CHAPTER 1:
Addressing Hospital Consolidation: Diagnosis, Prescription, and Treatment

ADDRESSING HOSPITAL CONSOLIDATION: DIAGNOSIS

Trend: Hospital consolidation has surged over the last 30 years, leading to a rise in mergers, acquisitions, and physicians employed by hospitals.[9] [10] This trend has driven the formation of large mega hospital systems that prioritize "profitability" over clinical objectives and patient wellbeing, resulting in highly concentrated markets where there is little meaningful competition.[11] [12] Also contributing to hospital consolidation is the payment differential between different sites of care—the more expensive hospital setting versus far less expensive independent physician practices. Research has found that payment differentials by site of care create incentives to consolidate health care markets.[13]

Patient Impact: Hospital consolidation has significantly increased health care costs and inefficiencies for patients and primary payers (i.e., employers, Medicare, state governments, and other payers) and reduced access.[14] [15] [16] Patients face higher insurance and out-of-pocket costs, restricted choice and access of providers and clinic locations, and greater administrative barriers from administrative red tape.[17] Consolidated hospital systems often result in "medical care deserts" for rural or underserved areas by closing less profitable satellite clinics, forcing patients to travel further for treatment or forego it altogether.[18] The consolidation model also shifts the focus from personalized, community-based care with local providers to a one-size-fits-all depersonalized health care model.[19] Despite promises of improved care coordination and efficiency, hospital consolidation has consistently failed to enhance the quality of care.[20] [21]

The Facts: Hospital-Physician Vertical Integration Results in Higher Costs

Vertical Integration Has Accelerated in the Last Decade

Hospital-physician vertical integration occurs when hospitals acquire independent physician practices or employ physicians to compete with independent physician practices. Hospitals typically force their employed physicians to cut off referrals to independent physicians, which in turn pressures additional independent physicians to become employed by the hospital.[i] Hospital-physician vertical integration has increased rapidly in recent years: from 2007 to 2017, the share of oncology physician practices that were vertically integrated within a hospital increased from 20 percent to 54 percent.[ii]

Consolidation Through Vertical Integration Raises Costs

A recent Health Economics study found that hospital-physician vertical integration is associated with increased Medicare Part B spending on physician-administered drugs. With oncology and hematology drugs, the average spend on these drugs increased 30 percent on a per physician basis after a physician went from being independent to integrated into a hospital. This increase is driven in part by using more expensive drugs, as well as shifts in site of care away from physician offices and toward higher cost hospital outpatient departments, a finding of multiple other studies on hospital-physician vertical integration. [i iii iv]

Sources:

i. *Capps C., et al. "The effect of hospital acquisitions of physician practices on prices and spending." J Health Econ. May 2018.* https://pubmed.ncbi.nlm.nih.gov/29727744/

ii. *Nikpay, Sayeh S., et al. "Hospital-Physician Consolidation Accelerated in the Past Decade in Cardiology, Oncology." Health Affairs. July 2018.* https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.1520

iii. *Levin, Jonathan S., et al. "Impact of hospital-physician vertical integration on physician-administered drug spending and utilization." Health Economics. 2024.* https://pubmed.ncbi.nlm.nih.gov/39533535/

iv. *Jung, Jeah, et al. "The Impact of Integration on Outpatient Chemotherapy Use and Spending in Medicare." Health Economics. 2019.* https://pmc.ncbi.nlm.nih.gov/articles/PMC6405302/

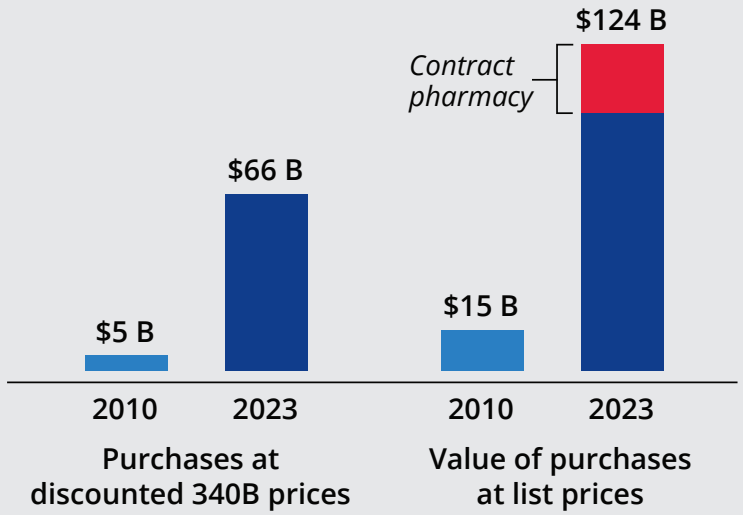
The Facts: 340B Drives Consolidation and Costs

The 340B Program Has Grown Enormously

340B has seen explosive growth in recent years, with no indication of slowing down. A Congressional Budget Office (CBO) analysis revealed that 340B drug spending grew from $6.6 billion in 2010 to $43.9 billion in 2021. Seventy-three percent of this growth is attributed to spending on cancer drugs, anti-infectives, and immunosuppressants.[i] These expensive drugs provide hospitals with substantial drug margins that further fuel consolidation. Unfortunately, a lack of legislative oversight has inadvertently created opportunities for hospitals, as well as vertically integrated PBM pharmacies, to exploit the program's well-intentioned framework, contributing to its massive growth.

In a recent report, the Health Resources and Services Administration (HRSA), which oversees 340B, highlighted that under 340B, drug purchases at discounted 340B spending reached a record of $66.3 billion in 2023, representing a 24 percent year-over-year increase (Figure 1).[ii, iii, iv] According to this report, sales for the top 10 340B drugs accounted for nearly one-third of all 340B purchases. An Avalere analysis compared 340B spending to Medicare spending and found that sales for the top 10 340B drugs exceeded sales for those drugs in Medicare.[v]

Figure 1: 340B Drug Pricing Program, Purchases by Covered Entities iv



Growing evidence shows that many hospitals abuse 340B, acquiring drugs at substantial discounts and generating huge profits. Originally created to serve a small number of safety-net hospitals, the program now covers thousands of covered entities and generates billions of dollars for hospitals.[vi] 340B has created unintended consequences that are harmful to patients and the health care system writ large through increasing prices and consolidation.

Hospitals are able to generate revenue through 340B based on the difference between the drug acquisition cost (discounted to the 340B ceiling price or even lower) and the reimbursement rate. 340B hospitals are not required to pass savings on to patients.

340B Hospitals Provide Inadequate Charity Care

There is little evidence that 340B hospitals are increasing care for underserved populations or using the revenue for charitable purposes. A 2021 study found no evidence that hospitals entering the 340B program increased their care for underserved populations any more than institutions not participating in the program—the core justification for receiving 340B discounts.[vi] A 2019 analysis of charity care data reported by hospitals in fiscal year (FY) 2017 Medicare cost reports reveal that many 340B hospitals are continuing to fall short of Congress' expectations when it comes to providing care to vulnerable patients. While some 340B hospitals provide considerable charity care, nearly one-third (29 percent) of 340B Disproportionate Share Hospitals (DSH) have charity care that represents less than one percent of total patient care costs.[vii] A 2024 study of charity care in U.S. nonprofit hospitals found wide variation in requirements for hospital financial assistance (including extensive paperwork requirements, inconsistent income limits, residency requirements), which pose significant barriers to equitable access to care.[viii]

It should be noted that many smaller rural hospitals use 340B as intended to benefit patients in need and rely on the program to stay viable. It is largely the mega hospital systems that are abusing the program to the detriment of certain smaller 340B providers, including rural hospitals, community health centers, and other 340B grantees.

The 340B Program's Negative Impact to Patients, Health Care Costs, and the Health Care System

The shift of cancer care out of independent community oncology practices and into hospital outpatient sites is costly for both patients and the health care system. Medicare Part B spending is higher in 340B DSH hospitals compared to non-340B hospitals, suggesting that there is a strong financial incentive at 340B hospitals to prescribe more drugs or more expensive drugs to Medicare beneficiaries.[viii] 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.

Sources:

i. *Congressional Budget Office. "Spending in the 340B Drug Pricing Program, 2010 to 2021." 17 June 2024. https://www.cbo. gov/publication/60339*

ii. *Health Resources and Services Administration. "2023 340B Covered Entity Purchases." October 2024. https://www.hrsa.gov/opa/updates/2023-340B-covered-entity-purchases*

iii. *DiGiorgio, Anthony M, and Wayne Winegarden. "Reforming 340B to Serve the Interests of Patients, Not Institutions." JAMA Health Forum. 26 July 2024. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2821579*

iv. *Fein, Adam J. "The 340B Program Reached $66 Billion in 2023—up 23% vs. 2022: Analyzing the Numbers and HRSA's Curious Actions." Drug Channels. 22 October 2024. http://www.drugchannels.net/2024/10/the-340B-program-reached-66-billion-in.html*

v. *Knox, Ryan P., et al. "Outcomes of the 340B Drug Pricing Program: A Scoping Review." JAMA Health Forum, 22 November 2023. https://jamanetwork.com/journals/jama-health-forum/fullarticle/2812107*

vi. *Alliance for 340B Integrity and Reform. "Left Behind: An Analysis of Charity Care Provided by Hospitals Enrolled in the 340B Program." Nov. 2019. https://340Breform.org/wp-content/uploads/2024/03/AIR340_LeftBehind-v6.pdf*

vii. *Messac, Luke, et al. "US Nonprofit Hospitals Have Widely Varying Criteria to Decide Who Qualifies for Free and Discounted Charity Care." Health Affairs. November 2024. https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.01615*

viii. *United States Government Accountability Office. "Medicare Part B Drugs Action Needed to Reduce Financial Incentives to Prescribe 340B Drugs at Participating Hospitals Report to Congressional Requesters." June 2015. https://www.gao.gov/assets/gao-15-442.pdf*

ADDRESSING HOSPITAL CONSOLIDATION: PRESCRIPTION AND TREATMENT

The 119th Congress must build on the momentum of site-neutral payment policy, 340B reform, and transparency requirements to stem the tide of hospital consolidation and negative impacts on patients and the health care system more broadly.

Implement Site-Neutral Payment Policies

- Legislate total site payment parity. Remove the "grandfathering" exception in Section 603 of the Bipartisan Budget Act of 2015, ensuring that the site-neutral payment policy is extended to all hospital-owned sites of care off-campus from the main hospital campus. Reimbursement will be based on independent physician office reimbursement, per the Medicare Physician Fee Schedule (MPFS).
- Ban all facility fees for hospital off-campus outpatient departments. Prevent hospital-owned off-campus outpatient departments from charging additional facility fees, reducing costs for patients and payers.
- Bundle and align radiation therapy technical payments at the hospital outpatient rate.

Tighten Hospital "Nonprofit" Status Requirements

- Modernize requirements for charity care in all nonprofit hospitals, which should provide a level of charity care commensurate with the tax breaks that accompany their nonprofit status.
- Require nonprofit hospitals to meet specific charity care standards or lose their nonprofit status. Nonprofit hospitals provide less charity care, on average, compared to other types of hospitals (government and for-profit hospitals).[1]

Strengthen 340B Participation Requirements

- Require that 340B hospitals deliver charity care that meets or exceeds their tax exemptions.
- Establish clear 340B patient eligibility requirements by defining who qualifies as a "340B patient" to ensure the program serves patients in need.
- Define standards for 340B hospital child sites such that 340B hospitals cannot funnel 340B savings through hospitals in disadvantaged areas to child sites in wealthy areas.
- Exclude for-profit PBMs from serving as 340B mail order contract pharmacies to prevent corporate profit-seeking from undermining the intent of the program by diverting 340B funds from helping patients to feeding corporate coffers.

CBO Estimate: Site-Neutral Payments Would Save $156.9 Billion Over 10 Years

Background

Medicare typically pays more for the same service when provided in a hospital outpatient department (HOPD) versus other settings, such as a physician office (e.g., independent community-based oncology practices) or ambulatory surgical center.

Policy Proposal and Estimated Savings

Congress has passed partial Medicare "site-neutral payment" legislation, under which certain HOPDs are paid the same as independent physician practices, but some in Congress want to expand that legislation to all HOPDs.

CBO notes that paying all HOPDs the same Medicare reimbursement paid to independent physician practices would save $156.9 billion over 10 years if this policy was implemented starting in 2026.[i]

Source:

i. *Congressional Budget Office. "Options for Reducing the Deficit: 2025 to 2034." December 2024.* https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf

Require Transparency and Reporting in 340B

- Require transparency and accountability as to how 340B discounts are used to help patients in need in conjunction with strengthened 340B participation requirements, with sufficient penalties for program misuse.
- Strengthen oversight of the 340B program by granting additional authority and resources to federal agencies to enforce 340B rules and oversee program compliance.
- Require 340B hospitals to have standardized charity care requirements and reporting processes.

Reimburse 340B Hospitals Based on Surveyed Acquisition Cost Prices

- Adjust 340B hospitals' reimbursement rate to be based on the CMS survey data of acquisition costs, as proposed in the 2021 Medicare Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. In changing the reimbursement rate, exempt smaller rural 340B hospitals.[22]
- Mandate CMS to conduct an updated survey of hospitals' 340B acquisition costs and discounts to ensure that Medicare reimbursement accurately reflects net drug acquisition costs.

Restrict Aggressive Debt Collection Practices by 340B Hospitals

- Prohibit 340B hospitals from using aggressive debt collection tactics (e.g., wage garnishment, property liens, credit reporting) against patients, especially low-income, uninsured, or underinsured patients.
- Require 340B hospitals to document and exhaust all financial assistance options (e.g., sliding scale of charity care) before pursuing collections and ensure transparent disclosure of these options to patients at admission and discharge.

CBO Estimates: Reining in 340B Spending Would Save Over $73 Billion Over 10 Years

Background

In 2018, CMS implemented a policy that significantly reduced Medicare reimbursement rates for 340B outpatient drugs, from average sales price (ASP) plus six percent to ASP minus 22.5 percent. The change was intended to better align Medicare's payments with the prices hospitals actually paid for 340B drugs, reducing what CMS viewed as excessive drug margins. Legal challenges and subsequent reversal of the policy set the payment rate back to ASP plus six percent, where it remains today.

Policy Proposal and Estimated Savings

In a 2024 CBO report, CBO estimates that if the ASP minus 22.5 percent payment rate for 340B drugs was instituted in January 2026, the policy would save approximately $24.2 billion from 2025-2029 and $73.5 billion from 2025 through 2034.[i]

In reality, the potential for 340B savings is much greater. CMS conducted a survey with 340B hospitals in 2020 and published the results in the 2021 HOPPS proposed rule. The survey found that the average acquisition cost discount for 340B drugs was 34.7 percent (a conservative estimate according to CMS). In order to set reimbursement closer to the average estimated acquisition cost from the survey, CMS would have to pay for Part B 340B drugs at ASP minus 28.7 percent (ASP minus 34.7 percent based on the survey results plus the six percent add-on).

The savings to Medicare from this lower 340B payment rate would be $93.8 billion from 2025 through 2034. This lower rate would also result in savings to Medicare beneficiaries.

Source:

i. Congressional Budget Office. "Options for Reducing the Deficit: 2025 to 2034." December 2024. https://www.cbo.gov/system/files/2024-12/60557-budget-options.pdf

ADDRESSING HOSPITAL CONSOLIDATION: ONGOING TREATMENT

The 120th Congress and beyond must ensure that there are effective guardrails for the 340B program, address anticompetitive hospital behavior, and ensure that rural hospitals and practices have a sustainable path forward.

Curb Unrestrained 340B Growth

- Transform 340B into a ***patient-centered*** program instead of a ***facility-centered*** program. 340B discounts should follow eligible patients in need, regardless of the care setting, providing direct out-of-pocket cost relief for qualifying individuals. Patient eligibility may be determined annually by issuing cards based on patients' tax returns, which may be used either for Medicaid enrollment or rebates paid to the entity purchasing the drugs.

Restrict Anticompetitive or Punitive Hospital Actions Against Independent Providers

- Ban "all or nothing" contracts, in which a hospital requires physicians to accept unfavorable terms because rejecting the contract entirely could mean losing hospital privileges or access to a significant portion of their patient base.
- Require hospitals to maintain specialty-specific privileges (corresponding with the physician's area of practice) for independent oncologists and other physician specialists in good standing with the facility.
- Enhance patient choice by preventing inpatient and emergency department referral systems from automatically mandating or preferring hospital-owned care options in referral systems while shutting out independent physicians.
- Enhance patient choice by requiring that inpatient and emergency department referral systems equitably provide information on care options owned and not owned by the hospital.

Support Rural Providers

- Extend existing physician and nurse incentive programs, such as tuition forgiveness and loan repayment, to independent physician practices serving rural areas, similar to those offered to hospitals.
- Increase the geographic practice cost index (GPCI) for rural areas to increase payment to rural practices, without reducing payment to those in urban areas.
- Adjust technical revenue payments, currently delivered per patient or individual fraction (for radiation oncology), to adequately cover the costs of acquiring and maintaining expensive equipment based on rurality.
- Allow physicians to own hospitals but require that they accept Medicaid patients at all locations.

Expand Site-Neutral Payment Policies

- Reduce payments to HOPDs to the ambulatory surgery center (ASC) payment rate for certain services, as referenced by the MedPAC 2022 Report to Congress.[23]
- Seek opportunities to expand site-neutral payment policy within Medicare, for both Medicare Fee-For-Service (FFS) and Medicare Advantage (MA), as well as for Medicaid.