



FLORIDA HOSPITAL ASSOCIATION

POLICY DOCUMENT

340B DRUG PRICING PROGRAM

ISSUE BRIEF

JANUARY 2023

Background

Since 1992, the federal 340B drug pricing program has helped providers treating high numbers of uninsured and low-income patients purchase certain outpatient drugs at discounted prices and use those savings to “stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.”

Hospitals must meet federally established eligibility criteria to qualify for the prescription drug discounts. Generally, this means the hospital: is government controlled or has a contract with the government to treat patients that are not entitled to Medicare or Medicaid benefits; has a sufficient Medicare disproportionate share hospital (DSH) adjustment percentage; and (for certain hospitals) does not obtain drugs through group purchasing arrangements. There are 42 Florida hospitals participating in the 340B program.¹

340B covered entities receive 340B discounts but get reimbursed by payers at the same rate received by non-340B providers. The amount of the discount varies by drug. **The difference between what 340B entities paid for the drug and what they would have paid absent 340B generates funding to invest in safety-net services. 340B pricing applies to covered outpatient drugs only. 340B prices are not available for hospitals to purchase inpatient drugs.** Hospitals and other qualified facilities can dispense the medicines they purchase at 340B discounted prices to Medicare and commercially insured patients while retaining the monetary difference between the purchase price and the reimbursed price.

Legislative History

Enacted in 1992, Section 340B of the Public Health Service Act, created under Section 602 of the Veterans Health Care Act, requires pharmaceutical manufacturers to enter into an agreement, called a pharmaceutical pricing agreement (PPA), with the HHS Secretary in exchange for having their drugs covered by Medicaid and Medicare Part B.

Under the PPA, the manufacturer agrees to provide front-end discounts on covered outpatient drugs purchased by specified providers, called “covered entities,” that serve the nation's most vulnerable patient populations. **The purpose of the 340B program is to enable covered entities “to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.”²**

¹ [340B Health](#)

² <https://www.340bhealth.org/members/340b-program/overview/>

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At the state level, manufacturers participating in Medicaid agree to provide outpatient drugs to covered entities at significantly reduced prices.

Section 340B(a)(4) of the Public Health Service Act specifies which covered entities are eligible to participate. These entities include:

Health Centers

- [Federally Qualified Health Centers](#)
- [Federally Qualified Health Center Look-Alikes](#)
- [Native Hawaiian Health Centers](#)
- [Tribal / Urban Indian Health Centers](#)

Ryan White HIV/AIDS Program Grantees

- [Ryan White HIV/AIDS Program Grantees](#)

Nonprofit Hospitals

- [Children's Hospitals](#)
- [Critical Access Hospitals](#)
- [Disproportionate Share Hospitals \(DSH\)](#)
- [Free Standing Cancer Hospitals](#)
- [Rural Referral Centers](#)
- [Sole Community Hospitals](#)

Specialized Clinics

- [Black Lung Clinics](#)
- [Comprehensive Hemophilia Diagnostic Treatment Centers](#)
- [Title X Family Planning Clinics](#)
- [Sexually Transmitted Disease Clinics](#)
- [Tuberculosis Clinics](#)

Hospital Eligibility for Participation

To participate in the 340B Program, hospitals must fall into one or more of the categories outlined above. Most hospitals qualify as DSH hospitals, meaning they are a private nonprofit hospital under contract with state or local government to provide health care services to low-income individuals who are not eligible for Medicare or Medicaid. And, they have a disproportionate share adjustment percentage greater than 11.75% for the most-recently filed Medicare cost report. Hospitals and all covered entities must recertify eligibility annually.

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The registration period for 340B Program registration of new covered entities and the addition of outpatient facilities is limited to the following:

- January 1– January 15 for an effective start date of April 1.
- April 1– April 15 for an effective start date of July 1.
- July 1– July 15 for an effective start date of October 1; and
- October 1–October 15 for an effective start date of January 1.

Covered entities will not be able to submit registrations outside of the dates listed above except when there is a declared Public Health Emergency.

340B Child Sites

A child site is an offsite hospital clinic, department, or service eligible to participate in 340B – eligible to purchase and provide 340B drugs to patients of the facility. An offsite hospital outpatient facility is eligible to be registered as a child site if it is listed as a reimbursable facility on the parent hospital’s most recently filed Medicare cost report and has associated outpatient costs and charges.

A free-standing clinic of the hospital that submits its own cost reports using a different Medicare provider number (not under the covered entity’s Medicare provider number) is NOT eligible. HRSA’s utilizes information from the hospital’s most recently filed cost report, including information from Worksheet A and Worksheet C and the associated trial balance to determine child site eligibility.

All clinics located offsite of the parent hospital, regardless of whether those clinics are in the same offsite building must register as child sites of the parent hospital if they choose to participate in the 340B Program. These clinics must be a reimbursable clinic of the hospital and have associated outpatient costs and charges to be able to register as child sites in 340B. This means that if a single offsite building provides pediatric care, radiology, and physical therapy, each service should be registered as a child site to be eligible for 340B. The single offsite building would not be one child site. Every eligible clinic which will purchase or use 340B drugs within such a hospital must register separately as a child site. Pharmacies are not eligible 340B covered entities and should not be listed as a child site with an associated 340B ID.

Program Qualification Requirements

To purchase drugs at the 340B price, covered entities must meet the following ongoing requirements:

- [Keep 340B OPAIS information accurate and up to date.](#) Register new outpatient facilities and contract pharmacies as they are added.
- [Recertify eligibility](#) every year.
- [Prevent diversion to ineligible patients](#) (PDF). Covered entities must not resell or otherwise transfer 340B drugs to ineligible patients.
- [Duplicate Discount Prohibition](#) Manufacturers are prohibited from providing a discounted 340B price and a Medicaid drug rebate for the same drug. Covered entities must accurately report how they bill Medicaid fee-for-service drugs on the Medicaid Exclusion File, as mandated by 42 USC 256b(a)(5)(A)(i).

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- [Prepare for program audits.](#) Maintain auditable records documenting compliance with 340B Program requirements. Covered entities are subject to audit by manufacturers or the federal government. Any covered entity that fails to comply with 340B Program requirements may be liable to manufacturers for refunds of the discounts obtained.

Disproportionate Share Hospitals (DSH), freestanding cancer hospitals, and children's hospitals must also refrain from participating in a group purchasing organization for covered outpatient drugs.

It is the covered entity's responsibility to notify drug manufacturers and wholesalers that it will now purchase outpatient drugs at 340B prices. The wholesalers and manufacturers verify the covered entity's enrollment on the 340B database and must sell its drugs at or below the maximum price determined under the 340B statute.³

Administration

HRSA and OPA are responsible for interpreting and implementing the 340B law. Questions about the 340B program may be submitted to HRSA's government contractor Apexus at apexusanswers@apexus.com.

The 340B Prime Vendor Program (PVP) is a contract awarded by HRSA. The prime vendor negotiates pricing discounts with participating manufacturers, provides education and resources such as 340B University, and offers technical assistance through Apexus Answers. The PVP is a voluntary program for covered entities and manufacturers alike. There is no fee for eligible covered entities to enroll and participate in the program.

What is the Discount?

A manufacturer may not charge more than the 340B ceiling price to covered entities regardless of whether the covered entity purchases pharmaceuticals through a wholesaler or directly from the manufacturer. The 340B ceiling price is the average manufacturer price (AMP) reduced by the unit rebate amount (URA). The discount for a covered entities is 51% lower than the average wholesale price average wholesale price. The URA is a minimum rebate percentage of 23.1% for most brand-name prescription drugs, 17.1% for brand-name pediatric drugs and clotting factor, and 13% for generic and over-the-counter drugs.⁴

Manufacturers must offer greater discounts on brand-name drugs if the manufacturer's best price for a drug is lower than AMP minus 23.1% for that drug and/or the price of the brand-name drug has increased more quickly than the rate of inflation. This is true for both single-source, brand-name drugs, and brand-name drugs that have generic competition. Generic drugs are not subject to a best price adjustment but, like brand-name drugs, must be offered at a greater discount if the price of the drug has increased more quickly than the rate of inflation. In addition, covered entities are free to negotiate discounts that are lower than the 340B ceiling price (i.e., sub-ceiling prices).

How Do Covered Entities Obtain Discounts?

³ <https://www.hrsa.gov/opa/program-requirements/index.html>

⁴ <https://www.340bhealth.org/members/340b-program/overview/>

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On April 1, 2019, HRSA launched a secure website that lists 340B ceiling prices for covered entities interested in validating the prices they pay for 340B drugs. Access to the ceiling price website is limited to the covered entity's authorizing official and primary contact and may not be shared with outside parties.

Pricing information available through the website was initially limited to the basic unit price but was expanded on July 1, 2019, to include the following additional data elements: (1) the raw ceiling price (AMP minus URA); (2) the package size; (3) the case "pack" size; and (4) the package adjusted price (raw ceiling price multiplied by the package size and case package size).

The 340B law creates a PVP to help covered entities negotiate sub-ceiling prices. Apexus has served as the Prime Vendor since 2004. A covered entity does not have to join the PVP to participate in 340B and may negotiate sub-ceiling discounts on its own. However, because the PVP can negotiate prices on behalf of many 340B purchasers, it has been able to negotiate favorable prices and develop a national distribution system that may not be possible for some covered entities to obtain individually.

How Much Do 340B Program Participants Save?

Pharmaceutical prices available through the 340B program are significantly lower than both retail and wholesale prices. The Government Accountability Office reported that program participants can save an estimated 20–50% off drug costs.⁵

Florida Medicaid reimburses for drugs purchased under the program at the actual purchased drug price which cannot exceed the 340B ceiling price plus a dispensing fee of \$10.24. This is adopted through AHCA Rule 59G-4.251 Prescribed Drugs Reimbursement Methodology.⁶

Duplicate Discount Prohibition

Section 42 USC 256b(a)(5)(A)(i) prohibits duplicate discounts. Manufacturers are not required to provide a discounted 340B price and a Medicaid drug rebate for the same drug. Covered entities must have mechanisms in place to prevent duplicate discounts.

Program Integrity – Audits and Oversight

HRSA's Program Integrity function involves maximizing oversight and managing compliance risks of the 340B program. This is achieved through annual recertification, integrity checks regarding eligibility requirements, and audits. Program integrity audits include both covered entities and manufacturers.⁷

Florida and 340B

Florida Medicaid Contact Details⁸

Technical Contact: Gainwell Technologies

⁵ <https://www.aha.org/fact-sheets/2020-01-28-fact-sheet-340b-drug-pricing-program>

⁶ <https://www.flrules.org/gateway/ruleno.asp?id=59G-4.251>

⁷ [HRSA 340B Program Integrity](#)

⁸ <https://www.340bpvp.com/resource-center/medicaid?Ntt=Florida>

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Rebate Contact

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Program Challenges – COVID 19 and Eligibility Criteria

Mandatory shutdowns of non-emergent procedures to make way for increased demand for COVID-19 care resulted in strained financial and operational resources for hospitals across the United States. These actions created an unfortunate consequence of significantly reduced patient volumes that changed some hospitals' payer mixes. This is specifically noted with respect to the proportion of a hospital's patients that were insured through Medicaid or Medicare Supplemental Security Income (SSI).

Hospitals report their share of patients who are Medicaid and Medicare SSI – referred to as the DSH Patient Percentage ("DPP") – on their Medicare cost report. This report is filed annually with CMS. A hospital's Medicare DPP is then converted to a DSH adjustment percentage. HRSA uses the DSH adjustment percentage to determine 340B eligibility.⁹

As patients delayed care due to the pandemic, many hospitals are now seeing sicker, higher acuity patients. For some hospitals, this drop in the Medicaid ratio was not offset by any increase in the Medicare SSI ratio because CMS has not updated these ratios since the pandemic.¹⁰ As a result, some hospitals have seen the decrease in their Medicare ratio has driven the DPP decrease and their DSH adjustment percentage, resulting in a loss of 340B eligibility.

⁹ [AHA COVID-19 Related Payer Mix Changes Threaten 340B Hospital Eligibility](#)

¹⁰ CMS publishes Medicare SSI ratios that hospitals use as part of calculating their DPP. The numbers are reported annually.

Impact of COVID-19 on Hospitals' DPP

$$\text{Medicare DPP} = \frac{\text{Medicare Supplemental Security Income Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$$

COVID-19
Payer Mix
Changes



$$\text{Medicare DPP} = \frac{\text{Medicare Supplemental Security Income Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Patient Days}}$$

The diagram shows the impact of COVID-19 payer mix changes on the Medicare Drug Payment Percentage (DPP) formula. A large downward arrow indicates the overall impact. The formula components are shown with red arrows indicating their direction of change: Medicare DPP (down), Medicare Supplemental Security Income Days (down), Total Medicare Days (down), Medicaid, Non-Medicare Days (down), and Total Patient Days (up).

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Implementation of Sec. 121 of the Consolidated Appropriations Act

Signed into law on March 15, 2022, the Consolidated Appropriations Act (Section 121) addresses challenges of maintaining 340B eligibility during the PHE by creating a pathway for certain hospitals to be reinstated into the 340B Drug Pricing Program if they meet the following conditions.¹¹

- The hospital must be classified as a disproportionate share hospital; sole community hospital; rural referral center; children's hospital; or a free-standing cancer hospital. The hospital must have been terminated from the 340B Program due to an inability to meet the statutorily required DSH percentage during Medicare cost reporting periods beginning October 1, 2019 and ending no later than December 31, 2022.
- The hospital must have been a covered entity on January 26, 2020, the day before the first day of the COVID-19 Public Health Emergency. Further, the hospital's termination must have been because of actions taken by or other impact on the hospital in response to, or because of, the COVID-19 Public Health Emergency.

If a hospital may be eligible for this exception and has not yet been contacted by HRSA, they should contact the 340B Prime Vendor at apexusanswers@340bpvp.com. Requests will be evaluated on a case-by-case basis.

Current Issues in 340B

PBMs offering preferential tiering for non-340B hospitals. Payors and pharmacy benefit managers (PBMs) are increasingly implementing “two-tier” pricing models under the 340B Program providing lower reimbursement rates for 340B covered entities than for non-340B entities. This practice is contrary to the legislative intent of the 340B statute, which intended for the benefits of the 340B program to remain with covered entities, not payers and other third parties in the drug supply chain. 340B reimbursement discrimination limits the ability of hospitals to provide care to the vulnerable populations that the program is intended to aid.

Despite the stated statutory intent of Congress, courts¹² and the administration¹³ have, to date, sided with PBMs and payers. The prevailing sentiment seems to be that, though Congress may have intended for the benefit to remain with the provider, and that such schemes may make it cost prohibitive for covered entities to participate in the 340B program, there is no statutory provision otherwise prohibiting such discriminatory practice.

HRSA's 340B prime vendor Apexus has confirmed the agency's position, noting in response to a Frequently Asked Question that, “There is no statutory provision in section 340B of the Public Health Service Act prohibiting a payer from reimbursing a 340B covered entity at a level that may be different than a non-340B entity.”¹⁴ According to Apexus, HRSA “strongly encourages the covered entity to reach out to the payer to craft an alternative business solution that permits each of the parties to fulfill their goals.”

¹¹ <https://www.hrsa.gov/opa/index.html>

¹² *Cares Community Health v. U.S. Department of Health and Human Services*, No. 18-5319 2019, slip. op. at 10 (D.C. Cir. Dec. 20, 2019)

¹³ Letter from the Health Resources Services Administration to Safety Net Hospitals for Pharmaceutical Access (Nov. 30, 2011)

¹⁴ See Apexus, [FAQ 1336](#)

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Given the position of CMS and HRSA, safety net providers have petitioned state legislatures to act on 340B two-tier pricing models. States have pursued a variety of activities to manage duplicative discounts. Safety net providers have successfully petitioned state legislatures to act on 340B two-tier pricing, with at least four states prohibiting PBMs from setting lower reimbursement rates.¹⁵

Several states prohibit covered entities, or a contract pharmacy acting on their behalf, from receiving a lower reimbursement than Medicaid for drugs provided under 340B. These states are Massachusetts, Minnesota, Montana, Oregon, Rhode Island, South Dakota, Utah, and West Virginia. Montana's law sets a reimbursement floor based on a calculation using national average drug acquisition costs (NADAC).¹⁶ This is the national average at which retail pharmacies purchase prescription drugs from manufacturers or wholesalers.¹⁷

American Hospital Association 340B Good Stewardship Principles

Because one of the biggest criticisms of the 340B program is its lack of transparency, AHA encourages hospitals to adhere to its "Commitment to Good Stewardship Principles," outlined below.

As of February 2020, **19 Florida 340B hospitals had signed onto these principles**, according to [AHA](#).

- **Communicate the Value of the 340B Program:** The hospital commits to preparing and publishing a narrative, on an annual basis, that describes how it uses 340B savings to benefit its community. The narrative would address those programs and services funded, in whole or in part, by 340B savings, including those services that support community access to care that the hospital could not continue without 340B savings. Examples of such programs and services will be particular for each hospital and could include programs that expand access to drugs for vulnerable populations, as well as access to a wide range of other services, such as preventive care, emergency services, cancer treatment, vaccinations, home-based care, and mental and behavioral health services.
- **Disclose Hospital's 340B Estimated Savings:** The hospital commits to publicly disclosing, on an annual basis, its 340B estimated savings calculated using a standardized method. That method would calculate 340B savings by comparing the 340B acquisition price to group purchasing organization pricing. If GPO pricing is not available for a 340B drug, the 340B acquisition price for a drug would be compared to another acceptable pricing source. To provide context for the estimated savings, a hospital could compare its 340B estimated savings to the hospital's total drug expenditures, as well as provide examples of its top 340B drugs. **Continue Rigorous Internal Oversight:** The hospital commits to continuing to conduct internal reviews to ensure that the hospital 340B program meets the Health Resources and Services Administration's program rules and guidance. Included in this effort is a commitment to regular and periodic training for the hospital's interdisciplinary 340B teams that encompass C-Suite executives, pharmacy, legal, and financial assistance, as well as community outreach and government relations staff, if applicable.

¹⁵ 340B Update: Safety Net Providers Fight Back Against [Two-Tier Pricing Models](#)

¹⁶ Montana [Code Annotated](#) 2021 TITLE 33. INSURANCE AND INSURANCE COMPANIES

¹⁷ [National Average Drug Acquisition Cost](#)

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Federal and State Legislation

In the 117th Congress, Rep. McKinley of West Virginia (D-WV) introduced HR 4390 the [PROTECT 340B Act](#). The bill would have prohibited pharmacy benefit managers and health insurance plans from discriminating against providers participating in the 340B drug pricing program, including pharmacies contracted with such providers to dispense 340B drugs. The bill was referred to two committees, did not receive a hearing.

During the 2022 state legislative session, Sen. Tom Wright introduced [SB 1344](#) the [Federal Drug Pricing Program](#). The bill would have defined the terms “340B entity” and “health insurer”; prohibited health insurers, pharmacy benefit managers, or third parties from reimbursing 340B entities at certain rates or imposing specified adjustments, exclusions, or claim requirements upon such entities. The bill was referred to three committees but did not receive a hearing.

Recent Developments

The 340B program has been the subject of several legal and regulatory challenges in recent years as pharmaceutical companies seek to limit participation and the federal government sought to reduce Medicare payments for 340B hospitals.

Contract Pharmacies

The 340B program provides discounts for drugs prescribed by a participating hospital regardless of whether the drugs are dispensed at the hospital or at a pharmacy in a different location that the hospital contracts with to provide such services. These community pharmacies are particularly important in communities where patients face transportation barriers, whether in rural areas where patients often do not live near the hospital, or in urban areas with poor public transit systems. For more than 20 years, HHS has consistently provided guidance affirming the statutory requirement that drug companies must provide discounts to hospitals that have these arrangements with community pharmacies, and the industry has complied.

In July 2020, [six drug companies](#) announced their decision to end discounted pricing to 340B hospitals for arrangements established with contract pharmacies, including community and specialty pharmacies.

In response to failing to provide discounts through community pharmacies, HRSA referred these companies to the Office of Inspector General (OIG) to impose [civil monetary penalties](#). HRSA noted that the 340B statute requires that manufacturers offer covered drugs at the 340B price, and that this obligation is not “qualified, restricted, or dependent” on how a covered entity chooses to distribute the drugs, including through the use of contract pharmacies. Additionally, the letters state that the 340B statute does not permit a manufacturer to place conditions on its statutory fulfillment obligations.

Several drug companies then filed lawsuits challenging the government’s authority to enforce penalties against them citing that the law did not require them to offer discounts through these authorized arrangements with community pharmacies. In the face of these ongoing legal proceedings, more drug companies ended their discounted pricing to providers. As of October 2022, 18 drug companies have adopted these restrictive policies.¹⁸

¹⁸ Eli Lilly, AstraZeneca, Sanofi, Novo Nordisk, Novartis, United Therapeutics, Boehringer Ingelheim, Merck, UCB, Amgen, AbbVie, Bristol Myers Squibb, Pfizer, GlaxoSmithKline, Gilead, Johnson & Johnson, Exelixis, and Bausch Health

There are at least three separate ongoing cases in three different U.S. Circuit Courts on the permissibility of contract pharmacies. Use of contract pharmacies remains inconsistent and the future of the 340B contract pharmacy model is uncertain.

Impact of contract pharmacy exclusion¹⁹

- Based on a May 2022 [survey](#), larger, mostly urban hospitals estimate their median loss from the restrictions at \$2.2 million a year, and 10% of them expect their losses to exceed \$21 million per year.
- Based on the same survey, smaller, mostly rural critical access hospitals project a median loss of \$448,000 a year, with 10% expecting more than \$1.3 million in annual losses.
- Hospitals that provide discounted drugs to low-income patients through community and specialty pharmacies report the restrictions are leading to patient care problems, including:
 - Delays in access to needed drugs (75%)
 - Financial hardships from higher bills (69%)
 - Worsened health outcomes (41%)
- More than 75% of hospitals surveyed reported that they likely will need to make cuts to vital health services and patient support programs.
- 33% of smaller, mostly rural hospitals report that the restrictions put their facilities at risk of closure.

2018 CMS Outpatient Rule

In 2018, CMS amended the hospital outpatient payment (OPPS) rules to reduce the reimbursement rates for hospitals participating in the 340B program because those hospitals can obtain the covered drugs at significant discounts under the program. CMS reduced the amount payable for separately reimbursable drugs dispensed by 340B hospitals from about 106 percent of the average sales price (ASP) to 77.5 percent of the ASP. This rate was intended to “better, and more appropriately, reflect the resources and acquisition costs that [340B] hospitals incur,” while also ensuring that beneficiaries “share in the savings on drugs acquired through the 340B Program.” CMS maintained this rule in its annual OPPS updates through 2021.

In response to these illegal reimbursement cuts, the American Hospital Association led a lawsuit challenging implementation of the 340B payment reduction, which eventually was heard by the U.S. Supreme Court. 36 state and regional hospital associations, including FHA, supported the AHA throughout the trial process, submitting multiple amicus briefs to the relevant courts.

Eventually the AHA won the lawsuit, and in a unanimous decision the Supreme Court cited the FHA amicus brief noting that Congress was “well aware” that 340B hospitals paid less for covered prescription drugs and that “340B hospitals perform valuable services for low-income and rural communities but have to rely on limited federal funding for support.” The agency was not authorized to change 340B

¹⁹ All data in this section is from 340b Health. <https://www.340bhealth.org/newsroom/stop340bcuts/>

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reimbursement rates without gathering data on what hospitals pay for outpatient drugs and that the decision to lower the reimbursement rate for 340B hospitals is unlawful.

In response to the Supreme Court ruling, the District Court for D.C. ordered HHS to immediately halt 340B reimbursement rate cuts for remainder of 2022 and CMS updated the policy in the final 2023 OPSS rule to restore ASP +6% as the reimbursement rate for 340B hospitals. The agency will upload revised OPSS drug files to apply payment at ASP plus 6% for 340B drugs for the rest of the year and will reprocess claims paid on or after September 28, 2022, at ASP plus 6%.

However, significant issues remain with regard to reversing the rate cuts for calendar years 2018–2022. Medicare OPSS payments are “budget neutral,” meaning rate cuts for 340B drugs increased payments for other services reimbursed through the OPSS. For CY 2023, the estimated impact of these shifts is \$1.96 billion. The AHA, as the successful party in the lawsuit, is working through the courts and negotiating with the agency to determine a solution. They have identified two priorities in this negotiation: 1) 340B hospitals should be made whole in an expeditious manner; and 2) hospitals that received higher payments because of budget neutrality should not be penalized. CMS requested public comment in its 2023 OPSS proposed rule and has signaled that they will provide a resolution between now and the issuance of the final 2024 OPSS rule. The AHA will urge the District Court to impose a faster timeline. As of January 2023, how to remedy previous cuts has been remanded back to HHS.

Solutions

Congressional Action: FHA supports Congressional action to ensure that 340B hospitals that were participating in the program during the COVID-19 Public Health Emergency and may have experienced changes to their DSH adjustment percentage due to the pandemic, retain their 340B eligibility. Congressional action is also needed to provide flexibility through the 1135 waiver process to address this issue. If not, it is likely that some 340B hospitals may lose access to the program, and it will jeopardize care for the patients and communities they serve.²⁰

OPSS Reimbursement Rates: On September 28, 2022, the U.S. Supreme Court issued a ruling in the *AHA v. Xavier Becerra* (HHS) case. It unanimously held that HHS exceeded its statutory authority by varying its 2018 and 2019 OPSS reimbursement rates for “340B hospitals” without having first conducted a statutorily mandated survey of hospitals’ acquisition costs.²¹ As mentioned above, there are significant issues remain regarding reversing the rate cuts for calendar years 2018–2022. AHA identified two priorities in their negotiation: 1) 340B hospitals should be made whole in an expeditious manner; and 2) hospitals that received higher payments because of budget neutrality should not be penalized. CMS requested public comment in its 2023 OPSS proposed rule and has signaled that they will provide a resolution between now and the issuance of the final 2024 OPSS rule. The AHA will urge the District Court to impose a faster timeline.

State Legislative Action: FHA also supports legislation that prohibits discriminatory practices by payers/PBMs such as two-tiered reimbursement and bans on contract pharmacies.

²⁰ AHA - COVID-19 Related Payer Mix Changes Threaten 340B Hospital Eligibility, January 2022

²¹ [AHA vs Xavier Becerra, Secretary of HHS, September 28, 2022](#)

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Table 1: List of 340B Hospitals in Florida January 2022

Company	City	District	340B ID	Entity Type	Medicare Provider Number	Parent CE ID	Rep. First	Rep. Last
MORTON PLANT NORTH BAY HOSPITAL	New Port Richey	12	DSH100063	DSH	100063		Gus Michael	Billrakis
FLORIDA HOSPITAL OCALA, INC. DBA ADVENTHEALTH OCALA	Ocala	3	RRC100062	RRC	100062	68289	Kat	Cammack
SHANDS TEACHING HOSPITAL AND CLINICS, INC.	Gainesville	3	DSH100113	DSH	100113	16379	Kat	Cammack
AdventHealth TAMPA	Tampa	14	DSH100173	DSH	100173	51472	Katherine	Castor
ST JOSEPH'S HOSPITAL	Tampa	14	DSH100075	DSH	100075	16955	Katherine	Castor
TAMPA GENERAL HOSPITAL	Tampa	14	DSH100128	DSH	100128	16429	Katherine	Castor
MEMORIAL HOSPITAL MIRAMAR	Miramar	20	DSH100285	DSH	100285		Sheila	Cherfilus-McCormick
MORTON PLANT HOSPITAL	Clearwater	13	DSH100127	DSH	100127	41753	Charles	Crist
ST. ANTHONYS HOSPITAL	Saint Petersburg	13	DSH100067	DSH	100067	22352	Charles	Crist
ORLANDO HEALTH	Orlando	10	DSH100006	DSH	100006	16912	Val Butler	Demings
BROWARD HEALTH MEDICAL CENTER	Fort Lauderdale	22	DSH100039	DSH	100039	17220	Theodore	Deutch
BROWARD HEALTH NORTH	Deerfield Beach	22	RRC100086	RRC	100086		Theodore	Deutch
CORAL SPRINGS MEDICAL CENTER	Coral Springs	22	DSH100276	DSH	100276	16138	Theodore	Deutch
LEE MEMORIAL HEALTH SYSTEM DBA LEE MEMORIAL HOSPITAL	Fort Myers	19	DSH100012	DSH	100012	18265	Byron	Donalds
Doctors Memorial Hospital, Inc	Perry	2	SCH100106	SCH	100106	22660	Neal	Dunn
JACKSON HOSPITAL	Marianna	2	DSH100142	DSH	100142	19749	Neal	Dunn
TALLAHASSEE MEMORIAL HEALTHCARE, INC	Tallahassee	2	DSH100135	DSH	100135	16398	Neal	Dunn
BETHESDA HOSPITAL	Boynton Beach	21	DSH100002	DSH	100002	17242	Lois	Frankel
LAKELAND REGIONAL MED CTR	Lakeland	15	DSH100157	DSH	100157	24425	C. Scott	Franklin
SOUTH FLORIDA BAPTIST HOSPITAL	Plant City	15	DSH100132	DSH	100132		C. Scott	Franklin
BAPTIST HOSPITAL	Pensacola	1	DSH100093	DSH	100093	18525	Matt	Gaetz
SACRED HEART HEALTH SYSTEM	Pensacola	1	DSH100025	DSH	100025	16123	Matt	Gaetz
HOMESTEAD HOSPITAL	Homestead	26	DSH100125	DSH	100125		Carlos	Gimenez
WEST KENDALL BAPTIST HOSPITAL	Miami	26	DSH100314	DSH	100314	40809	Carlos	Gimenez
SHANDS JACKSONVILLE MEDICAL CENTER	Jacksonville	5	DSH100001	DSH	100001	15970	Al	Lawson
AdventHealth Orlando	Orlando	7	DSH100007	DSH	100007	23549	Stephanie N.	Murphy
BAPTIST MEDICAL CENTER	Jacksonville	4	DSH100088	DSH	100088	14504	John H.	Rutherford
ST. VINCENTS MEDICAL CENTER SOUTHSID	Jacksonville	4	RRC100307	RRC	100307		John H.	Rutherford
BAPTIST HOSPITAL OF MIAMI, INC	Miami	27	DSH100008	DSH	100008	13592	Maria Elvira	Salazar
DOCTORS HOSPITAL	Coral Gables	27	DSH100296	DSH	100296		Maria Elvira	Salazar
MOUNT SINAI MEDICAL CENTER	Miami Beach	27	DSH100034	DSH	100034	15406	Maria Elvira	Salazar
SOUTH MIAMI HOSPITAL	Miami	27	DSH100154	DSH	100154	13594	Maria Elvira	Salazar
HEART OF FLORIDA REGIONAL MEDICAL CE	Davenport	9	RRC100137	RRC	100137	76191	Darren	Soto
WINTER HAVEN HOSPITAL	Winter Haven	9	DSH100052	DSH	100052	16697	Darren	Soto
HALIFAX HEALTH MEDICAL CENTER	Daytona Beach	6	DSH100017	DSH	100017	18321	Michael	Waltz
MEMORIAL HOSPITAL PEMBROKE	Pembroke Pines	23	DSH100230	DSH	100230	16076	Debbie	Wasserman Schultz
MEMORIAL HOSPITAL WEST	Pembroke Pines	23	DSH100281	DSH	100281	13746	Debbie	Wasserman Schultz
JACKSON HEALTH SYSTEM	Miami	24	DSH100022	DSH	100022	15268	Frederica S.	Wilson
MEMORIAL REGIONAL HOSPITAL	Hollywood	24	DSH100038	DSH	100038	9657	Frederica S.	Wilson