

Analysis of 340B Program Impact on Rural Hospitals

Prepared for The National Grange
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Contents

- 01** Background & Project Overview
- 02** Analysis Findings
- 03** Appendix: Background on 340B

Executive Summary

The National Grange partnered with Avalere Health to examine the impact of the 340B program on rural hospitals



Project objectives:

- With 340B reforms being proposed and other state and federal policies impacting rural healthcare providers in the coming years, Avalere Health supported The National Grange in examining the **impact of the 340B program on rural hospitals and the patients they serve.**
- The analysis will help support The National Grange's 340B **reform priorities and advocacy.**



Project approach: The analysis answers key questions such as:

- What percentage of **340B hospitals are in rural areas**, and what types of facilities are they?
- How does the **payer mix** (i.e., payer type) and **patient demographics** differ between rural and non-rural 340B hospitals?
- What is the **comparative utilization of 340B drugs** under Medicare Part B in rural versus non-rural hospital settings (based on hospital location)?
- How do **financial metrics**, such as revenue, costs, margin, uncompensated care, and 340B status differ between rural and non-rural providers?

Methodology

Avalere Health identified short-term acute care hospitals and critical access hospitals and assigned 340B status and 340B hospital type (DSH, RRC, CAH, SCH) based on OPAIS data, and rural/urban status based on hospital ZIP code using the USDA RUCA codes.

Avalere Health used the following data sources to understand various characteristics of 340B and non 340B hospitals:

- OPAIS, 340B hospitals active at any point between 2019-2023
- Medicare FFS claims (2019-2023)
- Medicare Advantage Encounter Data (2019-2023)
- Hospital Cost Report Data (2019-2023)

See appendix (slide 30) for further detail on the data sources used for each research question, and hospital characteristics and other variables included in the analysis.



Avalere Health’s analysis illustrates the unique characteristics of rural 340B hospitals

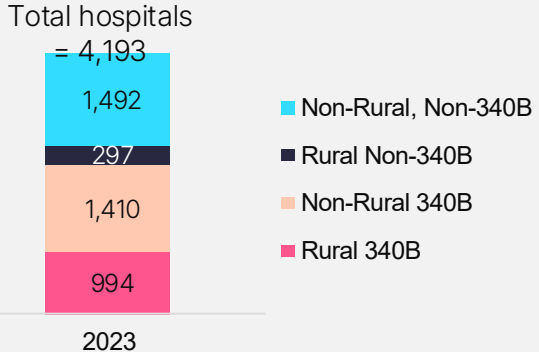
The 340B program is a key source of revenue for thousands of hospitals in the US.

- Of the over 4,000 hospitals in the US, the majority (57%) participated in the 340B program in 2023. Of all hospitals participating in the 340B program in 2023, 41% were rural hospitals.

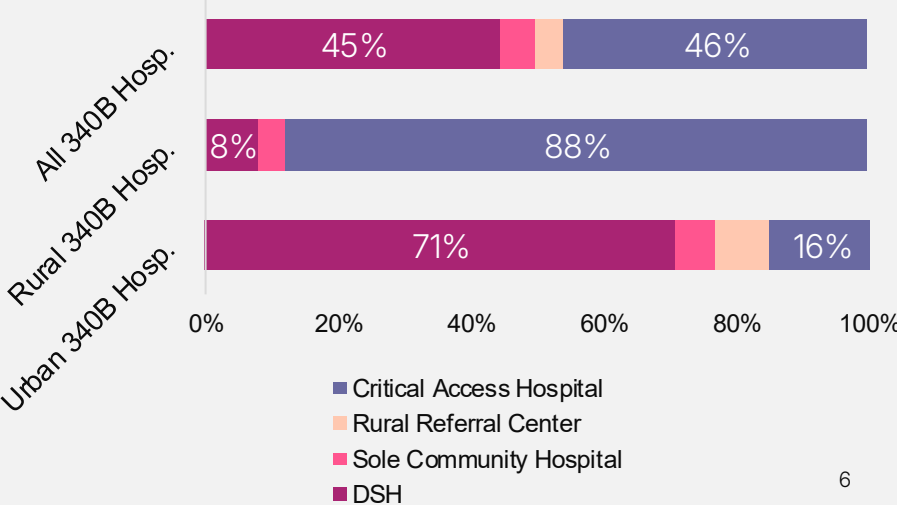
Rural 340B hospitals are more likely to be critical access hospital (CAH) and are more likely to offer skilled nursing services

- In 2023, among rural 340B hospitals, most hospitals (88%) were critical access hospitals, compared to just 16% of urban 340B hospitals.
- To qualify as a critical access hospital, a hospital must meet certain criteria, including:
 - ✓ Located in a rural area
 - ✓ Located over 15-35 miles from the nearest hospital
 - ✓ Have fewer than 25 inpatient beds
 - ✓ Provide 24/7 emergency services
- Rural 340B hospitals were more likely to offer certain long-term services in addition to acute care, such as skilled nursing facility swing beds.
- Rural 340B hospitals (compared to non-rural 340B hospitals) are more likely to serve rural, older, and dual-eligible patients.

340B and Rural/Non-Rural Status Across All Hospitals in the US, 2023



Share of 340B Hospitals by 340B Entity Status and Location Status, 2023



A DSH: Disproportionate Share Hospital
 Note: Bar graph results less than or equal to 5% not labeled

Rural 340B hospitals differ from their non-rural counterparts, highlighting the critical role of the program to offset costs

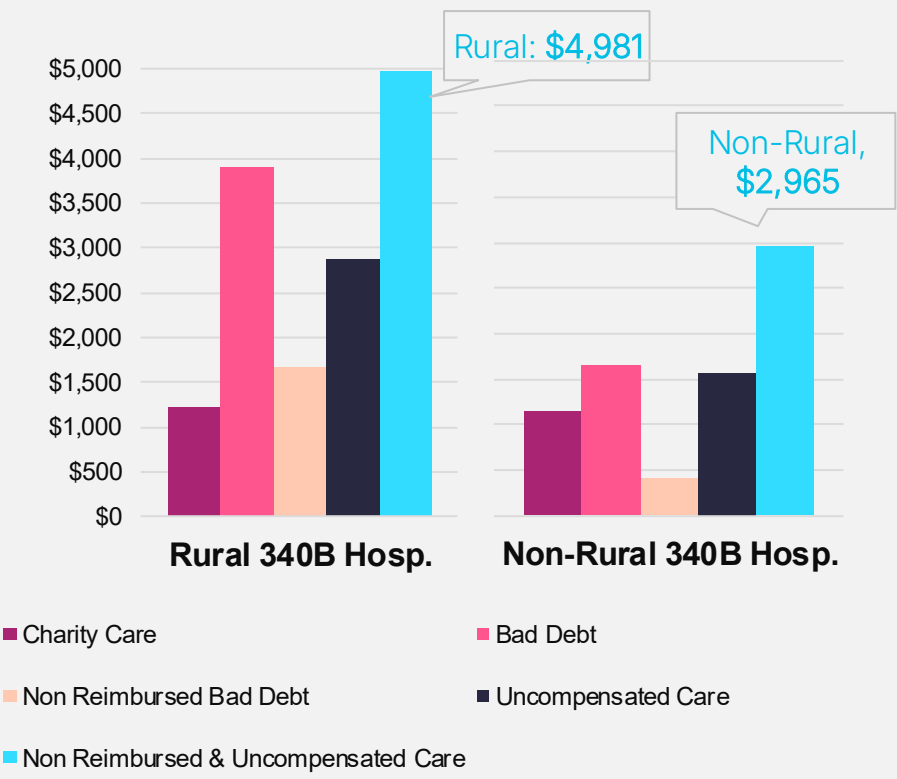
Rural 340B hospitals have notably higher non-reimbursed and uncompensated care metrics compared to non-rural 340B hospitals

- Average Charity Care, Bad Debt, and Uncompensated Care per discharge were higher in rural compared to non-rural 340B hospitals.
 - **Non-reimbursed & Uncompensated Care per discharge** in rural 340B hospitals (**\$4,981**) was **almost twice** the amount of that in non-rural 340B hospitals (**\$2,965**).
 - Rural 340B hospital **Bad Debt per discharge** (**\$3,902**) was **over twice** as high than non-rural hospitals (**\$1,650**).
 - Rural 340B hospital **Non-reimbursed Bad Debt** (**\$1,656**) per discharge was **over four times higher** than non-rural (**\$406**).
- The cost-to-charge ratio of rural 340B hospitals was nearly double that of non-rural 340B hospitals (in 2023, 59% in rural 340B hospitals, compared to 29% in non-rural 340B hospitals), indicating lower mark-ups (charges) and relatively higher facility costs and other fixed costs.

340B hospitals generate savings though a relatively small percentage of total hospital claims

- Based on Medicare claims data, 340B drug claims make up a small share (3% in 2023) of all claims for rural hospitals, but almost three quarters (75% in 2023) of drug payments, showing that 340B entities use the program to subsidize and generate savings for high-cost drugs.

Average Charity, Bad Debt, and Uncompensated Care Per Discharge, by Hospital Location and Year (\$M), 2023



A Note: [HRSA](#) defines CAH eligibility as: A private nonprofit hospital under contract with state or local government to provide health care services to low-income individuals who are not eligible for Medicare or Medicaid; Owned or operated by a unit of state or local government; A public or private nonprofit corporation that is formally granted governmental powers by a unit of state or local government

Rural hospitals use the 340B program to offset costs and serve the unique needs of rural communities

- Participation in the 340B program increased year-over-year from 2019-2023, among both rural and non-rural hospitals. Of over 4,000 hospitals in the US, over half participate in the 340B program.
 - The majority of rural 340B hospitals are CAHs (88% in 2023), while the majority of non-rural 340B hospitals are DSH (71% in 2023), indicating significantly different hospital dynamics (size, patient mix, etc.).
- Rural hospitals participating in 340B treat a different patient mix and face different financial pressures compared to non-rural hospitals.
 - Rural hospitals treat an older, more rural patient population; Medicare makes up a larger proportion of hospital discharges.
 - Rural hospitals face higher facility costs, more uncompensated care and bad debt, and lower operating margins than non-rural hospitals.
- While 340B drug claims make up a small proportion of total drug claims, they represent 70-80% of drug costs, indicating that both rural and non-rural 340B participants use the 340B program to subsidize high-cost drugs.
 - The average 340B drug claim among rural hospitals in 2023 was \$2,278, compared to an average drug claim (of all drug claims including non-340B drugs) of \$746.
 - Rural 340B hospital drug claims make up under 3% of the total volume of all hospital 340B drug claims from 2019 through 2023. In 2023, rural hospitals had 128,043 340B drug claims, compared to over 4.5 million non-rural hospital 340B drug claims.



340B Program Background

The 340B program plays a key role in supporting safety-net and rural providers



Program Overview

The 340B Drug Pricing Program is a federal program that requires manufacturers to provide prescription drugs at significant discounts to eligible providers (known as “covered entities”). The aim of the program is to help safety-net providers stretch limited resources, using savings to provide services to underserved populations.



Program Eligibility

Covered entities include non-profit healthcare organizations that receive federal funding or have certain federal designations. For hospitals, eligibility is contingent upon the populations served:

- For most hospitals (excluding CAHs), 340B eligibility is determined by a hospital-specific DSH percentage, capturing the share of inpatients that are Medicaid beneficiaries and low-income Medicare patients (*see slide 6*).
- In addition to meeting a certain DSH percentage threshold, a hospital must be owned or operated by a unit of state or local government; public, non-profit corporation; or private, non-profit corporation with state/local contracts to service indigent/low-income populations.
- Once the entity is eligible, hospitals may access 340B pricing for their patients, regardless of the patient's insurance status.

Avalere Health partnered with The National Grange to examine the impact of the 340B program on access to care and the viability of hospitals in rural areas.

340B eligibility requirements vary by hospital type



Types of 340B Covered Entities

6 types of hospitals may be considered 340B covered entities:

- Disproportionate Share Hospitals
- Critical Access Hospitals
- Rural Referral Centers
- Sole Community Hospitals
- Free Standing Cancer Hospitals*
- Children's Hospitals*

There are additional non-hospital covered entities:

- Black Lung Clinics
- Comprehensive Hemophilia Treatment Centers
- Federally Qualified Health Centers
- Federally Qualified Health Center Look-Alikes
- Ryan White HIV/AIDS Program Grantees
- Sexually Transmitted Disease Clinics
- Tribal & Urban Indian Health Centers
- Title X Family Planning Clinics
- Tuberculosis Clinics




340B eligibility is measured by a hospital-specific DSH percentage for most hospitals

DSH Percentage

For most hospitals (except critical access hospitals), 340B eligibility is measured by a hospital-specific DSH percentage that reflects the inpatient percentage of Medicaid patients as well as low-income Medicare patients. Specifically, the DSH percentage equals the sum of two ratios that reflect two groups of patients who are low-income but insured:

$$\text{DSH \%} = \frac{\text{Medicare SSI Inpatient Days}}{\text{Total Medicare Inpatient Days}} + \frac{\text{Medicaid, Non-Medicare Inpatient Days}}{\text{Total Inpatient Days}}$$

Under this formula, the growth of the Medicaid population can make it easier for some hospitals to qualify; a decrease in the Medicaid population has the potential to make it more difficult to reach thresholds.

 DSH percentage is used to quantify a hospital's status as a safety-net provider, but some have called the applicability of this metric into question. In particular, the use of inpatient population demographics may differ from the outpatient population (for whom the 340B program applies).

The 340B program plays a key role in supporting safety-net and rural providers



Eligible 340B hospitals purchase drugs at significantly discounted prices, approximately 25%-50% below standard prices.



Hospitals are required to meet certain criteria in order to qualify for the 340B program (e.g., CAHs are required to be non-profit, Sole Community Hospitals and RRCs must have a DSH of >8%)



Rural hospitals operate on minimal financial margins and treat high-need patient populations.

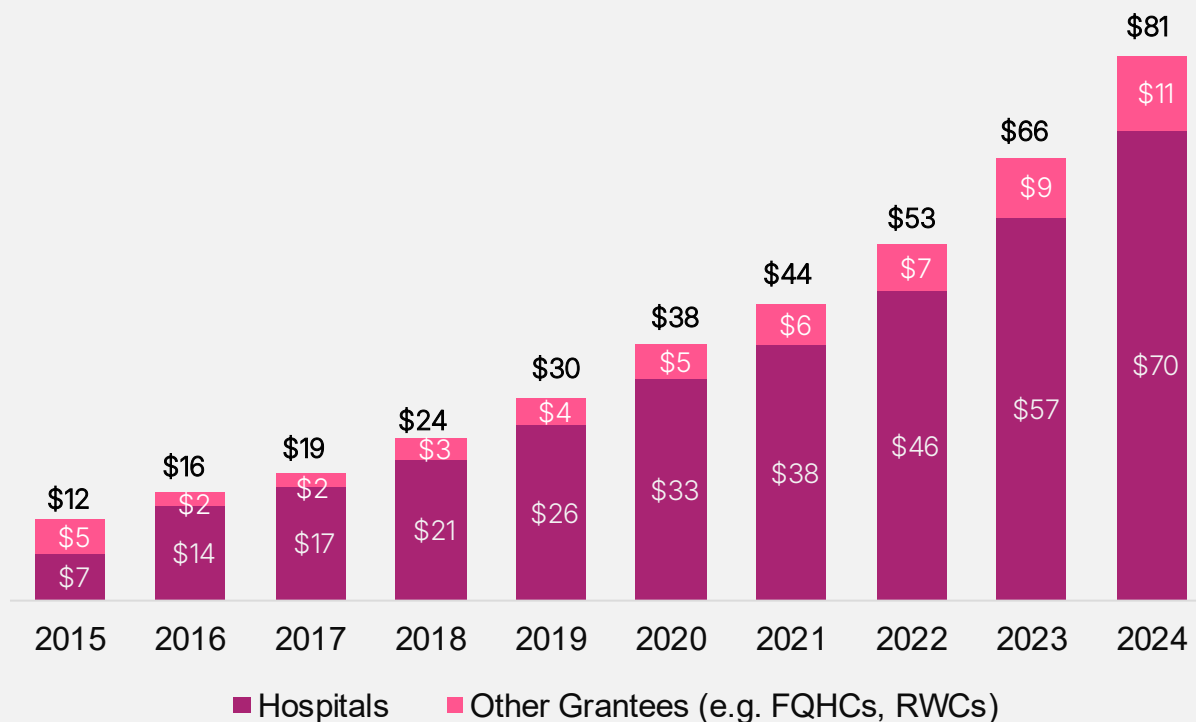


340B savings can be used by rural hospitals to help reduce out-of-pocket medication costs, expand charity care, and offer a variety of services.

The July 2025 One Big Beautiful Bill Act (OBBBA) is projected to reduce Medicaid funding by over \$1 trillion, placing additional financial pressure on rural hospitals.

The 340B program has grown substantially over the last decade, primarily driven by growth in hospital program funding

Figure 1: 340B Drug Sales from 2015-2024 (Billions)



Trends in the 340B program

- A September 2025 CBO report on the 340B program found that the annual spending on 340B drugs increased from **\$6.6B in 2010** to **\$43.9B in 2021**, an average annual growth rate of 19%.
- **Oncology drugs** accounted for **41% of 340B drug spending**, followed by anti-infective drugs at 15% and immunosuppressants at 14%.
- 340B program growth may **negatively impact** rural hospitals due to **additional program scrutiny** and potential reforms to the program (e.g., cuts to 340B funding, increased administrative burden from additional reporting requirements).

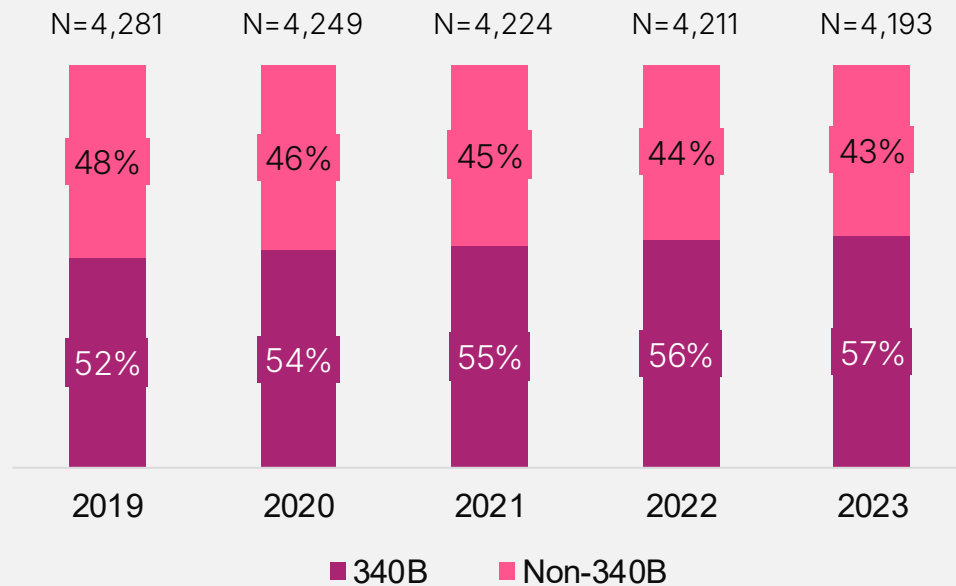


Analysis Findings

Of over 4,000 hospitals in the US, over half participate in the 340B program

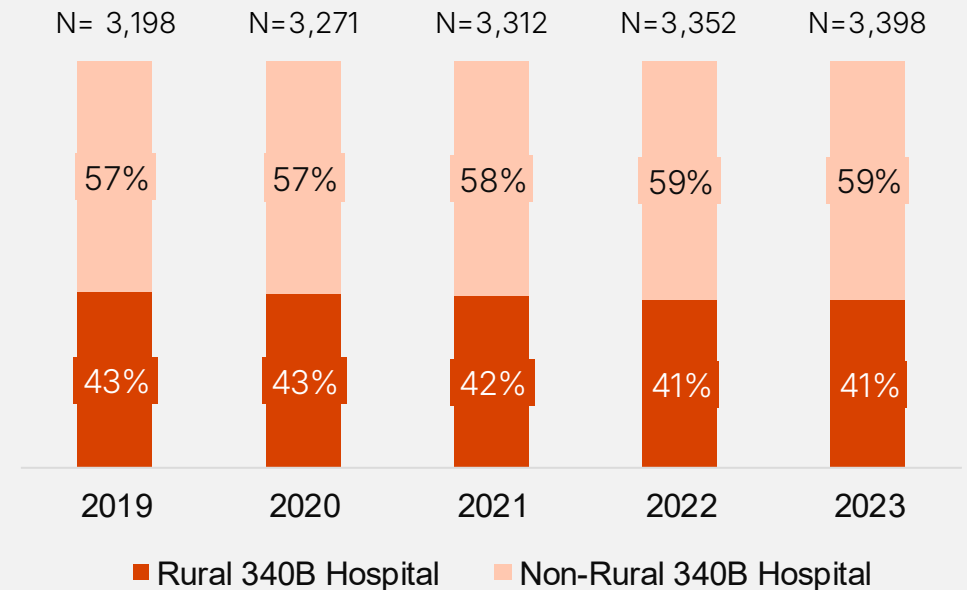
The share of 340B participation among hospitals has steadily increased from 52% of all hospitals in 2019 to 57% of all hospitals in 2023.

Share of 340B Hospitals of All Hospitals, 2019-2023



Of all hospitals participating in the 340B program, about 41% are rural hospitals, a slight decrease from 2019 (43%).

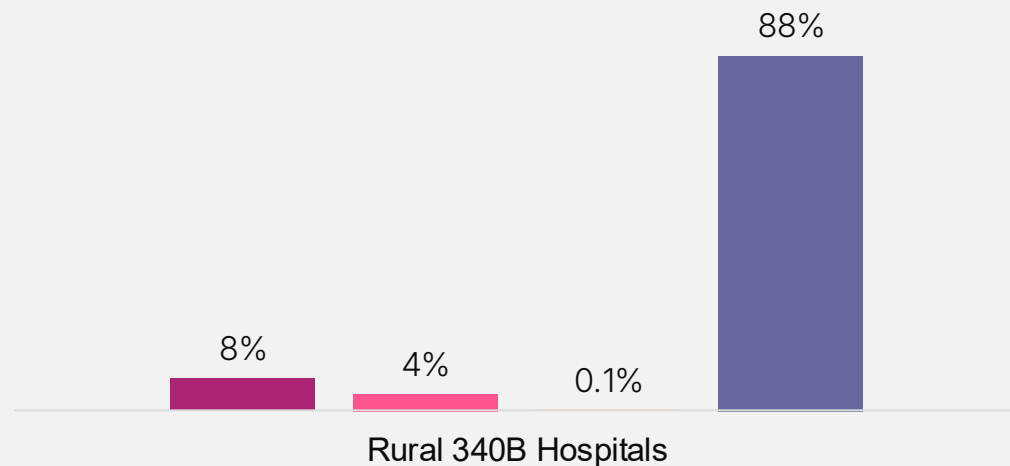
Share of Rural vs. Non-Rural 340B Hospitals, 2019-2023



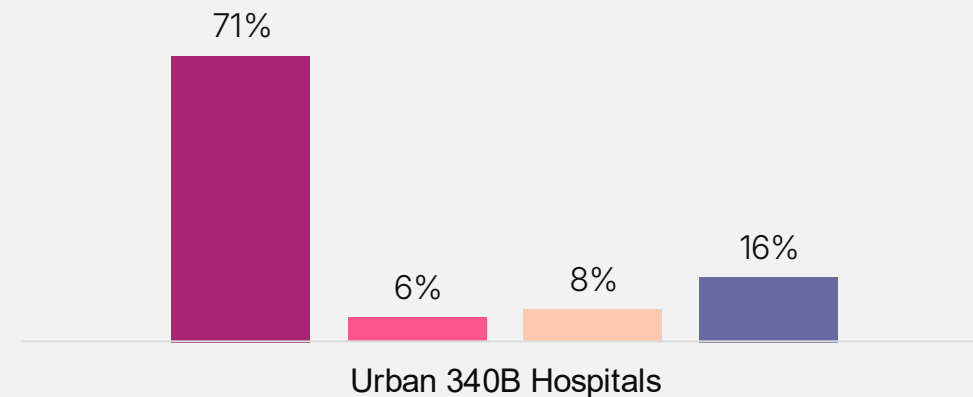
In 2023, most rural 340B hospitals were critical access hospitals, while most urban 340B hospitals were DSH hospitals

The share of types of 340B covered entities varied based on urban or rural status. In 2023, among rural 340B hospitals, most hospitals (88%) were CAH, compared to just 16% of rural 340B hospitals. Disproportionate Share Hospitals (DSH) made up 8% of rural 340B hospitals, compared to 71% of urban 340B hospitals.

Share of Rural Hospitals by 340B Status, 2023



Share of Urban Hospitals by 340B Status, 2023



- DSH
- Sole Community Hospital
- Rural Referral Center
- Critical Access Hospital

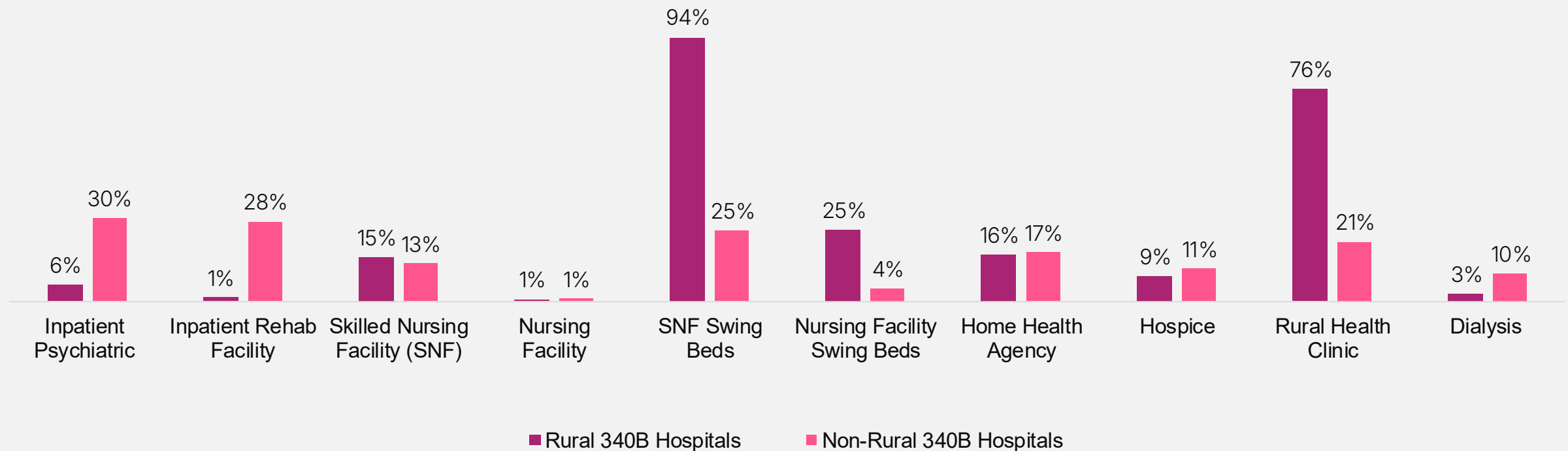
In 2023, <1% of 340B rural hospitals were rural referral centers. Despite being located in an urban ZIP code, urban hospitals may reclassify as "rural referral centers" based on other hospital characteristics in order to gain 340B status.



Rural 340B hospitals service offerings differed, in aggregate, from non-rural 340B hospital offerings

Rural 340B hospitals were more likely to offer nursing facility and skilled nursing facility swing beds and rural health clinics, and less likely to offer inpatient psychiatric and inpatient rehab, compared to non-rural 340B hospitals.

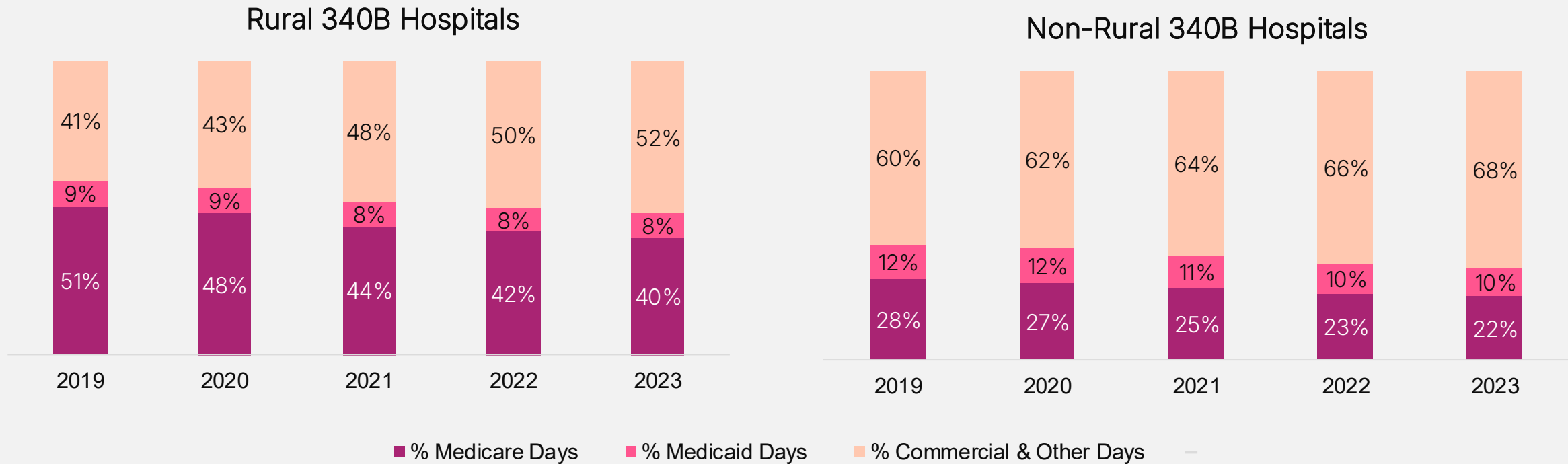
Percent of 340B Hospital Service Offerings by Rural vs. Non-rural Status, 2023



Rural 340B hospitals had a higher share of Medicare-beneficiary patient days compared to non-rural hospitals

Across all 340B hospitals, the share of commercial payer patient-days increased from 2019 through 2023, while the share of Medicaid and Medicare payer patient-days decreased over the same period in both groups.

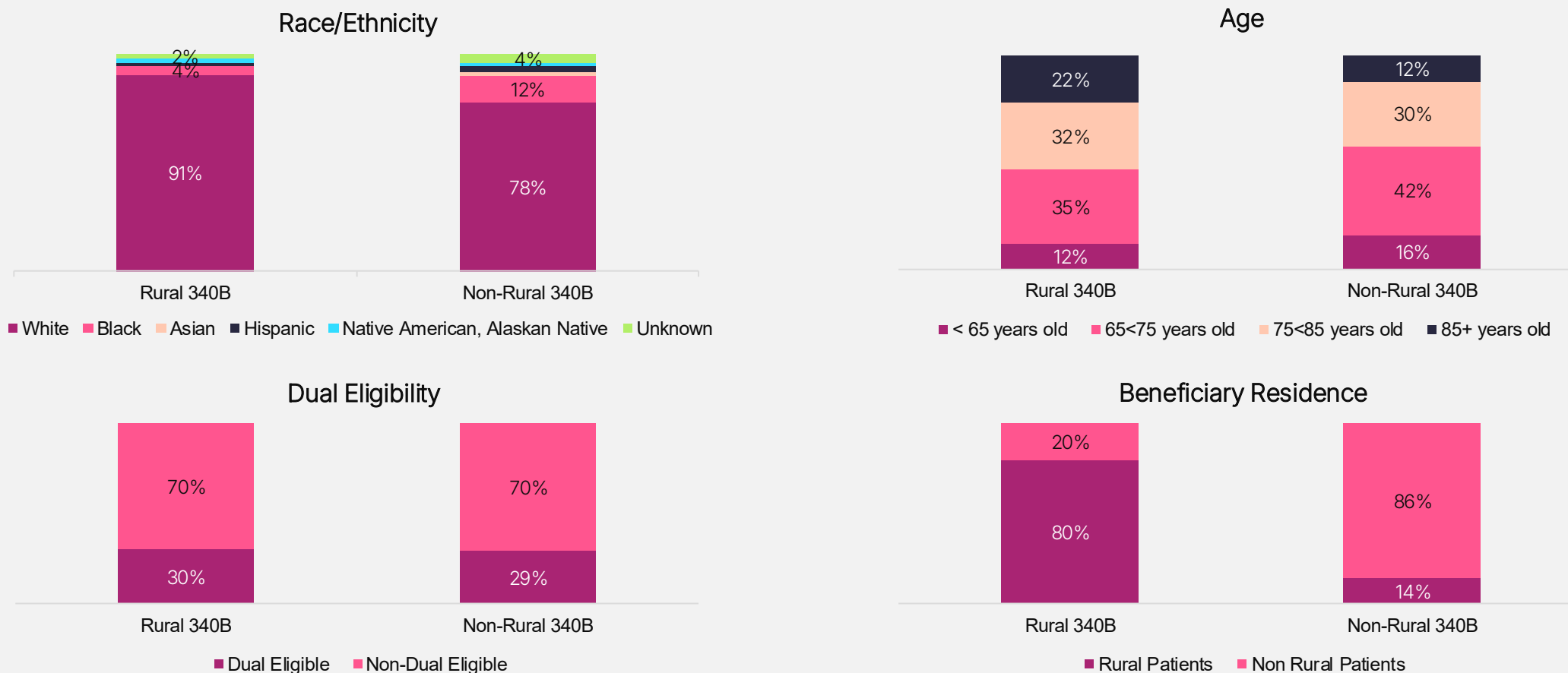
Share of Hospital Patient-days by Payer Type (Commercial, Medicare, Medicaid), 2019-2023



80% of the patients treated by rural 340B hospitals reside in a rural area, non rural 340B hospitals treat only 14% rural residents

Rural 340B hospitals also treat a larger proportion of White beneficiaries compared to non-rural 340B hospitals; beneficiary characteristics are similar for age, dual eligibility and gender. Across all CE types, rural hospitals serve more rural beneficiaries compared to urban hospitals.

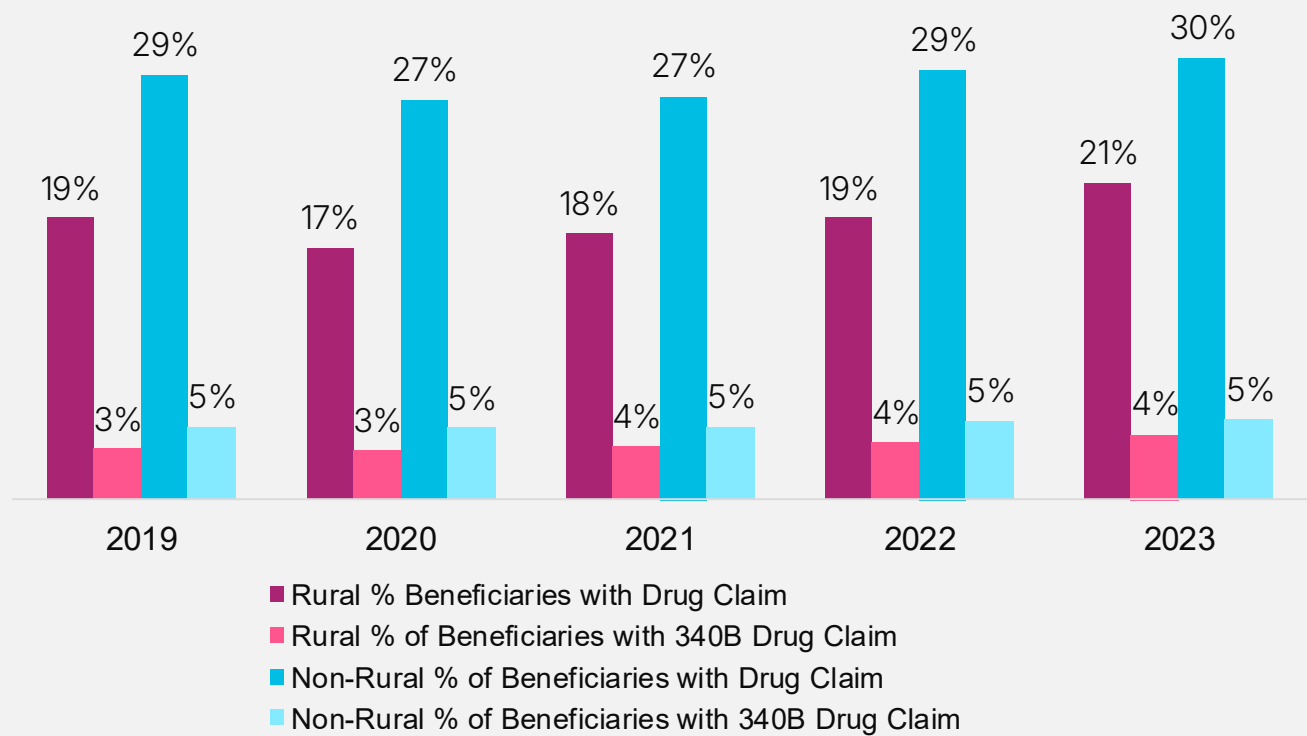
Medicare Beneficiary Demographics by 340B Hospital Location, 2023



Source: Medicare Claims and Encounter Data

Among rural and non-rural hospital Medicare claims, 340B drug claims make up a small share (3% to 5%) of all claims

Share of Medicare Beneficiaries by Claim Type, 2019-2023

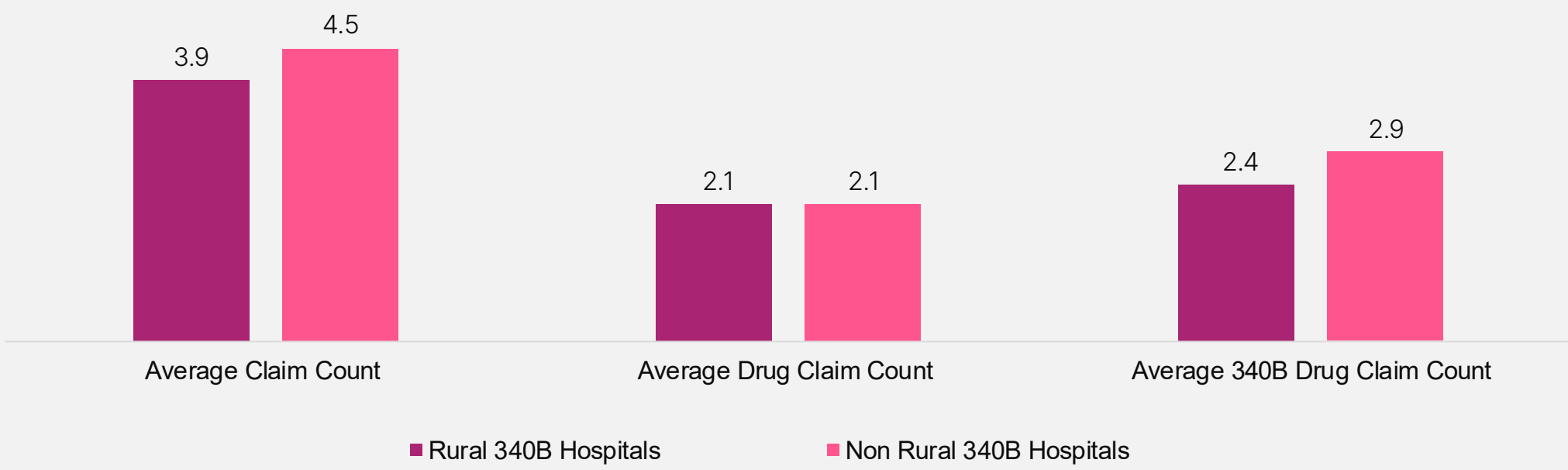


- Across the years studied, of all Medicare claims per hospital, a smaller share of rural hospital claims were drug claims compared to non-rural claims
- In addition, a smaller share of rural hospital claims were 340B drug claims compared to non-rural 340B drug claims
- The share of drug claims and 340B drug claims increased as a share of all Medicare claims from 2020 through 2023 for all hospital types

Rural hospitals had a lower number of Medicare claims per beneficiary, on average, compared to non-rural hospitals

This difference may reflect the varied service offerings and comparatively smaller size of rural hospitals compared to non-rural hospitals. Additionally, differences in the number of 340B drug claims may be a result of 340B child sites billing through the outpatient hospital.

Average Medicare Claim Count (Any Claim, Drug Claim, or 340B Drug Claim) per Beneficiary by Rural and Non-rural Hospital Status, 2023



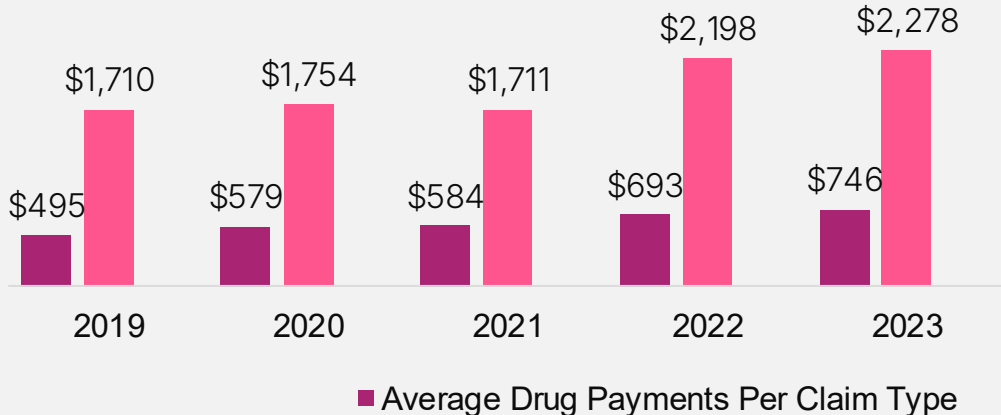
Source: Medicare Claims and Encounter Data

Average Medicare payments for 340B drug claims were approximately 3x that of all drug claims

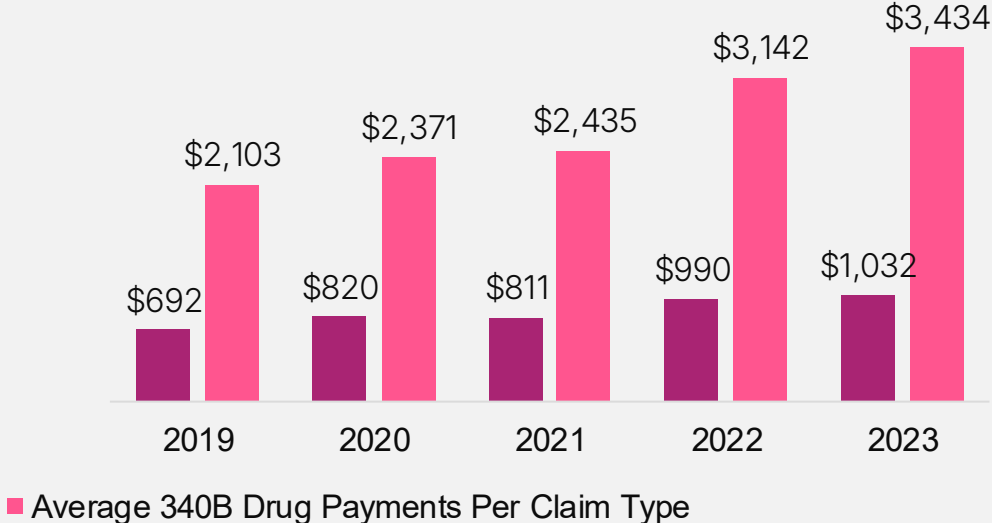
These results indicate that 340B hospitals, in rural and non rural settings, use the 340B program to subsidize the cost of more expensive drugs. On a per claim basis, non-rural 340B hospitals have higher Medicare payments per drug claim compared to rural 340B hospitals.

Once differences in number of claims per beneficiary are factored, average 340B drug payments per beneficiary among non-rural 340B hospitals are nearly double that of rural 340B hospitals.

Average Medicare Payments Per Claim Type, Rural 340B Hospitals



Average Medicare Payments Per Claim Type, Non-rural 340B Hospitals



Source: Medicare FFS Claims and Encounter Data

340B drug payments made up a significant amount of total drug payments in both rural and non-rural 340B hospitals

Average Share of Medicare Payments by Claim Type, Hospital Location and Year

Rural 340B Hospitals

| Year | Drug Payments as % of Total Payments | 340B Drug Payments as % of Total Payments | 340B Drug Payments as % of Total Drug Payments |
|------|--------------------------------------|---|--|
| 2019 | 7% | 5% | 74% |
| 2020 | 7% | 5% | 72% |
| 2021 | 7% | 5% | 69% |
| 2022 | 9% | 7% | 75% |
| 2023 | 10% | 8% | 75% |

Non-Rural 340B Hospitals

| Year | Drug Payments as % of Total Payments | 340B Drug Payments as % of Total Payments | 340B Drug Payments as % of Total Drug Payments |
|------|--------------------------------------|---|--|
| 2019 | 9% | 6% | 70% |
| 2020 | 10% | 7% | 72% |
| 2021 | 10% | 7% | 74% |
| 2022 | 12% | 10% | 79% |
| 2023 | 13% | 11% | 81% |

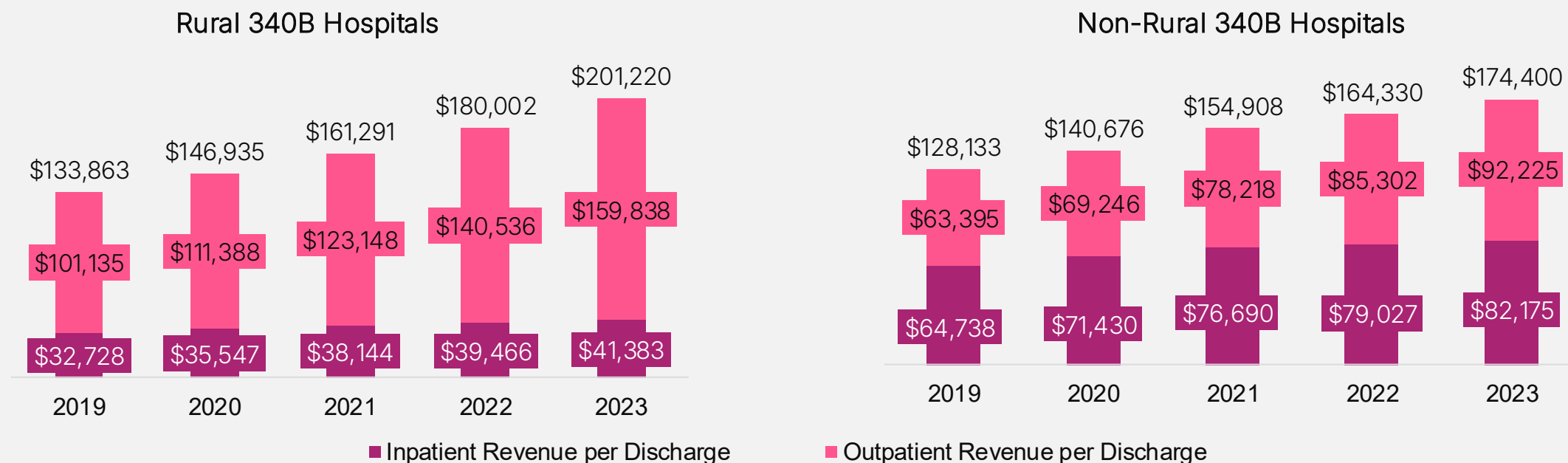
- 340B drug payments as a percentage of total drug payments were higher among non-rural 340B hospitals compared to rural hospitals.
- For non-rural 340B hospitals, 340B drug payments as a percentage of total drug payments increased year over year between 2019 and 2023.
- For rural 340B hospitals, 340B drug payments as a percentage of total drug payments remained flat to declining between 2019 and 2023.
- 97% of 340B drug claims occur in urban hospitals.



On a per discharge level, total revenue per is higher among rural 340B hospitals compared to non-rural hospitals

For both rural and non-rural 340B hospitals, revenue increased year over year across outpatient and inpatient settings. Rural hospitals had a greater share of outpatient revenue as a proportion of total revenue (76%-79%) compared to non-rural hospitals (with an outpatient revenue share of 49%-53%). Note that average Medicare payments are higher among non-rural 340B hospitals.

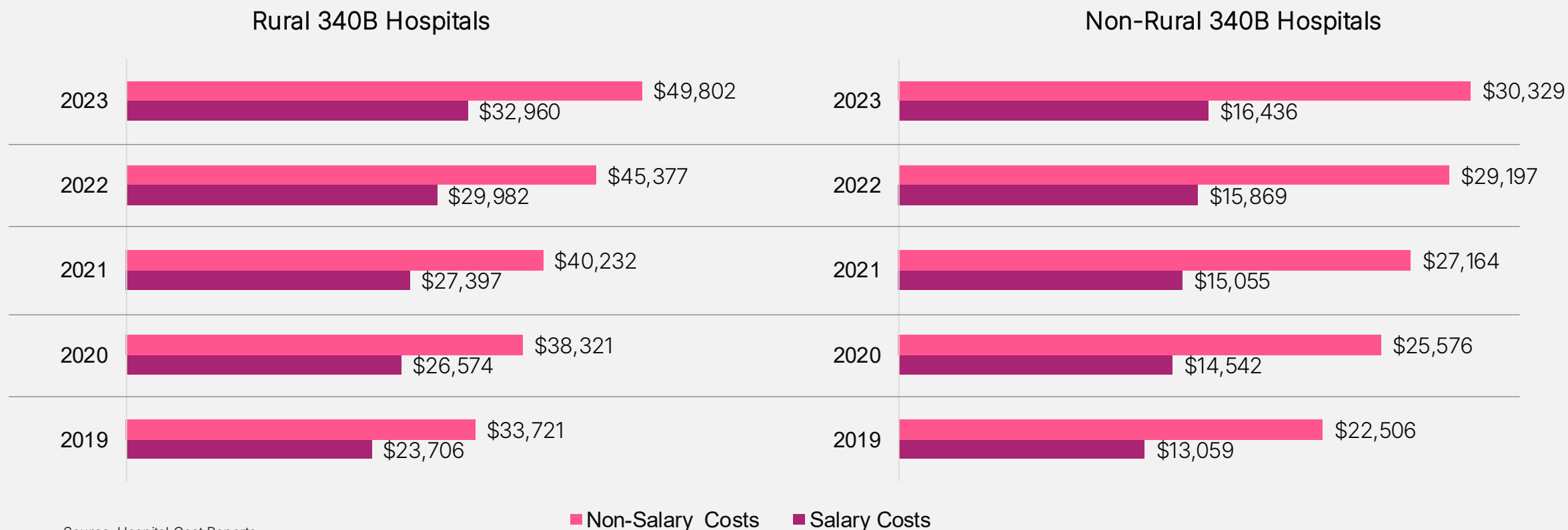
Average Inpatient, Outpatient and Total Revenue Per Discharge by Rural and Non-Rural Status, 2019-2023



Source: Hospital Cost Reports

Non-salary costs for rural 340B hospitals were significantly higher than those of non-rural 340B hospitals

Average Facility Costs per Hospital Discharge Among 340B Hospitals, by Hospital Location and Year

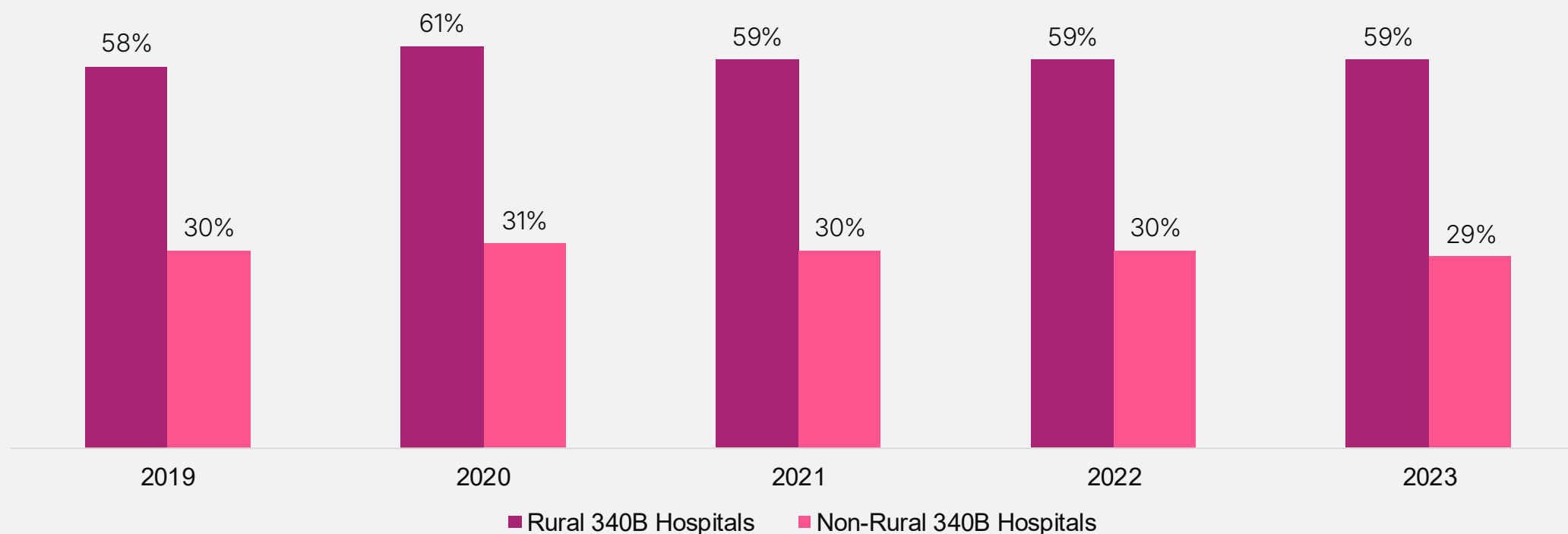


Source: Hospital Cost Reports

The average cost to charge ratio among rural 340B hospitals is approximately twice as high as non-rural 340B hospitals

The cost to charge ratio reflects the hospitals' mark-up on services (total costs as a percent of total billed charges), a lower ratio means higher markup.

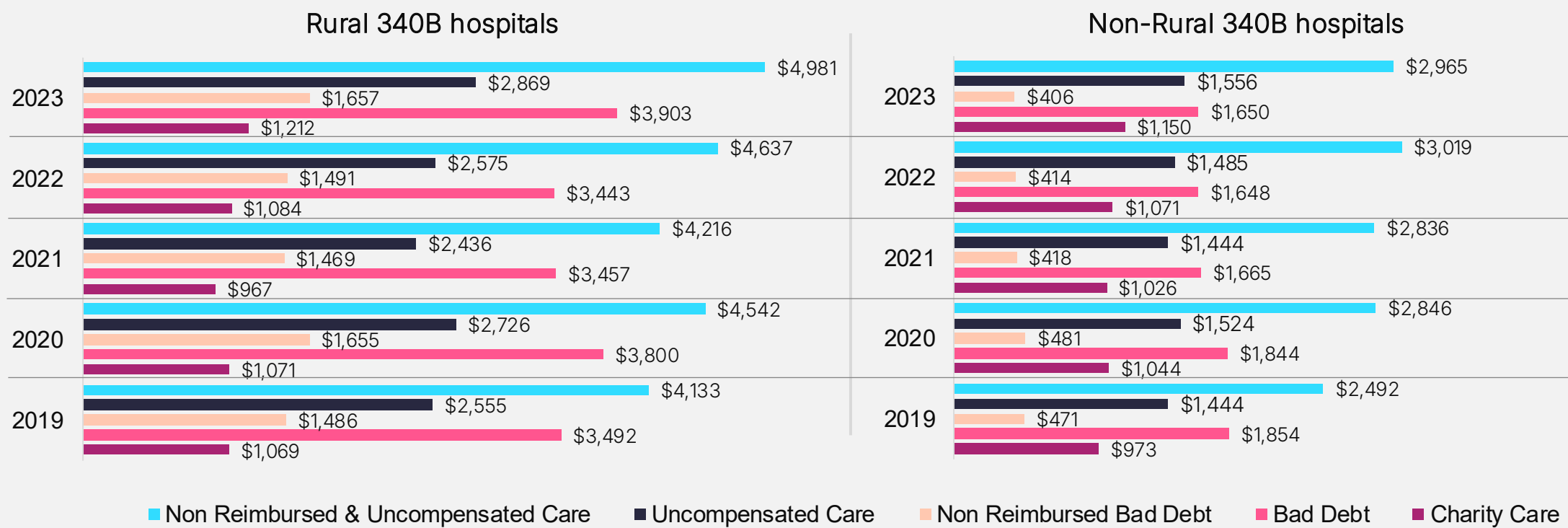
Average Cost to Charge Ratio among 340B Hospitals, by Hospital Location and Year



Average charity, bad debt, and uncompensated care per discharge was higher in rural hospitals compared to non-rural hospitals

Non-reimbursed & uncompensated care in rural 340B hospitals was nearly twice the amount of that in non-rural 340B hospitals.










Average Charity, Bad Debt, and Uncompensated Care Per Discharge, by Hospital Location and Year, 2019-2023



Note: All values in millions
Source: Hospital Cost Reports

Appendix

There are multiple stakeholders within the 340B program

| | | |
|---|--------------------------|---|
|  | HRSA OPA | Oversees the program and is responsible for compliance and integrity. |
|  | Manufacturers | Offer 340B-priced drugs to eligible covered entities at or below the 340B ceiling price. |
|  | Covered Entities (CE) | Participants (e.g., hospitals, health centers and other healthcare facilities) in the 340B program. |
|  | Contract Pharmacies (CP) | Pharmacies (e.g., retail or specialty pharmacies) that dispense 340B drugs under a contractual arrangement with a CE. |
|  | Hospital Child Sites | Outpatient facilities affiliated with eligible 340B hospitals and approved for participation. |
|  | Wholesalers | Facilitate supply chain product distribution and discounted drug prices to customers. |
|  | Patients | Receive care from CEs and utilize prescribed 340B drugs. |
|  | TPAs | Manage data, inventory tracking and financial transactions for CEs and CPs. |
|  | PBMs & Insurers | Reimburse pharmacies or CEs for prescription drugs. |

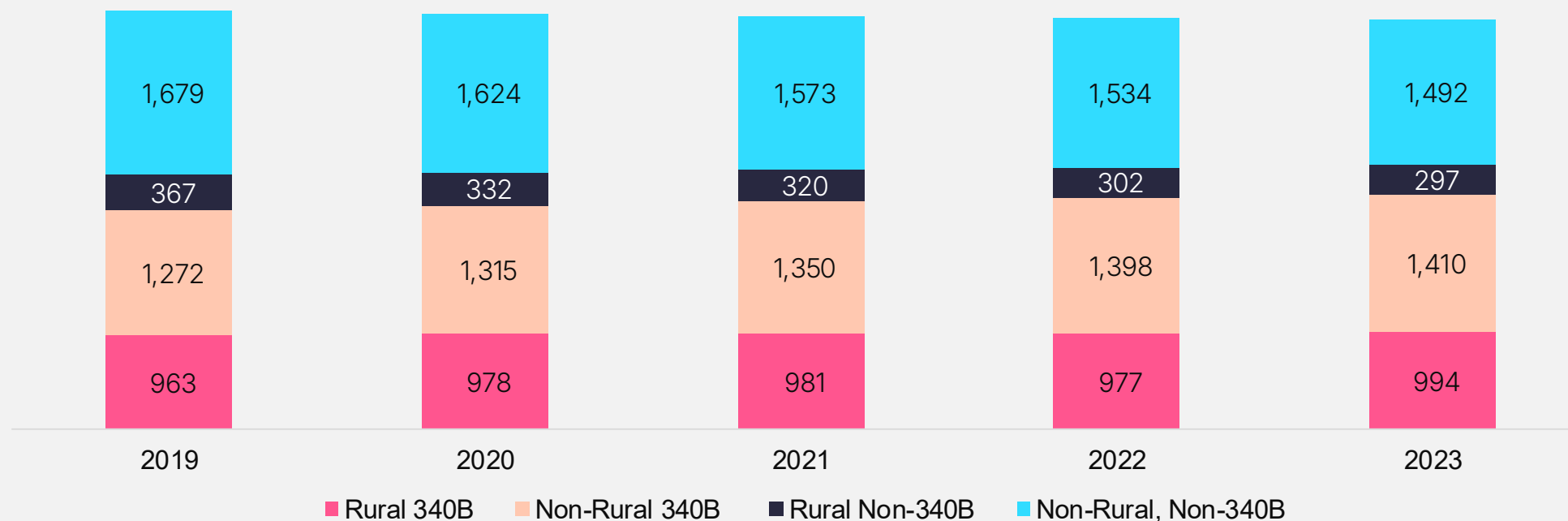
Methodology continued: data sources by research question

| Research Question | Data Source | Hospital and Patient Characteristics Analyzed |
|--|--|---|
| RQ1: Percentage of 340B hospitals in rural areas & facility types | <ul style="list-style-type: none"> • OPAIS (HRSA 340B registry) • Hospital Cost Report Data (HCRIS) | <ul style="list-style-type: none"> • Rural vs non-rural status • 340B covered entity type • Number of beds • Number of Days, • Total and net patient revenue |
| RQ2: Payer mix & patient demographic differences | <ul style="list-style-type: none"> • Medicare FFS and MA Claims (VRDC) • Hospital Cost Report Data (HCRIS) | <ul style="list-style-type: none"> • Number of beneficiaries (MA + FFS) • Count of beneficiaries with 340B and non-340B drug claims (MA + FFS) • Percentage of beneficiaries in rural and non-rural ZIP codes • Distribution of beneficiaries by Race, Ethnicity, • Percentage dual eligibility status beneficiaries |
| RQ3: Comparative utilization of 340B drugs | <ul style="list-style-type: none"> • Medicare FFS and MA Claims (VRDC) | <ul style="list-style-type: none"> • Outpatient 340B and non-340B Drug Claims Count (MA + FFS) • Total Medicare payments for drugs/all claims (MA + FFS) • Payments for 340B Drug Claims |
| RQ4: Financial metrics differences | <ul style="list-style-type: none"> • Hospital Cost Report Data (HCRIS) | <ul style="list-style-type: none"> • Hospital financial metrics (charity care, bad debt, uncompensated care, salaries, overhead costs) • Hospital revenue (inpatient and outpatient, net patient, net medicaid) |

Over half of hospitals participate in the 340B program; rural 340B hospitals represented 41% of 340B hospitals in 2023

The share of 340B hospitals increased over time, making up 52% of all hospitals in 2019, up to 57% of all hospitals in 2023.

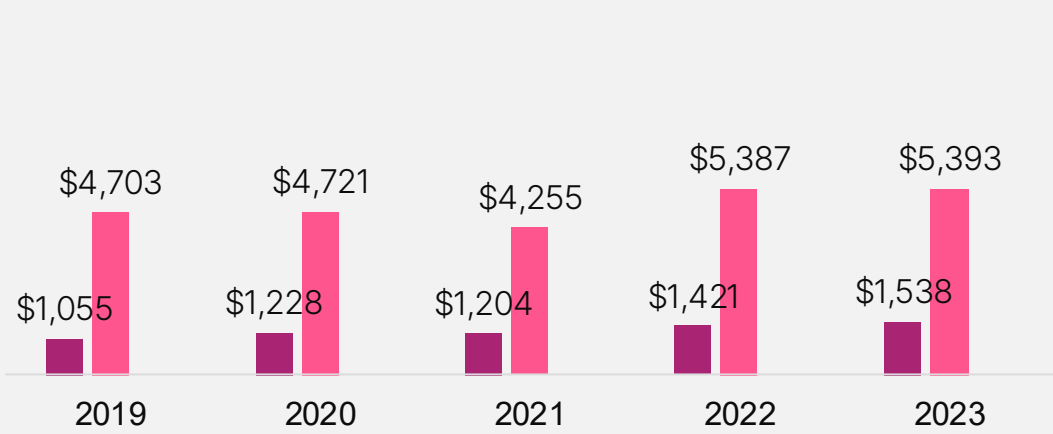
Number of Hospitals based on 340B Participation and Hospital Location, 2019-2023



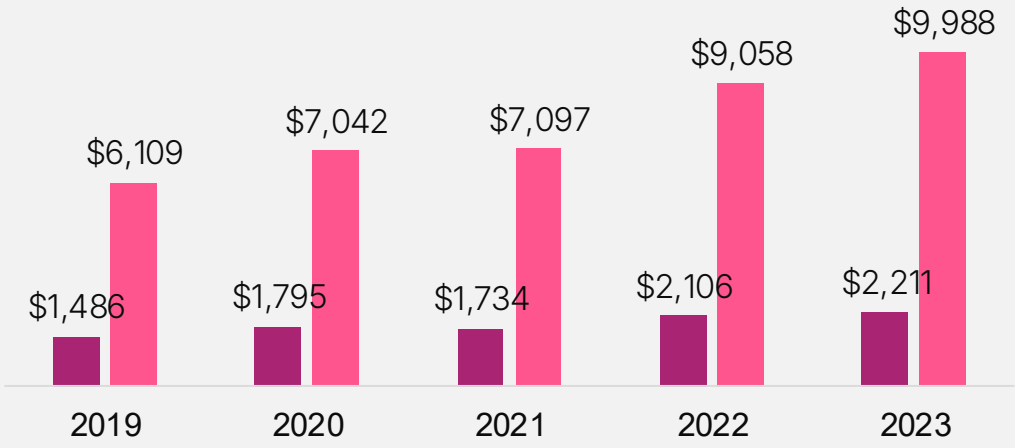
On average, rural 340B hospitals have lower drug spend per beneficiary for 340B drugs compared to non-rural 340B hospitals

The average 340B payment per beneficiary has increased by 14% per year among non-rural 340B hospitals, but only 5% per year among rural 340B hospitals.

Average Medicare Payments Per Beneficiary by Claim Type, Rural 340B Hospitals



Average Medicare Payments Per Beneficiary by Claim Type, Non-rural 340B Hospitals



■ Average Drug Payment Per Beneficiary
 ■ Average 340B Drug Payment Per Beneficiary



Source: Medicare Claims and Encounter Data