PIONEER HEALTH

The 340B Accountability Gap:

Charity Care, Uncompensated Care, and Medicaid Patient Volume Among 340B and Non-340B Hospitals

What the Data Mean for 340B Accountability and Reform

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Executive Summary

The 340B Drug Pricing Program gives eligible hospitals and clinics access to substantial manufacturer discounts on outpatient medicines. The policy rationale is straightforward: institutions serving vulnerable patients receive a federal financial benefit so they can stretch scarce resources and support care for low-income and uninsured populations.[1]

Yet the federal program does not require hospitals to meet a uniform charity-care standard, nor does it provide the public with a comprehensive accounting of the revenue hospitals generate through 340B and how they use those funds. That makes a basic accountability question difficult to answer: are hospitals receiving 340B benefits, intended to support patients, measurably doing more for vulnerable patients than hospitals outside the program?[1]

To provide a national benchmark, Pioneer Institute and Cancer*Care* compared 3,999 hospitals using RAND-transposed CMS Healthcare Cost Report Information System data linked to HRSA 340B covered-entity records. The analysis examined charity care, charity care for uninsured patients, initial obligations of uninsured patients approved for charity care, unreimbursed or uncompensated care, and Medicaid admission days.

Key Findings

- 340B hospitals reported significantly less charity care than non-340B hospitals: 2.16% versus 2.82% of operating expenses.
- Charity care for uninsured patients was also significantly lower among 340B hospitals: 1.60% versus 2.26%.
- The initial obligation of uninsured patients approved for charity care was significantly lower among 340B hospitals: 1.61% versus 2.27%.
- Overall unreimbursed or uncompensated care was lower among 340B hospitals, 6.90% versus 7.18%, but the difference was not statistically significant.
- 340B hospitals served a greater share of Medicaid patients: Medicaid admission days averaged 19.69% among 340B hospitals versus 17.76% among non-340B hospitals.
- Disproportionate Share Hospitals reported the highest Medicaid patient volume and stronger charity-care performance than the overall 340B average, while Critical Access Hospitals reported markedly lower levels on both measures.

340B hospitals reported significantly less charity care then non-340B hospitals: 2.16% versus 2.82% of operating expenses.

These comparisons should be viewed as a conservative accountability benchmark. Because 340B hospitals receive a federally created financial benefit in the form of mandatory drug discounts unavailable to hospitals outside the program, parity alone should not be the standard. Participating hospitals should be expected to demonstrate a measurable additional benefit for uninsured and underinsured patients.[1]

These results do not establish that 340B participation causes hospitals to provide less charity care. The study is cross-sectional and unadjusted. But they do show that receiving 340B benefits does not consistently correspond with greater direct financial assistance for patients. That is an accountability problem policymakers can address without waiting for a causal estimate.

The report also recommends extending accountability to contract pharmacies by requiring measurable patient assistance and de-linking contract-pharmacy compensation from drug prices. The latter could be achieved through a transparent, flat, per-prescription service fee aligned with the applicable Medicaid professional dispensing fee or a comparable service-based standard.[2, 3]

The 340B Program and the Accountability Question

The 340B Drug Pricing Program was established to expand access to care for low-income and uninsured patients by allowing safety-net hospitals and clinics to purchase outpatient drugs from manufacturers at discounted prices, with such discounts subsequently being arbitraged by the 340B entities to generate revenue.[1]

The program has expanded considerably. The Affordable Care Act extended hospital eligibility to rural referral centers (RRC), sole community hospitals (SCH), critical access hospitals (CAH), and certain free-standing children's and cancer hospitals in addition to DSH.[4] In 2010, Health Resources and Services Administration (HRSA) revised its guidance to allow covered entities to contract with multiple pharmacies without a fixed numerical limit.[5]

In 2025, IQVIA estimated that 340B purchases reached $179.5 billion when valued at list prices, while HRSA reported $100.0 billion in covered outpatient drug purchases under the program.[6, 7]

Growth by itself is not evidence that a program is failing. But growth increases the importance of knowing what taxpayers, patients, and policymakers receive in return for the financial benefit. Today, federal policy does not require 340B hospitals to report a complete accounting of 340B-related revenue publicly or to demonstrate that a defined share of that benefit is used for charity care or direct patient assistance.[1]

Growth by itself is not evidence that a program is failing. But growth increases the importance of knowing what taxpayers, patients, and policymakers receive in return for the financial benefit.

Some states have begun filling that gap. Minnesota, for example, requires detailed reporting of 340B revenues and other program-related financial information.[8,9] These state efforts underscore a broader federal problem: policymakers still lack standardized information linking the size of an institution's 340B benefit to measurable services for low-income and uninsured patients.

Contract-Pharmacy Compensation and Intermediary Incentives

This report's empirical analysis focuses on hospital performance. Contract-pharmacy compensation raises a separate but related accountability issue, addressed here as a policy consideration rather than as a finding of the hospital analysis. Contract pharmacies add another layer to the 340B financial model. A 2025 Senate U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP) Committee majority staff investigation found that contract-pharmacy agreements used multiple compensation structures, including fixed dispensing fees, percentages of third-party reimbursement, and combinations of the two. The report identified specialty-pharmacy arrangements in which CVS received 13% of the negotiated reimbursement rate and other arrangements in which Walgreens received administrative fees equal to 8% or 20% of contracted reimbursement.[1]

Percentage-based compensation creates a policy concern distinct from the value of the pharmacy's professional dispensing service. When a contract pharmacy's remuneration increases with the reimbursement value or claim value of the medicine, the payment can rise substantially simply because the drug is more expensive, even when the underlying dispensing service is similar. For a federal safety-net program, that price-linked structure can divert a larger share of the 340B margin to an intermediary without a corresponding increase in patient benefit.

This concern is now reflected in federal reform proposals. The 340B Drug Pricing Integrity and Affordability for Patients Act discussion draft released by Senate HELP Committee Chairman Bill Cassidy on June 25, 2026, would require contract-pharmacy payments to be a flat dollar amount, unrelated to a drug's price or discount. The draft would also cap per-dispense remuneration at 125% of the pharmacy's average

per-prescription dispensing fee paid by all third-party payers.[2] Medicaid offers a related service-based model: states generally reimburse a drug's ingredient cost separately from a professional dispensing fee intended to reflect pharmacy dispensing services. CMS reports, for example, a $10.50 professional dispensing fee in Kansas.[3]

Purpose of the Analysis

This analysis compares 340B and non-340B hospitals on reported measures directly relevant to care for low-income and uninsured populations. The objective is to establish an accountability benchmark: how do participating hospitals compare with hospitals that do not receive 340B-related revenue on charity care, charity care for uninsured, uncompensated care, and Medicaid patient volume?

Data and 340B Classification

We used RAND-transposed Center for Medicare and Medicaid Services (CMS) Health-care Cost Report Information System (HCRIS) hospital cost report data, obtained on May 1, 2025. We relied on the values reported in the RAND-transposed file and made no additional adjustments to the underlying cost report values.[10]

Hospital-Reported Source Data

Although Pioneer Institute obtained the analytic file from RAND, the underlying CMS HCRIS data are derived from Medicare hospital cost reports submitted directly by hospitals to CMS. RAND transposes and organizes these CMS data; it does not independently generate the hospital-reported charity-care, uncompensated-care, or operating-expense values analyzed here. The measures in this report therefore reflect hospitals' self-reported information.

Hospitals were linked to HRSA 340B covered-entity records. Hospitals identified as active 340B covered entities during the relevant reporting period were classified as 340B participants; hospitals without an active HRSA 340B designation were classified as non-340B.

Measures

- Charity care as a percentage of operating expenses;
- Charity care for uninsured patients as a percentage of operating expenses;
- Cost of the initial obligation of uninsured patients approved for charity care as a percentage of operating expenses;
- Unreimbursed or uncompensated care as a percentage of operating expenses; and
- Medicaid admission days as a percentage of total hospital days.

Hospital Groups and Exclusions

The principal comparison was between all 340B hospitals and all non-340B hospitals. We also examined four major 340B hospital categories: DSH, CAH, RRC, and SCH.

We excluded hospitals that did not report all required financial and patient-volume parameters used in the analysis.

Statistical Analysis

We compared unadjusted mean values across hospital categories. Because group sizes differed and we could not assume equal variances, we used Welch's t-test for inde-pendent samples with unequal variances for pre-specified comparisons. We assessed statistical significance at $P<.05$.

Results

The final analytic sample included 3,999 hospitals: 1,559 non-340B hospitals and 2,440 340B hospitals. The 340B group included 1,146 DSH hospitals, 1,060 CAHs, 121 RRCs, and 113 SCHs.

Charity Care and Assistance for Uninsured Patients

340B hospitals reported significantly lower average charity care than non-340B hospitals: 2.16% versus 2.82% of operating expenses. Charity care for uninsured patients was also lower: 1.60% versus 2.26%. The initial obligation of uninsured patients approved for charity care averaged 1.61% among 340B hospitals versus 2.27% among non-340B hospitals. All three differences were statistically significant.

Unreimbursed or uncompensated care was numerically lower among 340B hospitals (6.90% vs. 7.18%), but the overall difference was not statistically significant.

Hospital category	N	Charity care % OE	Uninsured charity care % OE	Initial uninsured obligation % OE	Unreimbursed/ uncompensated care % OE
Non-340B (all)	1,559	2.82	2.26	2.27	7.18
340B (all)	2,440	2.16[a]	1.60[a]	1.61[a]	6.90
DSH	1,146	2.62	2.09	2.10	7.04
CAH	1,060	1.69	1.09	1.11	6.92
RRC	121	2.07	1.51	1.52	6.12
SCH	113	2.00	1.50	1.50	6.20

Table 1. [a] Statistically significant difference compared with all non-340B hospitals, P<.05.

Medicaid Patient Volume

340B hospitals reported significantly higher Medicaid admission days than non-340B hospitals: 19.69% versus 17.76%. But averages conceal substantial variation. DSH hospitals reported 29.89% Medicaid admission days, whereas CAHs reported only 8.40%.

Hospital category	N	Medicaid admission days % of hospital days
Non-340B (all)	1,559	17.76
340B (all)	2,440	19.69[a]
DSH	1,146	29.89
CAH	1,060	8.40
RRC	121	19.64
SCH	113	22.12

Table 2. [a] Statistically significant difference compared with all non-340B hospitals.

340B hospitals reported significantly higher Medicaid admission days than non-340B hospitals: 19.69% versus 17.76%.

What the Findings Mean

The results reveal a clear accountability problem on direct patient assistance. 340B hospitals treated a greater share of Medicaid patients, demonstrating an important role in caring for low-income insured populations. At the same time, they reported significantly less overall charity care and charity care for uninsured patients than hospitals outside the program. A higher Medicaid share therefore does not answer the central question raised by these findings: whether hospitals receiving a substantial 340B financial benefit provide commensurately greater direct assistance to uninsured patients or those facing significant financial challenges.

Medicaid volume and charity care measure different dimensions of safety-net performance. Medicaid volume reflects service to low-income insured patients; charity care more directly measures financial assistance to vulnerable patients. Medicaid participation should not be treated as a substitute for charity care. A program intended to support low-income and uninsured populations should be accountable on both dimensions, particularly when participating hospitals receive a financial benefit unavailable to hospitals outside the program.

The DSH-CAH Difference Matters

The sharpest contrast is within 340B itself. DSH hospitals reported Medicaid admission days of 29.89% and charity care of 2.62% of operating expenses. CAHs reported Medicaid admission days of 8.40% and charity care of 1.69%.

That difference raises a structural question about 340B eligibility. DSH hospitals qualify through a framework tied to low-income inpatient burden. Other hospital categories enter the program through different statutory pathways. The data suggest that a single label, "340B hospital," can mask very different safety-net profiles.

A more coherent eligibility framework would preserve appropriate protections for rural access while also establishing a measurable minimum expectation that participating hospitals serve low-income populations.

Parity With Non-340B Hospitals Is an Insufficient Standard

The non-340B comparison should be understood as a floor, not a target: parity is an insufficient policy standard. A hospital that receives 340B discounts should not be able to satisfy the program's accountability expectations merely by matching the charity-care performance of hospitals that receive no 340B-related revenue. If 340B participation provides an additional financial benefit, the appropriate policy question is whether that benefit produces an additional, measurable safety-net return.

The comparison is also conservative because the measures analyzed here do not capture tax contributions. HRSA eligibility rules exclude for-profit hospitals from 340B and require participating hospitals to be government-owned or operated or to meet specified nonprofit requirements.[11] The non-340B comparison group, however, includes for-profit hospitals that pay local, state, and federal taxes. Those payments support public services and strengthen the tax base of the communities in which those hospitals operate. Yet this study does not reflect them in the charity-care, uncompensated-care, or Medicaid measures. As a result, the public value provided by the taxpaying segment of the non-340B group is greater than these findings alone indicate.

At the same time, 340B hospitals receive an additional federal financial advantage through mandatory manufacturer discounts. Many nonprofit 340B hospitals also benefit from federal income-tax exemption under section 501(c)(3), while public hospitals operate as governmental entities.[12] These advantages do not diminish the value of the care 340B hospitals provide; they raise the level of accountability that should accompany participation.

Accordingly, equal performance with non-340B hospitals should be viewed as a failure of additionality. A meaningful 340B accountability standard should require participating hospitals to demonstrate a measurable safety-net return above relevant non-340B benchmarks.

A higher Medicaid share therefore does not answer the central question raised by these findings: whether hospitals receiving a substantial 340B financial benefit provide commensurately greater direct assistance to uninsured patients or those facing significant financial challenges.

Transparency Is Necessary to Judge Performance

A major limitation of current federal policy is that the public cannot easily compare a hospital's 340B benefit size with the patient assistance it provides. Without standardized disclosure of 340B revenue and fund use, policymakers cannot determine whether institutions receiving the largest benefits also deliver commensurate support to low-income and uninsured patients.

This is not an argument that every 340B dollar must be booked as charity care. Hospitals may use program resources to maintain services, support staffing, subsidize clinics, or finance other activities that directly and specifically benefit low-income and uninsured patients. It is an argument for making those uses visible and measurable.

Charity-Care Reporting Allows Substantial Hospital Discretion

Although federal reporting frameworks define charity care and include reporting categories, hospitals retain substantial discretion in how they operationalize charity care through financial-assistance policies.[13] Institutions can differ in eligibility thresholds, documentation, patient-screening and presumptive-eligibility processes, application procedures, and accounting practices. Those choices affect whether eligible patients receive assistance and how that assistance is ultimately reported. Standardized categories therefore do not by themselves make charity-care measures fully comparable across hospitals.

Policymakers should strengthen reporting, documentation, and enforcement requirements. Transparent eligibility criteria, screening practices, approvals, denials, and financial-assistance policies would allow assessments of whether 340B savings expand direct patient assistance or are retained as institutional revenue.

The sharpest contrast is within 340B itself. DSH hospitals reported Medicaid admission days of 29.89% and charity care of 2.62% of operating expenses. (CAHs) reported Medicaid admission days of 8.40% and charity care of 1.69%."

Policy Recommendations

The findings support a more explicit accountability framework for hospital participation in 340B. Policymakers should focus on measurable eligibility, transparent reporting, and direct patient benefit.

1. Establish a Minimum Low-Income Patient-Burden Standard

Congress should establish a measurable minimum low-income patient-burden requirement across 340B hospital categories. The DSH framework is a logical starting point because it links eligibility to a hospital's low-income inpatient population. Policymakers should evaluate whether the existing DSH adjustment threshold, or a comparable category-adjusted measure, should serve as a baseline eligibility screen for other hospital categories.

2. Require Charity-Care and Uninsured Patient-Assistance Standards Significantly Above Non-340B Benchmarks.

340B participation should include explicit, enforceable expectations for direct patient assistance. Federal policy should require participating hospitals to provide overall charity care and charity care for uninsured patients at levels materially above appropriate non-340B benchmarks, with category-specific adjustments where necessary to account for hospital type, rurality, and patient population.

Congress and HRSA should establish a measurable margin above relevant non-340B performance that participating hospitals must meet to demonstrate incremental patient benefit.

3. Account for Tax Status and the Broader Public Contribution

Congress and HRSA should account for tax status and other public financial advantages when establishing 340B accountability benchmarks. Because the non-340B comparison group includes for-profit hospitals whose local, state, and federal tax payments represent a public contribution not captured by charity-care measures,[11] benchmarks should distinguish for-profit, nonprofit, and governmental hospitals from each other where appropriate.

If 340B participation provides an additional financial benefit, the appropriate policy question is whether that benefit produces an additional, measurable safety-net return.

4. Standardize Charity-Care Definitions and Reporting

Hospitals retain substantial discretion in how they design and implement financial-assistance policies. Federal standards should make charity-care measures more comparable across institutions by clarifying definitions, documentation requirements, eligibility practices, and reporting conventions.[13]

5. Require Auditable Reporting of 340B Revenue and Use of Funds

340B hospitals should separately track and publicly report revenue generated through 340B-related transactions and how those funds are used. Hospitals could satisfy the requirement through a separate account, dedicated ledger, or equivalent auditable accounting mechanism.

Reporting should also include material payments to outside entities involved in 340B transactions, including contract-pharmacy arrangements, so policymakers can see how much program revenue remains with the covered entity and how much flows to intermediaries.

6. Extend Patient-Assistance Obligations to Contract Pharmacies

Contract pharmacies that choose to participate in 340B should share in the program's patient-benefit obligations. Covered-entity agreements with contract pharmacies should require a defined level of assistance for uninsured and underinsured patients served through 340B arrangements. That assistance could include free or discounted medicines, reduced or waived dispensing charges, or other documented financial assistance under standardized eligibility criteria. A pharmacy that receives 340B-related remuneration should not participate solely as a revenue-generating intermediary without a measurable contribution to the vulnerable patients the program is intended to serve.

The precise accounting construct used for hospitals' charity care may not transfer directly to retail pharmacies. Still, the underlying principle should: if an outside pharmacy elects to participate in the 340B financial model, its contract should include an enforceable patient-assistance obligation rather than allowing all program-related remuneration to accrue as commercial revenue.

7. De-link Contract-Pharmacy Compensation From Drug Prices

Congress should prohibit contract-pharmacy compensation that is calculated as a percentage of a drug's reimbursement amount, claim value, retail or list price, 340B spread, or 340B savings. Contract pharmacies should instead be paid a flat professional service fee for each prescription dispensed on behalf of a covered entity. A transparent benchmark for that payment is the professional dispensing fee established by the applicable state Medicaid program, with narrowly defined adjustments when a pharmacy can document materially different services or costs.[3]

This recommendation would remove the direct link between a medicine's price and the pharmacy's 340B compensation. It is also directionally consistent with the June 2026 Senate HELP discussion draft, which would require flat-dollar contract-pharmacy

remuneration unrelated to drug price and would cap the fee at 125% of the pharmacy's average per-prescription dispensing fee from third-party payers.[2] The proposed Medicaid benchmark is simpler and publicly transparent because it ties payment to a government-established professional dispensing fee rather than the economics of the underlying drug transaction.

8. Give Patients a Clear Path to Financial Assistance

Participating hospitals should provide a standardized notice explaining that the institution participates in the 340B Drug Pricing Program and clearly identifying how patients can contact the hospital's financial-assistance and charity-care program.

A patient notice will not resolve program-wide accountability concerns, but it would connect the program's safety-net purpose to a practical benefit for patients who may qualify for assistance.

Conclusion

The 340B program is intended to strengthen the healthcare safety net. A program with that purpose should demonstrate, in measurable terms, that its financial benefits align with vulnerable patients' needs.

This analysis finds that 340B hospitals served a greater share of Medicaid patients than non-340B hospitals. It also finds that 340B hospitals reported significantly less charity care, less charity care for uninsured patients, and lower initial obligations of uninsured patients approved for charity care. Overall unreimbursed or uncompensated care was also lower, although that difference was not statistically significant.

The variation within 340B is equally important. DSH hospitals showed substantially greater low-income patient volume than CAHs, reinforcing the need to examine whether hospital eligibility rules consistently reflect safety-net burden.

The central policy implication is straightforward: 340B participation should not be judged successful merely because participating hospitals match non-340B hospitals. Hospitals receiving 340B discounts should demonstrate a measurably greater benefit for uninsured and underinsured patients.

The same accountability principle should extend to contract pharmacies through defined patient-assistance obligations and compensation tied to dispensing services, not drug prices.

Transparency and measurable accountability would not weaken the 340B program. They would establish the minimum evidence needed to show that a federal financial benefit intended for the safety net produces an incremental and demonstrable benefit for the patients and communities the program is meant to serve. The standard should be clear: 340B hospitals should do significantly more, not merely the same.

The central policy implication is straightforward: 340B participation should not be judged successful merely because participating hospitals match non-340B hospitals. Hospitals receiving 340B discounts should demonstrate a measurably greater benefit for uninsured and underinsured patients.

Endnotes

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About the Authors

Dr. Robert Popovian, Pharm.D., MS is the Founder of the strategic consulting firm Conquest Advisors. He also serves as Chief Science Policy Officer at the Global Healthy Living Foundation, Senior Healthy Policy Fellow at the Progressive Policy Institute, and Visiting Health Policy Fellow at the Pioneer Institute. He previously served as Vice President, U.S. Government Relations at Pfizer.

One of the country's foremost experts on every significant facet of biopharmaceuticals and the healthcare industry, he is a recognized authority on health economics, policy, government relations, medical affairs, and strategic planning.

Dr. Popovian has published extensively and referenced on the impact of biopharmaceuticals and health policies on costs and clinical outcomes in the most prominent medical sources and media publications, including the Wall Street Journal, Clinical Economics and Outcomes Research, The Oncologist, Journal of Vaccines and Vaccinations, Journal of American Pharmacists Association, Journal of Health Economics and Outcomes Research, USA Today, Washington Examiner, Managed Healthcare Executive, and The Hill. He is also a sought-after speaker and has been invited to provide detailed presentations, briefings, and expert reviews for the U.S. Congress and dozens of state legislatures, as well as at conferences andmedical symposiums throughout the country and worldwide.

Dr. Popovian is one of the select few researchers to study and publish clinical and policy-related economic analysis and empirical data regarding emerging payment models in the U.S. healthcare system and for biopharmaceutical reimbursement. His insight and analysis also led to one of the first inclusions of health outcomes data in a labeled indication of a biopharmaceutical.

Dr. Popovian is Chairman of the Board of Councilors at the University of Southern California School of Pharmacy, an Adjunct Clinical Assistant Professor at Rutgers School of Pharmacy, and an advisor to the Value of Life Sciences Innovation program at the Schaeffer Institute.

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Anne M. Sydor, PhD is the Founder and Principal of VT4—Voice to Test Transformed, a research design and communications consultancy firm. She has worked with dozens of individual researchers, nonprofit patient advocacy groups, and industry to design research, analyze data, and communicate results. She is also a Research Fellow at the Pioneer Institute.

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Michael Walker is Senior Fellow, Pioneer Analytics, and a principal in the data analysis firm, DataMadeUseful, LLC. Mr. Walker is responsible for the creation of more than 100 data visualization applications in Pioneer's US DataLabs, MA DataLabs, and Boston DataLabs. On this project, he created the 340B data applications utilizing HRSA Office of Pharmacy Affairs 340B data on covered entities and contract pharmacies, the Rand Hospital Cost Reports, and the Census Bureau's mapping poverty rates by of state legislative district.

In addition to his work with Pioneer, Mr. Walker has created more than 300 data applications for think tanks, newspapers, non-profit social service agencies, and state and local governments. He has an MBA from the Drucker School of Management, in Claremont, CA, and has 35 years' experience in Information Technology.

Dr. William Smith is Senior Fellow & Director of Pioneer Life Sciences Initiative. Dr. Smith has 25 years of experience in government and in corporate roles. His career includes senior staff positions for the Republican House leadership on Capitol Hill, the White House Office of National Drug Control Policy, and the Massachusetts Governor's office where he served under Governors Weld and Cellucci. He spent ten years at Pfizer Inc as Vice President of Public Affairs and Policy where he was responsible for Pfizer's corporate strategies for the U.S. policy environment. He later served as a consultant to major pharmaceutical, biotechnology and medical device companies. Dr. Smith earned his PhD in political science with distinction at The Catholic University of America.

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