HOW 340B DISPROPORTIONATE SHARE HOSPITALS (DSH) ARE FAILING TO REINVEST IN PATIENT CARE

ISSUE BRIEF

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EXECUTIVE SUMMARY

- The 340B program has grown exponentially, with 149 disproportionate share hospitals (DSHs) participating in 2004, jumping to 992 participating in 2023 (Figure 1). In total, DSHs accounted for more than 75% of total 340B purchases in 2023 (Figure 2).[ii] Yet there is little evidence of commensurate growth in benefit to vulnerable populations.
- Our analysis suggests that the additional dollars from the program were not used to increase rates of uncompensated care[a], increase spending on additional patient services, or employ more full-time employees (FTEs) to treat patients at 340B DSHs.
- Rather than improving and investing in efforts directly related to patient care, 340B DSH entities doubled the amount of dollars directed towards their financial portfolios and investments (e.g., stocks, bonds, and other financial instruments) on a per bed basis after enrolling in the 340B program.

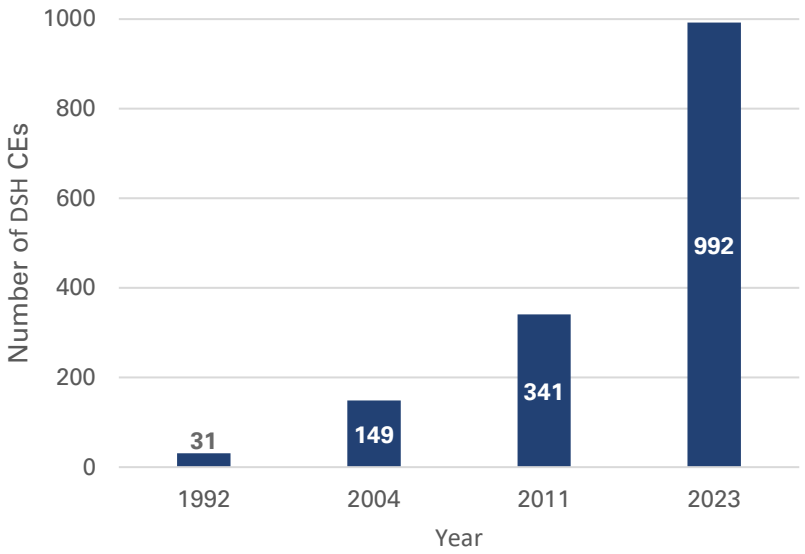
340B Introduction and Context

Since 1992, Section 340B of the Public Health Services Act has required manufacturers to provide discounted pricing to qualifying covered entities (CEs) for outpatient drugs. In 2021, CEs paid an average of 59% less for 340B medicines than the drug's list price.[iii] CEs can then charge patients and insurers the full list price, or much more, when dispensing the medicine, and keep the difference. 340B was originally targeted for a small number of federal grantees and hospitals serving a significant number of low-income, uninsured, and under-insured patients.[iv]

At 340B inception, there were 31 DSHs.[v] However, the number of hospitals that qualify as 340B CEs has dramatically increased due to numerous factors, including the Affordable Care Act's (ACA) expansion of eligible covered entity types and broader Medicaid eligibility. In 2023, over 2,521 hospitals (including 992 DSHs), were active in the program (Figure 1).

340B has become one of the largest federal drug purchasing programs and continues to grow each year.[vi] 340B purchases now comprise more than 18% of US outpatient drug sales, growing from $500M in 2004 to $2.4B in 2011, to over $66B in 2023.[vii,viii,ix] 340B DSHs accounted for more than 75% of 340B purchases in 2023 (Figure 2).

Figure 1. DSH CEs Exploded Between 1992 and 2023



[a] "Uncompensated care" includes bad debt, uninsured care, and charity care (i.e., health services for which hospital policies determine the patient is unable to pay).

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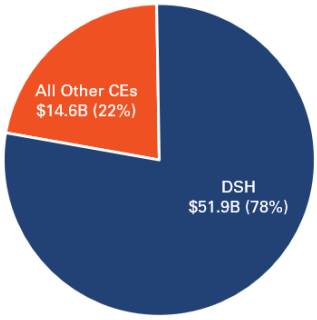
Intent vs Reality: Are 340B DSHs Using 340B Funds as Intended?

Figure 2. Purchases at 340B Prices Exceeded $66 Billion in 2023

Total 2023 340B Purchases = $66.5B

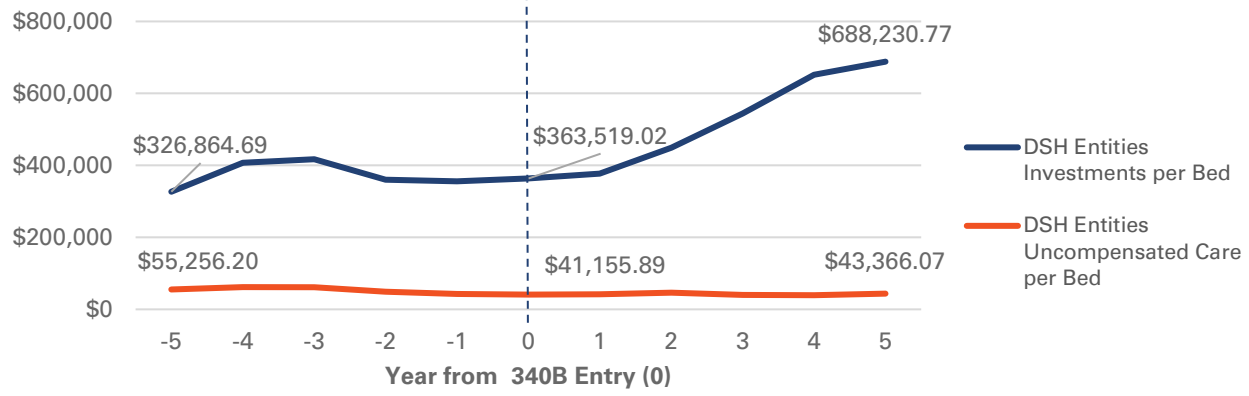


Unlike other federal drug programs, 340B effectively requires a transfer of funds in the form of mandated discounted prices from manufacturers to CEs with lax and overly broad guidance regarding various aspects of the program. There are many ways 340B hospitals could utilize revenue for the improvement of patient care, including free discharge medications, patient navigation and adherence programs, and patient financial support. In 2021, a 340B Health survey of hospitals self-reported that 88% of respondents indicated that 340B revenue was used to support uncompensated/non-reimbursed care, while 82% claimed 340B revenue went to provide access to care for low income and/or rural patients.[x] However, without clear reporting or transparency requirements, it is impossible to know exactly how DSH entities are using their 340B revenue.

Magnolia assessed available data to estimate how 340B DSHs are utilizing revenue generated from the program, looking specifically at the 73 DSHs that entered the 340B program in 2016 or 2017. Our findings suggest that:

- **340B DSHs in our study increased financial investments following 340B enrollment.** In the first 5 years following 340B enrollment for DSHs, overall financial investments per bed increased by 89% (Figure 3). Financial investments refer to stocks, bonds, and other financial instruments. By dividing reported financial investment growth by estimated program revenue, we find the equivalent of one-third of every 340B dollar is being directed toward bolstering 340B DSHs financial portfolios.
- **During this same period, uncompensated care, already a fraction of the financial investments value, actually decreased.** DSHs entering the 340B program between 2016 and 2017 reduced spending on uncompensated care per bed by 22%; uncompensated care includes charity care, uninsured care, and bad debt relief (Figure 3). This suggests that hospitals are not only failing to direct revenue into uncompensated care, but also that profit generated from their growing financial investments does not lead to an increase in uncompensated care.

Figure 3. Average Financial Investment and Uncompensated Care per Bed Pre- & Post-340B Entry



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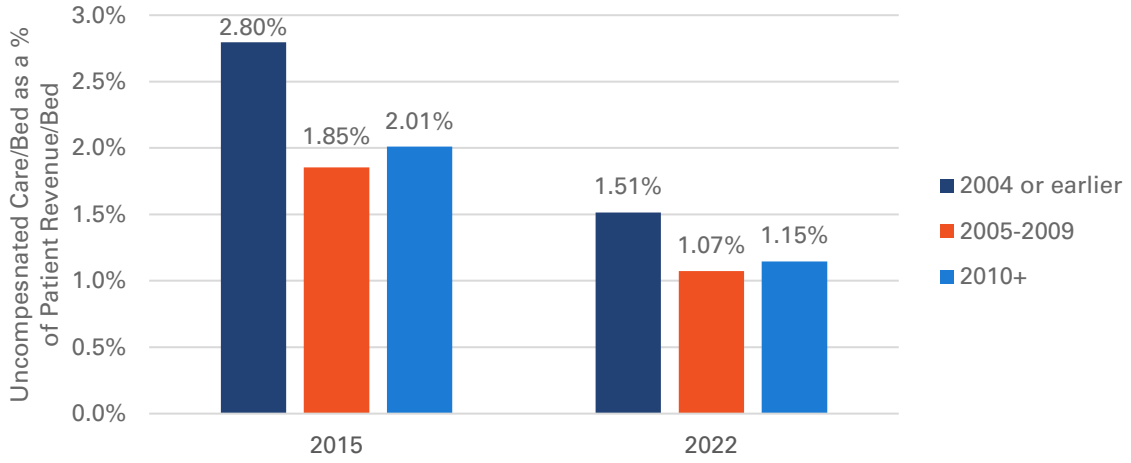
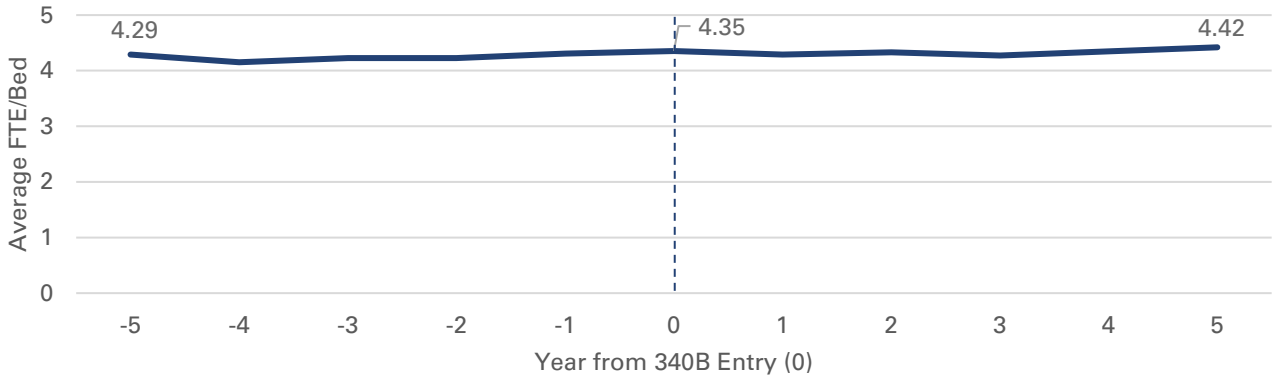
- **DSHs that qualified for 340B prior to 2005 provide higher levels of uncompensated care per bed than those that joined the program later** (Figure 4). This suggests that more recent 340B entrants may not be acting as true safety net hospitals committed to the vulnerable patients the program was created to serve.
- **All 340B DSHs, regardless of when they enrolled in the 340B program, have decreased spending on uncompensated care since 2015, and appear to be shifting their 340B funds away from direct patient care services.** While 340B DSH entities that joined 340B before 2005 have had the most significant decrease in uncompensated care spending, they still spend more per bed than hospitals that joined later (Figure 4).

Figure 4. While 340B DSH Entities Enrolled in 340B Before 2005 Spend More in Uncompensated Care per Bed, All Have Decreased Spending Over Time



- **340B DSHs did not appear to use their increased revenue from 340B or their increased financial investment portfolios to grow the number of full-time employees (FTEs) per bed.** The number of FTEs per bed at 340B DSHs who entered the program between 2016 and 2017 remained relatively stagnant, ranging from 4.2 to 4.4 pre- and post-enrollment. Using this as a proxy for spending on patient care, it appears 340B DSHs, in addition to reducing uncompensated care, are failing to increase spending on current care provided (Figure 5).

Figure 5. Average FTE per Bed Pre/Post-340B Entry is Stagnant for DSH Entities Entering 340B between 2016 and 2017



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Conclusion and Policy Implications

Despite 340B generating significant revenue for participating DSHs, these hospitals do not appear to be using funds from the program to increase support for those who need it most. Instead, the data shows that following entry into the 340B program, 340B DSHs increased their financial investments with no clear direct patient benefit. Congress and HRSA should reconsider the rules governing the 340B program to ensure that 340B revenue is being used appropriately.

In the current health care landscape, 340B revenue is primarily used to build DSHs financial portfolios, rather than improve patient care. Policies should require 340B DSHs to be true safety net hospitals and to reinvest 340B funds directly into patient care.

Methodology

340B Office of Pharmacy Affairs Information System (OPAIS) – Covered Entities database and National Academy for State Health Policy (NASHP) Hospital Cost Tool (HCT) of Medicare Cost Reports data was used to identify 340B CEs, assess hospital characteristics including investments, hospital assets, FTEs, uncompensated care, and charity care by hospital bed. To assess how hospital characteristics change after becoming a 340B entity, hospitals entering 340B between 2016 and 2017 with 11 years of cost report data (index year +/- 5 years pre/post) were included. To determine how hospital characteristics differ by time of entry into the 340B program, 340B hospitals with 9 years of cost report data between 2014 and 2022 were identified, and grouped by entry in 2004 or earlier, 2005-2009, and 2010 or later.

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[i] https://www.340bhealth.org/files/Dobson_Final_Report_February_2025.pdf
[ii] 2023 340B Covered Entity Purchases | HRSA
[iii] BRG (Bates White, LLC). *340B Program at a Glance - 2022*. Published December 2022. https://media.thinkbrg.com/wp-content/uploads/2022/12/06082105/340B-Program-at-a-Glance-2022_clean.pdf
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[vi] Blalock E. Measuring the relative size of the 340B program. May 2024. https://media.thinkbrg.com/wp-content/uploads/2024/05/13163125/340BProgram_Relative_Size_WP_2022Update.pdf
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[x] https://www.340bhealth.org/files/340B_Health_Survey_Report_2021_FINAL.pdf

COMMUNITY ACTION FOR RESPONSIBLE HOSPITALS

This analysis and issue brief were made possible through support from Community Action for Responsible Hospitals (CARH).