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The Honorable Greg Walden
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Michael C. Burgess
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Drug Discount Program: Characteristics of Hospitals Participating and Not Participating in the 340B Program

The 340B Drug Pricing Program was created in 1992 to enable eligible covered entities—including certain categories of hospitals—to obtain discounts on covered outpatient drugs. Eligible hospitals generally must meet a minimum Medicare disproportionate share hospital (DSH) adjustment percentage, a measure that identifies hospitals that treat a disproportionate number of low-income Medicare and Medicaid inpatients.[1] They also must either be state or local government-owned or -operated hospitals, nonprofit corporations formally granted state or local governmental powers, or private nonprofit hospitals with government contracts to provide health care services to low-income individuals not eligible for Medicaid or Medicare. According to the Health Resources and Services Administration (HRSA), the agency within the Department of Health and Human Services (HHS) responsible for administering and overseeing the 340B Program, the purpose of the program is to enable covered entities to stretch federal resources to reach more eligible patients and provide more comprehensive services.[2]

Eligibility for the 340B Program is determined pursuant to the definition of "covered entity" in section 340B of the Public Health Service Act and is generally limited to entities that participate in specified federal programs and six hospital types.[3] General acute care hospitals that have a

[1]Medicare is a federally financed program that provides health insurance coverage to people age 65 and older, certain individuals with disabilities, and those with end-stage renal disease. Medicaid is a joint federal-state health financing program that provides health insurance coverage to low-income and medically needy individuals.

[2]HRSA bases this on language in a House Energy and Commerce Committee report pertaining to language similar to what eventually became section 340B of the Public Health Service Act (PHSA). *See* H. Rep. No. 102-384, Pt. 2, at 12 (1992) (discussing bill to amend the Social Security Act). *See also* Veterans Health Care Act of 1992, Pub. L. No. 102-585, § 602(a), 106 Stat. 4943, 4967 (adding section 340B to the PHSA).

[3]With the exception of critical access hospitals, 340B-eligible hospitals are required to meet or have a payer mix that would allow them to meet statutorily specified minimum DSH adjustment percentages. Eligible hospitals must also be owned or operated by a unit of state or local government, nonprofit corporations formally granted governmental powers by a unit of state or local government, or private nonprofit hospitals with government contracts to provide health care services to low-income individuals not eligible for Medicare or Medicaid. PHSA § 340B(a)(4)(L)–(O) (codified at 42 U.S.C. § 256b(a)(4)(L)–(O)). Other than specified categories of hospitals, eligible entities include

DSH adjustment percentage greater than 11.75 percent have been eligible for the program since its inception in 1992. HRSA refers to such hospitals participating in the program as 340B DSH hospitals. Most of the other five hospital types became eligible for the program through the enactment of the Patient Protection and Affordable Care Act (PPACA) in 2010.[4] (See table 1.) The number of hospitals participating in the program increased over 60 percent from 2011 to 2016, from 1,465 to 2,399.[5] The increases occurred primarily among hospital types that first became eligible for the program in 2010.

Table 1: Summary of 340B Hospital Types, 2016

340B hospital type	Description	Number of 340B hospitals	Percentage of all 340B hospitals	Minimum DSH adjustment percentage requirement	First year of program eligibility
General acute care hospitals (340B disproportionate share hospitals (DSH))[a,b]	Hospitals that serve a disproportionate number of low-income Medicare and Medicaid inpatients	992	45%	>11.75%	1992
Children's hospitals (PED)[a]	Hospitals with inpatients predominantly age 18 or younger and that serve a disproportionate number of low-income Medicare and Medicaid inpatients	47	2%	>11.75%	2006
Critical access hospitals (CAH)[c]	Small, rural, geographically isolated hospitals	995	45%	N/A	2010
Freestanding cancer hospitals (CAN)[a]	Independent, nonprofit hospitals that treat patients with cancer and that serve a disproportionate number of low-income Medicare and Medicaid inpatients	3	<1%	>11.75%	2010
Rural referral centers (RRC)[a,d]	High-volume rural hospitals that treat a large number of complicated cases and that serve a disproportionate number of low-income Medicare and Medicaid inpatients	41	2%	≥8%	2010
Sole community hospitals (SCH)[a,e]	Geographically isolated hospitals that serve a disproportionate number of low-income Medicare and Medicaid inpatients	129	6%	≥8%	2010

Source: GAO analysis of Health Resources and Services Administration (HRSA) data. | GAO-18-521R

federally qualified health centers, urban Indian organizations, family planning clinics, sexually transmitted disease grantees, tuberculosis grantees, Native Hawaiian health centers, Ryan White AIDS Drug Assistance Programs, other Ryan White grantees, hemophilia treatment centers, and black lung clinics. Additionally, providers that meet all of the requirements for the federally qualified health centers program, but do not receive federal grants—referred to as federally qualified health center look-alikes—are eligible to participate in the 340B Program. PHSA § 340B(a)(4)(A)–(K) (codified at 42 U.S.C. §256b(a)(4)(A)–(K)).

[4]*See* Pub. L. No. 102-585, § 602(a), 106 Stat. 4943, 4967 (1992) (DSH); Pub. L. No. 109-171, § 6004, 120 Stat. 4, 61 (2006) (Children's hospitals (PED) eligibility through amendment to Social Security Act § 1927 (a)(5)(B)); Pub. L. No. 111-148, § 7101(a), 124 Stat. 119, 821 (2010) (PED eligibility through amendment to PHSA § 340B, freestanding cancer hospitals (CAN), critical access hospitals (CAH), rural referral centers (RRC), and sole community hospitals (SCH)).

[5]In 2011, we recommended actions that HRSA should take to improve program integrity, particularly given significant growth in the program in recent years. See GAO, *Drug Pricing: Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement,* GAO-11-836 (Washington, D.C.: Sept. 23, 2011). For additional reports on related issues, see Related GAO Products.

Note: The data in the table represent hospitals that participated in the 340B Program during all of 2016.

[a]These hospitals are among a broader group of hospitals that serve a disproportionate number of low-income Medicare and Medicaid inpatients, as measured by their Medicare DSH adjustment percentage, and that receive payments from the Centers for Medicare & Medicaid Services (CMS) to cover the costs of providing care to these patients in accordance with 42 U.S.C. § 1395ww(d)(5)(F).

[b]We use the term general acute care hospital to refer to hospitals that participate in the 340B Program under HRSA's 340B DSH type designation.

[c]CAHs are certified by CMS in accordance with 42 U.S.C. § 1395i-4(e).

[d]RRCs are classified by CMS in accordance with 42 U.S.C. § 1395ww(d)(5)(C)(i).

[e]SCHs are classified by CMS in accordance with 42 U.S.C. § 1395ww(d)(5)(D)(iii). A hospital may generally qualify for SCH status if it is determined that because of factors such as isolated location, weather conditions, travel conditions, or absence of other like hospitals, it is the sole source of inpatient hospital services reasonably available in a geographic area.

PPACA also permitted states to expand their Medicaid programs beginning January 1, 2014, to cover nearly all adults with incomes at or below 133 percent of the federal poverty level.[6] Prior to PPACA, state Medicaid programs were limited in their ability to provide Medicaid coverage to nonelderly and nonpregnant adults who were not eligible for Medicare.

Questions have been raised about the growth in the number of hospitals participating in the 340B Program and the impact on 340B participation of the states expanding their Medicaid programs (hereafter called Medicaid expansions) following PPACA. Questions also have been raised about whether hospitals in expansion states may be providing less charity care and uncompensated care—which generally represent services that hospitals provide to patients who are unable or unwilling to pay for their care—due to increased insurance coverage resulting from the Medicaid expansions.[7] In light of these questions, you asked us to examine the characteristics of hospitals that do and do not participate in the program and changes in those characteristics, if any, after the Medicaid expansions. In this report, we

1. compare certain characteristics of 340B and non-340B hospitals and
2. describe how, if at all, the characteristics of these hospitals changed after states' Medicaid coverage was expanded.

For our research objectives, we examined 2012 and 2016 data from the Centers for Medicare & Medicaid Services' (CMS) Medicare hospital cost reports and from HRSA's Office of Pharmacy

[6]A 5 percent income disregard was specified for calculating modified adjusted gross income, which, in effect, raised this income limit to 138 percent of the federal poverty level. *See* Pub. L. No. 111-148, § 2001(a), 124 Stat. 119, 271 (as amended by Pub. L. No. 111-152, § 1004(e), 124 Stat. 1029, 1036 (2010)) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII), (e)(14)(I)).

[7]In 2016, we reported that the number of Medicaid patients treated by a hospital is not a good indicator of the amount of uncompensated care provided by a hospital and that increased Medicaid coverage is typically associated with a decrease in hospitals' uncompensated care costs. See GAO, *Hospital Uncompensated Care: Federal Action Needed to Better Align Payments with Costs,* GAO-16-568 (Washington, D.C.: June 30, 2016). In addition, recent studies have found that states that expanded Medicaid coverage have experienced decreases in charity care and uncompensated care costs. For example, see Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP* (Washington, D.C.: Mar. 15, 2018) and Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* (Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, Mar. 28, 2018).

Affairs Information System (OPAIS).[8] We used 2012 data because this allowed us to examine hospital characteristics before Medicaid expansion, which occurred primarily in 2014.[9] We used 2016 data because this allowed us to examine hospital characteristics 2 or more years after the majority of the Medicaid expansions occurred, and these were the most recent cost report data available at the time of our analysis. We focused our analysis on three of the six hospital types eligible for the 340B Program—critical access hospitals (CAH), sole community hospitals (SCH), and general acute care hospitals (also referred to as 340B DSH)—because these three types accounted for over 95 percent of hospitals participating in the program in 2016.[10] To identify a hospital as 340B, we used OPAIS data to determine if it participated in the 340B Program for all of either 2012 or 2016. To identify the hospital type for 340B hospitals, we used the type designation specified in OPAIS.[11] To identify the hospital type for non-340B hospitals, we used the type designation in the hospital's Medicare cost report.[12] For our report, non-340B general acute care hospitals include acute care hospitals that were not categorized as any of the following hospital types: CAH, freestanding cancer hospital (CAN), children's hospital (PED), rural referral center (RRC), or SCH. These hospitals may include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

To compare 340B and non-340B hospitals, we used the 2016 cost report data to examine characteristics such as hospital size (based on the number of inpatient beds), teaching status (major teaching hospital, other teaching hospital, or nonteaching hospital), location (urban or rural), ownership type (government, voluntary nonprofit, or proprietary), and Medicare DSH adjustment percentage. We also used cost report data to calculate a hospital's (1) charity care, uncompensated care, total unreimbursed and uncompensated care, Medicare DSH adjustment payment, Medicare uncompensated care payment, and Medicaid revenue, all as a percentage

[8]Institutional providers that render services to Medicare beneficiaries are required to submit cost reports annually. Among other things, these reports contain self-reported information on facility characteristics, utilization data, and financial statement data. Because hospitals may have different fiscal year start and end dates, the time periods covered by the cost reports in our analysis vary.

As of December 31, 2017—the date of the most recent updates to the cost report files that were available at the time of our study—6,226 cost reports were submitted for fiscal year 2012 data and 5,601 cost reports were submitted for fiscal year 2016 data.

[9]PPACA also permitted an early expansion option whereby states could expand eligibility for low-income adults (or a subset of this population) starting on April 1, 2010. See Pub. L. No. 111-148, §§ 2001(a)(4), 10201(b), 124 Stat. 274, 918 (codified at 42 U.S.C. § 1396a(k)(2)). Six states expanded Medicaid through this option prior to 2014, although enrollment for this population was limited in these states.

[10]We excluded from our analysis hospitals that (1) were categorized as one of the remaining 340B hospital types: CAN, PED, or RRC; (2) were located outside the 50 states and Washington, D.C.; (3) had cost report periods that covered fewer than 10 or more than 14 months; (4) participated in the 340B Program for only part of a particular year (2012 or 2016); and (5) had missing or inconsistent data.

[11]Because a 340B hospital may change hospital type during the year, we categorized it as the hospital type through which it participated in the program for the majority of the year, or as the type it was during the latter part of the year if it participated as two types for the same amount of time.

[12]Some non-340B hospitals were designated as both PED and RRC or SCH and RRC in their cost reports. In these cases we designated the hospital as PED or SCH, respectively.

of total facility revenue; and (2) total facility margin.[13] We also examined the percentages of 340B and non-340B hospitals in our analysis that provided the highest and lowest amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care as a percentage of total facility revenue.[14] We selected these characteristics because they (1) allowed us to describe basic characteristics of 340B and non-340B hospitals (e.g., hospital size), (2) were related to 340B Program participation (e.g., DSH adjustment percentage), or (3) could be impacted by the Medicaid expansions (e.g., uncompensated care). Table 2 provides a summary of the numbers of hospitals included in our characteristics analysis.

Table 2: Number of 340B and Non-340B Hospitals Included in Our Hospital Characteristics Analysis, by Hospital Type, 2016

Type of hospital	340B hospitals	Non-340B hospitals
All hospitals	**1,867**	**2,030**
Critical access hospitals (CAH)	929	278
Sole community hospitals (SCH)	117	163
General acute care hospitals[a]	821	1,589

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Note: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

To describe any changes in the characteristics of 340B and non-340B hospitals after state Medicaid coverage was expanded, we used the 2012 and 2016 cost report data to examine certain characteristics described above. We limited this analysis to hospitals located in 24 states and Washington, D.C., that expanded Medicaid coverage by December 31, 2014, and 19 states that did not expand Medicaid as of January 2017. We excluded hospitals located in 2 states that expanded Medicaid in 2014—Arkansas and New Hampshire—because they expanded Medicaid to certain low-income adults under CMS-approved waivers that allowed them to use Medicaid funds to purchase private health insurance coverage.[15] Additionally, we excluded hospitals located in 5 states that expanded Medicaid coverage in 2015 or 2016 because the

[13]For these analyses, we used the values that were reported by the hospital on its cost report. For most analyses, we excluded hospitals that had a missing value for the characteristics of interest. For the following analyses, we also excluded hospitals that reported a negative value for the characteristics of interest: amounts of charity care, uncompensated care, total unreimbursed and uncompensated care provided, and net Medicaid revenue. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid). The reported value may be overstated if the hospital received payments from a public payer that exceeded costs, in which case the hospital is instructed to enter a value of zero for unreimbursed care for that payer.

[14]We considered hospitals to be among the highest or lowest providers of this care if the reported amounts, as a percentage of total facility revenue, were within the top or bottom quartile, respectively, across all hospitals within a hospital group (all hospitals, CAHs, SCHs, or general acute care hospitals).

[15]CMS officials told us that these newly covered patients would not be captured as Medicaid patients for the purposes of calculating a hospital's DSH adjustment percentage.

impact of these states' expansions might not be reflected in the 2016 data.[16] To examine the same group of hospitals over time, we limited this analysis to hospitals that (1) had submitted cost reports for both 2012 and 2016; (2) did not change hospital type between 2012 and 2016; and (3) for most analyses, did not change 340B participation status between 2012 and 2016. Table 3 provides a summary of the numbers of hospitals included in our Medicaid expansion analysis.

Table 3: Number of 340B and Non-340B Hospitals Included in Our Medicaid Expansion Analysis, by Hospital Type, 2012 and 2016

	2012		2016	
Type of hospital	**340B hospitals**	**Non-340B hospitals**	**340B hospitals**	**Non-340B hospitals**
All hospitals	1,151	1,898	1,450	1,599
Critical access hospitals (CAH)	480	433	705	208
Sole community hospitals (SCH)	44	141	60	125
General acute care hospitals[a]	627	1,324	685	1,266

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) did not submit cost reports for both 2012 and 2016; (3) had cost report periods that covered fewer than 10 or more than 14 months; (4) participated in the 340B Program for only part of a particular year (2012 or 2016); (5) changed hospital type between 2012 and 2016; and (6) had missing or inconsistent data.

For this analysis, we included hospitals located in 24 states and Washington, D.C. that expanded Medicaid coverage in 2014 and 19 states that did not expand Medicaid as of January 2017. We excluded hospitals located in 2 states that expanded Medicaid in 2014—Arkansas and New Hampshire—but used Medicaid funds to purchase private health insurance coverage, and in 5 states that expanded Medicaid in 2015 or 2016.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

To assess the reliability of the data we used in our analyses, we reviewed related documentation, interviewed officials from CMS and HRSA, and performed appropriate electronic data checks. On this basis, we determined that the data were sufficiently reliable for the purposes of our reporting objectives.

We conducted this performance audit from July 2017 to June 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, we found the following:

- In 2016, among all hospitals in our analysis, 340B hospitals were smaller in terms of the number of inpatient beds, and a somewhat higher percentage of these hospitals were teaching hospitals compared with non-340B hospitals. However, for nearly all characteristics included in our analysis, the differences between 340B and non-340B hospitals varied across the different hospital types. For example, while 340B general

[16]Alaska, Indiana, and Pennsylvania expanded Medicaid coverage in 2015. Louisiana and Montana expanded Medicaid coverage in 2016.

acute care hospitals (340B DSH) were much larger in terms of the number of inpatient beds compared with their non-340B counterparts, 340B and non-340B CAHs were similar in size in terms of the number of inpatient beds. In addition, a much higher percentage of 340B general acute care hospitals (340B DSH) were teaching hospitals compared with their non-340B counterparts, whereas the same percentage of 340B and non-340B SCHs were teaching hospitals. In addition, we found that the median amount of charity care provided by all 340B hospitals in our analysis was similar to the median amount provided by all non-340B hospitals, and the median amount of uncompensated care provided by these 340B hospitals was higher than that provided by their non-340B counterparts. But again, the differences between the 340B and non-340B hospitals varied across the different hospital types. For example, while the median amount of uncompensated care provided by 340B general acute care hospitals (340B DSH) was higher than that of their non-340B counterparts, the median amount provided by 340B CAHs was lower than that of non-340B CAHs. (See enc. I for further details on the characteristics of 340B and non-340B hospitals in 2016.)

- From 2012 to 2016, hospital participation in the 340B Program among general acute care hospitals (340B DSH) increased in Medicaid expansion states but did not increase in non-expansion states. This may be explained in part by an increase in the number of hospitals in expansion states that met the minimum Medicare DSH adjustment percentage required for 340B participation, as it identifies hospitals that treat a disproportionate number of low-income Medicare and Medicaid inpatients. From 2012 to 2016, the median Medicare DSH adjustment percentages for both 340B and non-340B general acute care hospitals increased in Medicaid expansion states and decreased in non-expansion states. In addition, the median amounts of charity care and uncompensated care provided by hospitals in Medicaid expansion states generally decreased more compared with hospitals in non-expansion states. This increase in 340B participation and decrease in charity care and uncompensated care may suggest that, in expansion states, hospitals experienced an increase in the number of patients covered by insurance, such as Medicaid. (See enc. II for further details about changes in characteristics of 340B and non-340B hospitals in Medicaid expansion and non-expansions states from 2012 to 2016.)

We provided a draft of this report to HHS for comment. HHS did not have any comments.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on GAO's website at http://www.gao.gov.

If you or your staffs have any questions about this information, please contact me at (202) 512-7114 or CosgroveJ@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report were Gerardine Brennan, Assistant Director; Aubrey Naffis, Analyst-in-Charge; George Bogart; Zhi Boon; Muriel Brown; Melissa Duong; Elizabeth Morrison; and Eric Wedum.

James Cosgrove
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Enclosures – 2

Enclosure I: Characteristics of 340B and Non-340B Hospitals, 2016

Hospital Size (based on Number of Inpatient Beds)

- In 2016, among all hospitals in our analysis, 340B hospitals were generally smaller (had fewer inpatient beds) than non-340B hospitals. However, there was variation among the different hospital types. For example,
    - while the median number of inpatient beds among 340B general acute care hospitals (340B disproportionate share hospitals (DSH)) was much larger than their non-340B counterparts, the median number of inpatient beds for 340B critical access hospitals (CAH) was similar to that of non-340B CAHs[17] (see table 4).

Table 4: Median Number of Inpatient Beds of 340B and Non-340B Hospitals, by Hospital Type, 2016

Type of hospital	340B hospitals	Non-340B hospitals
All hospitals in analysis (N=3,893)	**25**	**92**
Critical access hospitals (CAH) (N=1,207)	25	24
Sole community hospitals (SCH) (N=280)	63	68
General acute care hospitals (N=2,406)[a]	222	121

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Note: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

[17]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under the Health Resources and Services Administration's (HRSA) 340B DSH type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, freestanding cancer hospital, children's hospital, rural referral center, or sole community hospital. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Teaching Status

- In 2016, among all hospitals in our analysis, a somewhat higher percentage of 340B hospitals were teaching hospitals compared with non-340B hospitals. However, there was variation among the different hospital types. For example,
    - while a similar percentage of 340B and non-340B sole community hospitals (SCH) were teaching hospitals, a much higher percentage of 340B general acute care hospitals (340B DSH) were teaching hospitals compared with their non-340B counterparts, and
    - no CAHs were teaching hospitals (see table 5).

Table 5: Teaching Status of 340B and Non-340B Hospitals, by Hospital Type, 2016

	340B hospitals		Non-340B hospitals	
Type of hospital and teaching status	**Number**	**Percent**	**Number**	**Percent**
All hospitals in analysis (N=3,897)				
Teaching	**472**	**25**	**455**	**22**
Major teaching	187	10	88	4
Other teaching	285	15	367	18
Non-teaching	**1,395**	**75**	**1,575**	**78**
Critical access hospitals (CAH) (N=1,207)				
Non-teaching	**929**	**100**	**278**	**100**
Sole community hospitals (SCH) (N=280)				
Teaching	**15**	**13**	**21**	**13**
Major teaching	0	0	2	1
Other teaching	15	13	19	12
Non-teaching	**102**	**87**	**142**	**87**
General acute care hospitals (N=2,410)[a]				
Teaching	**457**	**56**	**434**	**27**
Major teaching	187	23	86	5
Other teaching	270	33	348	22
Non-teaching	**364**	**44**	**1,155**	**73**

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data.

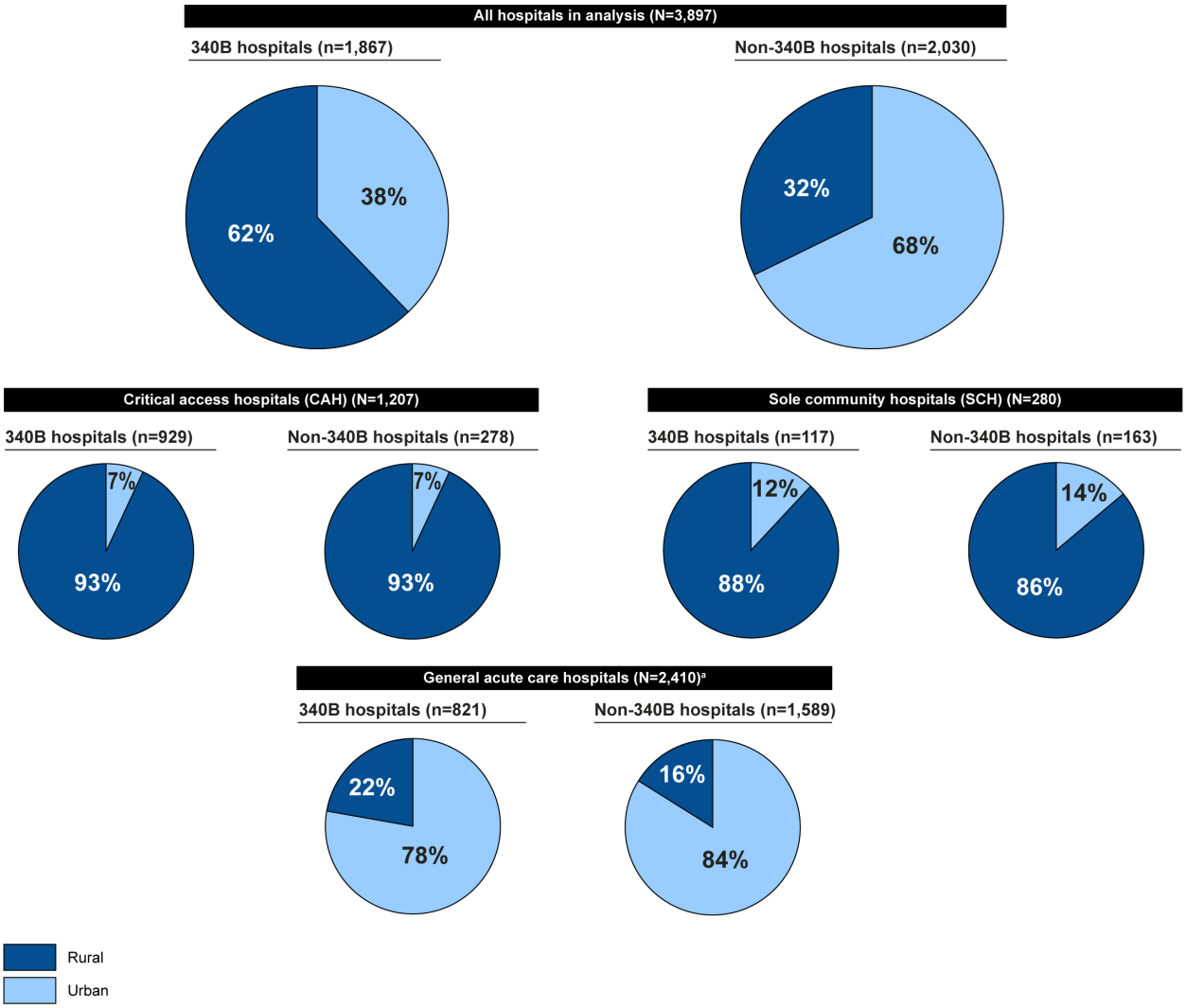
We defined major teaching hospitals as those that had a resident-to-bed ratio greater than 0.25.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Location

- In 2016, a much higher percentage of 340B hospitals in our analysis were rural compared with non-340B hospitals. However, within each hospital type, the percentages of urban and rural hospitals were more similar—that is, similar percentages of 340B and non-340B CAHs, SCHs, and general acute care hospitals were rural. (See fig. 1.)

Figure 1: Location of 340B and Non-340B Hospitals, by Hospital Type, 2016



Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data.

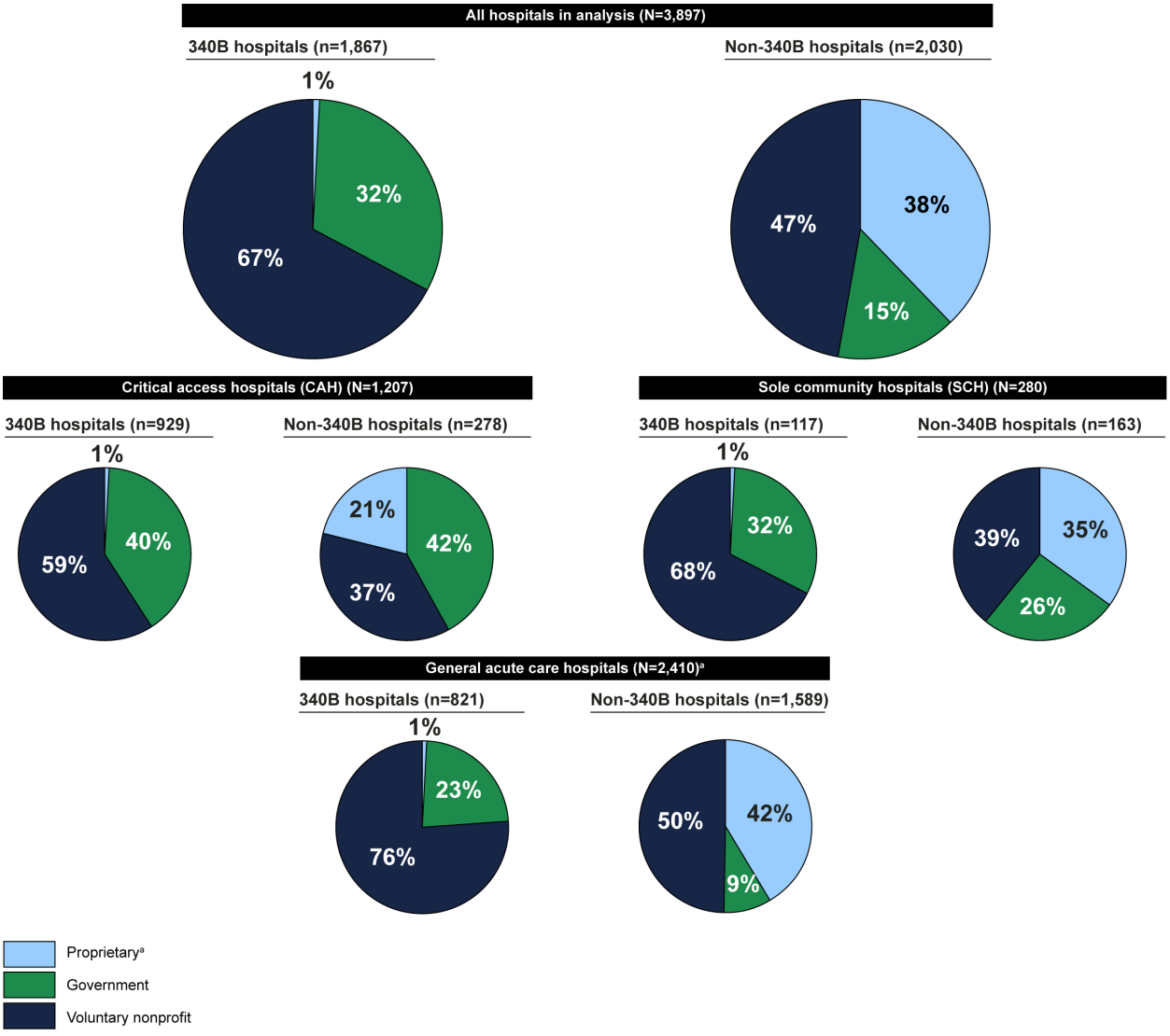
We categorized hospitals according to the standard geographic (non-wage) classification that was reported on their Medicare cost report.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Ownership Type

- In 2016, while a higher percentage of 340B hospitals in our analysis were government-owned or voluntary nonprofits compared with non-340B hospitals, there was variation among the hospital types. For example, a somewhat lower percentage of 340B CAHs were government-owned compared with non-340B CAHs. (See fig. 2.)

Figure 2: Ownership Type of 340B and Non-340B Hospitals, by Hospital Type, 2016



Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data.

We categorized hospitals according to the type of control that was reported on their Medicare cost report. Percentages may not sum to 100 due to rounding.

[a]Fourteen 340B hospitals in 2016 (7 CAHs, 1 SCH, and 6 DSH hospitals) reported "proprietary" as the type of control on their cost reports. Proprietary hospitals may include those owned by individuals, corporations, partnerships, or others. According to HRSA officials, if a 340B hospital reports its type as "proprietary" in its cost report, the agency asks the hospital to provide documentation of its nonprofit status.

[b]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

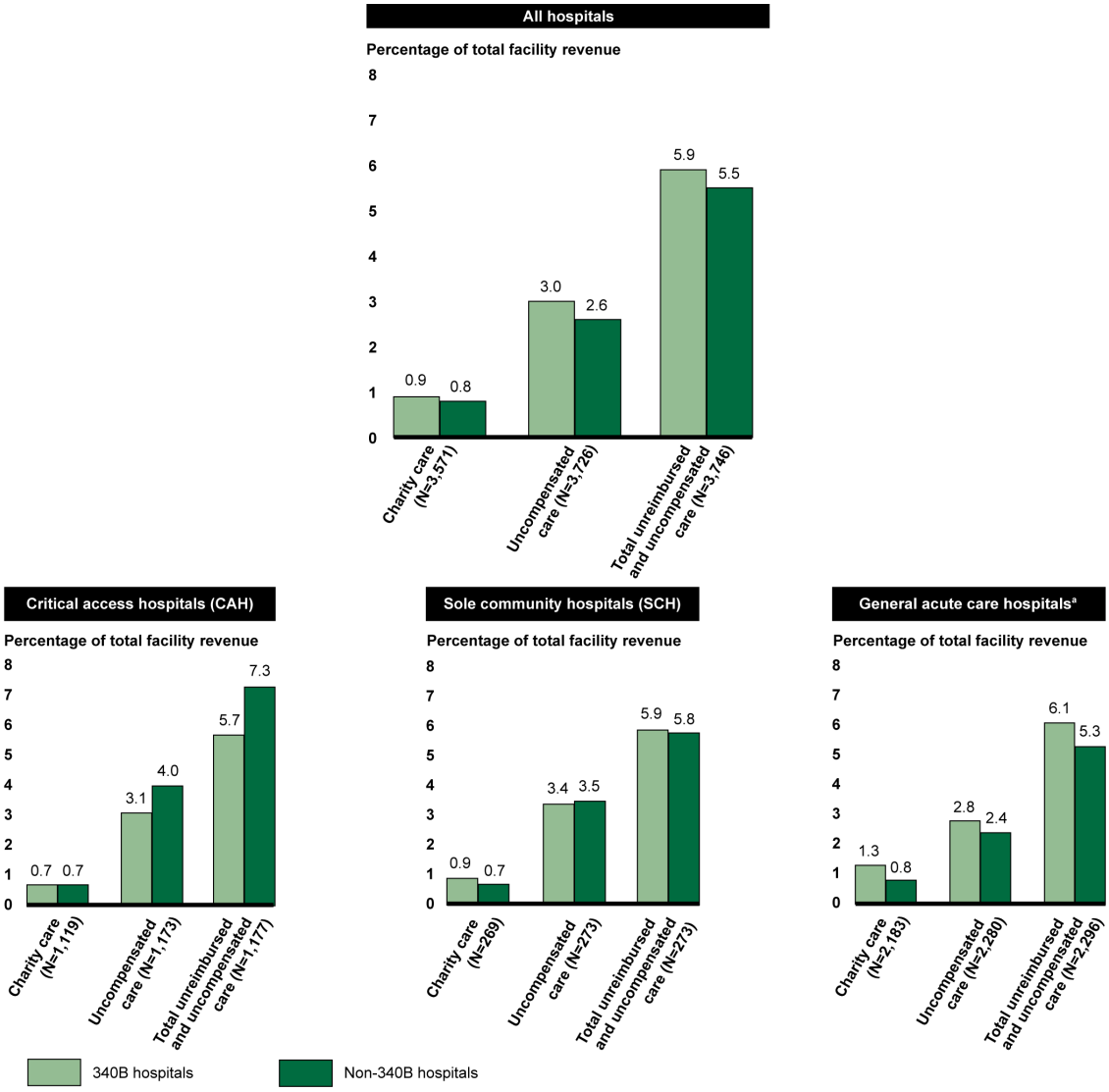
Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care

Charity care generally represents services for which a hospital demonstrates that a patient is unable to pay, and is based on a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Uncompensated care includes charity care and bad debt, which generally represents services for which a hospital determines that a patient has the financial capacity to pay, but is unwilling to do so. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid).

We examined the median amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care (as a percentage of total facility revenue) provided by 340B and non-340B hospitals.

- In 2016, among all hospitals in our analysis, when measured as a percentage of total facility revenue, the median amount of charity care provided was similar among 340B and non-340B hospitals, and the median amounts of uncompensated care and total unreimbursed and uncompensated care provided by 340B hospitals were higher than the median amounts provided by non-340B hospitals. However, there was variation among the different hospital types. For example,
    - while the median amount of charity care provided by 340B and non-340B CAHs was the same, the median amounts provided by 340B SCH and general acute care hospitals (340B DSH) were higher than their non-340B counterparts, and
    - while the median amount of uncompensated care provided by 340B general acute care hospitals (340B DSH) was higher than that of their non-340B counterparts, the median amount provided by 340B CAHs was lower than non-340B CAHs (see fig. 3).

Figure 3: Median Amounts of Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care Provided, as a Percentage of Total Facility Revenue, by Hospital Type, 2016



Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data. For these analyses, we also excluded hospitals that had a negative value for the variables of interest.

Charity care generally represents services for which a hospital demonstrates that a patient is unable to pay, and is based on a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Uncompensated care includes charity care and bad debt, which generally represents services for which a hospital determines that a patient has the financial capacity to pay, but is unwilling to do so. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid).

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

We also examined the percentages of 340B and non-340B hospitals in our analysis that provided the highest and lowest amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care. We considered hospitals to have provided a high or low amount of this care if the reported amounts, as a percentage of total facility revenue, were within the top or bottom quartile, respectively, across all hospitals within a hospital type (all hospitals, CAHs, SCHs, or general acute care hospitals).

- In 2016, among all hospitals in our analysis, when measured as a percentage of total facility revenue, a higher percentage of 340B hospitals provided high amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care compared with non-340B hospitals.

- While 340B hospitals in our analysis generally provided higher amounts of these types of care compared with non-340B hospitals, at least 20 percent of 340B hospitals (or 367 hospitals) were among those that provided the lowest amounts of these types of care. (See table 6.)

Table 6: Percentage of All 340B and Non-340B Hospitals in Analysis That Provided High and Low Amounts of Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care, as a Percentage of Total Facility Revenue, 2016

Type and minimum or maximum percentage of care	340B hospitals	Non-340B hospitals
High amounts of care		
Charity care (≥2.0 percent)	**26.5**	23.5
Uncompensated care (≥5.5 percent)	**26.5**	23.5
Total unreimbursed and uncompensated care (≥9.2 percent)	**25.6**	24.3
Low amounts of care		
Charity care (≤0.3 percent)	20.4	**29.7**
Uncompensated care (≤1.6 percent)	20.2	**29.7**
Total unreimbursed and uncompensated care (≤3.2 percent)	23.4	**26.6**

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—critical access hospitals (CAH), sole community hospitals (SCH), and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data. For these analyses, we also excluded hospitals that had a negative value for the variables of interest. For the charity care analysis, we included 3,571 hospitals; for the uncompensated care analysis, we included 3,726 hospitals; and for the total unreimbursed and uncompensated care analysis, we included 3,746 hospitals.

Charity care generally represents services for which a hospital demonstrates that a patient is unable to pay, and is based on a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Uncompensated care includes charity care and bad debt, which generally represents services for which a hospital determines that a patient has the financial capacity to pay, but is unwilling to do so. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid). We examined the percentages of 340B and non-340B hospitals in our analysis that provided the highest and lowest amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care. We considered hospitals to have provided a high or low amount of this care if the reported amounts, as a percentage of total facility revenue, were within the top or bottom quartile, respectively, across all hospitals within a hospital type.

- We found variation among the different hospital types. While a higher percentage of 340B general acute care hospitals (340B DSH) provided high amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care compared with their non-340B counterparts, a lower percentage of 340B CAHs provided high amounts of these types of care compared with non-340B CAHs. Additionally, there was much more variation among SCHs. (See tables 7, 8, and 9.)

Table 7: Percentage of 340B and Non-340B Critical Access Hospitals That Provided High and Low Amounts of Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care, as a Percentage of Total Facility Revenue, 2016

Type and minimum or maximum percentage of care	340B hospitals	Non-340B hospitals
High amounts of care		
Charity care (≥1.6 percent)	24.2	**28.1**
Uncompensated care (≥6.1 percent)	21.9	**35.9**
Total unreimbursed and uncompensated care (≥9.9 percent)	22.3	**34.5**
Low amounts of care		
Charity care (≤0.3 percent)	23.2	**31.6**
Uncompensated care (≤2.0 percent)	**25.8**	21.9
Total unreimbursed and uncompensated care (≤3.3 percent)	**26.2**	20.5

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration data. | GAO-18-521R

Notes: We excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered less than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data. For these analyses, we also excluded hospitals that had a negative value for the variables of interest. For the charity care analysis, we included 1,119 CAHs; for the uncompensated care analysis, we included 1,173 CAHs; and for the total unreimbursed and uncompensated care analysis, we included 1,177 CAHs.

Charity care generally represents services for which a hospital demonstrates that a patient is unable to pay, and is based on a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Uncompensated care includes charity care and bad debt, which generally represents services for which a hospital determines that a patient has the financial capacity to pay, but is unwilling to do so. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid). We examined the percentages of 340B and non-340B hospitals in our analysis that provided the highest and lowest amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care. We considered hospitals to have provided a high or low amount of this care if the reported amounts, as a percentage of total facility revenue, were within the top or bottom quartile, respectively, across all hospitals within a hospital type.

Table 8: Percentage of 340B and Non-340B Sole Community Hospitals That Provided High and Low Amounts of Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care, as a Percentage of Total Facility Revenue, 2016

Type and minimum or maximum percentage of care	340B hospitals	Non-340B hospitals
High amounts of care		
Charity care (≥1.7 percent)	**26.5**	23.7
Uncompensated care (≥6.0 percent)	**26.3**	23.9
Total unreimbursed and uncompensated care (≥8.8 percent)	23.7	**25.8**
Low amounts of care		
Charity care (≤0.3 percent)	15.0	**32.1**
Uncompensated care (≤1.9 percent)	**25.4**	24.5
Total unreimbursed and uncompensated care (≤3.7 percent)	22.8	**26.4**

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration data. | GAO-18-521R

Notes: We excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered less than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data. For these analyses, we also excluded hospitals that had a negative value for the variables of interest. For the charity care analysis, we included 269 SCHs; for the uncompensated care analysis, we included 273 SCHs; for the total unreimbursed and uncompensated care analysis, we included 273 SCHs.

Charity care generally represents services for which a hospital demonstrates that a patient is unable to pay, and is based on a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Uncompensated care includes charity care and bad debt, which generally represents services for which a hospital determines that a patient has the financial capacity to pay, but is unwilling to do so. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid). We examined the percentages of 340B and non-340B hospitals in our analysis that provided the highest and lowest amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care. We considered hospitals to have provided a high or low amount of this care if the reported amounts, as a percentage of total facility revenue, were within the top or bottom quartile, respectively, across all hospitals within a hospital type.

Table 9: Percentage of 340B and Non-340B General Acute Care Hospitals That Provided High and Low Amounts of Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care, as a Percentage of Total Facility Revenue, 2016

Type and minimum or maximum percentage of care	340B hospitals	Non-340B hospitals
High amounts of care		
Charity care (≥2.2 percent)	**31.0**	21.5
Uncompensated care (≥5.2 percent)	**29.3**	22.6
Total unreimbursed and uncompensated care (≥9.0 percent)	**28.2**	23.2
Low amounts of care		
Charity care (≤0.4 percent)	15.5	**30.5**
Uncompensated care (≤1.4 percent)	18.7	**28.5**
Total unreimbursed and uncompensated care (≤3.1 percent)	21.2	**27.1**

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered less than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data. For these analyses, we also excluded hospitals that had a negative value for the variables of interest. For the charity care analysis, we included 2,183 general acute care hospitals; for the uncompensated care analysis, we included 2,280 general acute care hospitals; for the total unreimbursed and uncompensated care analysis, we included 2,296 general acute care hospitals.

We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Charity care generally represents services for which a hospital demonstrates that a patient is unable to pay, and is based on a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Uncompensated care includes charity care and bad debt, which generally represents services for which a hospital determines that a patient has the financial capacity to pay, but is unwilling to do so. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid). We examined the percentages of 340B and non-340B hospitals in our analysis that provided the highest and lowest amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care. We considered hospitals to have provided a high or low amount of this care if the reported amounts, as a percentage of total facility revenue, were within the top or bottom quartile, respectively, across all hospitals within a hospital type.

Medicare DSH Adjustment Percentage, DSH Adjustment Payments, and Uncompensated Care Payments

To participate in the 340B Program as an SCH or general acute care hospital (340B DSH), the hospital must meet a minimum Medicare DSH adjustment percentage, among other program eligibility requirements. The DSH adjustment percentage is used to determine the amount of Medicare DSH payments received by hospitals. Starting in fiscal year 2014, as required by the Patient Protection and Affordable Care Act, Medicare DSH payments were reduced and the Medicare uncompensated care payment was established.[18] In fiscal year 2016, eligible hospitals received both of these types of payments to help offset their uncompensated care costs. Because CAHs do not need to meet a DSH adjustment percentage requirement to participate in the 340B Program, we excluded them from these analyses.

- In 2016, among the hospitals in our analysis that reported a positive DSH adjustment percentage, the median DSH adjustment percentages of 340B SCHs and general acute care hospitals (340B DSH) were higher than those of their non-340B counterparts.
- While the median DSH adjustment percentage of 340B SCHs (12.00) was higher than that of non-340B SCHs (9.47), at the median value, both groups of hospitals exceeded

[18]Pub. L. No. 111-148, §§ 3133, 10316, 124 Stat. 432, 946 (codified at 42 U.S.C. § 1395ww(r)).

the minimum DSH adjustment percentage requirement for participating in the 340B Program as an SCH (8.00). (See table 10.)

Table 10: Median Medicare Disproportionate Share Hospital (DSH) Adjustment Percentages of 340B and Non-340B Hospitals That Reported a Positive DSH Adjustment Percentage, by Hospital Type, 2016

Type of hospital	340B hospitals	Non-340B hospitals
Sole community hospitals (SCH) (N=245)	12.00	9.47
General acute care hospitals (N=1,974)[a]	18.67	10.17

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused this analysis on two of the six hospital types eligible for the 340B Program—SCH and general acute care hospitals (340B DSH). We excluded critical access hospitals (CAH) because they are not required to meet a minimum Medicare DSH adjustment percentage to participate in the program. We also excluded the remaining 340B hospital types—freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC)—because combined, they accounted for less than 5 percent of hospitals participating in the program in 2016. We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data.

To participate in the 340B Program as an SCH or general acute care hospital (340B DSH), the hospital must meet a minimum Medicare DSH adjustment percentage, among other program eligibility requirements. For SCHs, the DSH requirement is ≥8 percent. For DSH hospitals, the DSH requirement is >11.75 percent.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

- In 2016, when measured as a percentage of total facility revenue, the median Medicare DSH adjustment payment and uncompensated care payment received by 340B SCHs and general acute care hospitals (340B DSH) were higher than the median payments received by their non-340B counterparts. (See table 11.)

Table 11: Median Medicare Disproportionate Share Hospital (DSH) Adjustment and Uncompensated Care Payments, as a Percentage of Total Facility Revenue, Received by 340B and Non-340B Hospitals, by Hospital Type, 2016

Type of hospital and type of payment received	340B hospitals	Non-340B hospitals
Sole community hospitals (SCH)		
DSH adjustment payments (N=239)	**0.24**	0.18
Uncompensated care payments (N=239)	**0.47**	0.43
General acute care hospitals[a]		
DSH adjustment payments (N=2,049)	**0.46**	0.26
Uncompensated care payments (N=1,930)	**0.87**	0.61

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused this analysis on two of the six hospital types eligible for the 340B Program—SCH and general acute care hospitals (340B DSH). We excluded critical access hospitals (CAH) because they are not required to meet a minimum Medicare DSH adjustment percentage to participate in the program. We also excluded the remaining 340B hospital types—freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC)—because combined, they accounted for less than 5 percent of hospitals participating in the program in 2016. We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data.

Starting in fiscal year 2014, as required by the Patient Protection and Affordable Care Act, Medicare DSH payments were reduced and the Medicare uncompensated care payment was established. In fiscal year 2016, hospitals received both of these types of payments to help offset their uncompensated care costs. Total Medicare DSH adjustment payment was calculated by summing the hospital's DSH and capital DSH adjustment amounts. According to CMS officials, some SCHs may be paid under a hospital-specific payment rate and may not receive a DSH adjustment payment. In addition, non-340B general acute care hospitals that do not have a DSH adjustment percentage do not receive these Medicare payments.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Medicaid Revenue

- In 2016, among all hospitals in our analysis, when measured as a percentage of total facility revenue, the median amount of Medicaid revenue received by 340B hospitals was higher than the median amount received by non-340B hospitals. This was consistent across the three hospital types we examined, but most notable among the SCHs and general acute care hospitals. (See table 12.)

Table 12: Median Amount of Medicaid Revenue, as a Percentage of Total Facility Revenue, Received by 340B and Non-340B Hospitals, by Hospital Type, 2016

Type of hospital	340B hospitals	Non-340B hospitals
All hospitals in analysis (N=3,695)	**11.7**	**8.4**
Critical access hospitals (CAH) (N=1,161)	8.9	8.4
Sole community hospitals (SCH) (N=272)	10.7	8.5
General acute care hospitals (N=2,262)[a]	14.2	8.3

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data. For this analysis, we also excluded hospitals that had a negative value for the variables of interest.

We calculated Medicaid revenue by summing the hospital's net Medicaid revenue and any additional DSH or supplemental payments received from Medicaid as indicated in the Medicare cost report.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Total Facility Margin

- In 2016, among all hospitals in our analysis, 340B hospitals had a lower median total facility margin than non-340B hospitals. However, there was variation among the different hospital types. While 340B SCHs and general acute care hospitals (340B DSH) had lower median total facility margins than their non-340B counterparts, 340B CAHs had a much higher median total facility margin than non-340B CAHs. (See table 13.)

Table 13: Median Total Facility Margins for 340B and Non-340B Hospitals, by Hospital Type, 2016

Type of hospital	340B hospitals	Non-340B hospitals
All hospitals in analysis (N=3,787)	**3.07**	**4.97**
Critical access hospitals (CAH) (N=1,191)	2.42	0.01
Sole community hospitals (SCH) (N=274)	2.80	4.56
General acute care hospitals (N=2,322)[a]	4.07	5.93

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) had cost report periods that covered fewer than 10 or more than 14 months; (3) participated in the 340B Program for only part of 2016; and (4) had missing or inconsistent data.

Total facility margin was calculated as revenue minus costs divided by revenue. We included revenue and costs associated with all of a hospital's patients.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their

Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Enclosure II: Changes in Characteristics of 340B and Non-340B Hospitals in Medicaid Expansion and Non-expansion States from 2012 to 2016

Medicare Disproportionate Share Hospital (DSH) Adjustment Percentage and 340B Program Participation

To participate in the 340B Program as a sole community hospital (SCH) or general acute care hospital (340B DSH), the hospital must meet a minimum Medicare DSH adjustment percentage, among other program eligibility requirements.[19] Because critical access hospitals (CAH) do not need to meet a DSH adjustment percentage requirement, we excluded them from our analyses of DSH adjustment percentages and 340B Program participation.

- From 2012 to 2016, the median DSH adjustment percentage among 340B and non-340B SCHs, and 340B and non-340B general acute care hospitals in our analysis increased in Medicaid expansion states but only slightly increased or decreased in non-expansion states. (See table 14.)

Table 14: Change in Median Medicare Disproportionate Share Hospital (DSH) Adjustment Percentage from 2012 to 2016, by Hospital Type, 340B Participation, and Medicaid Expansion Status

Type of hospital and 340B participation status	Expansion states			Non-expansion states		
340B hospitals	**2012**	**2016**	**Percentage point change**	**2012**	**2016**	**Percentage point change**
Sole community hospitals (SCH)	11.2	12.0	0.8	11.6	10.5	-1.1
	(n=20)	(n=19)		(n=19)	(n=20)	
General acute care hospitals (340B DSH)[a]	21.8	24.4	2.6	16.0	14.7	-1.3
	(n=364)	(n=364)		(n=223)	(n=223)	
Non-340B hospitals						
SCHs	7.8	10.4	2.6	7.9	8.3	0.4
	(n=29)	(n=36)		(n=59)	(n=60)	
General acute care hospitals[a]	7.6	10.1	2.5	9.3	9.2	-0.1
	(n=366)	(n=447)		(n=444)	(n=443)	

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused this analysis on two of the six hospital types eligible for the 340B Program—SCH and general acute care hospitals (340B DSH). We excluded critical access hospitals (CAH) because they are not required to meet a minimum Medicare DSH adjustment percentage to participate in the program. We also excluded the remaining 340B hospital types—freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC)—because combined, they accounted for less than 5 percent of hospitals participating in the program in 2016. We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) did not submit cost reports for both 2012 and 2016; (3) had cost report periods that covered fewer than 10 or more than 14 months; (4) participated in the 340B Program for only part of a particular year (2012 or 2016); (5) changed hospital type or 340B participation status between 2012 and 2016 (e.g., 340B in 2012 but non-340B in 2016); and (6) had missing or inconsistent data.

For this analysis, we included hospitals located in 24 states and Washington, D.C., that expanded Medicaid coverage in 2014 and 19 states that did not expand Medicaid as of January 2017. We excluded hospitals located in 2 states that expanded Medicaid in 2014—Arkansas and New Hampshire—but used Medicaid funds to purchase private health insurance coverage, and in 5 states that expanded Medicaid in 2015 or 2016.

To participate in the 340B Program as an SCH or general acute care hospital (340B DSH), the hospital must meet a minimum Medicare DSH adjustment percentage, among other program eligibility requirements. For SCHs, the DSH requirement is ≥8 percent. For DSH hospitals, the DSH requirement is >11.75 percent.

[19]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under the Health Resources and Services Administration's (HRSA) 340B DSH type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: critical access hospital (CAH), freestanding cancer hospital, children's hospital, rural referral center, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

- From 2012 to 2016, among general acute care hospitals (340B DSH) in our analysis, participation in the 340B Program increased by nearly 6 percentage points among hospitals in Medicaid expansion states but did not increase among hospitals in non-expansion states. This may be because more hospitals in expansion states met the minimum Medicare DSH adjustment percentage requirement for 340B participation in 2016, as it identifies hospitals that treat a disproportionate number of low-income Medicare and Medicaid inpatients.
    - Among general acute care hospitals that did not participate in the 340B Program in 2012 but did participate in 2016, 53 percent of hospitals in expansion states did not meet the DSH adjustment percentage requirement in 2012, compared with only 30 percent of hospitals in non-expansion states.
- Participation in the 340B Program among SCHs, which first became eligible for participation in 2010, increased among hospitals in both Medicaid expansion and non-expansion states from 2012 to 2016. (See table 15.)

Table 15: Change in Percentage of Hospitals in Medicaid Expansion and Non-Expansion States That Participated in the 340B Program from 2012 to 2016, by Hospital Type

	Expansion states			Non-expansion states		
Type of hospital	2012	2016	Percentage point change	2012	2016	Percentage point change
Sole community hospitals (SCH)	31.5	41.1	9.6	18.8	26.8	8.0
	(n=23)	(n=30)		(n=21)	(n=30)	
General acute care hospitals (340B DSH)[a]	36.7	42.6	5.9	26.9	26.6	-0.3
	(n=381)	(n=442)		(n=246)	(n=243)	

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused this analysis on two of the six hospital types eligible for the 340B Program—SCH and general acute care hospitals (340B DSH). We excluded critical access hospitals (CAH) because they are not required to meet a minimum Medicare DSH adjustment percentage to participate in the program. We also excluded the remaining 340B hospital types—freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC)—because combined, they accounted for less than 5 percent of hospitals participating in the program in 2016. We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) did not submit cost reports for both 2012 and 2016; (3) had cost report periods that covered fewer than 10 or more than 14 months; (4) participated in the 340B Program for only part of a particular year (2012 or 2016); (5) changed hospital type between 2012 and 2016, and (6) had missing or inconsistent data.

For this analysis, we included hospitals located in 24 states and Washington, D.C., that expanded Medicaid coverage in 2014 and 19 states that did not expand Medicaid as of January 2017. We excluded hospitals located in 2 states that expanded Medicaid in 2014—Arkansas and New Hampshire—but used Medicaid funds to purchase private health insurance coverage, and in 5 states that expanded Medicaid in 2015 or 2016.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care

Charity care generally represents services for which a hospital demonstrates that a patient is unable to pay, and is based on a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Uncompensated care includes charity care and bad debt, which generally represents services for which a hospital determines that a patient has the financial capacity to pay, but is unwilling to do so. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid).

We examined the median amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care (as a percentage of total facility revenue) provided by 340B and non-340B hospitals.

- From 2012 to 2016, when measured as a percentage of total facility revenue, the median amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care provided by hospitals in Medicaid expansion states generally decreased more compared with hospitals in non-expansion states, regardless of 340B participation. The exception is among 340B SCHs, for which these amounts decreased more in non-expansion states. (See tables 16 and 17.)

Table 16: Change in 340B Hospitals' Median Amounts of Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care Provided, as a Percentage of Total Facility Revenue, from 2012 to 2016, by Hospital Type and Medicaid Expansion Status

Type of hospital and type of care provided	Expansion states			Non-expansion states		
	2012	2016	Percentage point change	2012	2016	Percentage point change
All hospitals in analysis						
Charity care	1.7	0.8	**-0.9**	2.0	1.9	-0.1
	(n=620)	(n=629)		(n=441)	(n=441)	
Uncompensated care	3.9	2.2	**-1.7**	6.2	5.8	-0.4
	(n=629)	(n=635)		(n=452)	(n=451)	
Total unreimbursed and uncompensated care	6.7	5.2	**-1.5**	7.4	7.3	-0.1
	(n=633)	(n=636)		(n=453)	(n=451)	
Critical access hospitals (CAH)						
Charity care	1.0	0.7	**-0.3**	1.2	1.1	-0.1
	(n=249)	(n=249)		(n=205)	(n=205)	
Uncompensated care	3.9	2.5	**-1.4**	5.4	5.1	-0.3
	(n=251)	(n=253)		(n=210)	(n=210)	
Total unreimbursed and uncompensated care	6.2	5.0	**-1.2**	6.7	7.1	0.4
	(n=253)	(n=254)		(n=211)	(n=210)	
Sole community hospitals (SCH)						
Charity care	0.8	0.4	-0.4	2.5	1.7	**-0.8**
	(n=19)	(n=20)		(n=17)	(n=19)	
Uncompensated care	2.9	1.5	-1.4	7.7	5.1	**-2.6**
	(n=20)	(n=20)		(n=19)	(n=19)	
Total unreimbursed and uncompensated care	3.9	5.0	1.1	8.3	7.1	**-1.2**
	(n=20)	(n=20)		(n=19)	(n=19)	
General acute care hospitals (340B DSH)[a]						
Charity care	2.1	1.0	**-1.1**	2.8	3.0	0.2
	(n=352)	(n=360)		(n=219)	(n=217)	
Uncompensated care	4.0	2.0	**-2.0**	6.7	6.1	-0.6
	(n=358)	(n=362)		(n=223)	(n=222)	
Total unreimbursed and uncompensated care	7.2	5.5	**-1.7**	7.5	7.4	-0.1
	(n=360)	(n=362)		(n=223)	(n=222)	

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) did not submit cost reports for both 2012 and 2016; (3) had cost report periods that covered fewer than 10 or more than 14 months; (4) participated in the 340B Program for only part of a particular year (2012 or 2016); (5) changed hospital type or 340B participation status between 2012 and 2016 (e.g., 340B in 2012 but non-340B in 2016); and (6) had missing or inconsistent data. For these analyses, we also excluded hospitals that had a negative value for the variable of interest.

The bolded percentage point changes decreased more than their counterparts.

Charity care generally represents services for which a hospital demonstrates that a patient is unable to pay, and is based on a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Uncompensated care includes charity care and bad debt, which generally represents services for which a hospital determines that a patient has the financial capacity to pay, but is unwilling to do so. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid).

For this analysis, we included hospitals located in 24 states and Washington, D.C., that expanded Medicaid coverage in 2014 and 19 states that did not expand Medicaid as of January 2017. We excluded hospitals located in 2 states that expanded Medicaid in 2014—Arkansas and New Hampshire—but used Medicaid funds to purchase private health insurance coverage, and in 5 states that expanded Medicaid in 2015 or 2016.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

- The median amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care provided by non-340B hospitals in non-expansion states generally increased or stayed approximately the same between 2012 and 2016. (See table 17.)

Table 17: Change in Non-340B Hospitals' Median Amounts of Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care Provided, as a Percentage of Total Facility Revenue, from 2012 to 2016, by Hospital Type and Medicaid Expansion Status

	Expansion states			Non-expansion states		
Type of hospital and type of care provided	2012	2016	Percentage point change	2012	2016	Percentage point change
All hospitals in analysis						
Charity care	1.3	0.6	**-0.7**	1.2	1.1	-0.1
	(n=602)	(n=613)		(n=732)	(n=776)	
Uncompensated care	3.1	1.7	**-1.4**	3.9	4.2	0.3
	(n=642)	(n=645)		(n=809)	(n=817)	
Total unreimbursed and uncompensated care	5.5	4.5	**-1.0**	5.6	6.0	0.4
	(n=646)	(n=649)		(n=811)	(n=821)	
Critical access hospitals (CAH)						
Charity care	0.7	0.4	**-0.3**	0.9	0.8	-0.1
	(n=71)	(n=75)		(n=84)	(n=94)	
Uncompensated care	3.6	2.7	**-0.9**	5.3	6.9	1.6
	(n=79)	(n=81)		(n=102)	(n=103)	
Total unreimbursed and uncompensated care	6.3	5.4	**-0.9**	7.6	9.1	1.5
	(n=79)	(n=81)		(n=103)	(n=104)	
Sole community hospitals (SCH)						
Charity care	1.0	0.3	**-0.7**	0.9	0.9	0.0
	(n=37)	(n=36)		(n=80)	(n=81)	
Uncompensated care	3.3	2.1	**-1.2**	4.2	4.8	0.6
	(n=39)	(n=37)		(n=81)	(n=81)	
Total unreimbursed and uncompensated care	5.2	4.6	**-0.6**	6.1	6.3	0.2
	(n=39)	(n=37)		(n=81)	(n=81)	
General acute care hospitals[a]						
Charity care	1.4	0.6	**-0.8**	1.3	1.2	-0.1
	(n=494)	(n=502)		(n=568)	(n=601)	
Uncompensated care	3.1	1.6	**-1.5**	3.6	3.9	0.3
	(n=524)	(n=527)		(n=626)	(n=633)	
Total unreimbursed and uncompensated care	5.3	4.4	**-0.9**	5.3	5.7	0.4
	(n=528)	(n=531)		(n=627)	(n=636)	

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) did not submit cost reports for both 2012 and 2016; (3) had cost report periods that covered fewer than 10 or more than 14 months; (4) participated in the 340B Program for only part of a particular year (2012 or 2016); (5) changed hospital type or 340B participation status between 2012 and 2016 (e.g., 340B in 2012 but non-340B in 2016); and (6) had missing or inconsistent data. For these analyses, we also excluded hospitals that had a negative value for the variable of interest.

The bolded percentage point changes decreased more than their counterparts.

Charity care generally represents services for which a hospital demonstrates that a patient is unable to pay, and is based on a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Uncompensated care includes charity care and bad debt, which generally represents services for which a hospital determines that a patient has the financial capacity to pay, but is unwilling to do so. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid).

For this analysis, we included hospitals located in 24 states and Washington, D.C., that expanded Medicaid coverage in 2014 and 19 states that did not expand Medicaid as of January 2017. We excluded hospitals located in 2 states that expanded Medicaid in 2014—Arkansas and New Hampshire—but used Medicaid funds to purchase private health insurance coverage, and in 5 states that expanded Medicaid in 2015 or 2016.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

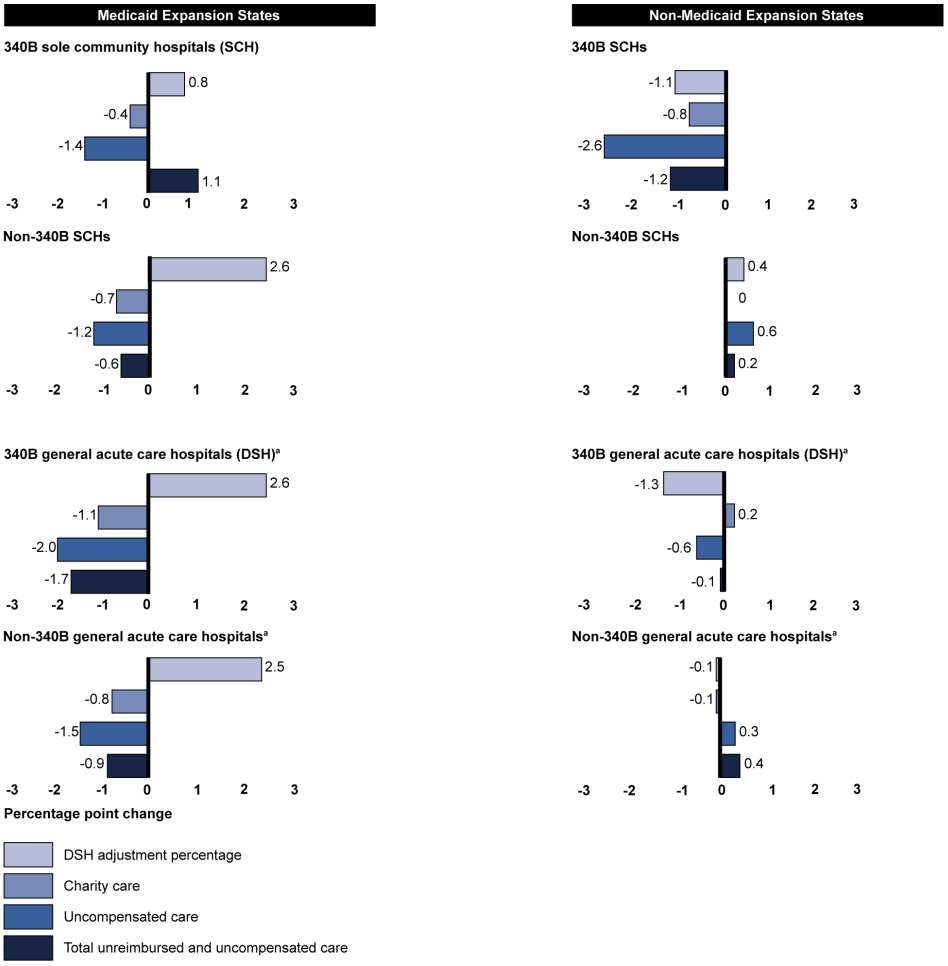
Relationship of Changes in Medicare DSH Adjustment Percentage and Changes in Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care

- From 2012 to 2016, among hospitals in Medicaid expansion states, the median DSH adjustment percentage increased while the median amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care provided, as a percentage of total facility revenue, generally decreased.

- In contrast, among hospitals in non-expansion states, the median DSH adjustment percentage generally decreased and the median amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care provided generally increased or decreased less compared with hospitals in expansion states. (See fig. 4.)

- This finding may reflect that, in Medicaid expansion states, hospitals experienced an increase in the number of patients covered by insurance, such as Medicaid, and therefore provided less charity care and uncompensated care, which are generally provided to patients who are unable or unwilling to pay for their care. The exception was among 340B SCHs, for which the median amounts of charity care, uncompensated care, and total unreimbursed and uncompensated care decreased more for hospitals in non-expansion states.

Figure 4: Change in Hospitals' Median Medicare DSH Adjustment Percentages and Median Amounts of Charity Care, Uncompensated Care, and Total Unreimbursed and Uncompensated Care Provided, as a Percentage of Total Facility Revenue, from 2012 to 2016



Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused this analysis on two of the six hospital types eligible for the 340B Program—SCH and general acute care hospitals (340B DSH). We excluded critical access hospitals (CAH) because they are not required to meet a minimum Medicare DSH adjustment percentage to participate in the program. We also excluded the remaining 340B hospital types—freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC)—because combined, they accounted for less than 5 percent of hospitals participating in the program in 2016. We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) did not submit cost reports for both 2012 and 2016; (3) had cost report periods that covered fewer than 10 or more than 14 months; (4) participated in the 340B Program for only part of a particular year (2012 or 2016); (5) changed hospital type or 340B participation status between 2012 and 2016 (e.g., 340B in 2012 but non-340B in 2016); and (6) had missing or inconsistent data. For the charity care, uncompensated care, and total unreimbursed and uncompensated care analyses, we also excluded hospitals that had a negative value for the variable of interest. The number of hospitals included in this analysis varied by characteristic, 340B participation status, Medicaid expansion status, and year. For SCHs, the number of hospitals ranged from 17 to 81 in the 2012 analyses and from 19 to 81 in the 2016 analyses. For general acute care hospitals, the number of hospitals ranged from 219 to 627 in the 2012 analyses and from 217 to 636 in the 2016 analyses.

Charity care generally represents services for which a hospital demonstrates that a patient is unable to pay, and is based on a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. Uncompensated care includes charity care and bad debt, which generally represents services for which a hospital determines that a patient has the financial capacity to pay, but is unwilling to do so. Total unreimbursed and uncompensated care includes charity care, bad debt, and costs not reimbursed by public payers (such as Medicaid).

For this analysis, we included hospitals located in 24 states and Washington, D.C., that expanded Medicaid coverage in 2014 and 19 states that did not expand Medicaid as of January 2017. We excluded hospitals located in 2 states that expanded Medicaid in 2014—Arkansas and New Hampshire—but used Medicaid funds to purchase private health insurance coverage, and in 5 states that expanded Medicaid in 2015 or 2016.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Medicaid Revenue

- From 2012 to 2016, when measured as a percentage of total facility revenue, the median amount of Medicaid revenue received by both 340B and non-340B hospitals increased more in Medicaid expansion states compared with non-expansion states. (See table 18.)

Table 18: Change in Median Amount of Medicaid Revenue Received as a Percentage of Total Facility Revenue, from 2012 to 2016, by Hospital Type, 340B Participation, and Medicaid Expansion Status

Type of hospital and 340B participation status	Expansion states			Non-expansion states		
340B hospitals	**2012**	**2016**	**Percentage point change**	**2012**	**2016**	**Percentage point change**
All hospitals in analysis	11.4	14.6	3.2	9.8	10.2	0.4
	(n=631)	(n=632)		(n=454)	(n=448)	
Critical access hospitals (CAH)	7.3	11.1	3.8	6.4	6.7	0.3
	(n=251)	(n=252)		(n=211)	(n=208)	
Sole community hospitals (SCH)	8.5	10.8	2.3	9.8	8.8	-1.0
	(n=20)	(n=20)		(n=20)	(n=19)	
General acute care hospitals (340B DSH)[a]	14.2	17.0	2.8	12.5	12.1	-0.4
	(n=360)	(n=360)		(n=223)	(n=221)	
Non-340B hospitals						
All hospitals in analysis	6.9	9.9	3.0	6.8	6.9	0.1
	(n=638)	(n=638)		(n=793)	(n=808)	
CAHs	7.6	9.4	1.8	7.2	7.9	0.7
	(n=79)	(n=80)		(n=99)	(n=100)	
SCHs	7.3	9.4	2.1	6.5	6.6	0.1
	(n=40)	(n=37)		(n=81)	(n=80)	
General acute care hospitals[a]	6.7	10.0	3.3	6.9	6.8	-0.1
	(n=519)	(n=521)		(n=613)	(n=628)	

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) did not submit cost reports for both 2012 and 2016; (3) had cost report periods that covered fewer than 10 or more than 14 months; (4) participated in the 340B Program for only part of a particular year (2012 or 2016); (5) changed hospital type or 340B participation status between 2012 and 2016 (e.g., 340B in 2012 but non-340B in 2016); and (6) had missing or inconsistent data. For this analysis, we also excluded hospitals that had a negative value for the variables of interest.

We calculated total Medicaid revenue by summing the hospital's net Medicaid revenue and any additional DSH or supplemental payments received from Medicaid as indicated in the Medicare cost report.

For this analysis, we included hospitals located in 24 states and Washington, D.C., that expanded Medicaid coverage in 2014 and 19 states that did not expand Medicaid as of January 2017. We excluded hospitals located in 2 states that expanded Medicaid in 2014—Arkansas and New Hampshire—but used Medicaid funds to purchase private health insurance coverage, and in 5 states that expanded Medicaid in 2015 or 2016.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Total Facility Margin

- From 2012 to 2016, among all hospitals in our analysis, the median total facility margin decreased more for hospitals in non-Medicaid expansion states compared with hospitals in expansion states, but there was variation by hospital type. (See table 19.)
    - Among both 340B and non-340B CAHs and SCHs, the median total facility margin increased in expansion states but decreased in non-expansion states.
    - Among 340B and non-340B general acute care hospitals, the median total facility margin decreased or stayed approximately the same in Medicaid expansion states but increased in non-expansion states.

Table 19: Change in Median Total Facility Margin from 2012 to 2016, by Hospital Type, 340B Participation, and Medicaid Expansion Status

Type of hospital and 340B participation status	Expansion states			Non-expansion states		
340B hospitals	**2012**	**2016**	**Change**	**2012**	**2016**	**Change**
All hospitals in analysis	3.6	3.4	-0.2	4.2	3.6	-0.6
	(n=637)	(n=638)		(n=455)	(n=454)	
Critical access hospitals (CAH)	3.1	3.3	0.2	4.0	2.1	-1.9
	(n=254)	(n=254)		(n=212)	(n=212)	
Sole community hospitals (SCH)	3.7	4.1	0.4	4.2	3.3	-0.9
	(n=20)	(n=20)		(n=20)	(n=20)	
General acute care hospitals (340B DSH)[a]	4.0	3.4	-0.6	4.3	5.0	0.7
	(n=363)	(n=364)		(n=223)	(n=222)	
Non-340B hospitals						
All hospitals in analysis	5.2	5.3	0.1	6.2	6.0	-0.2
	(n=663)	(n=660)		(n=821)	(n=827)	
CAHs	1.0	1.8	0.8	1.2	-2.2	-3.4
	(n=83)	(n=83)		(n=106)	(n=107)	
SCHs	5.8	7.9	2.1	7.1	5.0	-2.1
	(n=40)	(n=37)		(n=81)	(n=81)	
General acute care hospitals[a]	5.6	5.7	0.1	6.9	7.6	0.7
	(n=540)	(n=540)		(n=634)	(n=639)	

Source: GAO analysis of Centers for Medicare & Medicaid Services and Health Resources and Services Administration (HRSA) data. | GAO-18-521R

Notes: We focused our analysis on three of the six hospital types eligible for the 340B Program—CAH, SCH, and general acute care hospitals (340B DSH)—which accounted for over 95 percent of hospitals participating in the program in 2016. We excluded the remaining 340B hospital types: freestanding cancer hospitals (CAN), children's hospitals (PED), and rural referral centers (RRC). We also excluded from our analysis hospitals that (1) were located outside the 50 states and Washington, D.C.; (2) did not submit cost reports for both 2012 and 2016; (3) had cost report periods that covered fewer than 10 or more than 14 months; (4) participated in the 340B Program for only part of a particular year (2012 or 2016); (5) changed hospital type or 340B participation status between 2012 and 2016 (e.g., 340B in 2012 but non-340B in 2016); and (6) had missing or inconsistent data.

Total facility margin was calculated as revenue minus costs divided by revenue. We included revenue and costs associated with all of a hospital's patients.

For this analysis, we included hospitals located in 24 states and Washington, D.C., that expanded Medicaid coverage in 2014 and 19 states that did not expand Medicaid as of January 2017. We excluded hospitals located in 2 states that expanded Medicaid in 2014—Arkansas and New Hampshire—but used Medicaid funds to purchase private health insurance coverage, and in 5 states that expanded Medicaid in 2015 or 2016.

[a]We use the term general acute care hospital to refer to hospitals that participated in the 340B Program under HRSA's 340B disproportionate share hospital (DSH) type designation, and non-340B acute care hospitals that are not categorized in their Medicare cost report as any of the following hospital types: CAH, CAN, PED, RRC, or SCH. These non-340B hospitals may also include those that serve a disproportionate number of low-income inpatients but do not participate in the 340B Program.

Related GAO Products

Drug Discount Program: Status of Agency Efforts to Improve 340B Program Oversight. GAO-18-556T. Washington, D.C.: May 15, 2018.

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