



The 340B Program Impact on Rural Hospitals

Executive Summary

Foreword

The National Grange has a profound and longstanding commitment to the health and well-being of rural communities. As a grassroots organization with more than a century and a half of history and service in rural America, we see firsthand the devastating impact that hospital closures have on families, farmers, seniors, and small businesses. When a rural hospital shuts its doors, it is not just a loss of medical services; it is the loss of emergency care, maternity services, local jobs, and a critical pillar of community stability. The National Grange understands that rural patients already face significant barriers to care, and each closure further widens the gap, putting lives at risk and threatening the future of rural communities.

At the same time, the National Grange is deeply concerned that misuse of the 340B Drug Pricing Program by large, non-rural hospital systems is diverting critical resources away from the small rural providers the program was originally intended to support. Although eligible hospitals are expected to use 340B savings to provide safety net services, particularly for uninsured and vulnerable populations, when entities outside of vulnerable rural communities exploit the program's benefits without reinvesting in patient care, it weakens the financial stability of rural hospitals that rely on those savings to keep their doors open. In fact, a recent study¹ found mixed evidence that 340B revenue funded health care specifically for low-income populations. This potential distortion of the program could undermine its purpose and further strain the fragile rural health care infrastructure that so many communities depend on.

Situation Overview

Rural Health Inequities. In 2025, the National Grange issued the 2025 Rural Health Report², shedding light on the persistent disparities and barriers to care that rural Americans, who are 20% of the US population, face. From limited access to primary care providers and specialists and longer travel times, to higher rates of chronic illness and gaps in behavioral

health services, rural communities continue to struggle with inequities that impact quality of life and overall well-being.

Contributing to this inequity, nearly 200 rural hospitals have closed or discontinued inpatient care in the United States since 2010, leaving millions of Americans without access to emergency services, testing, inpatient care, and primary care,^{3,4} Closures have increased at an alarming rate in the past few years,⁵ with rural hospitals operating on minimal financial margins and treat high-need patient populations. Moreover, the July 2025 One Big Beautiful Bill Act (OBBBA) is projected to reduce Medicaid funding by over \$137 billion over 10 years⁶, placing additional financial pressure on rural hospitals.

The 340B Program. A federal drug pricing program, 340B*, which requires significant drug manufacturer discounts, was codified into federal law⁷ with the aim of helping safety-net providers such as rural hospitals and clinics stretch limited resources, using savings to provide services to underserved populations. In the 340B program, drugmakers provide heavily discounted drugs for outpatient use to participating hospitals and clinics. These 340B providers, known as “covered entities,”* then prescribe the discounted drugs to patients and may charge non-discounted prices to payers to generate 340B net revenues.^{8,9} This analysis by Avalere Health found that in 2023, 41% of 340B hospitals were classified as rural. In the same year, rural 340B hospital Medicare drug claims made up less than 3% of total 340B hospital Medicare drug claims.

Program Growth. This critical program for rural patients and providers is at risk because the national 340B program has grown substantially over the last decade, driven in part by expanded eligibility in participant providers (covered entities), growth in outpatient care, increases in drug utilization, and the cost of drugs.^{10,11,12,13} A September 2025 CBO report¹⁴ 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%.

Drivers of Growth. Illustrating the increase in covered entities as a driver of the 340B program increase, a National Grange-sponsored analysis by Magnolia Market Access, released in February 2026,¹⁵ revealed that Medicare hospital reclassification policies are increasingly diverting resources intended for rural hospitals to large urban health systems, weakening the rural health care safety net and threatening access to care for millions of rural Americans. Specifically, the analysis revealed that many urban hospitals are exploiting Medicare’s rules by first reclassifying themselves as “administratively rural” to access benefits meant for true rural providers. These “administratively rural” entities then use the Geographic Classification Review Board process to reclassify themselves back to urban status for wage index purposes. This dual classification, treated as rural for some payments and urban for others, allows large, well-resourced metropolitan hospitals to maximize reimbursement while diverting critical support away from the rural hospitals that rely on it.

In fact, a Johns Hopkins/Brown University study in *Health Affairs* showed that 25 large urban hospitals used a rule change based upon two federal court decisions to use a two-step

reclassification process to be designated as both rural and urban for Medicare purposes. The study stated, “As a result, urban hospitals can maintain their high urban wage index for standard payments while also qualifying for special rural designations, such as Sole Community Hospital or Rural Referral Center (RRC) statuses that come with significantly higher reimbursements.”¹⁶

The growth of the 340B program has led to increased scrutiny and proposed reforms. The aim of the 340B program is to help safety-net providers stretch limited resources, using savings to provide services to underserved populations. As such, the significant growth in annual spending on 340B drugs while rural hospitals continue to close their doors has raised serious concern for our rural communities.

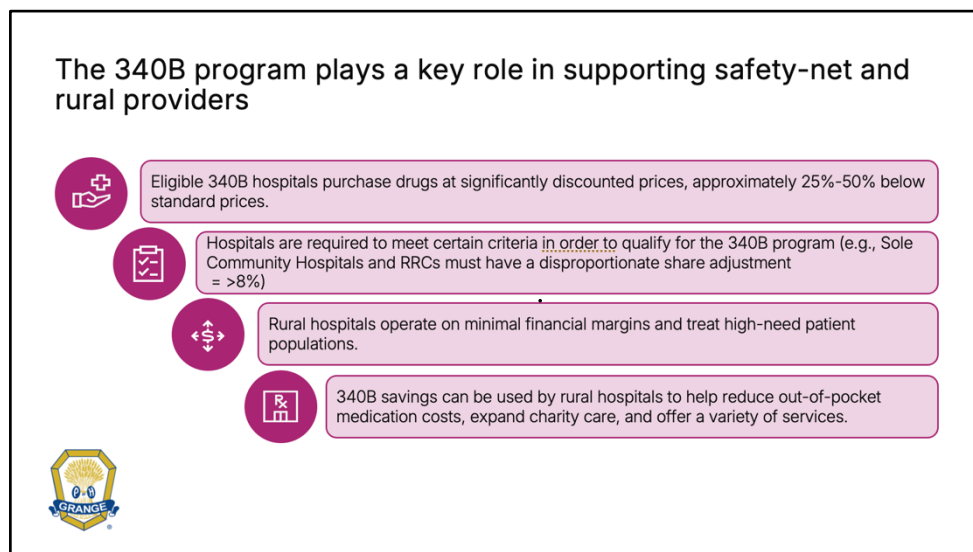


Figure 1. The 340B program plays a key role in supporting safety-net and rural providers.

Purpose of the Study/Analysis

To better understand the impact of the 340B program on rural hospitals and the patients they serve, the National Grange partnered with Avalere Health to examine the characteristics of rural vs. non-rural hospitals, the services they offer, the patients they treat and the financial challenges they face. This analysis supports the National Grange’s 340B reform priorities and advocacy for the necessary funding for rural hospitals in the coming years. (See Appendix for Methodology) Examples of key questions answered by the analysis were:

- 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?

Analysis Findings: 340B Impact on Rural Hospitals

Key Takeaways

The Dramatic Divide: Rural vs. Non-Rural Hospitals

The Avalere Health analysis reveals dramatic differences between rural and non-rural hospitals in patient populations, care delivery and financial metrics¹⁷.



1. **Rural hospitals serve distinct patient populations.** Based on an Avalere Health analysis of Medicare claims, patients who are served at these facilities tend to require a unique mix of services for both inpatient and outpatient treatments.

In particular, Medicare patients served by rural hospitals tend to be older than those treated at non-rural hospitals. Rural hospitals provide a range of inpatient and outpatient services, including care through rural health clinics and specialized services such as advanced nursing care. According to the National Grange, these age and care characteristics may indicate a greater need for more complex care among the rural hospital patient population.

2. **Rural hospitals face a distinct set of financial challenges.** They face higher levels of bad debt and uncompensated care compared to non-rural hospitals.
3. **The 340B program is a key source of cost savings for rural hospitals.** In 2023, 41% of entities participating in the 340B program were rural hospitals.
4. **340B is a lifeline for rural health care.** As rural hospitals continue to close and those remaining face significant financial pressures, the 340B program

cost savings are essential to ensuring quality care for these underserved communities, enabling access to lifesaving specialty care, such as cancer drugs, in rural areas for medically complex patients.

- 5. **Rural hospitals are not driving 340B program growth.** Rural 340B hospital Medicare drug claims made up less than 3% of total 340B hospital Medicare drug claims from 2019-2023. In 2023, rural hospitals had 128,043 Medicare 340B drug claims, compared to over 4.5 million non-rural hospital Medicare 340B drug claims.

Analysis Findings: 340B Impact on Rural Hospitals

Rural vs. Non-Rural Hospitals: Patient Characteristics, Services and Hospital Types

- **Patient Characteristics and Services.** Medicare patients in rural hospitals are more likely than their urban counterparts to be older and more likely to be dual-eligible (covered by Medicare and Medicaid), thus predominantly over age 65, with a higher proportion over age 85. Rural hospitals are more likely to offer rural health clinics compared to non-rural hospitals (76% vs. 21%, respectively) and long-term care services, such as skilled nursing facility swing beds (94% vs. 25%, respectively). Eighty percent (80%) of the patients treated by rural 340B hospitals reside in rural areas; non-rural 340B hospitals treat only 14% rural residents.

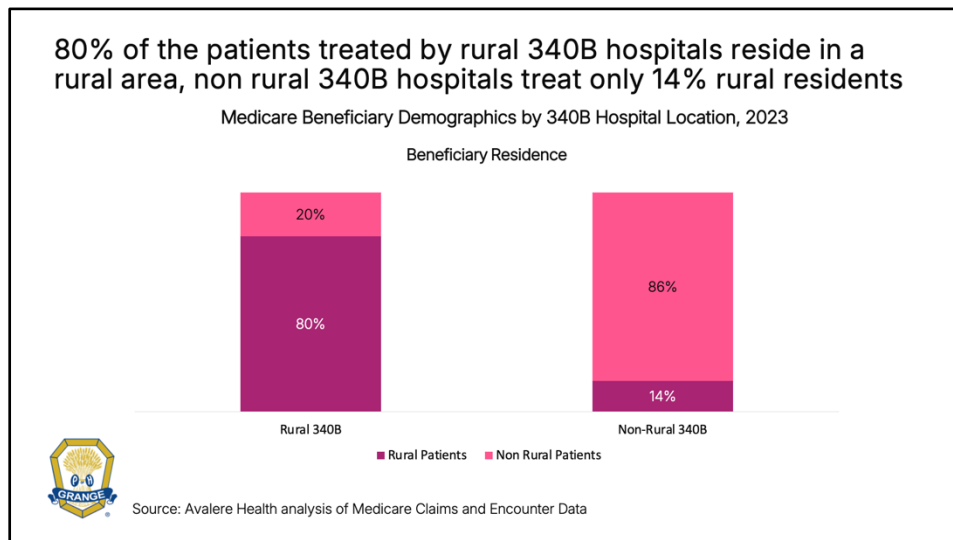


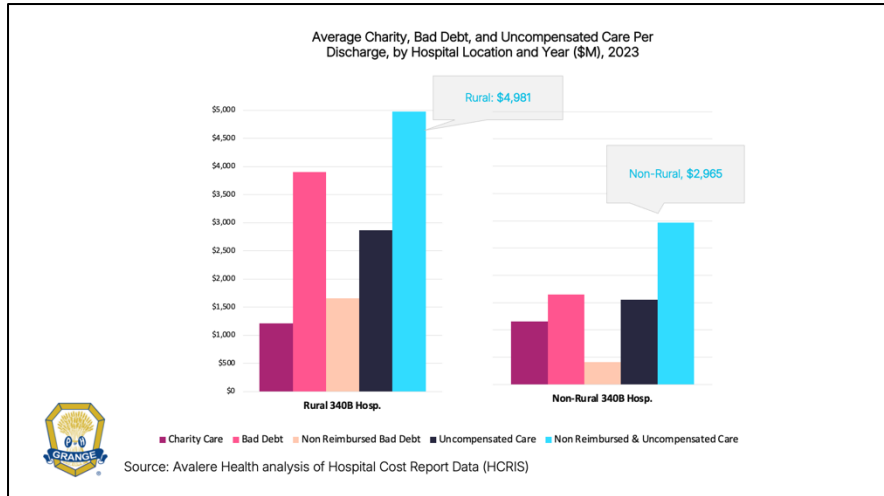
Figure 2. 80% of patients treated by rural hospitals reside in a rural area; non-rural 340B hospitals treat only 14% rural residents.

- **Beneficiary/Payer Mix.** Commercially insured and Medicaid beneficiaries represent a smaller share of patients in rural hospitals than in non-rural hospitals, as measured by the share of discharges and patient days by payer.

- **Hospital/Provider Types.** There are a number of different types of hospitals that can apply for the 340B program, but their eligibility criteria differ significantly, and each type has different requirements.
 - Rural 340B hospitals are more likely to be located 15-35 miles from the nearest hospital, have fewer than 25 inpatient beds, and provide 24/7 emergency services.
 - Examples of non-hospital-covered 340B entities include Federally Qualified Health Centers, Black Lung Clinics, and Tribal Indian Health Centers. These entities have more specialized requirements for participating in the 340B program than the DSH hospitals, which are only required to meet more limited criteria.
 - As noted in the previously referenced Hopkins/Brown study, many of the urban hospitals being reclassified as rural are Rural Referral Centers (RRCs).¹⁸ In fact, these hospitals serve a very small share of rural patients. For instance, according to the Avalere Health analysis, in 2023 only 12% of Medicare patients served by RRCs actually lived in rural areas.¹⁹
- **Drug Discounts.** Eligible 340B hospitals purchase drugs at significantly discounted prices, approximately 25%-50% below standard list prices.²⁰ 340B savings can be used by rural hospitals to help reduce out-of-pocket medication costs, expand charity care, and offer a variety of essential services such as obstetric care.

Financial Metrics: The Financial Challenges of 340B Rural Hospitals

- Rural 340B hospitals have noticeably 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 340B hospitals compared to non-rural 340B hospitals. In 2023, non-reimbursed and uncompensated care costs per discharge in 340B rural hospitals was nearly twice the amount of that in 340B non-rural hospitals (\$4,981 vs. \$2,965, respectively).
- Rural 340B hospitals experience higher levels of bad debt and uncompensated care per discharge compared to non-rural 340B hospitals. In 2023, in 340B hospitals, rural bad debt per discharge (\$3,903) was more than twice that of non-rural hospitals (\$1,650). Rural non-reimbursed bad debt per discharge (\$1,656) was four times as high compared to non-rural hospitals (\$406).



Source: Hospital Cost Report Data (HCRIS)
 Figure 3. Average Charity, Bad Debt and Uncompensated Care Per Discharge, by Hospital Location and Year (\$M), 2023

- Rural 340B hospitals face higher facility costs compared to non-rural 340B hospitals and have minimal operating margins²¹.
- Rural hospitals have higher cost-to-charge ratios (CCR), meaning that the markup is smaller. The CCR compares what it actually costs a hospital to provide care to what the hospital bills (charges) for that care.
- 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.

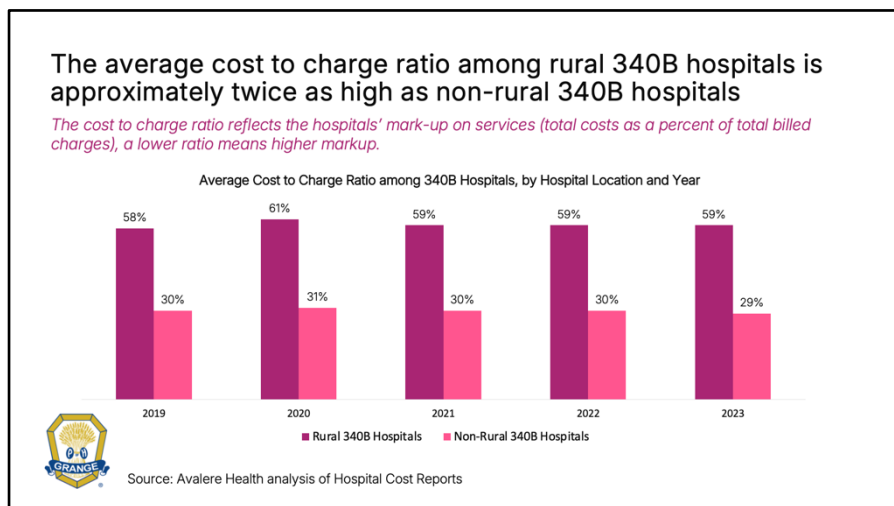


Figure 4. The average cost-to-charge ratio among 340B rural hospitals is approximately twice as high as that of non-rural 340B hospitals.

- A higher cost-to-charge ratio, as in rural hospitals, suggests greater pricing pressures and may reflect higher staffing needs, medical complexity, or limited economies of scale.

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

- 340B hospitals generate savings through a relatively small percentage of total hospital claims. Based on Medicare claims data, in rural 340B hospitals, 340B drug claims make up 25% of drug claims and 75% of drug payments in rural hospitals, indicating that 340B hospitals use the program to subsidize and generate savings in specialty medicines.
- 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 \$746.22.
- From 2019 through 2023, in 340B hospitals, average Medicare payments for 340B drug claims were approximately three times 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 than rural 340B hospitals.

CONCLUSION and CALL TO ACTION

The data are clear. Given the financial constraints of rural hospitals, 340B programs are essential for delivering lifesaving specialty medicines, such as cancer drugs, to older and more medically complex patients, and they play a critical role in helping rural hospitals.

Rural hospitals use 340B in limited volume but high-impact ways. The program enables access to lifesaving high-cost treatments and supports financial sustainability in communities with few healthcare alternatives. Rural hospitals are not the drivers of 340B growth; they use the program selectively for essential specialty care.

The National Grange calls upon policymakers to preserve and protect 340B for rural providers, because it is essential to protecting access across rural America. We embrace the following advocacy principles:

Policy reforms must:

- Protect rural providers from unintended harm.
- Recognize the disproportionate financial vulnerability of rural providers.
- Prevent policies that unintentionally accelerate rural hospital closures.
- Ensure continued access to a full range of medicines, including specialty drugs, in rural communities.
- Reform 340B without weakening rural healthcare.

- Close loopholes that allow non-rural hospitals and Rural Referral Centers to take unfair advantage of programs intended for rural communities.

Finally, reforms targeting concerns in large urban systems should not undermine access to care in rural America.

In this spirit, the National Grange urges policymakers to make 340B reforms that ensure discounted drug savings while protecting true rural hospitals. Reforms should also include closing the dual classification loophole by tying rural payment enhancements and program eligibility to true rural demographics, ensuring that limited federal resources are directed to the hospitals and patients they were designed to support.

*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. The 340B program applies to all covered outpatient drugs, including both Medicare Part B physician-administered drugs and Medicare Part D prescription drugs, but it does not apply to inpatient drugs. The 340B Drug Pricing Program was created by the Veterans Health Care Act of 1992 and codified in section 340B of the Public Health Service Act.

** A specialty drug is generally a medication used to treat rare, chronic, or complex conditions that require specialized handling and intensive patient monitoring.²²

APPENDIX

Methodology: In order to perform the analysis, Avalere Health first identified short-term acute care hospitals and critical access hospitals and assigned 340B status and 340B hospital types based on Office of Pharmacy Affairs Information System (OPAIS) data and rural/urban status based on hospital ZIP codes using the U.S. Department of Agriculture Rural Urban Commuting Area codes (USDA RUCA) codes.

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

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

Data Sources used for answering research questions were as follows:

1. What percentage of 340B hospitals are in rural areas, and what types of facilities are they?

Data Sources: OPAIS (HRSA 340B Registry; Hospital Cost Report Data (HCRIS)

Characteristics Analyzed: Rural vs. non-rural status; 340B covered entity type; number of beds, days and total and net patient revenue.

2. How does the payer mix (i.e., payer type) and patient demographics differ between rural and non-rural 340B hospitals?

Data Sources: Medicare FFS and Medicare Advantage (MA) Claims, Virtual Research Data Center (VRDC)

Characteristics Analyzed: 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

3. What is the comparative utilization of 340B drugs under Medicare Part B in rural versus non-rural hospital settings (based on hospital location)?

Data Sources: Medicare FFS and MA Claims (VRDC)

Characteristics Analyzed: Outpatient 340B and non-340B Drug Claims Count (MA + FFS); Total Medicare payments for drugs/all claims (MA + FFS); Payments for 340B Drug Claims

4. How do financial metrics, such as revenue, costs, margin, uncompensated care, and 340B status differ between rural and non-rural providers?

Data Source: HCRIS

Characteristics Analyzed: Hospital financial metrics (charity care, bad debt, uncompensated care, salaries, overhead costs); Hospital revenue (inpatient and outpatient, net patient, net Medicaid)²³

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- ⁶ Kaiser Family Foundation. (2025, July 24). How might federal Medicaid cuts in the enacted reconciliation package affect rural areas? <https://www.kff.org/medicaid/how-might-federal-medicaid-cuts-in-the-enacted-reconciliation-package-affect-rural-areas/>
- ⁷ Veterans Health Care Act of 1992, Pub. L. No. 102–585
- ⁸ The Commonwealth Fund. (2025, August). The 340B Drug Pricing Program: How it works and why it’s controversial. <https://www.commonwealthfund.org/publications/explainer/2025/aug/340b-drug-pricing-program-how-it-works-and-why-its-controversial>
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- ¹¹ Congressional Budget Office. (2023). *Prices for brand-name drugs under selected federal programs*.
- ¹² U.S. Government Accountability Office. (2018). *Drug pricing: Manufacturer discounts in the 340B program offer benefits, but federal oversight needs improvement* (GAO-18-480).
- ¹³ IQVIA Institute for Human Data Science. (2025, April 30). *Understanding the use of medicines in the U.S.* <https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/understanding-the-use-of-medicines-in-the-us-2025>
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- ¹⁷ Avalere Health. (2025, December). *Analysis of HRSA’s 340B Office of Pharmacy Affairs Information System (OPAIS) data, Medicare claims, and hospital cost reports*.
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