HC Econ 201 – Advanced Topics in Medical Economics and Finance

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Guest: Sumona Das Gupta

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UW Medicine

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Healthcare Finance/Medical Economics Series

101 – The basics of healthcare finance. (Sept)

201 – Advanced topics in Healthcare Finance and Medical Economics (You are Here)

301 – IN PERSON. Case studies for UW Medicine and Healthcare for the next decade. (Upcoming, in-person and deep dive into critical healthcare issues for UW Medicine)

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Index

- Advanced Topics in Reimbursement for services
  - Review reimbursement principles
  - Industry Trends and Risks
  - Payor Behaviors
- Value-based payment evolution
  - Political winds
  - Finance and Operational model evolution
  - UW Medicine value-based, population health initiatives
- 340b pricing – Sumona Das Gupta (Director Pharmacy)
- Summary

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Review: Contracting at UW Medicine: *How Do We Get Paid?*

- All reimbursements for medical services negotiated by UW Medicine Contracting & Payer Relations Department ("Contracting")
- Two hospitals (HMC and UWMC), UWP, and Airlift Northwest
- Commercial and Government/Managed Government payers (Medicare, Medicaid, Tricare, etc.)
- Negotiations focus on total annual dollar reimbursement by UW Medicine entity and UW Medicine system
- $ 3.4 Billion in annual reimbursement
- Key factors in contracting process: payer mix, acuity mix, market trends, institutional mission, language, access, law/regulations

Review: Reimbursement

- Reimbursement at UW Medicine is chiefly through fee-for-service methods
- Generally, follows Medicare methodology; **know Medicare, know all**:
  - Inpatient: **DRG**
  - Outpatient: **APC**
  - Professional: **RBRVS** (RVU)
- Lump sum reimbursement with allowances for high cost “outliers”
  - Base/Conversion Factor x Weight = Reimbursement Amount
  - Rudimentary value-based concepts in these CMS methodologies

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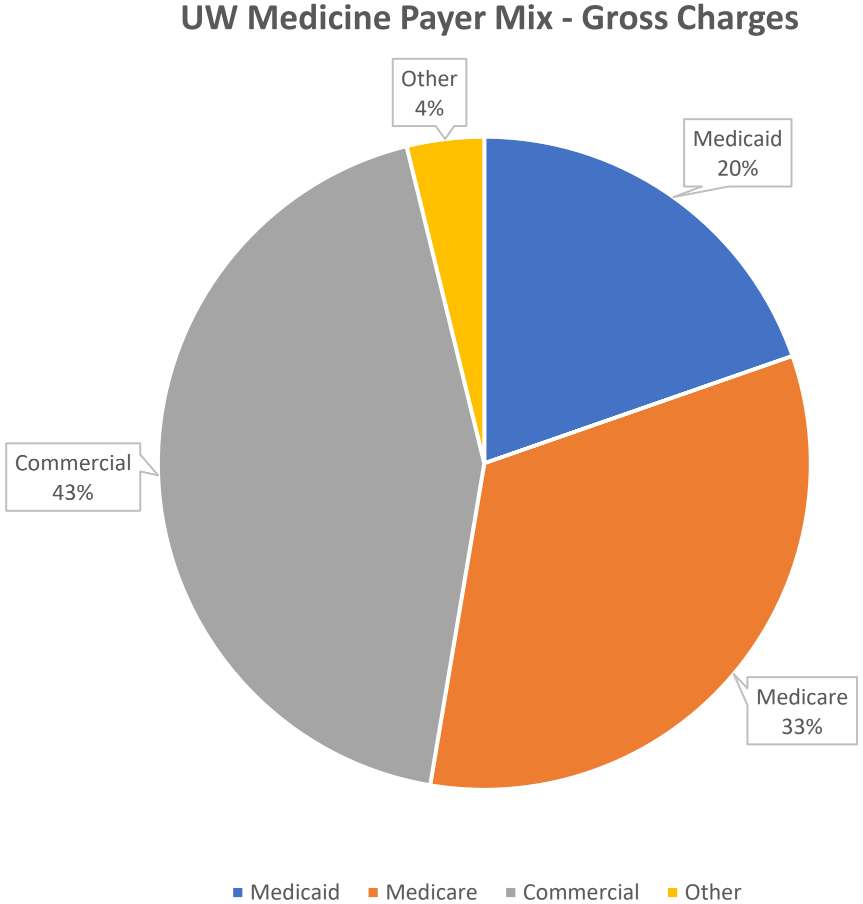
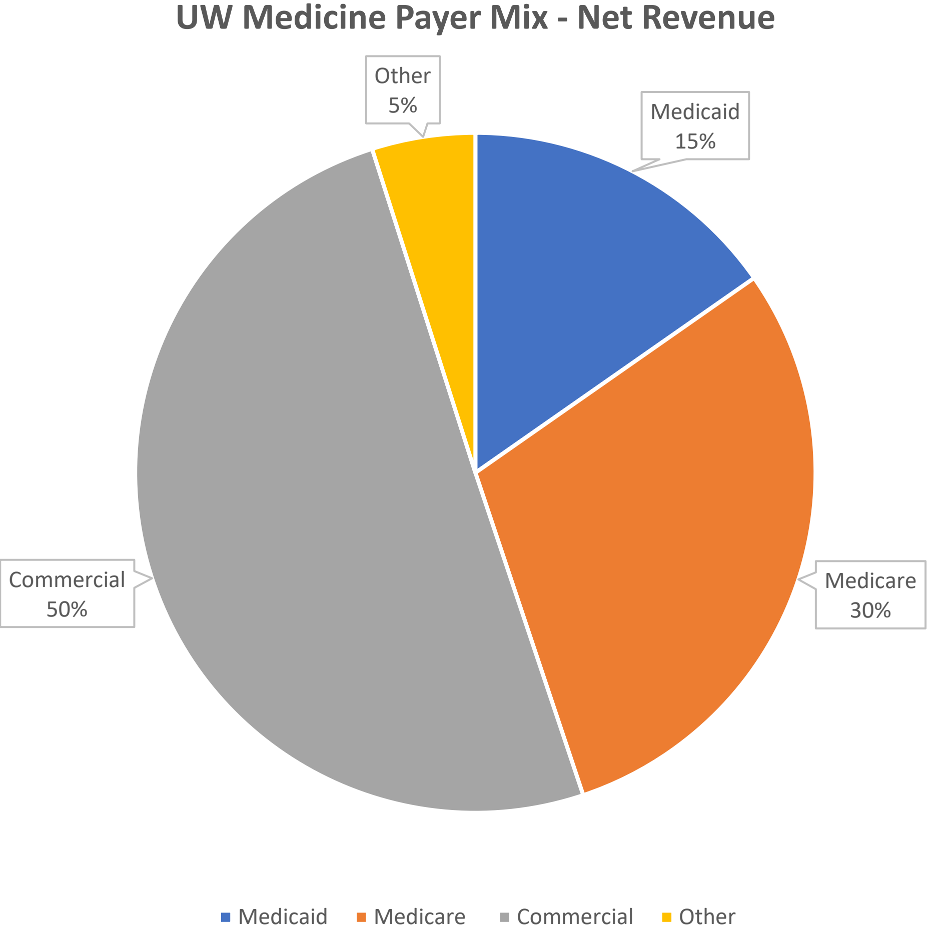
UW Med Payer Mix – Gross Charges: $10.5 Billion



UW Med Payer Mix – Net Revenue: $3.36 Billion



Payer Mix (cont.)

- % of Billed Charges
  - Medicare: 39%
  - Medicaid: 23%
  - Commercial: 32%
- % of Dollars Reimbursed
  - Medicare: 27%
  - Medicaid: 14%
  - Commercial: **54%**
- What conclusions can we make based on the above differences?

- UW Medicine Mission:
  - "UW Medicine has a single mission: **To improve the health of the public**. The 30,000 members of our community advance this mission through the excellence of their work in **patient care**, **medical education** and **research**."

Fee-For-Service Reimbursement

- Fee-for-service reimbursement is the predominant means for payment at UW Medicine and in US healthcare, at large
- Think about…
  - What are some **drawbacks** of fee-for-service reimbursement?
  - What are some **advantages** of fee-for-service reimbursement?
  - In what ways does fee-for-service **bolster** the UW Medicine Mission?
- In what ways does fee-for-service reimbursement **hold back** UW Medicine from achieving its Mission?

Participation Difficulty – Patients and Providers

Patients and Provider are frequently unable to understand healthcare costs or find information sufficient to fully participate as consumers; lack of clarity related to:

- Procedure costs (*direct/indirect*) and prices (*charge master*, *shoppable services*, *self-pay discounts*)
- Payer coverage and negotiated rates (*commercial insurance*, *Medicare/Medicare Advantage*, *Medicaid*)
- Reimbursement arrangement/structure (*fee-for-service*, *value-based*, *bundled payment*)
- Patient Co-Pay/Co-Insurance Differences

Industry Trends and Risks

- High/variable Inflation
- Labor costs
- Supply shortages
- Rising drug costs
- Price Transparency Rules
- CMS Initiatives (e.g., TEAM) and direction of HHS
- State legislative and agency efforts
- Uncertainty of Affordable Care Act, Premium Subsidies, Medicare payments

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- Payers:
  - Collect Premiums from Members/Purchasers
  - Reimburse according to member’s benefits, payer policy, contract terms, and law
  - Manage premium dollars through:
    - Prior Authorization
    - Medical Necessity Criteria
    - Denials
    - Audits
    - Steerage/network make-up
  - Motivation?
  - The three “Ds”
  - PBMs, AI, Acquisitions

BREAK

5 Minute Break

UW Medicine Mission/Vision

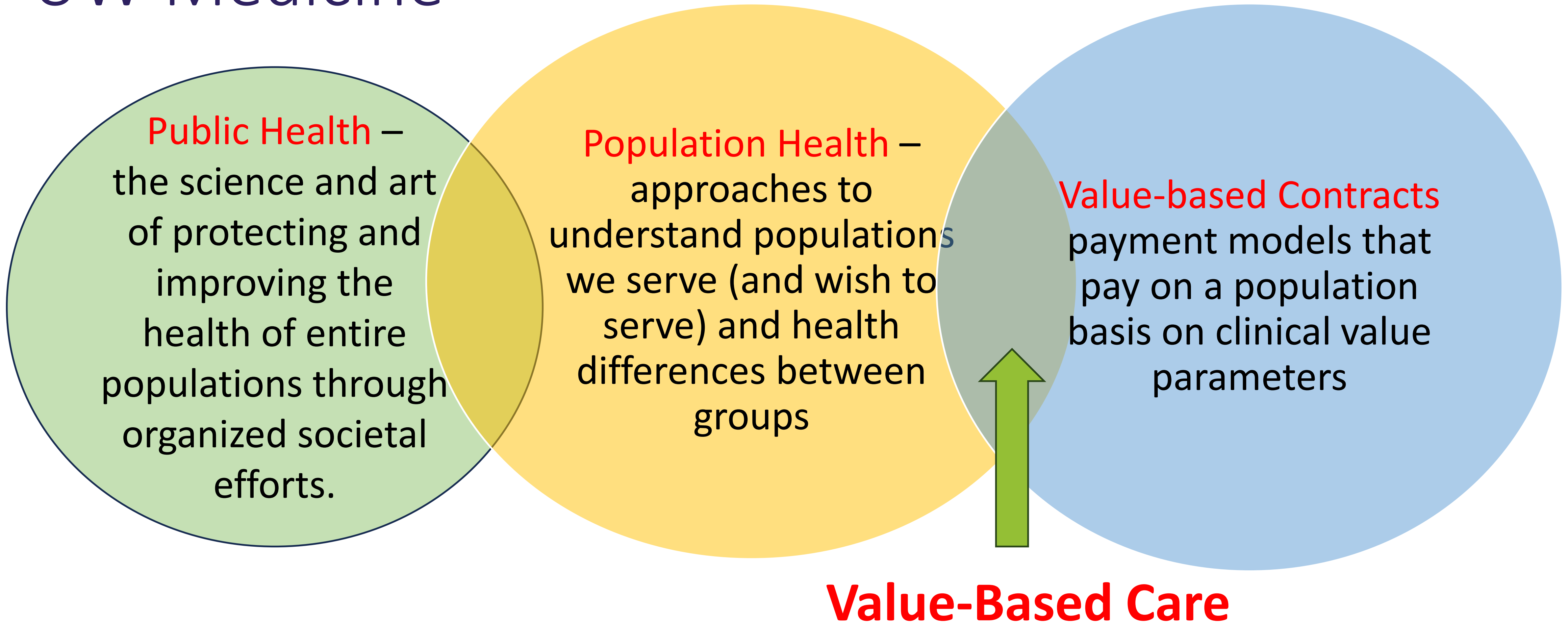
UW Medicine has a single mission:

To improve the health of the public.

Vision: UW Medicine will provide:

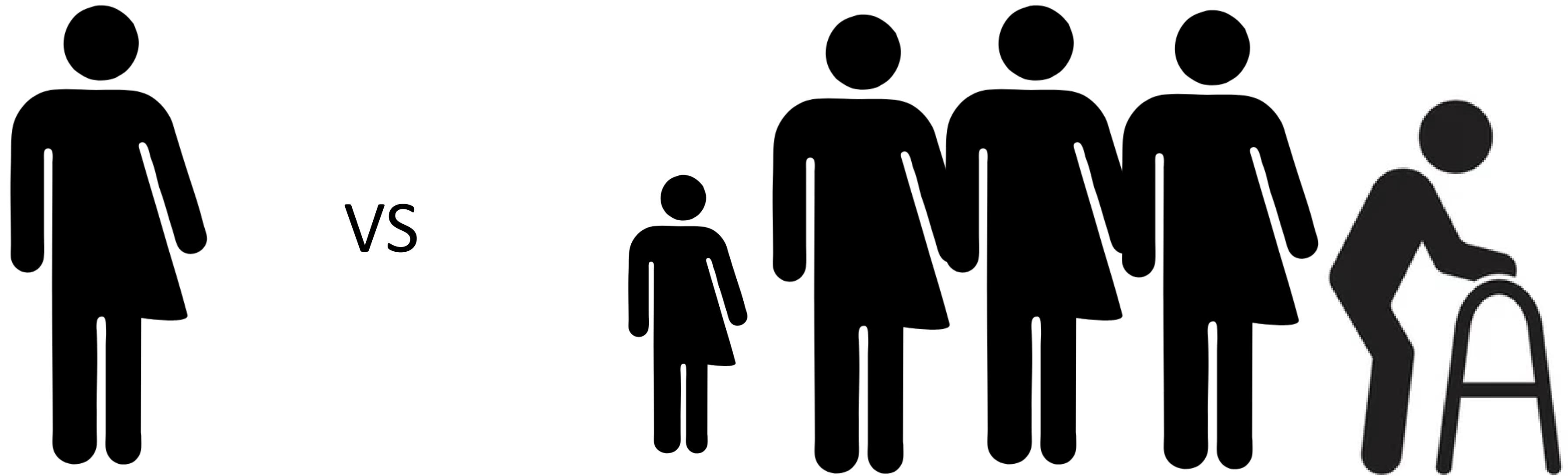
A care experience for patients and their families that helps them achieve their personal goals for wellness and disease management; an educational environment for health professionals, students and trainees that prepares them for leadership in their professional careers; and a research enterprise for scientists that enables them to advance medical knowledge and clinical innovations with groundbreaking discoveries.

Public, Population Health, and Value-based Care at UW Medicine



Patient vs. Population approaches

- Public Health, Population Health, Value-based care, patient centered care are all a continuum

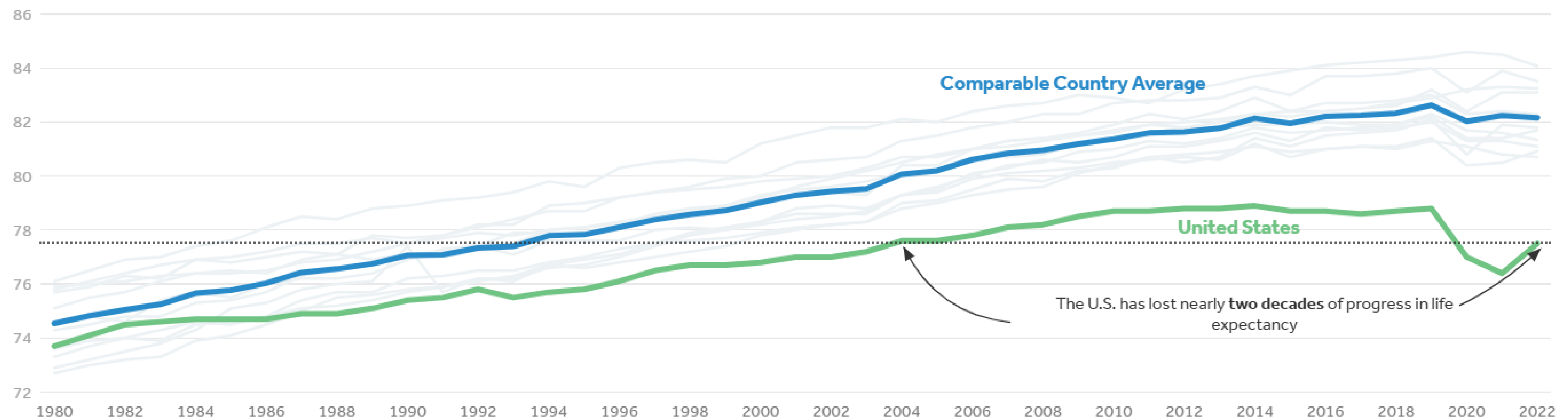


US Spends significantly more in total ($5.3 Trillion) and per capita ($12,197 in 2021) than other economically developed countries. Allocation is also different with high administrative costs.

Very complex payment models lead to high administrative burden

- Admin costs in the US $1,055 per capita (Germany #2 at $306)
- US physicians devote 13% of working hours vs 8% in Canada
- At least half of Administrative expenditures are considered wasteful.

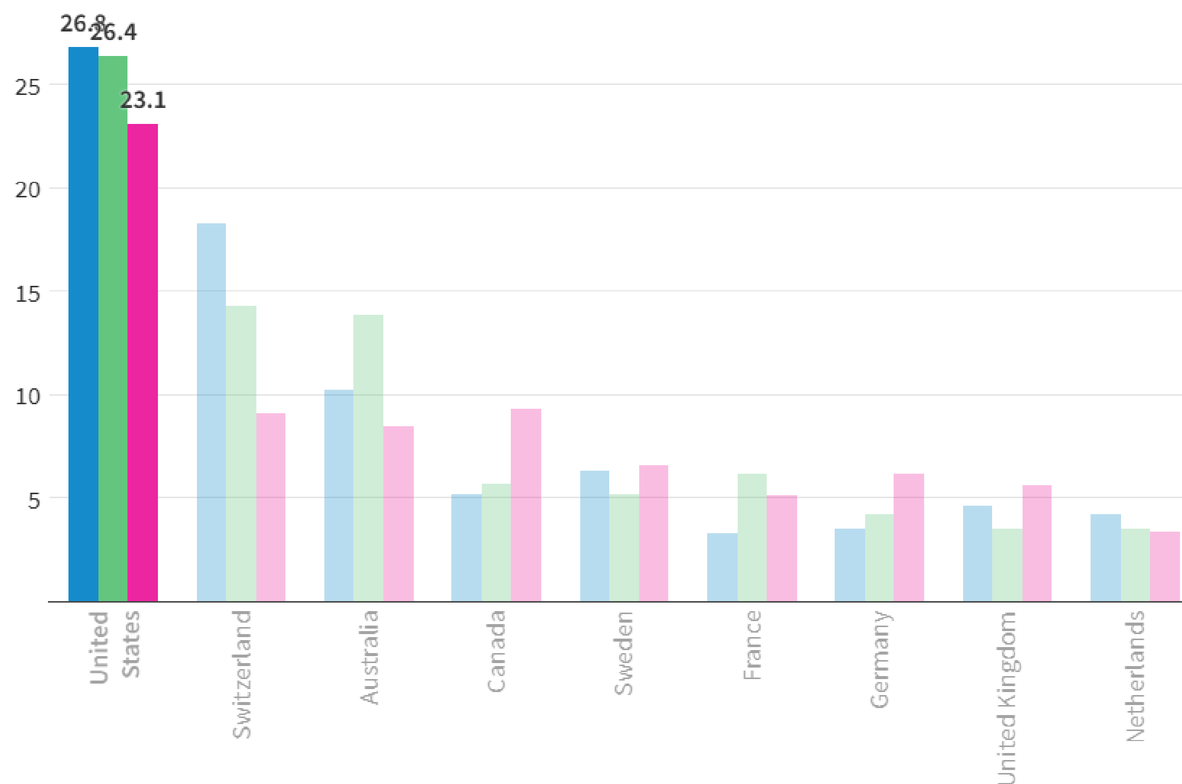
From a societal view, we do not get resulting outcomes from our high healthcare expenditure.



H.R. 1 aka One Big Beautiful Bill Act (OB3) Signed into law July 4, 2025

- **Medicaid**
  - Reductions ($1 Trillion over 10 years starting in 2028)
  - added work requirements and added cost sharing
  - increased eligibility requirements
  - limit on provider taxes (hospital fees)
- **Medicare**
  - Permanently allows high-deductible health plans to cover telehealth before the deductible while making bronze and catastrophic healthcare plans
  - Temporary 2.5% payment increase for physicians
  - Expand Orphan drug exclusion
- **Rural Health Transformation Fund**
  - $50 billion over 5 years with $181 million coming to Washington in 2026
  - Funds several UW-led initiatives project ECHO, WWAMI rural family residency network
  - Digital health grants

Costs Matter - More than 1 in 4 Americans skip healthcare due to costs



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General Statements on US Healthcare

- Complex
- Costs are not transparent
- Fee-for-service doesn’t incentivize value management and relatively underpays for preventative and wellness services. The wRVU was not created to align with outcomes.
- Commercial pays more than governmental payors, resulting in cross-subsidization, resulting in incentives to optimize “payor mix”
- Safety net organizations are at risk for “adverse payor selection” even if there is no bias internal to that organization.

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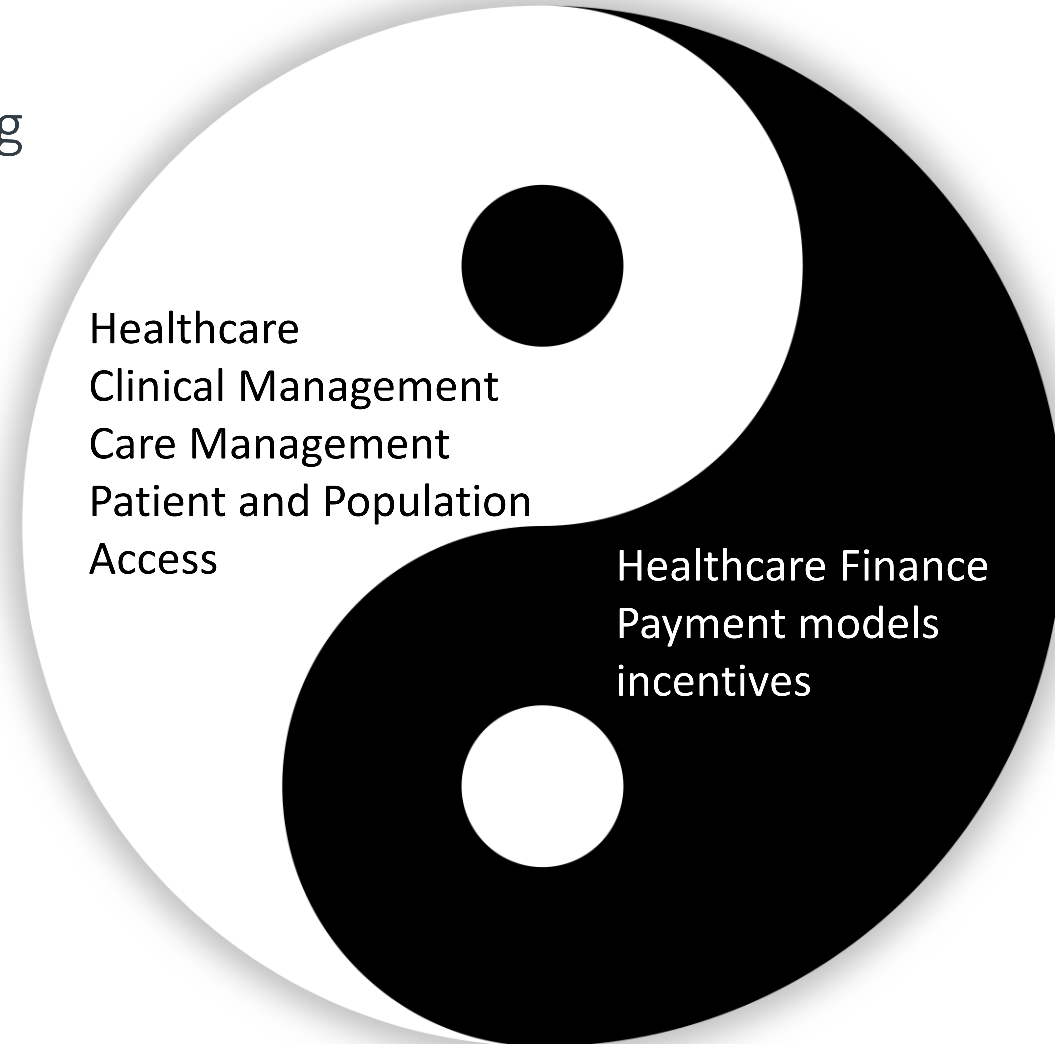
"EVERY SYSTEM IS PERFECTLY DESIGNED TO GET THE RESULTS IT GETS"

- W. Edwards Deming



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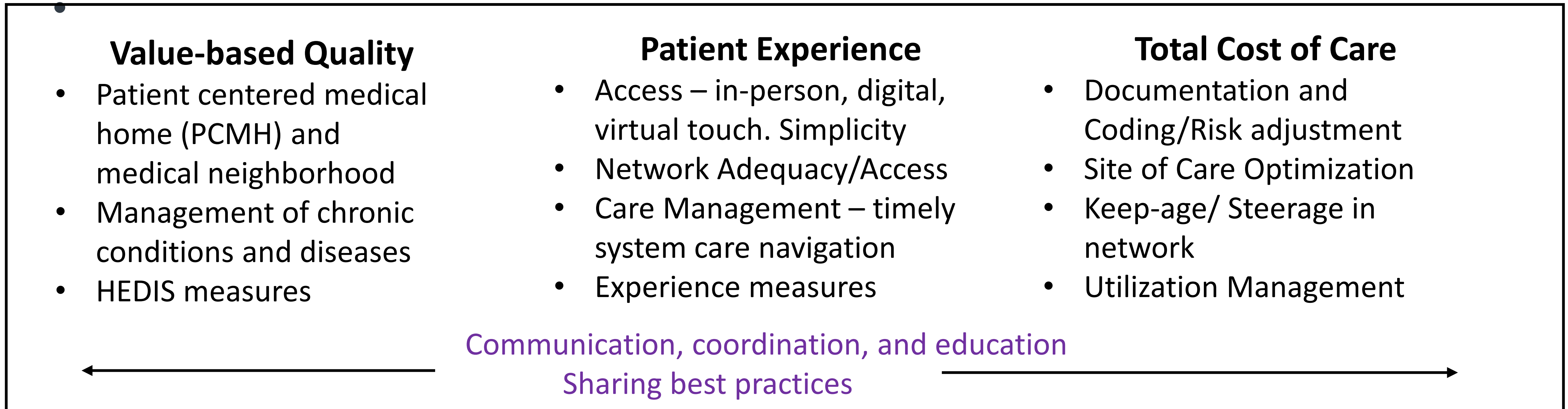
Maximizing Clinical Value through value-levers

What is the “unit of measurement” that matters for our mission?

$$\text{Clinical Value} = \frac{\text{Quality Care and Patient Experience}}{\text{Net Cost to Deliver}}$$



Market forces work better the closer one approaches a perfect market

- Requirements for a perfect market (red = not generally present)
  - The product is well-defined and the same across firms
  - All firms can’t set their own prices
  - No single firm has a significant market share
  - Consumers have all the accurate information about firms, products, and prices
  - There are low barriers and costs to entry and exit the market.

Examples	Closer to Perfect Markets	Farther from Perfect Market
Encounters	Urgent Care, Wellness Visits/ Annual physical	Undiagnosed specialty consult.
Procedures	Colonoscopies, Elective Hip and Knee Replacements.	Bone Marrow Transplant, Trauma surgery
Care Model	Urgent Care	Prevention, Wellness, Equity

Costs of Healthcare – Patients and Providers

Patients and Provider are frequently unable to understand healthcare costs or find information sufficient to fully participate as consumers; lack of clarity related to:

- Procedure costs (*direct/indirect*) and prices (*charge master*, *shoppable services*, *self-pay discounts*)
- Payer coverage and negotiated rates (*commercial insurance*, *Medicare/Medicare Advantage*, *Medicaid*)
- Reimbursement arrangement/structure (*fee-for-service*, *value-based*, *bundled payment*)
- Patient Co-Pay/Co-Insurance Differences
- An example in the studied referenced here cash pay for an elective total hip ranged from $11,100 to $125,798

Rosenthal JA, Lu X, Cram P. Availability of Consumer Prices From US Hospitals for a Common Surgical Procedure. JAMA Intern Med. 2013;173(6):427–432. doi:10.1001/jamainternmed.2013.460

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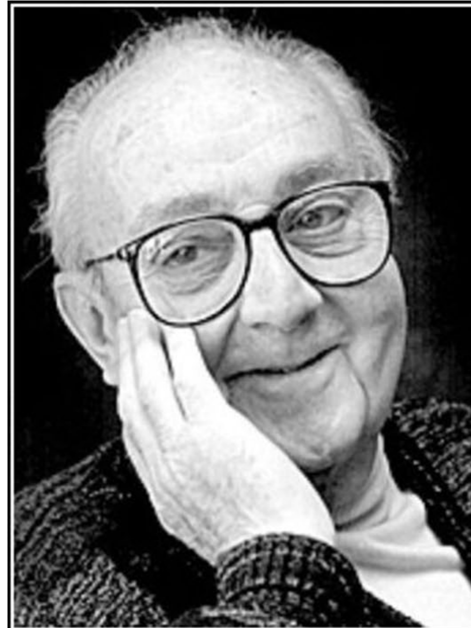
Balancing the financial and care models

DRIVERS OF SUCCESS IN VALUE-BASED CARE



All models are wrong, but some are useful.

— George E. P. Box —

AZ QUOTES

UW Medicine - Play off strengths

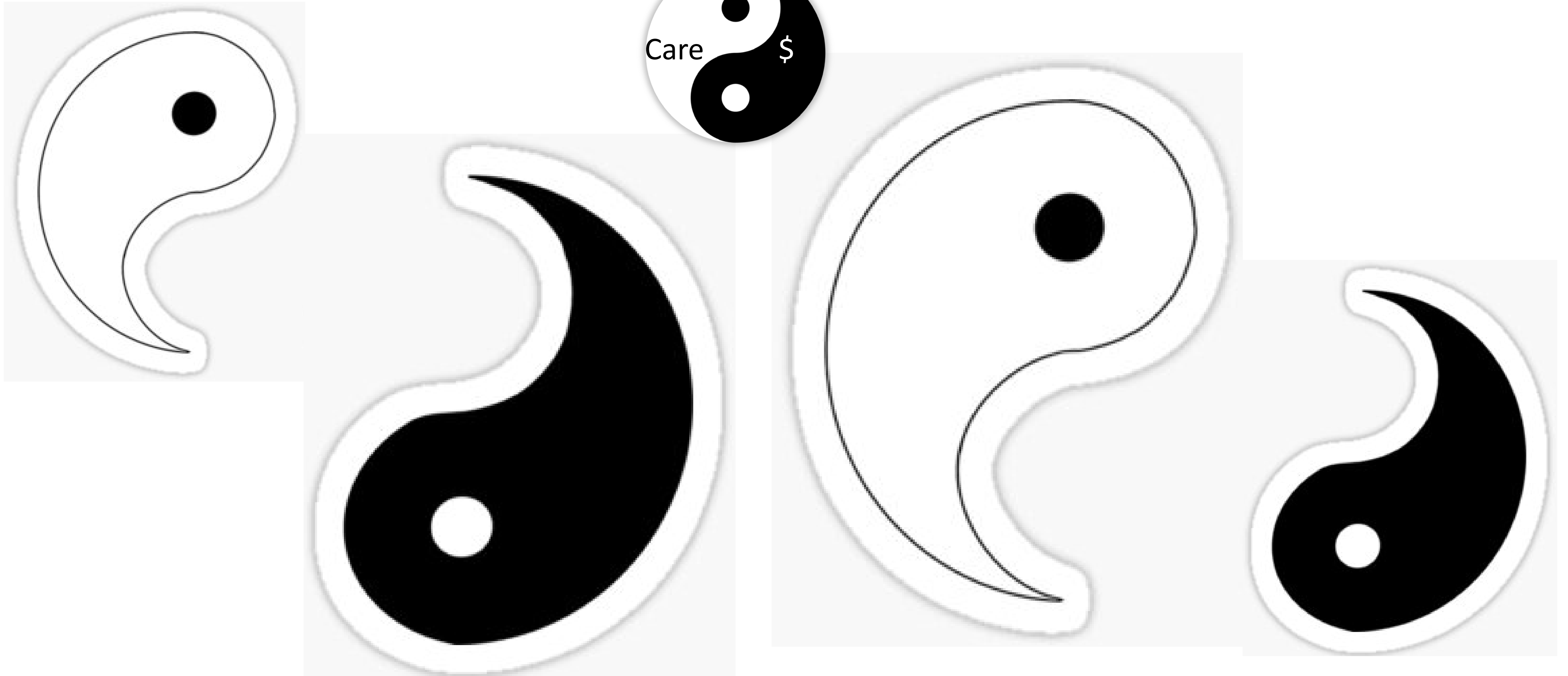
- Mission orientation – improve the health of the public
- Large reach of people, processes – WWAMI, UW “upper” campus, UW Medicine, Networks
- Human Capital - SME – nearly all aspects under the above relationships, driving regional, national, and international thought leadership
- Brand recognition

Mitigate your weakness

- UW Medicine federated model of multiple stakeholders with multiple operational/value-models
- Funds flows designed for Fee-for-service payments
- Low Margins
- Increasing Costs to deliver (Medical Inflation)

Balancing the financial and care models

UW Medicine has blended payment models, but strives for a singular care model



Key Aspects to Value-based Care

- Contracted Care Delivery Cohort – Tax ID Number (TIN)
- Contracted Population/Comparator populations
- Performance Parameters
  - Quality
  - Risk-Adjusted Cost benchmarks
  - Experience Measures
  - Gated performance measures
- Data/Contract Management
- Cost to manage the populations and synergies
- Integration with care delivery model (patient vs. population)

Who are "we" in the contract?

- **Tax ID Number (TIN) vs NPI** – Often contracts are written for the Tax ID Number (TIN) for the medical groups. Some organizations including UW Medicine, combine many providers under one TIN for administrative simplification which is done under UW Physicians (UWP). Other contracts (ACO LEAD) contract by NPI. Making Care primary operates under a TIN then NPI of designated primary care providers.
  - Challenge – MSSP and the Fred Hutchinson Cancer Center
- **Clinically Integrated Network (CIN) -** A network of healthcare providers, such as hospitals and physicians, who collaborate to improve patient care quality, reduce costs, and demonstrate value through shared performance measures. Although this may be used similar to an Accountable Care Organization (ACO), a CIN is a legal entity often comprised of a network of organizations coming together to bid/take on and manage/execute on value-based arrangements. Boeing is managed by Embright, a CIN co-owned mainly by UW Medicine and MultiCare.
  - Challenge If one organization performs significantly better (or worse), the network performance is affected.

Contracted Population

- Who are the patients included in the contract?
  - Prospective Attribution – participants are identified at the beginning of a performance period.
  - Retrospective Attribution – assigns patients to providers after the care has been delivered, usually based on claims data for the performance period.
- Who are the comparator populations?
  - Baseline data
  - Comparative populations to determine shared savings
  - May be historical or a non value-based cohort

Performance Measures

- Quality –
  - Often multiple negotiable measures, often reflecting the population needs for the contract.
  - Define the target, usually endorsed by a national group like The National Committee for Quality Assurance (NCQA) and picked from a list of Healthcare Effectiveness Data and Information Set (HEDIS) that have fixed definitions
  - Define the performance target
- Experience
  - Similarly, often derived from some nationally published database defined by Medicare or other National Groups (eg Press Ganey).
  - Specific measures and benchmarks like quality

2024 Quality Performance by Org - HCA

HCA - PEBB

	MultiCare Connected Care	Seattle Childrens Care Network	Skagit Regional Health	UWM-CC-Allegro	UWM-CC-UWM Physicians	UWM-CC-Valley Medical Center	Total Network Rate	Contractual Target
1-Diabetes patients with A1C>9.0%	57.10%		69.20%		63.00%	52.40%	**58.0%**	79.1%
Asthma Medication Ration (AMR)	80.10%	71.90%			83.30%	87.50%	**80.3%**	91.2%
Depression Medication Management (12 Weeks)	85.90%		90.30%		87.50%	85.30%	**86.3%**	83.5%
Depression Medication Management (6 Months)	70.40%		67.70%		75.20%	73.60%	**72.1%**	71.2%
Controlling High Blood Pressure	59.80%		58.50%		62.60%	66.40%	**60.6%**	71.6%
Follow-Up after ED Visit for Substance Use	Too few cases to break out by site						**25.0%**	39.3%
Immunization (child - Combo 10)	53.70%	68.70%		78.00%	61.40%	0.00%	**62.7%**	67.2%
Cervical Cancer Screening	64.90%		60.70%		73.90%	69.80%	**65.2%**	79.4%
Breast Cancer Screening	77.00%		78.10%		79.20%	74.70%	**75.7%**	78.4%
Colorectal Cancer Screening	68.40%		62.50%		69.80%	69.80%	**66.1%**	65.7%
1-NTSV C-Section	Too few cases to break out by site						**75.8%**	85.7%

HCA - SEBB

	MultiCare Connected Care	Seattle Childrens Care Network	Skagit Regional Health	UWM-CC-Allegro	UWM-CC-UWM Physicians	UWM-CC-Valley Medical Center	Total Network Rate	Contractual Target
1-Diabetes patients with A1C>9.0%	54.2%		74.0%		54.6%	46.4%	**52.4%**	79.1%
Asthma Medication Ration (AMR)	80.4%	76.2%			86.4%	0.0%	**81.8%**	91.2%
Depression Medication Management (12 Weeks)	86.7%		82.1%		79.3%	85.7%	**84.2%**	83.5%
Depression Medication Management (6 Months)	71.9%		67.9%		69.6%	62.9%	**68.7%**	71.2%
Controlling High Blood Pressure	58.0%		55.6%		58.7%	64.5%	**58.3%**	71.6%
Follow-Up after ED Visit for Substance Use	Too few cases to break out by site						**12.5%**	39.3%
Immunization (child - Combo 10)	50.9%	62.1%		74.3%			**58.9%**	67.2%
Cervical Cancer Screening	66.7%		63.3%		71.2%	68.2%	**63.4%**	79.4%
Breast Cancer Screening	79.2%		78.5%		77.6%	69.2%	**74.7%**	78.4%
Colorectal Cancer Screening	60.9%		56.9%		66.4%	62.4%	**58.5%**	65.7%
1-NTSV C-Section	Too few cases to break out by site						**58.8%**	85.7%

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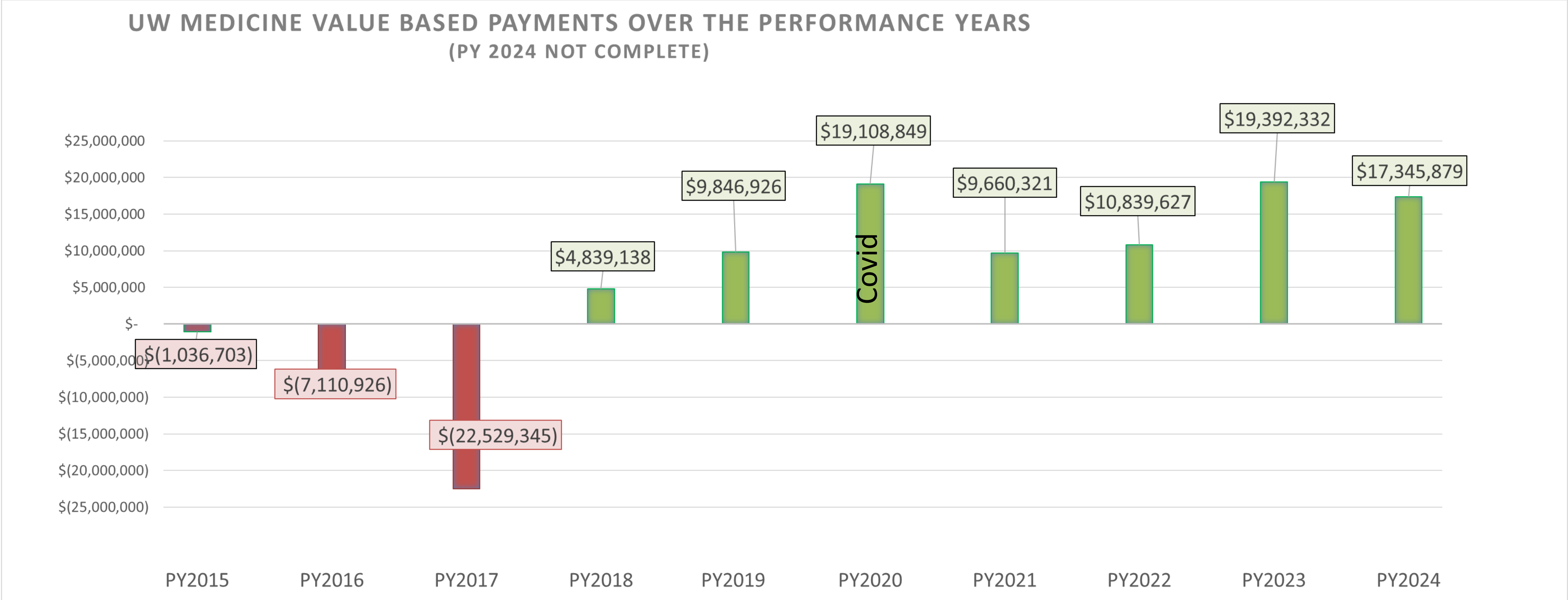
Costs: Medical Loss Ratio (MLR) and Shared Savings

- Often based on some version of the Medical Loss Ratio
  - Defined by the Affordable Care Act requires insurance companies to spend at least 80-85% of the premium dollar on medical care. The remainder pays for overhead expenses such as marketing, salaries, administrative costs, profits, and agent commissions.
- Example of a shared saving calculation

Example Contract Settlement	PY 2023	If risk ratio was 0.9
Settlement ($)	$1,000,000	-$3,750,000
Completed PMPM	$500	$500
Risk Adjusted Benchmark	$520	$425
Risk Score Ratio	1.1	0.9
Benchmark PMPM (not risk adjusted)	$472	$472
Members	50,000	50,000

Value-based performance 2015 - 2024 excluding MIPS payment adjustments



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Different perspectives on healthcare cost

1. Cost to produce – regardless of model of payment FFS or FFV, reducing costs to produce a "unit" of healthcare is beneficial to health systems.

2. Cost of care to payor –
   1. Financial risk-taking entity is paid a per-member per-month (PMPM) and then is accountable for the ultimate health care payments
   2. Often called total cost of care this lens is important for the risk-taking entity.

Potential misalignment of these costs/profits. Example.

- A highly efficient Emergency Room visit might be profitable for a healthcare system, but if that visit was avoidable with better primary care, it may drive costs up despite being profitable for the healthcare system.

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Data Contract Management

- Data from Payor often claims based
  - Latency
  - Completeness
  - Errors (including truncation)
- Each quality measure has inclusions and exclusions which need to be confirmed
- Data “chases” are a key part of value-based care programs and is validated by both the payor and the care teams.
- Performance latency - UW Medicine doesn’t fully reconcile performance in value-based contracts until about 9 months after the end of the performance period.

Market relevancy

- What do the entities that pay for health care require, want, and need?
- Important to think of who pays for healthcare
  - Patients – premiums, co-pays, balance billing, self-pay, etc
  - Employers – direct ACO contracting Boeing, PEBB and SEBB act as payors.
  - Insurers – note their customers are employers or Governmental programs such as Medicare Advantage or Medicaid.

Medicare is leading the movement to Value Based Payment models

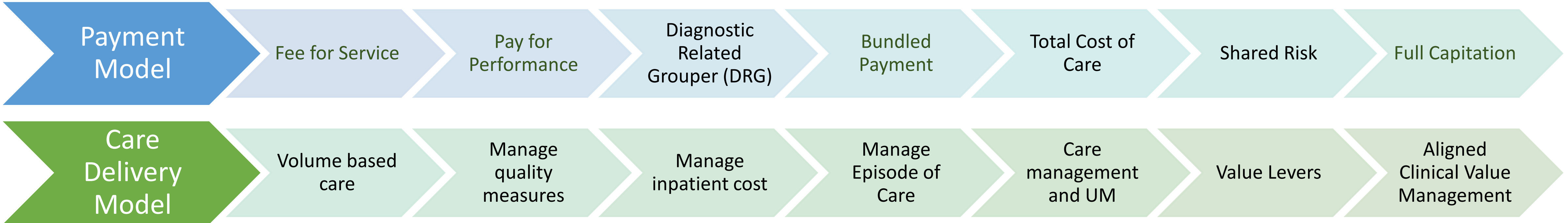
Bipartisan support continues to exist for Medicare to offload management of clinical value to other entities which could include insurers, venture-capital backed integrated systems, or traditional healthcare systems.

GOAL STATEMENT

Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of two-sided risk APMs.

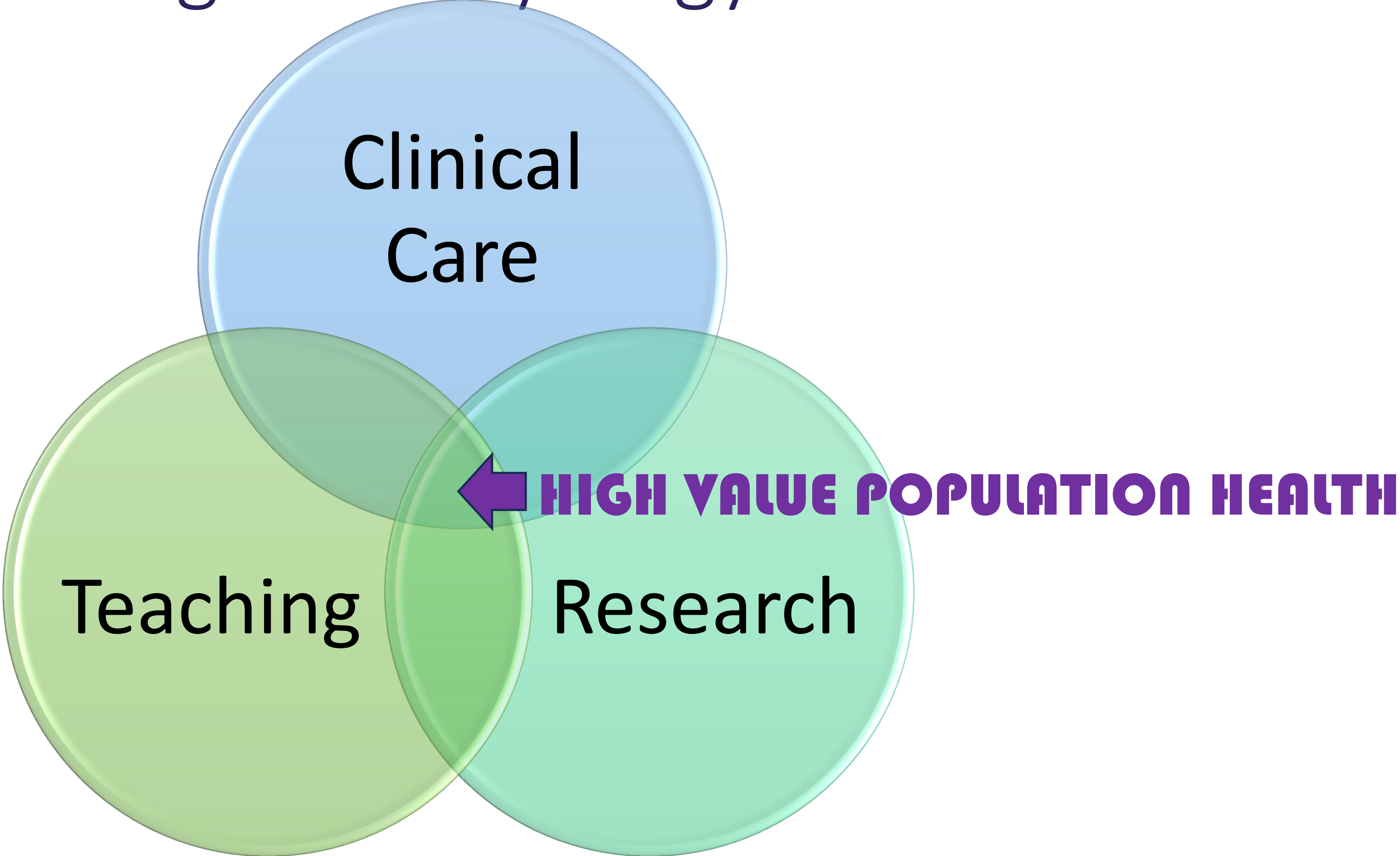
	Medicaid	Commercial	Medicare Advantage	Traditional Medicare
2020	15%	15%	30%	30%
2022	25%	25%	50%	50%
2030	50%	50%	100%	100%

Different payment and care delivery models



- Currently, UW Medicine has contracts in most of these categories, but UW is biased toward the FFS compared with other systems and disruptors in our market.
- Factors for success
  - Align long-term supportive structures
  - Develop a strategy to grow programs strategically
  - Innovate with payors (CMS, CMMI, and others)

Learning Health System
Organizational Ikigai and Synergy



Capitation – taking on financial risk?

- Contrast limited capitation vs. full capitation
- Nearly all of our inpatient payment is paid by an "episode" capitation (DRG)
- Bundle payments are similarly fixed on an episode usually including a hospitalization (or surgical center) plus 30 or 90 days cost with quality measures.
- Full capitation makes the healthcare entity essentially the insurer and responsible for managing total cost of care for a defined population. UW Medicine does not have any of these arrangements at this time.

Key Questions on UW taking financial risk

- What entity (who) will make the financial decisions to deny if UW Medicine takes financial risk for populations (e.g. creates a health plan)?
- What are other options to take on financial risk?
  - Commercial ACOs
  - Align with Medicare Advantage Programs
  - Traditional Medicare (e.g. MSSP, MCP, ACO-REACH, etc)
  - Medicaid Risk
- What is necessary to succeed in value-levers and program support?
  - Embright
  - Choice Care Board

NEW MODELS

- ACCESS
- ACO LEAD
- Ambulatory Specialty Model
- TEAM

PROGRAM	MODEL TYPE	STATUS & WINDOW	PARTICIPANTS	CORE FEATURES
MSSP	Permanent ACO	Ongoing; updates for 2027 agreements	ACOs formed by TIN-based providers	Shared savings/losses tied to quality & cost
QPP	Clinician payment program	Rules for 2025–2026 maintain thresholds	Clinicians, groups, APM entities	MIPS/MVPs/APP reporting; Advanced APM pathway
ASM	Mandatory specialty model	2027–2031 performance; adjustments 2029–2033	Specialists in selected CBSAs	Performance-based Part B adjustments
ACCESS	Voluntary chronic care model	2026–2036 national test	Organizations offering tech-enabled care	Outcome-aligned recurring payments
LEAD	Voluntary ACO model	2027–2036 performance	Existing ACOs, FFS providers	Capitated payments; Global/Professional risk
MAHA ELEVATE	Preventive care grants	Launch Sep 2026; 3-year awards	Health systems & partners	Evidence generation for lifestyle interventions

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340B 101
Drug Discount Program

Sumona Das Gupta, JD

Director, Pharmacy Business and Strategic Development

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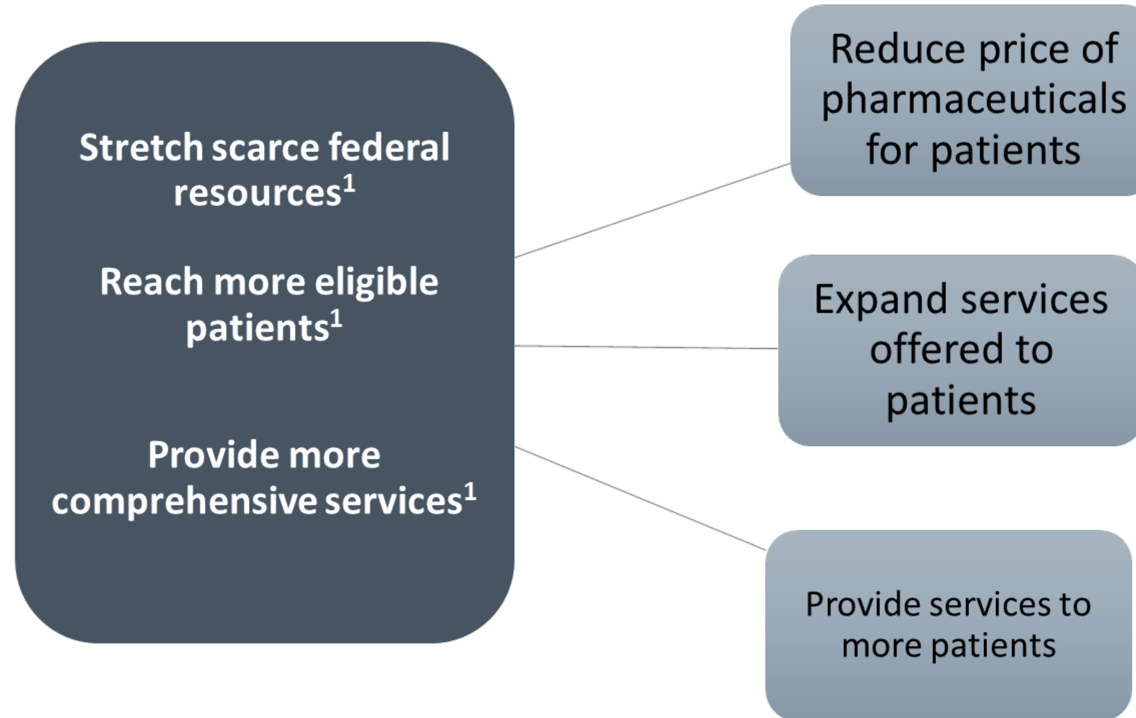
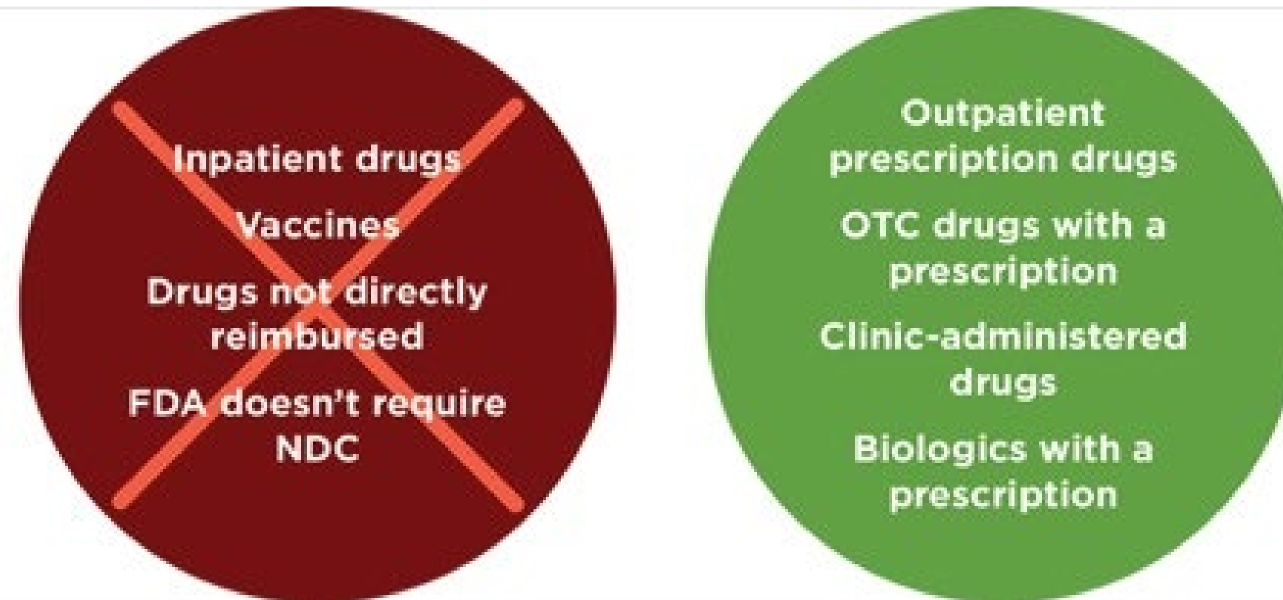
Intent of the 340B Program



340B Eligible Drugs



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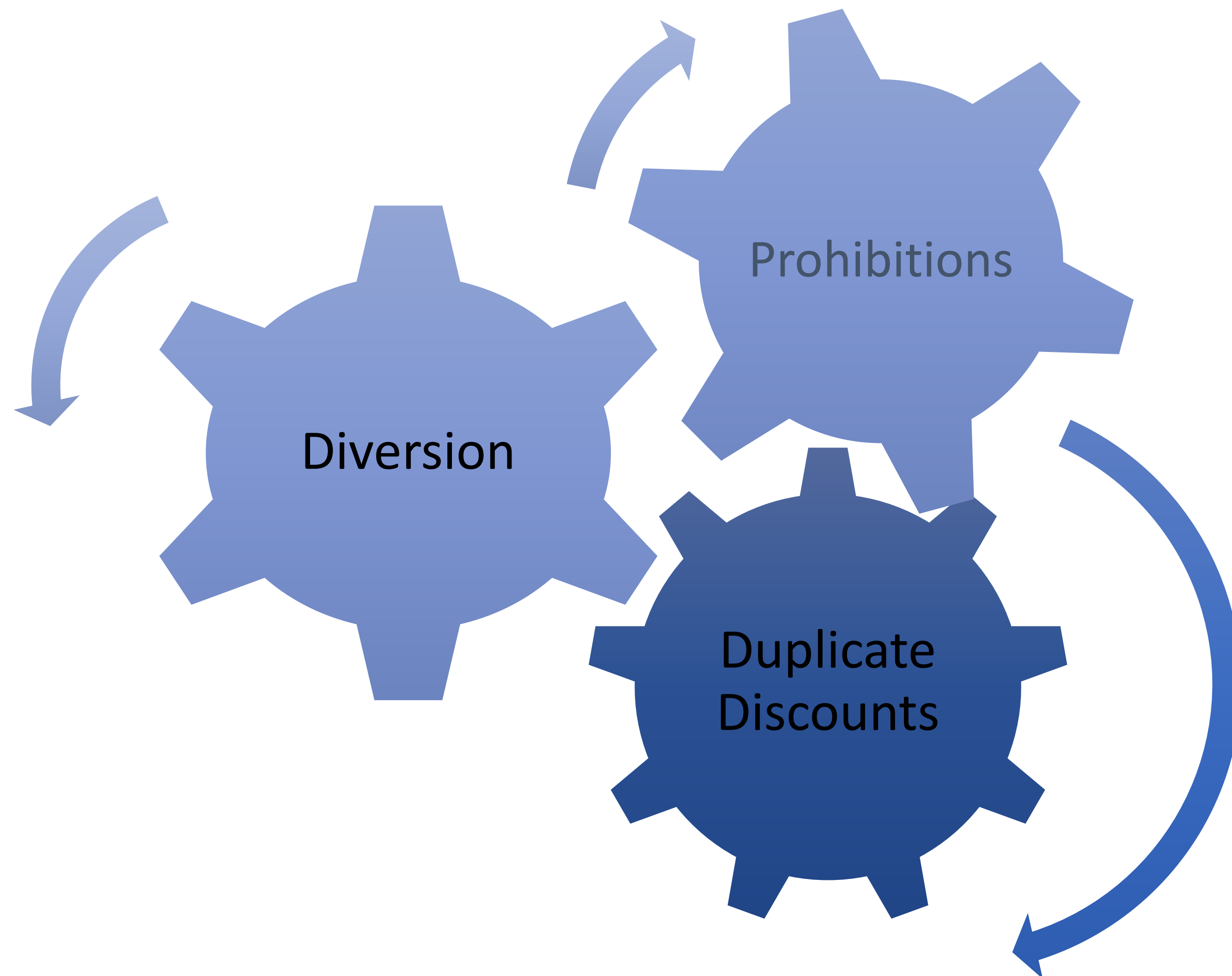
DSH Qualification and Outpatient Facilities

- For outpatient facilities to become eligible for the 340B Program:

- Disproportionate Share Hospital (DSH) percentage of greater than 11.75%.
- The outpatient facility must be an integral part of the hospital.
- The outpatient facility must be included as reimbursable on the covered entity's **most recently filed** Medicare Cost Report.
- The parent hospital and additional outpatient facilities must be registered on the OPA website if outside the four walls of the parent.

340B General Compliance Risks



340B Drug Diversion

- Drugs must be administered to an eligible patient CE has established a relationship with the individual, such that the CE maintains records of the individual's health care; and

- Individual receives health care services from a health care professional who is either employed by the CE or provides health care under contractual or other arrangements such that responsibility for the care provided remains with the CE; and

- Individual receives health care service(s) from the CE which is consistent with the services(s) for which grant funding or federally-qualified health center look-alike status has been provided to the entity.

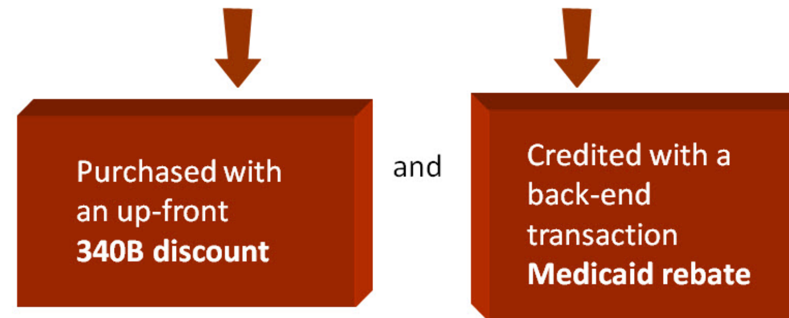
- Note, not considered a patient if the only health care service is the dispensing of a drug for self-administration.

340B and GPO Exclusion

Wholesaler Account Setup -DSH/PED/CAN with GPO Prohibition

Inpatient	Outpatient (not 340B eligible)	Outpatient (340B eligible)
GPO	Non-GPO/WAC	340B
• GPO Contract • DSH Inpatient GPO Contracts (DSH only) • GPO or Wholesaler Generic Source Program • Individual Hospital Agreement	• WAC Pricing • PVP Sub-WAC (if enrolled in PVP) • Apexus Generic Portfolio (AGP) (if enrolled in PVP) • Individual Hospital Agreement (single entity only)	• PHS/340B • PVP Sub-340B (if enrolled in PVP) • Apexus Generic portfolio (AGP) (if enrolled in PVP) • Individual Hospital Agreement (single entity only)
Account #1	Account #3	Account #2

340B AND DUPLICATE DISCOUNT



- UWMC and HMC are 340B “carve-in” entities and designated as such on the Medicaid Exclusion File (“MEF”) on the OPA Database.
- UWMC and HMC use a Medicaid Billing Number that has been provided to the Washington State Health Care Authority and listed on the MEF.
- All contract pharmacies carve-out FFS and MCO Medicaid prescriptions.

340B Program at UW Medicine

UW Medicine Neighborhood Clinics (12)

University of Washington Medical Center

Airlift Northwest

Northwest Hospital & Medical Center

UW Medicine Research / South Lake Union

Valley Medical Center

Harborview Medical Center

University of Washington Physicians

340B Oversight Committee

- **340B Oversight Committee**:
  - ✓Multi-disciplinary team with representatives from all 340B Covered Entities within UW Medicine including HMC.
  - ✓Oversight duties of the Committee include:
    - ❑Regulatory developments and operational considerations impacting the 340B Program.
    - ❑ Compliance education to staff and faculty.
    - ❑Annual review of policies and procedures, risk assessment, and regular audits.
    - ❑Guidance for governmental and non-governmental audits impacting the 340B program.

340B Advocacy

- Harborview Medical Center SHE Clinic will be highlighted in the Health Equity Report published by 340B Health in October 2023
- UW Medicine participates in 340B Health lobbying efforts in Washington DC
- Developing a detailed and updated 340B impact profile for UWMC and HMC
- Reviewing participation in the AHA good stewardship principles: 340B Hospital Commitment to Good Stewardship Principles | AHA

UW Medicine

University of Washington (UW) Medical Center and Harborview Medical Center

The Impact of 340B

The **340B prescription drug program** is a lifeline for safety-net providers as a support to critical health services in our communities. The program is tailored to include only hospitals providing a high level of service to individuals with low incomes, or those serving isolated rural communities. Savings from the 340B program help hospitals meet healthcare needs of underserved patients across the country.

UW Medicine is a health system with a single mission to improve the health of the public. As the only comprehensive clinical, research, and learning health system in the five-state Washington, Wyoming, Alaska, Montana, and Idaho region, UW Medicine provides everything from primary and preventative care to specialized care for the most complex medical conditions.

UW Medicine: By the Numbers

- $621 million in uncompensated care in Fiscal Year 2021
- 1,377,099 patient visits in Fiscal Year 2021
- 340B contract pharmacy savings covered only 20% of UW Medicine's uncompensated care in Fiscal Year '21

340B in Action at UW Medicine

340B discounts allow UW Medicine to provide comprehensive inpatient and outpatient services to uninsured and underinsured patients, including UW Medicine's:

- **International Medicine Clinic**, serving the region's refugee and non-English speaking community
- **Pioneer Square Clinic**, serving the city of Seattle's homeless population
- **SHE Clinic**, providing trauma-informed care to sex workers working near Aurora Avenue, by female-identified providers empathetic to the sense of the fear and shame experienced by female sex workers.

The Impact on Social Programs Caused by Manufacturer 340B Restrictions

Actions by a subset of drug manufacturers to severely restrict 340B discounts for drugs dispensed through community pharmacies have increased UW Medicine's financial losses to a degree that **UW Medicine hospitals will be unable to continue to absorb these losses without impacts to patient care including the specific programs mentioned above.**

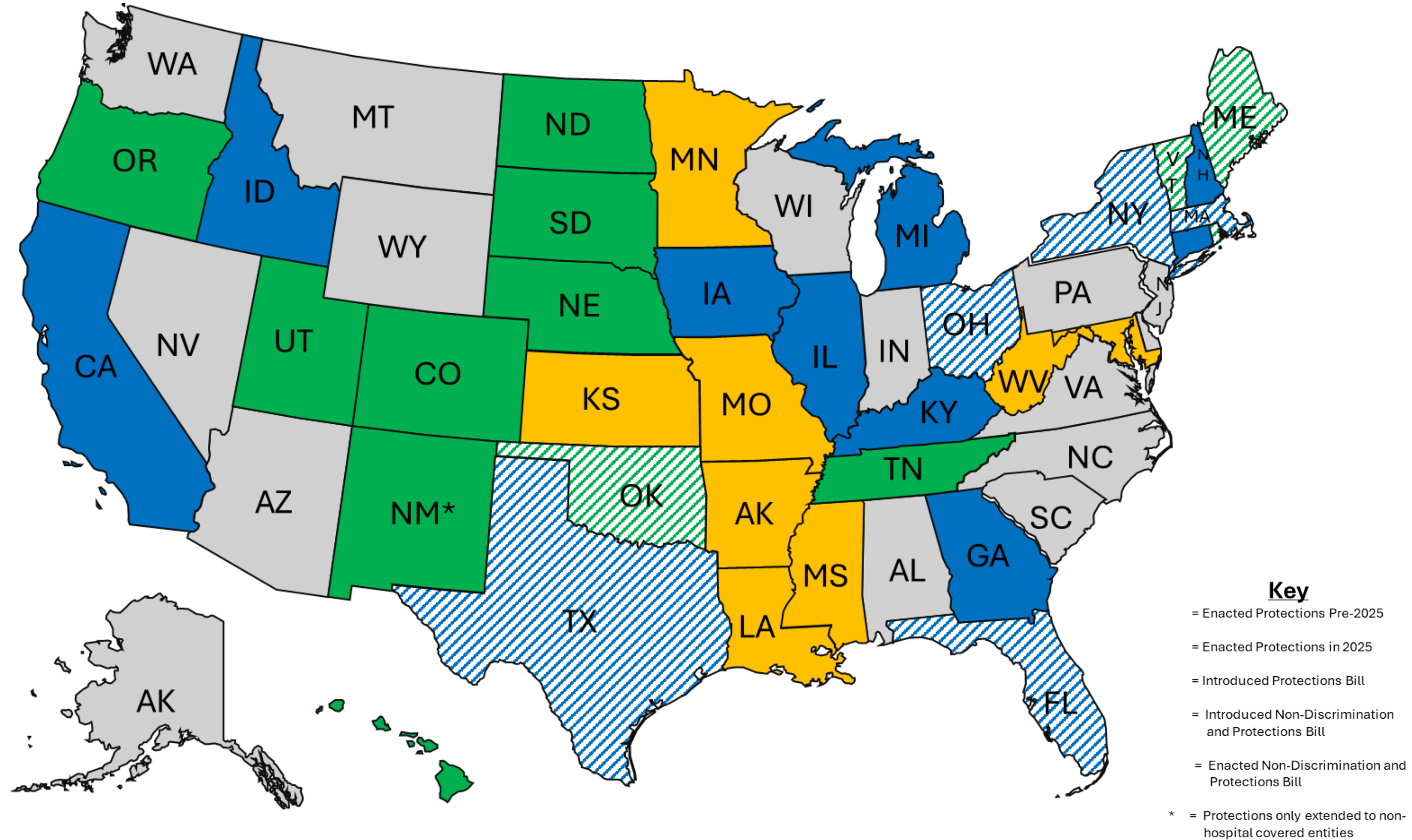
340B Contract Pharmacy Restrictions

- Starting in 2020 over 40 drug manufacturers have restricted products from contract pharmacies that have significantly impacted 340B hospitals.

- Two federal court cases have ruled in favor of drug manufacturers, and one court case is pending. Court cases have ruled that drug manufacturers may bar access to 340b discounts for contract pharmacies. One exception was offered: drug manufacturers must allow a covered entity access to a single contract pharmacy if it does not operate its own retail pharmacies.

- Prior to 2023, several of drug companies permitted access through data submission. After the first district court case early 2023, many drug manufacturers further restricted access.

340B Contract Pharmacy State Legislation



340B Contract Pharmacy State Legislation

Contract Pharmacy Protections:

- Prohibits manufacturers, distributors, or third-party logistics providers from directly or indirectly restricting the delivery or acquisition of a 340B drug
- Prohibits these entities from also requiring a 340B entity to submit any claims or utilization data as a condition for allowing acquisition or delivery

Violations:

- The draft bill also includes sections for a state to enable penalties for violations under existing state law

Severability:

- The model bill includes language ensuring the law will survive if a court strikes down a portion of the language

340B Contract Pharmacy State Legislation

- Drug companies argue state contract pharmacy laws violate the Supremacy Clause of the U.S. Constitution, which prohibits states from enacting laws that conflict with federal laws and/or concerns topics that are exclusively reserved for the federal government.

- The 8th Circuit rejected PhRMA's Supremacy Clause argument; the Supreme Court refused to overturn the 8th Circuit's decision.

- Federal district courts in Arkansas, Louisiana, Mississippi, Maryland, and Missouri have also rejected drug companies' Supremacy Clause arguments.

- A federal district in West Virginia has agreed with PhRMA's Supremacy Clause argument and is temporarily blocking the law from being enforced (12/17/24)

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340B Rebate Model

- As a result of the Inflation Reduction Act (IRA), manufacturers are pushing for the 340B program to be a rebate model instead of an upfront discount model.

- HRSA approved the 340B rebate model for only the manufacturers and drugs that were within scope of the IRA.

- This would have resulted in hospital cash flow impacts, administrative burden to submit data, and discretion for the manufacturers to deny rebate. The recourse for the hospital would be a lengthy appeal process.

- Maine court said that the 340B rebate model was a violation of the Administrative Procedures Act (APA) and government is not appealing at this time.

QUESTIONS?

Do not edit
How to change the design

On a scale of 1-10 (1=completely unaware, 10=expert understanding), how well do you think you understand the financing, and challenges, of how healthcare services are reimbursed?

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Questions and Feedback link

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QUESTIONS?