Nonprofit Hospitals Do Not Use the 340B Program to Expand Unprofitable Care:

340B Nonprofit Hospitals Do Not Expand Unprofitable Care in Socioeconomically Disadvantaged Communities

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HEALTH EQUITY COLLABORATIVE

The Health Equity Collaborative

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Executive Summary

The **340B Drug Pricing Program** (**340B Program**) was designed to support **safety-net health care facilities** serving low-income and uninsured populations. It allows eligible hospitals and clinics ("**covered entities**") to purchase outpatient drugs at deep discounts while receiving standard reimbursement, which can far exceed the discounted purchase price, especially for **commercially insured** patients. **Covered entities** retain the difference between the discounted purchase price and standard reimbursement, with the expectation that these funds will be used for low-income patient care. The program does not, however, require **covered entities** to report how 340B-generated funds are used or to use them for low-income patients.

Multiple studies have found no greater incidence of **uncompensated** or **charity care** among 340B hospitals relative to non-340B hospitals and no evidence of improved quality of care for low-income patients. To expand on this analysis, our study assessed 1) whether the **340B Program** expanded in socioeconomically advantaged versus disadvantaged communities, 2) whether 340B hospitals increased unprofitable, high-need services in socioeconomically disadvantaged communities**;** and 3) whether the **340B Program** expanded via **child sites** in socioeconomically advantaged versus disadvantaged communities. Specifically, it considered how services changed at **public hospitals** (government owned and operated hospitals, see more detailed definition on page 6) and **nonprofit hospitals** (privately owned hospitals) after participating in the **340B Program,** using a statistical analysis (difference-in-differences approach). The study found:

Finding #1: The 340B Program Expanded in Socioeconomically Advantaged and Moderately Advantaged Communities

- Between 2015 and 2024, the number of U.S. counties with 340B hospitals increased by 29%, with the number of hospitals participating in the **340B Program** increasing by 35%.
- This growth was primarily due to the expansion in **nonprofit hospitals**. 64% of counties where **nonprofit hospitals** began participating in the **340B Program** during the study period (i.e., counties with no 340B **nonprofit hospital** prior to 2015) were socioeconomically advantaged and moderately advantaged counties based on the Centers for Disease Control and Prevention's **Social Vulnerability Index** (an index measuring a community's vulnerability to stresses on health).
- Conversely, 54% of counties where **public hospitals** began participating in the **340B Program** during the study period were socioeconomically disadvantaged counties.

Finding #2: After 340B Participation, Only 340B Public Hospitals Expanded Unprofitable Care

- For **nonprofit hospitals**, 340B participation was not associated with offering more **unprofitable services** that are typically not adequately reimbursed, such as mental health care or obstetrics.
- For **public hospitals**, 340B participation was associated with offering additional **unprofitable services** (an 8% higher likelihood of offering psychiatric care).

Finding #3: The 340B Program Expanded Through Child Sites in Socioeconomically Advantaged and Moderately Advantaged Communities

- 69% of U.S. counties with **child sites** affiliated with hospitals that joined the **340B Program** between 2015 and 2024 were classified as socioeconomically advantaged and moderately advantaged counties, as measured on the **Social Vulnerability Index**.

The results of the study suggest that as currently structured, **nonprofit hospitals** are not using the **340B Program** to increase **unprofitable services**. These results support the following policy recommendations:

1) **Increase the level of transparency in the 340B Program.**
2) **HRSA should collect and publish governmental contracts to provide care for low-income patients that are a requirement for 340B eligibility for nonprofit hospitals.**
3) **Reevaluate 340B eligibility requirements to ensure 340B hospitals serve the needs of low-income patients.**

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About the Author

The Health Equity Collaborative (HEC) is a diverse community comprised of dozens of national, public health, patient advocacy, and multicultural organizations that are committed to supporting equity and combating disparities experienced by underserved populations. HEC is a project of MANA Action, a 501c4 not-for-profit organization.

Charles River Associates (CRA) assisted in the data analysis and drafting of this paper on behalf of the Health Equity Collaborative.

Introduction

The **340B Drug Pricing Program** (**340B Program**) was designed to support **safety-net health care facilities** that serve a greater volume of low-income and uninsured patients.[1] The **340B Program** allows participating hospitals and clinics, called **covered entities**, to purchase outpatient medicines at discounts that average 53.4% off the drug's **wholesale acquisition cost** (**WAC**) and then charge insurers the full price, retaining the difference. [2]

Some 340B **covered entities** play a crucial role as a safety net for millions of people in the U.S. with low incomes and complex health care needs.[3] Many operate in rural areas and treat vulnerable populations, such as children or older individuals, often offering free or discounted care and prescription drugs to qualifying patients.[4] However, in recent years, the **340B Program** has been expanding into higher-income areas, with more than half of all hospitals now participating in the **340B Program**.[5] The problem is that the **340B Program** generates the most funding for **covered entities** that prioritize wealthier, **commercially insured** patient populations. Consider a **covered entity** where 15% of patients are low-income and uninsured and for whom the entity receives little to no drug reimbursement, while the remaining 85% of patients are **commercially insured** and for whom the entity receives full commercial insurance reimbursement. The **covered entity** retains money on the difference for 85% of its patients. Conversely, a **covered entity** in a low-income area, where most patients are uninsured, likely retains far less. As a result, 340B **covered entities** have a financial incentive to provide care to patients with commercial insurance. For hospitals, this incentive often leads to them acquiring outpatient clinics, called "**child sites**" that are affiliated with a covered "parent entity," in wealthy areas.[6]

The **340B Program** does not require **covered entities** to report how much revenue they generate or how they spend 340B generated funds. Despite being characterized as a safety net program, the reality is the **340B Program** does not incentivize hospitals to provide outpatient care to low-income patient care.[7] In fact, studies have found no higher rate of **uncompensated care** among 340B hospitals compared to non-340B hospitals, with some finding that 340B hospitals spend proportionately less on **charity care** than non-340B hospitals.[8] Studies also find no improvement in the quality of care for low-income patients associated with the **340B Program**.[9]

The literature finds that **nonprofit hospitals**, representing the vast majority of 340B hospitals (71% of all hospitals participating in the **340B Program**), do not expand their provision of **unprofitable services** after participating in the **340B Program.**[10] Services with low reimbursement rates, such as mental health or substance abuse care, are identified as unprofitable in the literature.[11] **Nonprofit hospitals** have also received increasing governmental scrutiny over their eligibility and their drug spending under the

340B Program. For example, the Government Accountability Office (GAO) has raised concerns that **HRSA** is not providing enough oversight of **nonprofit hospitals** to ensure they meet the 340B eligibility requirements.[12]

An important question is whether **covered entities** in the **340B Program** have realigned their behavior with the original intent of the **340B Program**, or whether they have continued to use it to generate funds for **covered entities** as opposed to increasing care for low-income patients, reinforcing the need for significant reform.

This study builds on the methodology in Owsley (2024) and uses more recent data to assess 1) whether the **340B Program** expanded in socioeconomically advantaged versus disadvantaged communities; 2) whether 340B hospitals increased unprofitable, high-need services in socioeconomically disadvantaged communities**;** and 3) whether the **340B Program** expanded via **child sites** in socioeconomically advantaged versus disadvantaged communities. Specifically, this study considered how services changed for **public hospitals** (28% of all hospitals in the **340B Program**) and **nonprofit hospitals** (71% of all hospitals in the **340B Program**) after 340B participation.

This study concludes with policy recommendations for retargeting the **340B Program** toward low-income patients. More details on the methodology can be found in the **Methodology Appendix**. **Box 1** describes the key definitions used in this report.

What is a Public Hospital versus a Nonprofit Hospital?[13]

Public Hospitals

- **Owned and operated by government entities, including state, county, and city authorities.**
- **Often require approval from government entities to make major financial decisions.**
- **Financials are highly transparent to government officials.**

Nonprofit Hospitals

- **Privately owned hospitals that do not generate profit for their owners and reinvest revenue into capital expenditures (e.g., constructing new facilities), hospital operations, salaries, and patient care.**
- **Only require approval from their board to make financial major decisions.**
- **Financials are not as transparent to government officials as public hospitals.**

Types of Short-Term General Hospitals Analyzed in this Study[14]

Critical Access Hospital (CAH): A rural hospital designated by CMS to provide essential local care, meeting specific requirements on size, location, and services. CAHs do not have to meet a DSH threshold to be eligible for the 340B Program. In 2026, CAHs comprised 46% of hospitals in the 340B Program but only represented less than 2% of 340B sales to hospitals in 2024 due to their small size.

Disproportionate Share Hospital (DSH): A hospital that maintains a DSH adjustment percentage greater than 11.75% to qualify for the 340B Program. This percentage is based on a hospital's share of low-income Medicare and Medicaid inpatients. In 2026, DSH hospitals comprised 44% of hospitals in the 340B Program and 79% of 340B sales to hospitals in 2024.

Rural Referral Center (RRC): These hospitals can be in a rural or urban areas and are not required to treat rural patients. RRCs can qualify for 340B with a DSH adjustment percentage of at least 8% to qualify for the 340B Program. In 2026, RRC comprised 5% of hospitals in the 340B Program and 2% of 340B sales to hospitals in 2024.

Sole Community Hospital (SCH): A hospital that serves as the primary or only source of care in its geographic area, that must maintain a DSH adjustment percentage of 8% to qualify for the 340B Program. In 2026, SCH comprised 4% of hospitals in the 340B Program and less than 1% of 340B sales to hospitals in 2024.

Box 1: Key Definitions

340B Drug Pricing Program (340B Program): Federal program under Section 340B of the Public Health Service Act that since 1992 has required pharmaceutical manufacturers participating in Medicaid and Medicare Part B to provide outpatient drugs at significantly reduced prices to eligible health care organizations.[15]

Commercially Insured: Individuals who have health insurance through private, nongovernment sources, such as employer-sponsored or individually purchased plans. [16]

Public Hospitals: Hospitals owned and operated by government entities, including state, county, and city authorities. [17]

Nonprofit Hospitals: Privately owned hospitals that do not generate profit for their owners but reinvest surplus revenue into capital expenditures (e.g., constructing new facilities), hospital operations, staff salaries, and patient care. In order for these hospitals to be eligible for the 340B Program, they must meet other eligibility criteria and either have a contract with a state/local government to provide care to low-income residents who are ineligible for Medicare/Medicaid, or be formally granted governmental powers. [18]

Child Site: Off-site outpatient facilities that are affiliated with a covered entity and that can access 340B drug pricing when they are registered as a child site with HRSA.[19]

Safety-Net Health Care Facilities: Health care facilities that deliver a disproportionate share of care to low-income, uninsured, and underinsured populations. These providers typically include community health centers, public hospitals, and disproportionate share hospitals. [20]

Covered Entities: Health care organizations that are eligible to participate in the 340B Program, including certain federal grantees, federally qualified health centers, Ryan White HIV/AIDS Program providers, children's hospitals, critical access hospitals, and disproportionate share hospitals that meet eligibility thresholds. [21]

Wholesale Acquisition Cost (WAC): The manufacturer's list price for a drug sold to wholesalers or direct purchasers, excluding discounts, rebates, and other price concessions. [22]

Disproportionate Share Hospitals (DSH): For 340B eligibility, DSH hospitals must have a DSH percentage greater than 11.75%. The DSH percentage is the combination of two shares: 1) the share of inpatient hospital days that are for low-income Medicare patients relative to total Medicare inpatient days, and 2) the share of inpatient hospital days that are for patients covered only by Medicaid relative to total inpatient days. [23]

Uncompensated Care: Health care services provided for which no payment is received. Uncompensated care includes both charity care and bad medical debt. [24]

Charity Care: Health care services provided free of charge or at a reduced price to patients who meet a hospital's eligibility criteria for financial assistance. [25]

Unprofitable Services: Hospital services that typically operate at a financial loss due to low reimbursement rates. Examples include psychiatric care, burn care, and obstetrics. [26]

Health Resources and Services Administration (HRSA): An agency in the U.S. Department of Health and Human Services responsible for improving access to health care for uninsured or medically vulnerable individuals. HRSA administers the 340B Program through its Office of Pharmacy Affairs. [27]

Social Vulnerability Index (SVI): A composite index developed by the Centers for Disease Control and Prevention that measures a community's relative vulnerability to external stresses on human health, including poverty, lack of transportation, and housing instability. Higher SVI scores indicate greater vulnerability. **Socioeconomically disadvantaged communities** have a high vulnerability score on the SVI, and **socioeconomically advantaged communities** have a low vulnerability score. [28]

Summary of Findings

This analysis found the following evidence:

Finding #1:

Between 2015 and 2024, the number of U.S. counties with 340B hospitals grew by 430 (a 29% increase), with the number of hospitals participating in the **340B Program** growing by 691 (a 35% increase).

This growth was primarily due to the growth in the number of counties with **340B nonprofit hospitals.**

- The number of counties with 340B **nonprofit hospitals** increased by 33%, compared to only 21% for **public hospitals**.
- Notably, 64% of counties where **nonprofit hospitals** began participating in the **340B Program** during the study period (i.e., counties with no 340B **nonprofit hospital** prior to 2015) were socioeconomically advantaged and moderately advantaged counties as measured on the **Social Vulnerability Index**, which measures a community's relative vulnerability to stresses on human health, including poverty, lack of transportation, and housing instability.[i] Conversely, 54% of counties where **public hospitals** began participating in the **340B Program** during the study period were socioeconomically disadvantaged counties.

> These results indicate that 340B **nonprofit hospitals** are expanding in socioeconomically advantaged and moderately advantaged communities, potentially increasing their share of **commercially insured** patients and enabling them to generate additional funds from discounted drug prices under the **340B Program**.

Finding #2:

- For **public hospitals**, 340B participation was associated with offering more **unprofitable services** (an 8% higher likelihood of offering psychiatric care).
- For **nonprofit hospitals**, 340B participation was not associated with offering more **unprofitable services**.

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i A socioeconomically advantaged community is characterized by higher household incomes, higher educational attainment, and access to transportation, and a moderately advantaged community is characterized by intermediate income levels and educational attainment. Conversely, a socioeconomically disadvantaged community is characterized by lower household incomes and limited access to transportation (Centers for Disease Control and Prevention, "CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI)," May 14, 2024, https://stacks.cdc.gov/view/cdc/158998#:~:text=Title%20:%20CDC/ATSDR%20Social%20Vulnerability,Office%20of%20Innovation%20and%20Analytics).

Finding #3:

- 69% of U.S. counties with **child sites** affiliated with hospitals that joined the **340B Program** between 2015 and 2024 were classified as socioeconomically advantaged and moderately advantaged counties, as measured on the **Social Vulnerability Index**.

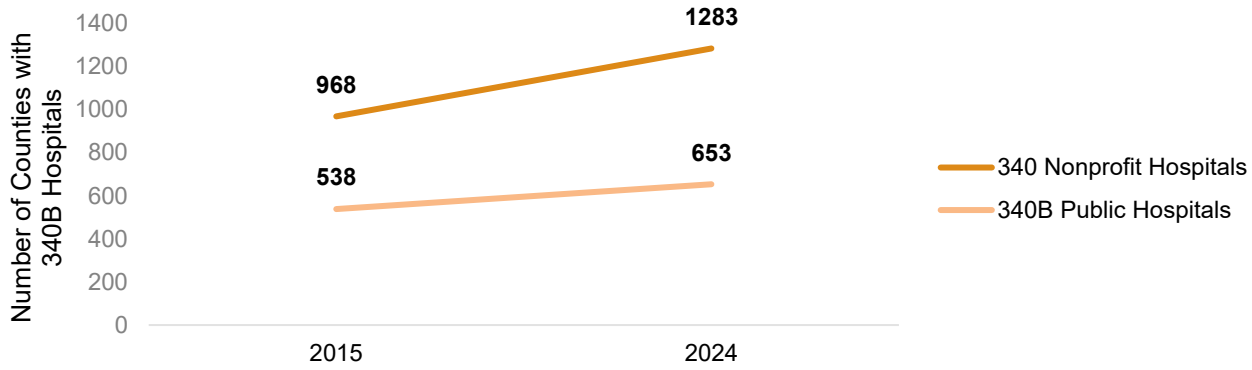
We describe the findings in more detail below.

Finding #1: The 340B Program Expanded in Socioeconomically Advantaged and Moderately Advantaged Communities

Between 2015 and 2024, the number of hospitals participating in the **340B Program** grew by 691, a 35% increase (from 1,991 to 2,682). As shown in **Figure 1**, between 2015 and 2024, the number of U.S. counties with 340B hospitals grew by 430, a 29% increase (from 1,506 to 1,936).

This growth was largely driven by **nonprofit hospitals**. The number of counties with 340B **nonprofit hospitals** increased by 33%, compared to only 21% for **public hospitals**. Similarly, the number of **nonprofit hospitals** participating in the **340B Program** grew by 40% (from 1,383 to 1,942), while the number of **public hospitals** participating in the **340B Program** only grew by 22% (from 608 to 740).

Figure 1: Number of Counties with 340B Hospitals by Hospital Ownership (2015–2024)



As shown in **Figure 2**, of the 315 counties where a **nonprofit hospital** first began participating in the **340B Program** during the study period (i.e., counties with no 340B **nonprofit hospital** prior to 2015), 64% of them were socioeconomically advantaged and moderately advantaged counties as measured on the **Social Vulnerability Index**. As shown in **Figure 3**, 340B **nonprofit hospitals** expanded into new counties at similar rates across all **Social Vulnerability Index** categories.

Figure 2: Number of Counties with Newly Participating 340B Nonprofit Hospitals (2024)

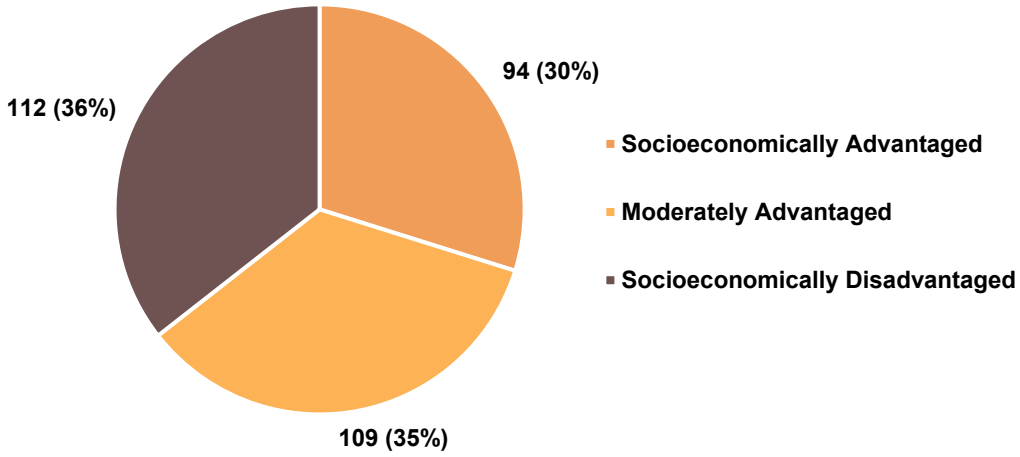
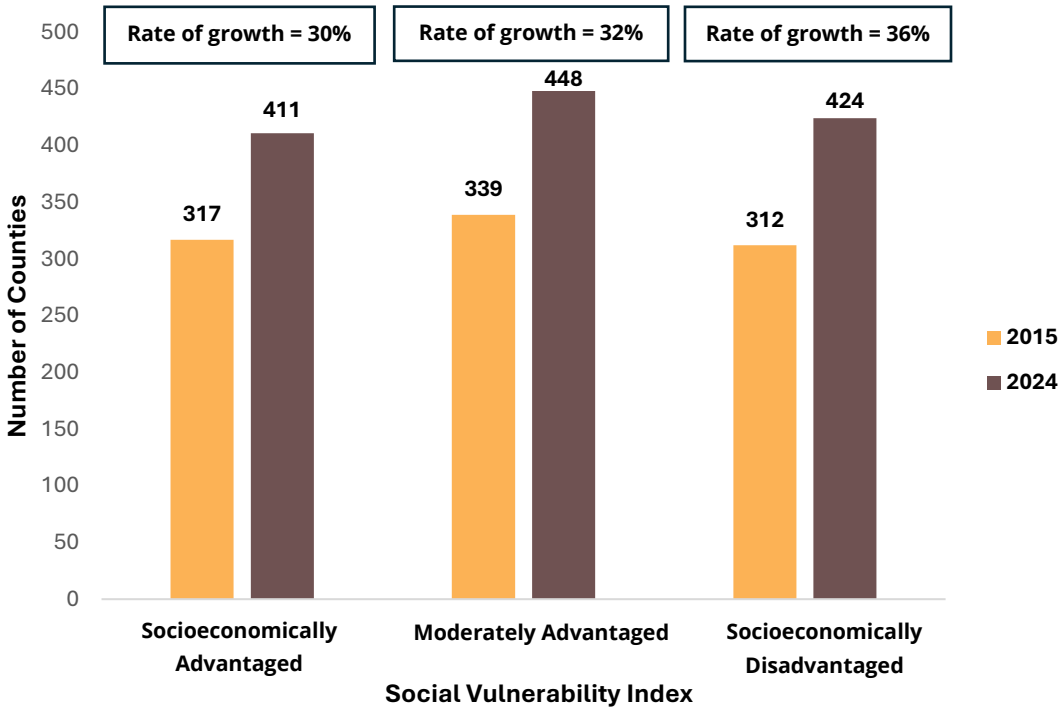


Figure 3: Growth in the Number of Counties with 340B Nonprofit Hospitals (2015–2024)



Conversely, as shown in **Figure 4**, of the 115 counties where a **public hospital** first began participating in the **340B Program** during the study period (i.e., counties with no 340B **public hospitals** prior to 2015), 54% of counties with 340B **public hospitals** were socioeconomically disadvantaged as measured on the **Social Vulnerability Index**. As

shown in **Figure 5**, the rate of growth for 340B **public hospitals** in socioeconomically disadvantaged counties was more than double the rate in socioeconomically advantaged counties.

Figure 4: Number of Counties with Newly Participating 340B Public Hospitals (2024)

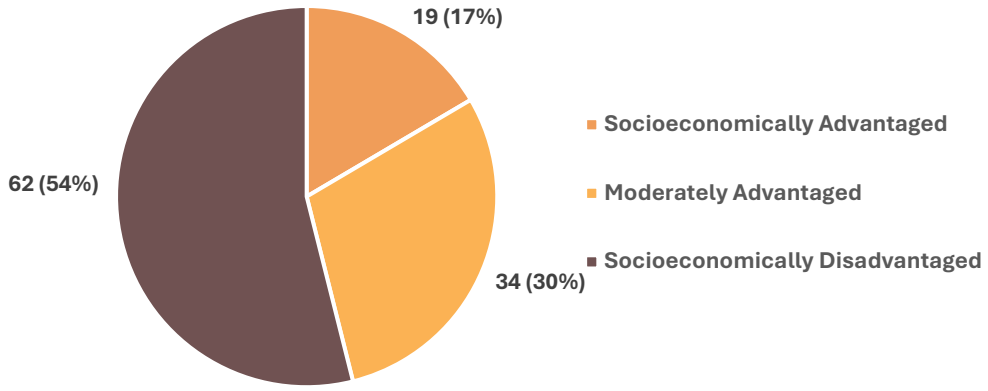
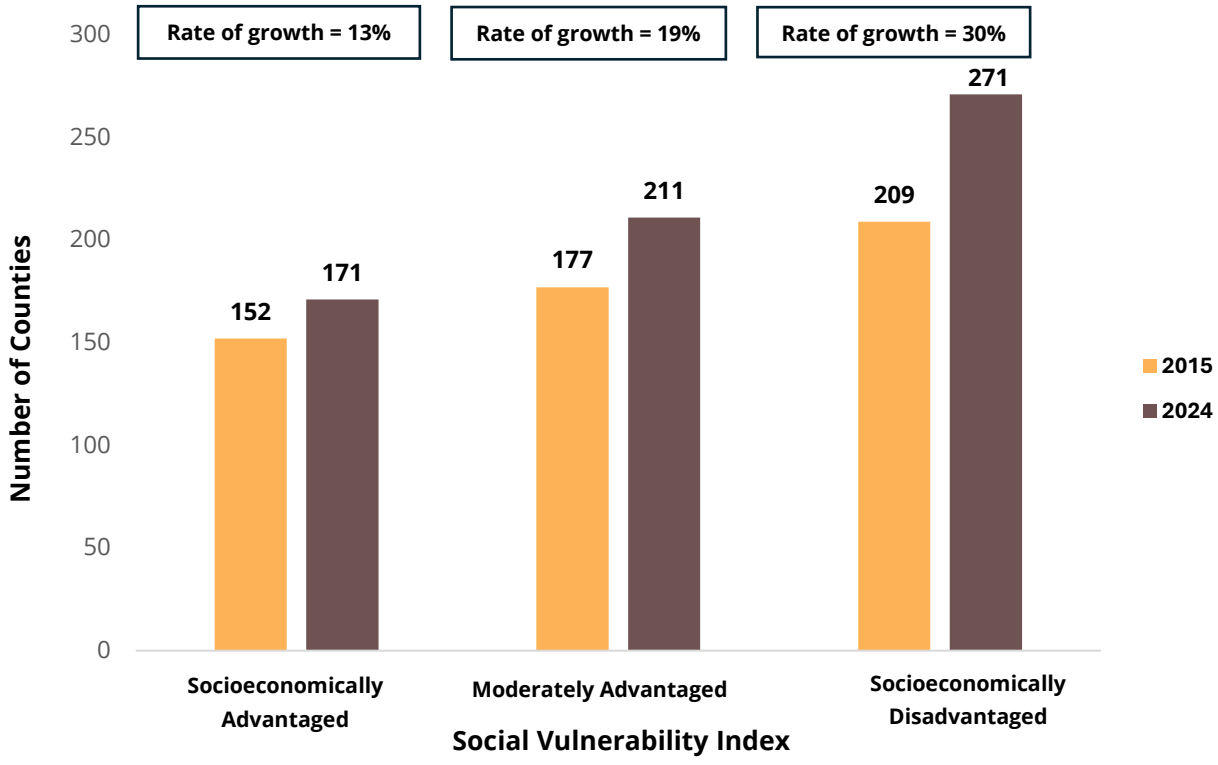


Figure 5: Growth in the Number of Counties with 340B Public Hospitals (2015–2024)



The **340B Program** was designed to increase access to care for low-income patients. As a result, we would expect the majority of counties with 340B hospitals to be designated as

socioeconomically disadvantaged, and we would expect that majority of the **340B Program's** expansion to occur in socioeconomically disadvantaged counties.

> The majority of counties with 340B **public hospitals** were socioeconomically disadvantaged counties and 340B **public hospitals** showed the highest rate of expansion in socioeconomically disadvantaged counties. Conversely, the majority of counties with 340B **nonprofit hospitals** were not socioeconomically disadvantaged, and 340B **nonprofit hospitals** showed nearly equivalent rates of expansion in socioeconomically advantaged, moderately advantaged, and disadvantaged counties.

These results show that 340B **nonprofit hospitals** are expanding in socioeconomically advantaged and moderately advantaged communities, which are likely to have a higher percentage of **commercially insured** patients compared to socioeconomically disadvantaged communities. Expansion into socioeconomically advantaged communities could allow 340B **nonprofit hospitals** to increase the number of **commercially insured** patients that they serve, which in turn could allow them to generate additional funds from the difference between a drug's discounted purchase price and standard reimbursement under the **340B Program**. Conversely, 340B **public hospitals** expanded in counties with a higher percentage of low-income patients relative to 340B **nonprofit hospitals**, likely increasing access to care for low-income patients in line with the original intent of the **340B Program**.

Finding #2: After 340B Participation, Only 340B Public Hospitals Expanded Unprofitable Care

As shown in **Table 1** below, 80% of the 340B hospitals in our study were **nonprofit hospitals** and only 20% were **public hospitals**. **Table 1** also shows that consistent with Owsley (2024), this study found that for **nonprofit hospitals**, 340B participation was not associated with an increase in **unprofitable services**. For **public hospitals**, 340B participation was associated with a statistically significant 8% increase in the likelihood of offering an **unprofitable service** (0.078, p = 0.06), outpatient psychiatric care. This result is striking when put in the context of the broader literature that finds that psychiatric services, given their low profitability, are particularly vulnerable to closures.[29]

The difference-in-differences[ii] results shown in **Table 1** are consistent with Owley (2024) and compare service availability in hospitals that began participating in the **340B Program** between 2017 and 2022 with those that had never participated in the **340B Program**.

Table 1: Difference-in-Differences Estimates of Service Provision by Hospital Ownership

	Difference-in-differences estimate (90% CI); P value	
Service	Public hospitals	Nonprofit hospitals
Hospitals, No.	224	883
Any unprofitable services	0.050 (-0.020 to 0.121); p = 0.24	-0.021 (-0.047 to 0.006); p = 0.19
Total unprofitable services	0.001 (-0.035 to 0.036); p = 0.98	-0.009 (-0.021 to 0.004); p = 0.26
Substance use	-0.027 (-0.087 to 0.033); p = 0.46	-0.004 (-0.016 to 0.008); p = 0.55
Inpatient psychiatric	-0.021 (-0.080 to 0.037); p = 0.55	-0.011 (-0.035 to 0.013); p = 0.45
Outpatient psychiatric	0.078† (0.009 to 0.146); p = 0.06	-0.020 (-0.057 to 0.016); p = 0.36
Burn care	-0.024 (-0.075 to 0.028); p = 0.45	-0.002 (-0.015 to 0.011); p = 0.80
Obstetrics	-0.031 (-0.082 to 0.020); p = 0.32	-0.002 (-0.020 to 0.017); p = 0.88

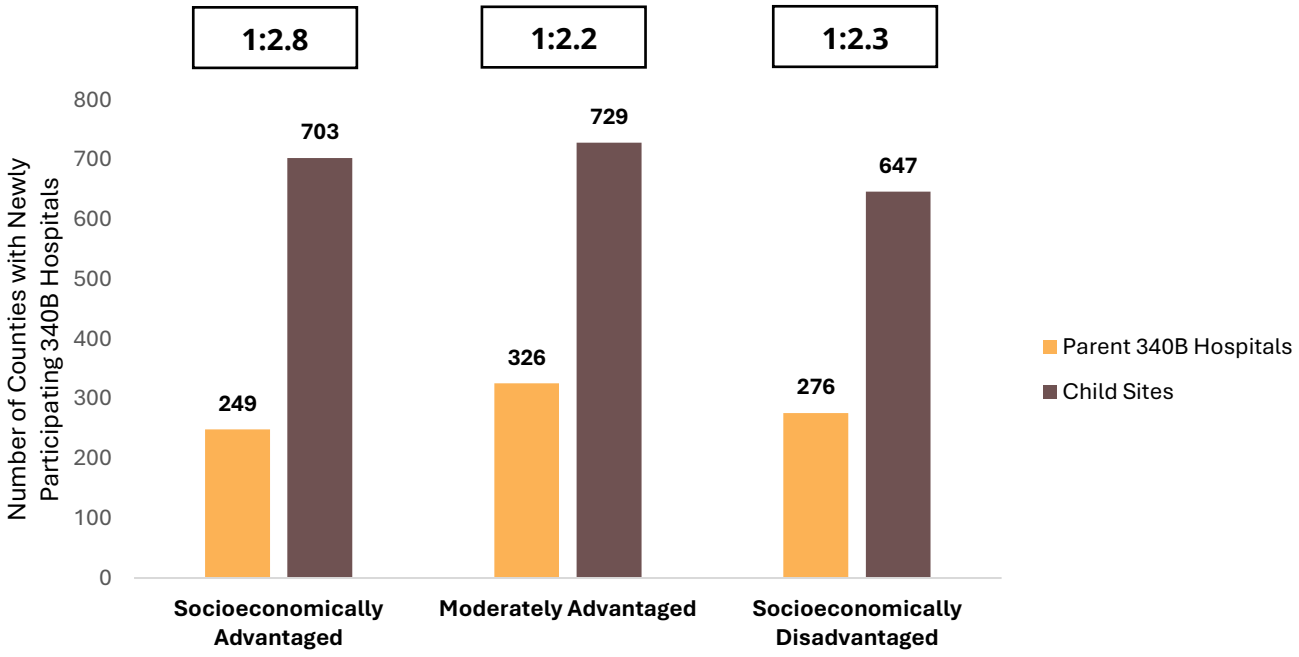
Note: † indicates $p < 0.10$ (two-sided).

ii A difference-in-differences test allows this analysis to compare service availability in short-term general hospitals that were highly similar except for participation in the **340B Program** starting in 2017. Under this approach, the only difference between the participating and non-participating hospitals should be 340B participation, allowing this analysis to directly assess the effect of 340B participation on hospital service availability.

Finding #3: The 340B Program Expanded Through Child Sites in Socioeconomically Advantaged and Moderately Advantaged Communities

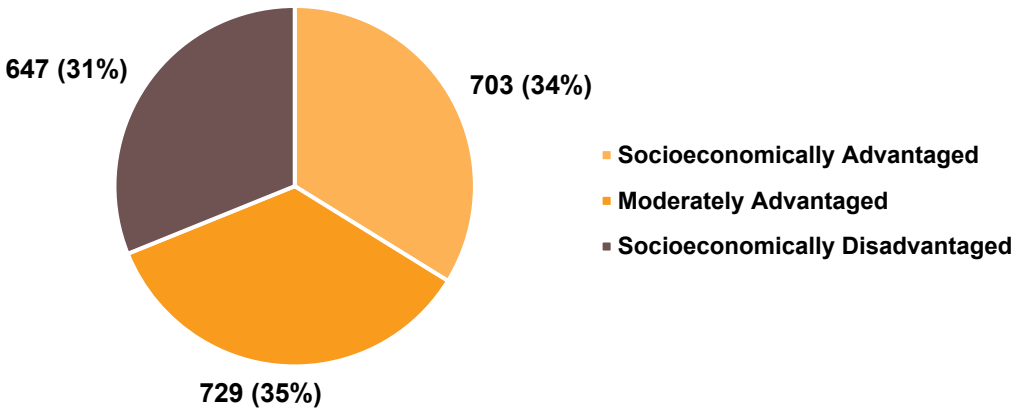
As shown in **Figure 6**, in socioeconomically advantaged counties with 340B **covered entities**, there were nearly three **child sites** affiliated with every one 340B hospital that joined the **340B Program** between 2015 and 2024. There were fewer child sites in socioeconomically disadvantaged areas, with just over two **child sites** affiliated with every one 340B hospital that joined the **340B Program** between 2015 and 2024.

Figure 6: Counties with Newly Participating 340B Hospitals and their Child Sites (2015–2024)



As shown in **Figure 7**, 69% of U.S. counties with **child sites** affiliated with hospitals that joined the **340B Program** between 2015 and 2024 were classified as socioeconomically advantaged and moderately advantaged, as measured by the **Social Vulnerability Index**.

Figure 7: Counties with Child Sites of Newly Participating 340B Hospitals (2015–2024)



Our results are consistent with the broader literature that 340B hospitals often purchase **child sites** that are located in more affluent communities.[30] Acquiring **child sites** in more affluent communities does not impact the parent hospital's eligibility for the **340B Program** (because eligibility is based on an inpatient metric) and does not increase access to care if the 340B parent hospital is only purchasing a preexisting **child site** as opposed to opening up a new outpatient care location.[31]

The literature indicates that the **340B Program** creates financial incentives to increase an entity's share of **commercially insured** patients, while still maintaining program eligibility, so that the entity can generate greater funds from the difference between a drug's discounted price and its standard reimbursement.[32] Therefore, it should not be surprising that 340B **nonprofit hospitals** tend to be located in socioeconomically advantaged and moderately advantaged counties with higher percentages of **commercially insured** patients rather than socioeconomically disadvantaged counties

Our analysis suggests that as currently structured, the **340B Program** creates financial incentives for 340B hospitals to increase care access for **commercially insured** patients residing in more socioeconomically advantaged counties while providing the minimum amount of inpatient care to low-income patients to maintain eligibility for the **340B Program**. This analysis suggests that 340B **nonprofit hospitals,** (71% of hospitals in the **340B Program** in 2026) may not be using the program as intended to expand care targeted at low-income patients.

Conclusion and Policy Recommendations

This study's findings indicate that 340B **nonprofit hospitals,** which account for 71% of 340B hospitals, are not increasing **unprofitable services** or expanding primarily in socioeconomically disadvantaged communities. Conversely, 340B **public hospitals** are increasing their **unprofitable services** in socioeconomically disadvantaged communities.

Public hospitals experience a greater degree of governmental oversight than **nonprofit hospitals**, especially when it comes to their financials,[33] which may partially explain why **public hospitals** are more likely to use the **340B Program** to increase access to an **unprofitable service**. [34]

> The results suggest that greater governmental scrutiny, or other policy changes, may be warranted, particularly for 340B **nonprofit hospitals** to facilitate a reallocation of financial resources more in line with the original intent of the **340B Program**. The findings suggest the following reforms:

1) **Increase the level of transparency in the 340B Program.**
    a. **Rationale** Policymakers and regulators should have greater visibility into the funds hospitals generate from the **340B Program**, so that they can compare a hospital's investment in **unprofitable services** and expansion into socioeconomically disadvantaged communities to the funds hospitals generate from the **340B Program**.

    Recommendations:

        i. **Covered entities** should be required to report on the funds they generate from the **340B Program**, net the acquisition cost of the medicines.

2) **HRSA should collect and publish governmental contracts to provide care for low-income patients that are a requirement for 340B eligibility for nonprofit hospitals.**
    a. **Rationale** Along with meeting other 340B eligibility criteria, 340B **nonprofit hospitals** must have a contract with a state or local government to provide health care services to low-income individuals who are ineligible for Medicare or Medicaid.[35] In 2019, the GAO called on **HRSA** to exercise greater oversight of these contracts to ensure 340B **nonprofit hospitals** meet 340B eligibility requirements and provide care to low-income patients.[36] Given this study's

findings that 340B **nonprofit hospitals** are not increasing **unprofitable services** and past research showing they do not provide more **uncompensated** or **charity care** relative to non-340B hospitals,[37] **HRSA** should 1) collect 340B **nonprofit hospitals'** governmental contracts, regardless of how long they have participated in the **340B Program**; and 2) publish these contracts. Collecting and publishing these contracts would provide more transparency for regulators over what services 340B **nonprofit hospitals** have committed to provide and better enable them to check whether 340B **nonprofit hospitals** are fulfilling their commitments.

Recommendations:

i. **HRSA** should collect and publish governmental contracts to provide care for low-income patients that are a requirement for 340B eligibility for **nonprofit hospitals**.

3) Reevaluate 340B eligibility requirements to ensure 340B hospitals serve the needs of low-income patients.

a. **Rationale:** This study found that **nonprofit hospitals** did not increase the **unprofitable services** they offered and expanded in socioeconomically advantaged and moderately advantaged counties.

b. **Recommendations:**

i. More targeted eligibility standards for **covered entities** would help ensure that they serve the safety-net populations they were originally intended to serve, including reform efforts targeted at **DSH hospitals**. Based on this analysis, the **DSH** eligibility threshold should be abandoned in favor of a more holistic review of a hospital's activity, including the amount of **charity care** they provide and financial losses associated with providing care to Medicaid patients,[38] to exclude **nonprofit hospitals** that are not using the **340B Program** to benefit disadvantaged communities.

Methodology Appendix

Leveraging the methodology of Owsley (2024), this study used a difference-in-differences analysis from 2015 to 2023 to assess how the availability of **unprofitable services** changed after 340B participation.

This study used the following data sources: **Health Resources and Services Administration** (**HRSA**) Office of Pharmacy Affairs Information System (OPAIS) to identify 340B **covered entities**; Centers for Medicare & Medicaid Services (CMS) Hospital Cost Report Information System and Provider of Services files to obtain additional hospital characteristics including **DSH** percentage and status as a short-term general hospital; proprietary hospital data to obtain hospital service availability; American Community Survey and U.S. Centers for Disease Control and Prevention Wide-Ranging Online Data for the **Social Vulnerability Index**.

The difference-in-differences analysis compared service availability in short-term general hospitals that began participating in the **340B Program** between 2017 and 2022 with those that had never participated in the **340B Program**. Using **HRSA** OPAIS and proprietary hospital data, our sample included 883 **nonprofit** and 224 **public** short-term, general, and acute care U.S. hospitals not participating in the **340B Program** before 2017 and were still participating in the **340B Program** by 2023. The analysis controlled for variations in county-level characteristics such as the **Social Vulnerability Index**, median income, percentage of uninsured individuals, percentage of minority-identifying individuals, and the percentage of individuals over age 65. The analysis also controlled for hospital-level characteristics such as the number of admissions, status as a teaching hospital, multihospital system membership, and Critical Access Hospital designation.

The model's dependent variable measured whether hospitals expanded **unprofitable services** after 340B participation. Using the approach of Horwitz and Nichols 2009, 2022[39] to identify **unprofitable services**, this study included burn clinics, inpatient psychiatric, outpatient psychiatric, and obstetric services as **unprofitable services**.

For the **child site** analysis, this study used data from the **HRSA** 340B Office of Pharmacy Affairs Information System (OPAIS) to identify 340B **child sites** associated with hospitals that initiated participation in the **340B Program** between 2015 and 2024. All hospitals and

their affiliated **child sites** with participation at any point from 2015 through May 2026 were included in the analysis, without excluding entities that subsequently terminated participation. **Child site** locations were mapped to counties using the 2025 Q4 U.S. Department of Housing and Urban Development ZIP code–to–county crosswalk,[iii] and county-level socioeconomic status was assessed using the **Social Vulnerability Index**, calculated as the mean of available values from 2014, 2016, 2018, and 2022 at the Federal Information Processing Standards ("FIPS") code level. Counties were then categorized as socioeconomically advantaged, moderately advantaged, or socioeconomically disadvantaged based on **Social Vulnerability Index** values.

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