

Health Capital Group White Paper

**Increasing Dominance of Large Hospitals and Academic Medical Centers
in the 340B Drug Pricing Program**

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Executive Summary

- **Large hospitals dominate the structural expansion of the 340B Program:** Hospitals in the top quartile by bed size represent 33% of the 1,844 hospitals that were continuous 340B participants from 2017 through 2023, but accounted for 81% of child site increases and 60% of contract pharmacy relationship growth from 2017-2023.
- **Major teaching hospitals show disproportionate expansion** from 2017-2023: Large “major teaching” hospitals (primarily Academic Medical Centers, or AMCs) averaged nearly twice as many child sites (49.6 vs. 25.4) and contract pharmacy relationships (93.8 vs. 51.4) compared to similarly-sized non-teaching hospitals.
- **Child site gap is widening dramatically:** Teaching hospitals had 66% more child sites than non-teaching hospitals in 2017, a gap that widened to 95% by 2023.
- **New entrants follow the same pattern:** Among 415 hospitals joining 340B between 2017-2023, the largest hospitals (36.6% of new entrants) represented 71.9% of new child sites and 62.4% of new contract pharmacy relationships.

Methodology

- Data analyzed from HRSA Office of Pharmacy Affairs Information System (OPAIS) database as of Q4 2023
- Examined hospitals continuously in 340B from 2017-2023 plus new entrants during that period
- Measured two key indicators: number of child sites (defined by HRSA as “off-campus outpatient facilities”) and contract pharmacy relationships
- Hospitals categorized by bed size quartiles and teaching status, as defined in their Medicare cost reports

Growth Metrics (2017-2023)

- Average 340B hospital added 4.2 child sites and 22.1 contract pharmacy relationships
- Large 340B hospitals added over 10 child sites and nearly 70 contract pharmacy relationships each
- Large 340B teaching hospitals accounted for 67.8% of child site growth and 54% of contract pharmacy relationship growth despite representing only a minority (40%) of all large hospital participants

Implications

- Previous research shows child sites are often located in higher-income areas with better-insured residents
- Program growth is increasingly captured by large hospitals with substantial financial resources rather than small safety-net providers
- Findings suggest that 340B growth will continue to concentrate among the largest systems and may accelerate healthcare consolidation, potentially leaving smaller institutions and community-based providers at a disadvantage
- Findings support the need for fundamental redesign or course correction of the 340B Program to better serve its intended purpose

Introduction

The 340B Drug Pricing Program (340B) allows eligible hospitals and clinics to purchase outpatient drugs at deeply discounted prices.¹ 340B clearly benefits hospitals; how those specific benefits are distributed to patients (if at all) is a matter of heated debate.² An increasing body of research suggests that the program raises health care costs overall,³ including by encouraging and rewarding hospital consolidation,⁴ and that 340B expansion (e.g., opening satellite 340B clinics or contract pharmacy locations) has been mainly associated with pursuit of profit opportunity rather than patient access.⁵ As noted by the Congressional Budget Office, “the 340B Program encourages behaviors—including the prescription of more and higher-priced drugs, the expansion of services, and the integration of hospitals and off-site clinics—that tend to increase federal spending.”⁶ Beyond a need for greater transparency, a relevant question for policymakers is whether 340B has drifted far enough from its intended course to require a full redesign, or simply a course correction.

One way to answer this question is to examine which kinds of hospitals are most involved in 340B and how that has changed in recent years. 340B proponents often point to its critical role in sustaining critical access hospitals (CAH) and other small safety net providers.⁷ Is 340B’s structural expansion driven mainly by smaller safety net hospitals, or have other forces come to dominate the program in recent years? That is the empirical question answered in this paper.

Data and Methods

Two important measures of the level of 340B activity at a participating hospital are the number of active 340B child sites and the number of active contract pharmacy (CP) relationships. Hospitals use child sites to expand the reach of their 340B Program - examples include satellite oncology clinics, urgent care centers, orthopedics clinics and other outpatient sites. Hospitals establish CP relationships to connect purportedly eligible covered entity “patients” with the 340B Program. The connection is often invisible to patients, who are not required to be made aware that their prescriptions are being filled with

340B inventory that is available to hospitals at a steep discount through the program. Instead, hospitals and their CP agents generally earn and share profits on the difference between a drug’s reimbursement value and the deeply discounted price. We examine how the proliferation of child sites and CP relationships may differ based on hospital size and teaching status to determine which types of hospitals are most directly involved with (and are capturing the benefit of) 340B.

We extracted data on all active 340B covered entities and child sites each quarter between Q4 2017 and Q4 2023 from the HRSA Office of Pharmacy Affairs Information System (OPAIS) database.⁸ We gathered data on all participating 340B hospitals in 2023 including the number of beds in 2023 and teaching status as listed in the hospitals’ Medicare cost reports.⁹ We included hospitals designated as “major teaching” institutions as a category in our analyses; almost all AMCs are major teaching hospitals, and the majority of major teaching hospitals are AMCs.¹⁰ We assigned hospitals to bed size quartiles and tabulated the increase in child sites and active CP relationships by hospital between 2017 and 2023. OPAIS identifies whether hospitals and sites are active 340B participants every quarter. We examined two groups of hospitals: those that were active participants in 340B continuously over the entire period and those that joined over the period. We used these data to compare growth rates by hospital size quartile and teaching status over the period. We note that while OPAIS is the program’s participation ledger, HRSA audits have routinely flagged inaccurate or outdated records; even after rigorous deduplication and cleaning, residual misclassification risk remains. This caveat is amplified for teaching hospitals, given frequent provider-based reclassifications, rotating resident clinics, research/mixed use settings and Medicaid/contract pharmacy carve in/carve out controls, and timing lags between operations, cost reporting, and OPAIS updates that can mask true eligibility. Our choice of counts (child sites & CP relationships) captures structural expansion, they do not measure 340B volume or drug mix.

Results

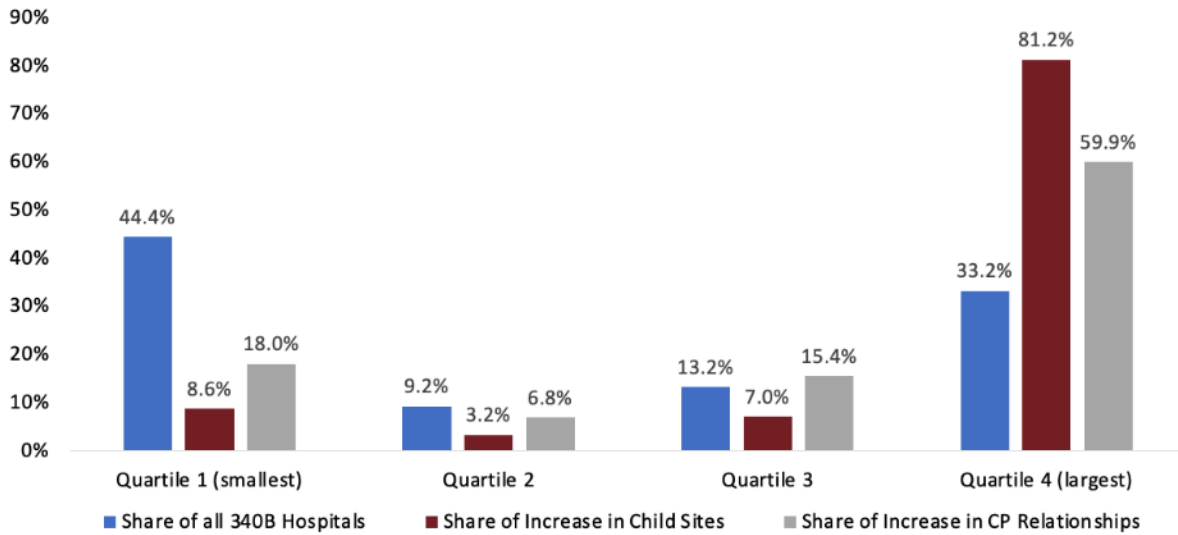
Table 1 shows how growth in sites and CP relationships varies by bed size for hospitals that have been continuous 340B participants from 2017 - 2023.

Table 1. Hospital Size and 340B Growth for Continuous 340B Participants, 2017 – 2023										
National Bed Size Quartile	340B Hospitals	Average Beds	Average Child Sites 2017	Average Child Sites 2023	Average Child Site Increase	% Child Site Increase	Average CPs 2017	Average CPs 2023	Average CP Increase	% CP Increase
1	818	22.0	2.5	3.3	0.8	33.0%	4.3	13.2	9.0	210%
2	169	46.0	5.3	6.8	1.5	27.9%	7.9	24.3	16.4	206%
3	244	119.9	8.4	10.7	2.2	26.5%	10.4	36.2	25.8	248%
4	613	447.7	25.1	35.4	10.3	41.0%	29.1	69.0	39.9	137%
Total	1844	178.7	11.0	15.3	4.2	38.2%	13.7	35.8	22.1	162%

Source: Medicare cost reports, OPAIS database, Health Capital Group analysis

The average hospital in our data added 4.2 child sites over the period and 22.1 CP relationships, reflecting the dramatic growth in 340B’s reach over the period. The largest hospitals dominated both categories of growth; hospitals in the highest size group added over 10 child sites on average over the period and nearly 70 CP relationships each. Chart 1 shows the relative contributions from each category of hospital between 2017 and 2023.

Chart 1. Relative Contribution to 340B Growth by Hospital Bed Count of 340B Hospital, 2017 - 2023



Source: Medicare cost reports, OPAIS database, Health Capital Group analysis

Large hospitals (top quartile of bed size for all hospitals) accounted for 33% of all 340B hospitals but 81% of the increase in hospital child sites from 2017 - 2023 and 60% of the increase in contract pharmacy relationships. Child sites are a major opportunity for hospitals to establish relationships with potentially profitable 340B patients; previous research has shown that hospitals locate such sites disproportionately in higher income areas with better insured residents.¹¹

Table 2 shows how the growth in child sites and CP relationships has differed based on teaching status. Most teaching hospitals are very large, so we restricted our comparison to only non-teaching 340B hospitals in the highest quartile by bed size.

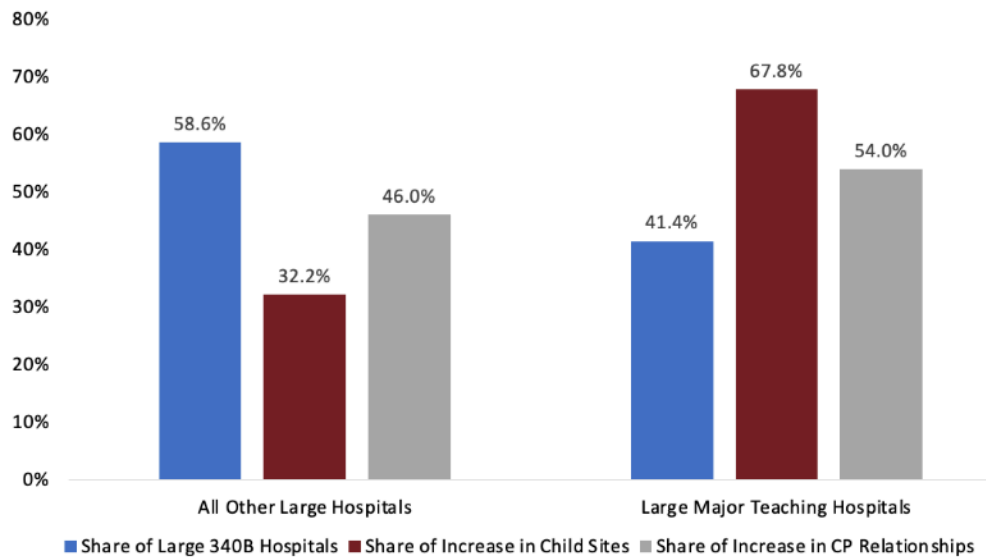
Table 2. Major Teaching Hospitals vs. Other Large 340B Hospital Contribution to Growth, 2017 – 2023										
National Bed Size Quartile	340B Hospitals	Average Beds	Average Child Sites 2017	Average Child Sites 2023	Average Child Site Increase	% Child Site Increase	Average CPs 2017	Average CPs 2023	Average CP Increase	% CP Increase
Large Non-Teaching Hospitals	359	388.3	19.7	25.4	5.7	28.7%	20.1	51.4	31.3	156.2%
Large Major Teaching Hospitals	254	531.7	32.8	49.6	16.9	51.5%	41.9	93.8	51.9	124.0%
Total	613	447.7	25.1	35.4	10.3	41.0%	29.1	69.0	39.9	137.0%

Source: Medicare cost reports, OPAIS database, Health Capital Group analysis. Notes: large hospitals include all 340B hospitals that are in the top quartile based on bed size.

Table 2 shows a dramatic difference between large teaching and non-teaching 340B hospitals. While teaching hospitals are somewhat larger on average (532 beds vs. 388 beds), on average major teaching hospitals have almost twice as many child sites (49.6 vs. 25.4) and CP relationships (93.8 vs. 51.4). The growth in child sites has been particularly sharp for teaching hospitals, with the gap between teaching and non-teaching hospitals growing from 66% (32.8 vs. 19.7) to 95% in just six years. As noted above, adding child sites has proved to be an effective way for hospitals to establish relationships with more patients across a broader geography, while adding CP relationships allows these hospitals to fill prescriptions for such patients with 340B-priced drugs to generate more program profits.

Chart 2 shows the contributions from large major teaching vs. large non-teaching hospitals between 2017 and 2023.

Chart 2. Relative Contribution to 340B Growth from Large Hospitals, by Teaching Status, 2017 - 2023

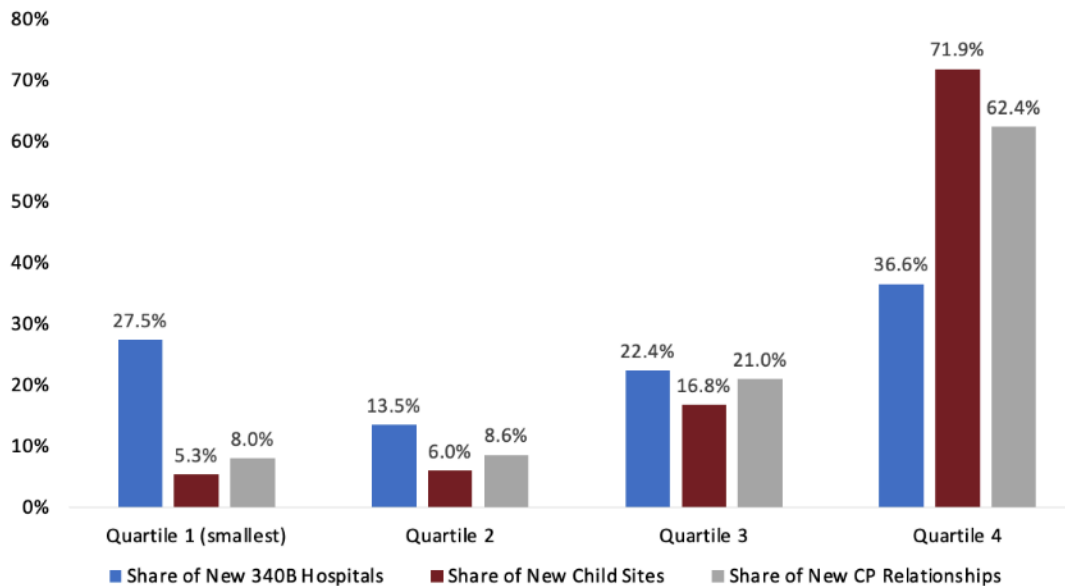


Source: Medicare cost reports, OPAIS database, Health Capital Group analysis

While large major teaching hospitals represented just above 40% of the total number of large hospital 340B participants, they accounted for 67.8% of the growth in child sites and 54% of the growth in CP relationships over the period.

The 340B Program has continued to add participants every year; 415 hospitals joined 340B between 2017 and 2023. Chart 3 characterizes the size and relative contribution by size for those hospitals that were new to the 340B Program over the study period.

Chart 3. Share of Hospitals, Child Sites and CP Relationships for 415 Newly-Joined 340B Hospitals, 2017-2023



Source: Medicare cost reports, OPAIS database, Health Capital Group analysis

While only 36.6% of the new entrants were in the largest hospital quartile, that group represented 71.9% of the new child sites and 62.4% of the CP relationships affiliated with those hospitals, furthering the predominance of large hospital-affiliated sites and CP relationships benefiting from the 340B Program.

Policy Implications

Has 340B’s rapid expansion been driven by patient need—or by the market power of large teaching hospitals with greater resources, staffing, and financial reserves? The Congressional Budget Office recently linked program growth to hospital integration with offsite clinics, expanded facility participation, and a surge in contract pharmacy use. Our analysis confirms that these trends are concentrated among large hospitals—and disproportionately among teaching institutions.

Previous research has demonstrated how the proliferation in 340B child sites is associated with financial opportunism, not expanding care to underserved communities.¹² Researchers and policymakers still lack a systematic understanding of whether the explosive growth in the 340B Program is enabling or undermining its original goals.¹³ While hospital groups claim an increase in overall community benefit spending¹⁴ (a measure required to justify non-profit hospital tax advantages), other analyses find that the

largest 340B hospitals' share of actual charity care continued to decline despite their growing program revenues.¹⁵ The dominance of large entities in contract pharmacy relationships has additional ramifications since prescription attribution is governed by opaque third-party administrator (TPA) agreements, rather than transparent standards. When patient definitions broaden without requiring a clear care nexus between the patient and the covered entity, attribution may favor well-resourced hospital systems with superior data feeds, strong IT integration, and comprehensive prescriber affiliation capture – at the expense of smaller, less-resourced rural providers who may find themselves at a persistent disadvantage. Calls for greater disclosure of TPA mechanisms have thus grown in response to this opacity.

Conclusion

Discussions about 340B reform frequently highlight concerns raised by small safety-net hospitals regarding their access to discounted 340B pricing. However, it is important to note that most of the rapid 340B growth drawing policymakers' scrutiny has been driven by large systems with substantial financial resources. A recent analysis illustrated why taxpayer advocates are concerned about how certain 340B entities manage surplus funds, counting over \$17 billion in offshore holdings in the publicly available tax records of dozens of 340B hospitals across six states. Virtually all of those offshore funds listed are linked to teaching hospitals.¹⁶

Taken together, these developments raise the question of whether, without more substantial reforms, 340B will continue to concentrate among the largest systems and potentially accelerate healthcare consolidation – leaving smaller institutions and community-based providers at a disadvantage. Mounting evidence of the growing cost of 340B to payers, patients and taxpayers underscores the need for policymakers to consider changes to program design and oversight that will prevent or reverse its unintended drift from the original program mission of benefiting vulnerable patients.

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