B hospitals generally ranges from 1 percent lower to 7 percent higher. Staff noted that 340B hospitals are more likely to be larger, teaching hospitals, and care for patients who are young, disabled, and receive Part D’s Low-Income Subsidy (LIS).

In their initial analysis, staff found that in hospitals with newly gained 340B status, there was no consistent pattern of increased cancer drug spending relative to other hospitals. However, a regression analysis at the Metropolitan Statistical Area (MSA) level suggested a modest effect for some cancer types. Specifically, the effects of 340B market share were statistically significant for 2 out of 5 of the five cancer types: prostate and lung cancer. However, staff were unable to attribute these findings to incentives created by 340B discounts. Staff summarized their findings with the following three takeaways:

- There is evidence of higher drug spending at 340B hospitals for some cancer types;
- The effects on cancer drug spending are likely to be idiosyncratic and not generalizable to other cancers or conditions; and
- Overall effects on cost sharing for cancer patients is likely to be small, if any, depending on the type of cancer and the patient’s supplemental coverage.

Staff asked the Commissioners to provide feedback on the analysis and for guidance on finalizing the report to meet the March 2020 deadline.

**Commissioners’ Discussion**

**Clarifying Questions**

**Commissioner Brian DeBusk** asked staff to explain what other sources of discounts are available to all hospitals. He asked whether these discounts could also create incentives. Staff said on the Part B side, rebates and tiers might have some impact on the types of drugs that hospitals select. They also said that some providers receive bigger discounts than others, so they expect to see some variation in prices. However, staff said they would not expect other providers to receive discounts close to the size of those received through 340B.

**Commissioner Jaewon Ryu** emphasized that staff’s analysis was based on data prior to the 2018 payment cut to 340B entities. He asked if this would affect the analysis by essentially leveling the margins. Staff said they think of the payment cut as essentially washing away the basic rebate in the 340B program. However, they said the inflation rebate can still create substantial margins.

**Commissioner Kathy Buto** said older drugs tend to get bigger discounts in the 340B program. She asked staff if they have looked at the mix of older versus newer drugs in 340B hospitals. Staff said the drugs used for specific cancer types are generally similar, so there is no significant difference between the same cancer types. Commissioner Buto then asked staff how much the 340B drug payment cost differential has
contributed to hospital margins. Staff said it has resulted in approximately a 1-2 percent increase in margins. However, in 2018, the payment cut essentially eliminated this increase.

Commissioner Amol Navathe asked staff if they have a sense of the characteristics of hospitals that are gaining 340B status. He said this might help the Commission interpret staff’s analysis. Chairman Francis Crosson said he thinks all hospitals would ideally like to qualify for 340B status. He said their previous analysis suggests that many hospitals are achieving 340B status through horizontal consolidation. Staff said new 340B hospitals are generally smaller than others and have more older patients. However, staff said they do not know all of the demographics for these hospitals, so it is something they can spend more time analyzing. Commissioner Navathe suggested looking at consolidation activity prior to achieving 340B status. He said they should try to understand how hospitals achieved 340B status and what steps they took to get there.

Commissioner Pat Wang said the Commission should also consider whether industry changes—such as Medicaid expansion under the Affordable Care Act—might have qualified more hospitals for 340B status.

Vice Chairman Paul Ginsburg said 340B hospitals are much more likely to be teaching hospitals. He noted that teaching hospitals generally have a different spending pattern, so staff should hold this variable constant in the regression model. Staff said they did control for teaching status in their analysis.

Commissioner Lawrence Casalino argued that hospitals do not order drug treatments—doctors do (in this case, oncologists). He said it might be interesting to look at oncologists employed by hospitals versus oncologists who are not employed by hospitals. Staff said they could do this analysis, but they do not know if they can complete it in the short term. Vice Chairman Paul Ginsburg said a lot of the ordering is done on an outpatient basis, so the analysis might not be particularly helpful. He said it would be a very difficult case mix adjustment.

Commissioner Bruce Pyenson suggested that staff describe the cash flow process for 340B in their report. Staff said they would incorporate this information. Commissioner Pyenson then asked staff to explain why dedicated cancer centers were not included in their study. Staff said they did include these centers in the MSA analysis.

Commissioner Pat Wang said that hospitals are increasingly acquiring physician practices. She asked staff if they looked into whether there was more of this activity in 340B hospitals versus non-340B hospitals. Staff said they did not examine this trend in their study.

**Discussion**

Commissioner Lawrence Casalino asked staff whether it would be out of scope to mention in the report that 340B status can increase spending in more than one way. He recommended including some discussion of the potential for 340B status to drive hospital employment of oncologists. He said he does not think the Commission has the data for a full analysis, but they could mention it. Executive Director James Mathews said the Commission could raise this as a possibility, but agreed that they do not have to data to say anything definitive.

Commissioner Jonathan Perlin suggested looking at the relationship between 340B status and consolidation. He said the Commission could approach this by looking at services offered and studying whether these services shift over time as hospitals become 340B-eligible.
Commissioner Warner Thomas said he is not sure the modest evidence of higher drug spending that staff found is entirely accurate. He said they do not have evidence of the severity or stage of cancer, which significantly drives the type of treatment a patient receives. Commissioner Thomas also noted that LIS patients, who make up a significant portion of 340B patients, generally arrive at hospitals with a later stage of cancer because they do not have access to screening and preventative care. He said this can also drive a higher cost structure. Commissioner Thomas suggested mentioning these possibilities in the report.

Executive Director James Mathews said one critique of prior studies is that they do not sufficiently control for patient characteristics. He said staff attempted to do this in their analysis by stratifying by cancer type. However, they do not have granular data on the stage of cancer. He said staff alludes to this in the chapter by noting the potential for unmeasured patient characteristics. However, he said it is difficult to adjust for this.

Commissioner Bruce Pyenson said there are also huge shifts in therapy occurring today that are probably not reflected in the report’s data.

Commissioner David Grabowski said the report did a good job of getting to the direct effects on payment. However, he also suggested that the Commission might want to think about indirect effects and at least mention them in the context of the report.

Vice Chairman Paul Ginsburg said it is important to mention the possibility that 340B status could affect hospital acquisition or hiring of oncologists.

Commissioner Kathy Buto agreed with the other commissioners. She said they need to look at impact on higher costs to the Medicare program—not just drugs. She said it is hard to pick out a real increase in drug costs. She said she thinks the costs of 340B to the Medicare program are much broader than just drug prices.

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We hope this summary was helpful to you. Please do not hesitate to contact us if you have any questions.