EVIDENCE PACKET · RESEARCH STATUS: 29 JULY 2026

Mass General Brigham and 340B: what the public record can—and cannot—show

The proposed plan has the right accounting instinct, but the public record does not support a precise MGB or Massachusetts-wide 340B "profit" number. It supports a verified participation footprint, one disclosed $97.5–$98 million retroactive CMS payment, a documented MGH savings method, and strong evidence that acquisition discounts were not routinely passed through to commercial payers in a defined Massachusetts sample.

Prepared for investigative research · Entity boundary: MGB enterprise, its Massachusetts hospital covered entities, and the MGB group Form 990 are kept separate. "Savings," "revenue," "spread," "community benefit," and "profit" are not interchangeable.

Plain-language answer. 340B lets eligible hospitals buy some outpatient drugs below ordinary prices. A hospital can then be paid by an insurer at a reimbursement rate that is higher than its acquisition cost. That difference is a potential gross spread, not automatically profit and not automatically money returned to the patient. For MGB, the exact yearly purchase cost, reimbursement spread, contract-pharmacy net, and patient-level pass-through are not publicly disclosed in a way that can be audited from Form 990 or public hospital claims alone.

6 + 1

Six active Massachusetts MGB hospital parent IDs plus one Cooley Dickinson parent record terminated 4/1/2026

$97.5–98m

One-time CMS remedy MGB reported in 2024 for 2018–2022 340B-acquired pharmaceutical underpayments

$22.1m

2016 Massachusetts HPC commercial-claims sample; not an MGB total and not 340B savings

1. Findings at a glance

Question	Finding	Confidence
Does MGB use 340B?	Yes. HRSA's public registry shows active hospital covered-entity records for the MGB Massachusetts footprint. MGH's parent record is DSH220071; its public comment documents an earlier 2017 start, a 2020 termination, and reinstatement in 2021.	Confirmed
How much has Massachusetts used or made?	No defensible statewide or MGB-specific annual purchase, savings, spread, or profit total was found. HRSA publishes national purchases, not a Massachusetts/MGB profit ledger.	Not publicly determinable
What dollar event is public?	MGB reported receiving $98m; its audited statements estimated $97.5m, as a one-time CMS remedy for 340B-acquired pharmaceutical underpayments in 2018–2022.	Confirmed, but not profit
Does Form 990 answer the question?	No. The 2024 MGB group XML has no literal 340B field/value. Schedule H reports broad community-benefit categories, which cannot be re-labeled as 340B savings or patient pass-through.	Confirmed limitation
Do patients directly receive the discount?	MGH described a financial-assistance policy, but said participation in 340B was not likely to change its need-based approach. It did not provide a patient-level 340B discount ledger. GAO found no universal federal requirement for covered entities to discount low-income uninsured patients at contract pharmacies.	Not proven either way for current MGB

2. The 340B footprint that can be verified

The registry is a participation and registration system—not a financial statement. The parent IDs below are the Massachusetts hospital records used for the footprint analysis; child-site and pharmacy registrations are counted separately. A blank termination date is treated as active in the registry snapshot.

Hospital / registry name	340B ID	Type	Start shown	What this establishes
Massachusetts General Hospital	DSH220071	DSH	3/24/2021 current record; public comment notes 4/1/2017 start and 4/1/2021 reinstatement	Active parent record; MGH's DSH participation history is documented.
Brigham and Womens Hospital	RRC220110-00	RRC	1/1/2019	Active parent record at 75 Francis Street, Boston.
Brigham and Women's Faulkner Hospital	DSH220119	DSH	7/1/2017; no term shown	Active hospital parent record at 1153 Centre Street, Boston.
Cooley Dickinson Hospital	RRC220015-00	RRC	4/6/2023; term 4/1/2026	Historical parent record; do not count as active after 4/1/2026 without a replacement record.
Martha's Vineyard Hospital	CAH221300-00	CAH	9/24/2010; no term shown	Active critical-access hospital parent record at 1 Hospital Road, Oak Bluffs.
Nantucket Cottage Hospital	SCH220177-00	SCH	1/1/2026; no term shown	Active small-rural-hospital parent record at 57 Prospect Street, Nantucket.
North Shore Medical Center / Salem Hospital	DSH220035	DSH	9/5/2008; no term shown	Active hospital parent record at 81 Highland Avenue, Salem.

Important boundary: The MGB job posting says the enterprise program oversees "9 entities," but the public posting does not enumerate them. That number cannot safely be converted into "nine Massachusetts hospital parents." Newton-Wellesley, McLean, Mass Eye and Ear, and Spaulding were not counted as separate current Massachusetts hospital parents in this report; MGH's export does show at least one MGH child site located at Newton-Wellesley. The registry snapshot includes six active parent records in the table and one Cooley Dickinson record that terminated on 4/1/2026.

For the MGH exact-name OPAIS export, the result contained 146 covered-entity rows, including 69 active rows and 75 terminated/other rows. It contained 531 populated contract-pharmacy registrations, of which 303 had no contract-term date in the export, collapsing to 50 unique current pharmacy locations under the export's address fields. These are registrations, not unique stores and not dollar volumes.

3. What MGH itself disclosed

In its 2017 response to the U.S. House Committee on Energy and Commerce, Massachusetts General Hospital (the document identifies DSH220071) gave unusually direct answers:

- MGH said it enrolled in 340B as a disproportionate-share hospital on April 1, 2017, so it had no 2012–2016 340B data responsive to the committee's request.
- It reported $43.5 million of unreimbursed charity care in FY2016 and 14,945 uninsured encounters. Those figures are charity-care figures, not 340B savings.
- Its savings method was the difference between the applicable GPO price and 340B price by NDC, multiplied by actual quantities purchased on a monthly and year-to-date basis.
- MGH said it had not yet attempted to quantify the amount received when an insured patient's reimbursement exceeded the 340B price, citing the recent implementation, claims adjudication delays, and the need to account for direct and indirect costs.
- It reported 56 340B child sites under DSH220071 (eight eligible April 1, 2017; 48 beginning July 1, 2017; one additional site planned for October 1, 2017).
- As of September 2017, it had no contract-pharmacy relationships; it had submitted an application involving Partners Healthcare Specialty Pharmacy.

> *MGH's answer is evidence of the method and the disclosure gap. It is not evidence that MGH earned zero spread; it is evidence that MGH had not yet produced that calculation in the response.*

Primary document: Massachusetts General Hospital, "Response to the Committee on Energy and Commerce," pp. 1–4.

4. The money: separate the categories

Category	Public MGB evidence	Why it is not the answer to "340B profit"
340B acquisition savings	MGH described a GPO-minus-340B price method times quantities; MGB's current job posting refers to monthly savings opportunities.	Actual NDC-level prices, quantities, wholesaler fees, returns, inventory accounting, and entity allocation are not public.
Reimbursement spread	MGH said in 2017 it had not yet attempted the calculation when insured reimbursement exceeded 340B price.	It requires claim-level reimbursement, acquisition cost, units, payer rules, reversals, and cost allocation.

Category	Public MGB evidence	Why it is not the answer to “340B profit”
CMS remedy	**$97.5m audited estimate / $98m reported receipt** in 2024 for 2018–2022 340B-acquired pharmaceutical underpayments.	A one-time retroactive payment correction is not a recurring annual margin or net profit measure.
Community benefit	FY2024 group Schedule H: $128.7m net financial assistance at cost; $662.2m unreimbursed Medicaid; $1.485bn total Schedule H community benefit.	These are broad nonprofit reporting categories, on a group-return boundary, and are not tagged to 340B.
Patient pass-through	MGH described a need-based patient discount and financial-assistance policy; MGB publicly describes uses of savings in broad program terms.	No public patient-level ledger connects a 340B acquisition to a lower bill, copay, or collected amount.

MGB’s 2024 financial-results release is the primary source for the CMS remedy. The IRS 2024 group XML is the primary filing source; the packet’s local extraction records the Schedule H categories and confirms that the downloaded XML contains no literal “340B” or “340 B” term.

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5. Massachusetts evidence on price pass-through

The Massachusetts Health Policy Commission analyzed 2016 commercial claims for 15 injectable chemotherapy drugs. The final sample covered 12,490 outpatient claims, 600,598 units, and 32 acute-care hospitals (17 340B-eligible and 15 non-340B). Sample spending was $22.1 million; paying the median price would have reduced that sample by approximately $6.8 million, or 31%.

> **What the HPC result does say:** after excluding two high-priced outliers that were not 340B hospitals, 340B-eligible hospitals did not have consistently higher or lower commercial prices than non-340B hospitals. The HPC interpreted this as evidence that lower acquisition costs were not typically passed along to commercial payers and consumers.

> **What it does not say:** it is not an MGB-specific annual 340B profit estimate; it does not observe MGB’s confidential acquisition invoices; and it does not prove that every MGB patient paid more than an estimated acquisition cost.

HPC 2018 Cost Trends Report, pp. 18–19 · Technical Appendix, §4.2

6. New public claims evidence: named MGB facilities

A later HPC presentation used CHIA APCD claims from 2019–2021, five large payers, and 15 physician-administered drugs. It estimated acquisition cost using CMS ASP files, reducing the estimate by 22.5% where 340B participation applied. The chart reports aggregate commercial spending *over estimated acquisition price* for each hospital—not MGB invoices, not audited savings, and not net profit.

Facility shown in HPC chart	Spending over estimated acquisition price	Interpretation
Nantucket Cottage Hospital	198%	Highest named MGB-associated value in the chart; small-volume caution applies.
Martha's Vineyard Hospital	197%	Very high modeled commercial spread; not an invoice-based 340B savings figure.
Brigham and Women's Hospital	158%	Commercial payments in the sample were modeled at 158% above estimated acquisition cost.
Massachusetts General Hospital	155%	Commercial payments in the sample were modeled at 155% above estimated acquisition cost.
Brigham and Women's Faulkner Hospital	152%	Commercial payments in the sample were modeled at 152% above estimated acquisition cost.
North Shore Medical Center / Salem Hospital	115%	Commercial payments in the sample were modeled at 115% above estimated acquisition cost.
Newton-Wellesley Hospital	69%	Appears in the HPC chart even though it was not counted as a separate current hospital parent in the OPAIS footprint table.
Cooley Dickinson Hospital	32%	Historical OPAIS parent record terminated 4/1/2026; the chart's 2021 value remains useful historical evidence.

> **What this adds:** the public record now contains named MGB-facility signals, not just a statewide average. **What it still cannot do:** convert a modeled commercial price-over-cost percentage into MGB's annual 340B savings or profit without actual NDC-level acquisition costs, units, fees, and collections.

HPC / David Auerbach presentation, slide 19. The chart's 15-drug list includes Alimta, Avastin, Darzalex, Entyvio, Herceptin, Kadcyla, Keytruda, Neulasta, Ocrevus, Opdivo, Perjeta, Remicade, Rituxan, Sandostatin Lar Depot, and Tysabri.

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7. CMS now has the acquisition-cost lane the original plan anticipated

The original plan's reference to a CMS acquisition-cost survey is now concrete. CMS established the OPPS Drug Acquisition Cost Survey (ODACS) in the CY2026 final rule; the submission window is closed. The survey collected outpatient acquisition data for July 1, 2024 through June 30, 2025, including separate 340B units and total net acquisition cost by specified NDC. CMS required hospitals to include NDC-level discounts, rebates, and concessions and to exclude returned or inpatient-only purchases.

CMS's CY2027 proposed rule says the survey found large disparities between 340B and non-340B acquisition costs and, in some cases, beneficiary cost sharing greater than the hospital's total drug price. CMS proposed paying 340B-acquired drugs at ASP minus 33.4% for CY2027. This is a national Medicare policy signal, not an MGB disclosure; the public materials do not publish MGB's submitted rows.

CMS ODACS overview · ODACS FAQ · CY2027 proposed-rule fact sheet

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8. Massachusetts data access is feasible, but controlled

CHIA's APCD documentation confirms the fields needed for a patient-level commercial analysis: charge, paid amount, allowed amount, copay, coinsurance, deductible, non-covered amount, and patient total out-of-pocket. CHIA defines allowed amount as paid amount plus patient responsibility, usually below the billed charge. That directly fixes the original plan's charge-versus-reimbursement problem.

CHIA requires an application, data-use agreement, and secure delivery. De-identified data may be requested for benchmarking and cost analysis without an IRB authorization package; identifiable data requests require methodology, justification, publication plans, and patient authorization or an IRB/privacy-board waiver. A realistic first request is de-identified 2019–2024 medical claims for the named MGB facilities, the 15-drug HCPCS/NDC crosswalk, allowed/paid/patient-responsibility fields, and facility identifiers.

CHIA APCD currency-field guide, pp. 13–14 · CHIA MA APCD application process

9. MassHealth's current 340B policy lane

MassHealth's FY2026 340B/high-cost-drug impact report proposes limiting payment for four very-high-cost drugs when purchased through 340B for MassHealth members: Aucatzyl, Encelto, Kebilidi, and Zevaskyn. Implementation is no sooner than May 4, 2026. MassHealth says member coverage is not reduced and the policy does not affect 340B drugs used for other patients.

MassHealth could not estimate aggregate savings because the amount depends on value-based contracts and clinical outcomes. It also says affected hospitals are reimbursed at actual acquisition cost regardless of purchase method, so the direct hospital impact is expected to be temporary cash flow, while the Commonwealth may gain value-based-contract savings. This is important payer context but does not disclose MGB's realized 340B margin.

MassHealth FY2026 340B/High-Cost Drugs Impact Report

10. Why the original calculation plan needs guardrails

Proposed move	Assessment	Correction
Reimbursement minus 340B cost = "profit"	**Directionally right**	Call it a gross spread until acquisition, dispensing, billing, inventory, contract-pharmacy, bad-debt, and overhead costs are allocated. Then call the remainder a modeled net spread—not audited profit.
Use 25% / 45% / 65% savings assumptions	**Scenario only**	Use sensitivity bands only when an invoice or authoritative acquisition-cost input is unavailable. 340B ceiling prices vary by drug, manufacturer, package, rebate/price exceptions, and timing; one system-wide rate is not a fact.
Use Medicare Part B public files to identify 340B claims	**Useful, but incomplete**	JG/TB modifiers are useful for 2024–2025 hospital outpatient testing. ODACS now supplies a separate acquisition-cost lane for July 2024–June 2025, but public materials do not release MGB's submitted rows. Neither reconstructs 2018–2022 by itself.
Subtract patient liability from the spread	**Incomplete**	Use allowed amount, insurer payment, deductible/coinsurance, contractual adjustments, financial-assistance eligibility, reversals, and actual collection. A billed charge is not reimbursement; a patient payment above estimated acquisition cost is suggestive, not conclusive proof of no downstream benefit.

Proposed move	Assessment	Correction
Use Form 990 to locate 340B profit	**Invalid as a standalone test**	Use Form 990/Schedule H for entity identity and broad charity/community-benefit categories. Do not relabel those lines as 340B dollars.

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11. The remaining precise next research steps

1. **Obtain MGB's internal 340B ledger:** annual savings reports by covered entity, NDC, quantity, acquisition price, GPO comparator, manufacturer, and month; split-billing accumulator; replenishment and reversal logs.
2. **Reconcile pharmacy economics:** wholesaler invoices, 340B administrator fees, dispensing fees, contract-pharmacy settlement files, owned-pharmacy transactions, and inventory-to-charge capture.
3. **Build the hospital crosswalk:** OPAIS parent/child IDs, NPI, Medicare provider number, Medicaid number, MGB legal entity, hospital campus, mixed-use area, and service date. Preserve historical terminations.
4. **Run a claims sample:** CHIA APCD commercial claims with NDC/HCPCS, units, allowed/paid amounts, patient liability, reversals, and facility/physician identifiers; test 2024–2025 JG/TB claims separately.
5. **Model the patient result:** link claim lines to patient assistance, charity-care, copay-waiver, bad-debt, and actual collections data. Report direct point-of-sale aid separately from downstream community programs.
6. **Check Medicare and MassHealth lanes:** Medicare reimbursement rules and MassHealth 340B/high-cost-drug reports can explain payer mechanics, but neither substitutes for MGB's acquisition and settlement records.
7. **Request a management representation:** ask MGB to state, for each year and entity, gross 340B savings, net spread after fees, dollars used for direct patient discounts, dollars used for other programs, and the exact denominator used.

To make those remaining steps executable, the packet includes two unsent drafts: `CHIA-APCD-data-request-draft.md` and `MGB-340B-records-request-draft.md`.

A publication-grade conclusion should use a three-tier output: confirmed reported dollars; reproducible modeled estimates with a stated uncertainty band; and unresolved claims requiring internal records. Never convert an unresolved row into "zero."

12. Source method and limitations

I prioritized HRSA OPAIS and pricing materials, MGB's own response and financial release, the IRS e-file XML, CMS modifier guidance, GAO's contract-pharmacy review, and Massachusetts HPC reports. I used a source ledger with entity, period, locator, evidence tier, and limitations. Registry exports were read structurally and checked for historical versus active rows; they were not treated as financial data. PDF pages were rendered for visual review where text extraction was incomplete.

The main unresolved question is not "whether MGB participates"—that is established. It is the dollar bridge from confidential acquisition price to actual reimbursement, fees, collections, and patient benefit. That bridge is an internal accounting and claims-reconciliation exercise, not something the public Form 990 or a generic 340B percentage can supply.

Evidence packet files. The companion source ledger is `research/mgb-340b/source-ledger.csv`. The report is designed for browser reading and print-to-PDF. Access dates are shown where current registry or web materials can change.