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MEDICARE PART B DRUGS

Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals

GAO Highlights

Highlights of GAO-15-442, a report to congressional requesters

Why GAO Did This Study

Approximately 40 percent of all U.S. hospitals participate in the 340B Drug Pricing Program, and the majority of 340B discounted drugs are sold to hospitals. Medicare reimburses hospitals for Part B drugs under a statutory formula regardless of the prices hospitals paid for the drugs. Stakeholders have questioned the increase in hospital participation in the 340B program, and the implications for Medicare and its beneficiaries, especially regarding cancer care; and whether certain of the program's hospital eligibility criteria target hospitals appropriately.

GAO was asked to review hospitals' participation in the 340B and Medicare programs. This report (1) compares 340B hospitals with non-340B hospitals in terms of financial and other characteristics and (2) compares spending for Medicare Part B drugs at 340B hospitals, for all drugs and for oncology drugs, with spending at non-340B hospitals. To examine hospital participation using the most recent data available, GAO analyzed 2008 and 2012 data from HRSA and CMS to compare characteristics and Medicare Part B drug spending for 340B hospitals and non-340B hospitals.

What GAO Recommends

Congress should consider eliminating the incentive to prescribe more drugs or more expensive drugs than necessary to treat Medicare Part B beneficiaries at 340B hospitals.

View GAO-15-442. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

Certain providers, including hospitals that serve a disproportionate number of low-income patients, have access to discounted prices on outpatient drugs through the 340B Drug Pricing Program, which is administered by the Health Resources and Services Administration (HRSA) within the Department of Health & Human Services (HHS). In 2012, these hospitals—referred to as 340B disproportionate share hospitals (DSH) because they are eligible for the program based on their serving a disproportionate share of low-income patients and other specified criteria—were generally larger and more likely to be teaching hospitals compared with non-340B hospitals. They also tended to provide more uncompensated and charity care than non-340B hospitals; however, there were notable numbers of 340B hospitals that provided low amounts of these types of care. For example, 12 percent of 340B DSH hospitals were among the hospitals that reported providing the lowest amounts of charity care across all hospitals in GAO's analysis. Overall financial margins for 340B DSH hospitals tended to be lower compared with non-340B hospitals, which could be attributable, in part, to the tendency for 340B DSH hospitals to provide more uncompensated and charity care.

GAO found that in both 2008 and 2012, per beneficiary Medicare Part B drug spending, including oncology drug spending, was substantially higher at 340B DSH hospitals than at non-340B hospitals. This indicates that, on average, beneficiaries at 340B DSH hospitals were either prescribed more drugs or more expensive drugs than beneficiaries at the other hospitals in GAO's analysis. For example, in 2012, average per beneficiary spending at 340B DSH hospitals was $144, compared to approximately $60 at non-340B hospitals. The differences did not appear to be explained by the hospital characteristics GAO examined or patients' health status. The Centers for Medicare & Medicaid Services (CMS), which administers the Medicare program, uses a statutorily defined formula to pay hospitals for drugs at set rates regardless of hospitals' costs for acquiring the drugs. Therefore, there is a financial incentive at hospitals participating in the 340B program to prescribe more drugs or more expensive drugs to Medicare beneficiaries. Unnecessary spending has negative implications, not just for the Medicare program, but for Medicare beneficiaries as well, who would be financially liable for larger copayments as a result of receiving more drugs or more expensive drugs. In addition, this raises potential concerns about the appropriateness of the health care provided to these beneficiaries. HRSA and CMS have limited ability to counter this incentive because the 340B statute does not restrict covered entities from using drugs purchased at the 340B discounted price for Medicare Part B beneficiaries and the Medicare statute does not limit CMS reimbursement for such drugs.

In commenting on a draft of this report HHS noted some concerns with GAO's conclusions and suggested that further analysis may be needed to examine patient outcomes and differences in health status. GAO believes its methods appropriately support its conclusions as further discussed in the report.