



Charles N. Kahn III
President and CEO

July 28, 2023

The Honorable John Thune
511 Dirksen Senate Office Building
United States Senate
Washington, D.C. 20510

The Honorable Debbie Stabenow
713 Hart Senate Office Building
United States Senate
Washington, D.C. 20510

The Honorable Shelley Moore Capito
170 Russell Senate Office Building
United States Senate
Washington, D.C. 20510

The Honorable Tammy Baldwin
141 Hart Senate Office Building
United States Senate
Washington, D.C. 20510

The Honorable Jerry Moran
521 Dirksen Senate Office Building
United States Senate
Washington, D.C. 20510

The Honorable Benjamin Cardin
509 Hart Senate Office Building
United States Senate
Washington, D.C. 20510

Delivery via email to: Bipartisan340BRFI@mail.senate.gov

Dear Senators Thune, Capito, Moran, Stabenow, Baldwin, and Cardin,

The Federation of American Hospitals (FAH) is pleased to provide this response to your bipartisan request for information (RFI) regarding the 340 Drug Discount Program. We commend the working group for its leadership on bipartisan solutions to the 340B program and to ensure the program meets its original intent.

The FAH is the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States. FAH members provide patients and communities with access to high-quality, affordable care in both urban and rural areas across 46 states, plus Washington, DC and Puerto Rico. Our members include teaching, acute, inpatient rehabilitation, behavioral health, and long-term care hospitals and provide a wide range of inpatient, ambulatory, post-acute, emergency, children's, and cancer services. Tax-paying hospitals account for approximately 20 percent of community hospitals nationally.

The FAH very much welcomes the opportunity to comment on your bipartisan RFI on the 340B program and “to provide information that will help Congress further the original intent of the program...” which as you note was “to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.” Along those lines, there has been a significant, steady erosion in Medicaid and Medicare payments resulting in payments that fall far below the typical cost of care – ten percent below according to MedPAC. And while Federal payments erode, hospital drug costs continue to escalate.

The 340B program, established 31 years ago, is an important safeguard, yet due to a regrettable anachronism in the law, tax-paying hospitals – approximately 20 percent of all community hospitals nationwide -- are ineligible to participate and offer to the communities and patients they serve the benefits this program was intended to confer to them. Broad eligibility should be the hallmark of safety-net programs such as 340B. Artificial distinctions between classes of hospitals providing safety-net services inappropriately harms hospitals and the communities that rely on them for care. FAH member hospitals serve as essential health care institutions for some of the nation’s most challenged communities, providing charity and uncompensated care to patients who have few, if any, alternatives to address their health care needs. They are anchor institutions in cities across rural and urban America.

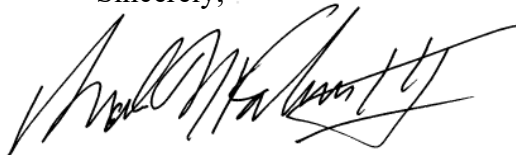
As you know, the 340B program is intended to benefit health care providers that serve low-income and other vulnerable populations. For a hospital to qualify for 340B discounts, the hospital must be receiving a Medicare Disproportionate Share Hospital (DSH) payment adjustment of at least 11.75 percent or – in the case of rural referral centers or sole community hospitals – 8 percent. Not all hospitals that meet these low-income patient thresholds, however, are eligible for the 340B program. A hospital must also be (1) owned or operated by state or local government, (2) a public or private non-profit corporation which is formally granted governmental powers by state or local government, or (3) a private non-profit organization that has a contract with a state or local government to provide care to low-income individuals who do not qualify for Medicaid or Medicare. Given these criteria, tax-paying hospitals that provide care to high-concentrations of low-income or uninsured patients are ineligible because of their ownership structure, even though a significant number of such hospitals meet and exceed the applicable Medicare low-income patient thresholds.

This prohibition on participation clearly undermines program intent. This is especially true when one considers that FAH member hospitals provide greater levels of charity and uncompensated care measured as a percentage of operating costs than 340B hospitals. Recent cost report data reveals that charitable services at FAH member hospitals accounted for 4.4 percent of operating costs, while charitable services at 340B hospitals account for 2.5 percent of operating costs. Uncompensated care costs at FAH hospitals accounted for 5.5 percent of operating costs compared to 3.5 percent for 340B hospitals. Medicaid utilization is comparable at approximately 27 percent for FAH members and 29 percent for 340B hospitals. Tax-paying hospitals serve some of the most at-risk counties across the country. For example, in the 15 Texas counties that border Mexico, tax-paying hospitals account for 86 percent of Medicare discharges, 83 percent of Medicaid discharges, and 62 percent of all uncompensated care costs.

Your RFI correctly notes that “as the health care delivery system has evolved, so too has the 340B program evolved to enable health care providers to offer improved services and care in communities they serve.” Yet, that evolution is woefully incomplete. It must go further to meet the needs of the millions of patients that access care in tax-paying hospitals, in particular those patients who live in rural communities where access to 24/7 emergency care in addition to the full spectrum of essential primary care is solely through a tax-paying hospital that also provides a crucial economic crutch to support local law enforcement, teachers, and firefighters. Enabling these hospitals to lower drug costs for patients through eligibility to participate in the 340B program, however it may be reformed, is a long overdue evolutionary step that will further the original program intent “to provide more patients with more services.”

Thank you for the opportunity to share our recommendation on improving the 340B program, and if you have any questions or would like to discuss this further, please do not hesitate to contact me at (202) 624-1534.

Sincerely,

A handwritten signature in black ink, appearing to read "William H. Bennett", written in a cursive style.