CAPITOL STREET

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340B Cut Is Back & Worse For Hospitals in 2027

ASP-33% Proposed As Congress Weighs 340B Legislation

Relevant Companies: HOSPITALS & BIOPHARMA

Our Take & Next Up

CMS is proposing significant reimbursement cuts for 340B drugs (ASP-33%) to hospitals, while Congress continues to develop 340B reform (although 2026 action is unlikely). 340B drug revenue is directly being targeted by CMS with proposed payment cuts for 340B drugs to ASP-33% in the proposed 2027 Hospital Outpatient Prospective Payment System (OPPS) rule. As a reminder, drugs are generally paid at ASP+6% under Medicare. This Medicare cut would create a discrepancy of ~40% of ASP for 340B drugs compared to non-340B drugs.

On our radar: CMS is also set to reintroduce a 340B rebate model pilot shortly. We believe the pilot will mirror the previous 340B alternative rebate model (struck by courts) and will impact 2026 & 2027 negotiated drugs (our take is here).

Separately, Congress is still refining 340B legislative reform, focused on transparency and data gathering. We note that 2026 action via Congress is unlikely as reforms are still premature with limited vehicles for healthcare (except for a must pass health extenders bill in December), but transparency enjoys bipartisan and bicameral support. Lawmakers are increasingly aware of 340B program growth and hospital gaming, but consensus on broad 340B program changes is unlikely to materialize in 2026.

Key Points

In the rule released this morning (here), CMS proposes cutting Medicare pay for 340B drugs to ASP-33.4%. 340B dependent hospitals are expected to be the most impacted as CMS intends to offset payment cuts with an increase in OPPS payments for non-drug services by an equivalent amount. As a reminder, drugs and biologicals are generally paid at ASP+6%, WAC+6%, or 95% of AWP.

This is a steep pay cut to hospitals for 340B drug reimbursement and it will reduce Medicare drug payment by $4.55 B and beneficiary drug payment costs by $1.15 B in 2027. CMS previewed cuts to 340B entities when they finalized a drug acquisition cost survey requirement in the CY 2026 OPPS rule. See our analysis of 2026 final OPPS here. From January to April 2026, CMS conducted a Drug Acquisition Cost Survey to collect NDC-level pricing data on separately payable 340B and non-340B drugs. CMS states that proposed 340B payment cuts aligns with hospital drug acquisition costs determined through the survey.

CMS seeks comment on setting the rate at ASP-28% (derived from HRSA 340B ceiling price data).

- Hierarchy when ASP is unavailable: WAC minus 33.4%; if WAC is unavailable, 59.69% of AWP; MUC-priced 340B drugs at 100% of MUC; invoice-priced drugs at the invoice amount (each already reflecting the 340B discount).
- Alternative under comment: CMS seeks comment on setting the rate at ASP minus 28% instead, derived from HRSA 340B ceiling-price data (AMP minus the unit rebate amount) rather than survey data, updatable as new ceiling prices and claims utilization publish.
- Open comment areas: CMS solicits comment on using 340B covered entity status as the grouping characteristic, on the single-discount-factor approach, on omitting an add-on payment, and on the ceiling-price alternative.

We note that publicly traded hospitals have little-to-no 340B exposure. Publicly traded hospitals include HCA, Universal, Tenet, Ardent and others.

CMS presents results from its new Outpatient Drug Acquisition Cost Survey (ODACS), developed to validate Medicare 340B payment rates against actual hospital acquisition costs. The 2025-26 data collection follows earlier 340B payment-rate litigation (*American Hospital Association v. Becerr*a) and is intended to build an evidentiary record for future 340B payment-rate policy.

- Hospitals' survey-reported 340B acquisition costs were approximately 33.4% below average sales price (ASP), while non-340B acquisition costs ran about 2.7%-2.8% above ASP; a finding CMS says validates continued scrutiny of 340B payment levels.
- CMS cross-validated this against HRSA 340B ceiling prices, which were 28%-29.2% below ASP in aggregate, reinforcing that the acquisition-cost discount is real and consistent across therapeutic classes.
- The rule details extensive data-cleaning methodology (geometric-mean outlier trimming, exclusion of implausible 340B ceiling-price violations, IU/MG unit errors) used to refine the ~160,430 survey records to ~146,117 for margin calculations.
- Response rates were higher among non-340B hospitals (53.3%) than 340B hospitals (28.6%), and CMS acknowledges responding hospitals skewed smaller, more rural, and less teaching-intensive than the overall eligible population, prompting use of inverse probability weighting.

OTHER 340B CATALYSTS

Transparency is a low hanging fruit for 340B legislative reform, but may not materialize this year. We note that odds of passage are slim for 340B reform, but we could see movement on transparency requirements in 2026. In fact this week, House Ways & Means Cmte (Chair Smith, MO) passed 340B reporting requirements for high-revenue hospitals, including total number of individuals that received 340B drugs, aggregate net 340B payment amount, and aggregate costs incurred to participate in the 340B program.

On the Senate side, outgoing Senate HELP Chair Cassidy (R-LA) proposed comprehensive 340B reforms that will need a new champion after 2026. A discussion draft released in June includes (1) codification of discount requirements (including option for retroactive rebates by manufacturers), (2) 340B entity reporting requirements, (3) clarification of key terms including “patient”, (4) restriction on patient OOP for 340B drugs, and (5) restrictions on child sites.

HRSA will release a new 340B rebate model (any day now). The new 340B model could resemble the previously proposed pilot through retrospective rebates for 2026 & 2027 negotiated drugs or establish a 340B/IRA clearinghouse within HRSA to address duplicate discounts. As a reminder, the prior 340B model attempted to implement alternative backend rebates for 2026 selected negotiation drugs, but was withdrawn due to litigation from the hospital industry. See our previous analysis here.

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