# Medicaid Cuts and 340B: What health systems need to know now

## How H.R. 1 puts 340B eligibility at risk

- **Medicaid reform could reduce DSH days and put 340B eligibility at risk.** H.R. 1, the "One Big Beautiful Bill Act," enacted July 4, 2025, significantly alters Medicaid coverage and financing. Work reporting requirements for expansion adults and other provisions are expected to reduce Medicaid enrollment and countable Medicaid inpatient days for the disproportionate share hospital (DSH) adjustment percentage filed on hospitals' Medicare Cost Reports. As Medicaid enrollment declines, countable inpatient days fall. The resulting decreases to DSH percentages could put 340B eligibility at risk, as 340B eligibility is verified for many institutions via their annual Medicare Cost Report filing.

- **Certain hospitals can lose 340B eligibility.** Health Resources and Services Administration (HRSA) thresholds differ by hospital type. DSHs must have a Medicare DSH adjustment percentage greater than 11.75%. Freestanding cancer (CAN) and children's (PEDS) hospitals must either exceed 11.75% or qualify via an alternative indigent care calculation. Sole Community Hospitals (SCH) and Rural Referral Centers (RRC) must have 8% or more. Critical Access Hospitals (CAHs) participate under separate eligibility criteria.

- **A dual financial exposure is emerging.** Coverage losses can reduce Medicaid volume (and raise uncompensated care). H.R. 1 also tightens Medicaid financing tools like provider taxes and state-directed payments—putting supplemental revenue at risk even for hospitals that remain 340B-eligible.

- **The financial impact to the health system enterprise is material.** We recently analyzed a nine-hospital system participating in 340B and found that loss of 340B discounts would swing EBIDA from +$11 million to –$42 million (a loss of $53 million). Nationally, modeling hospital financials without 340B discounts results in negative aggregate operating margins, particularly among safety-net providers.

- **Federal cuts compound the risk.** H.R. 1 includes approximately $900 billion in federal Medicaid reductions over 10 years and is projected to increase the uninsured population by 10 million people—most losing Medicaid or CHIP coverage. Rural hospitals and those with high Medicaid populations are disproportionately exposed.

## What this means for hospitals and health systems

- **340B is not just a pharmacy issue—it is a health system margin stabilizer.** Loss of 340B disproportionately affects drug-intensive service lines such as oncology, infusion, and specialty pharmacy. For many health systems, it is the difference between positive and negative operating performance.
- **DSH percentage is now a strategic KPI.** Executive teams must elevate DSH monitoring from an annual cost report exercise to a real-time enterprise metric with board-level visibility.
- **Financial risk is nonlinear.** A modest decline in Medicaid inpatient days can tip a hospital below the DSH eligibility threshold, creating a sudden and severe margin event rather than a gradual erosion.
- **State-level implementation will determine the speed of impact.** Work requirement rollouts, redetermination processes, and supplemental payment adjustments will vary by state. Systems that wait for finalized guidance will be reacting, not leading.
- **Mission risk accompanies financial risk.** As 340B savings erode, systems will face difficult trade-offs around sustaining essential services for vulnerable populations.

## What healthcare organizations need to do now

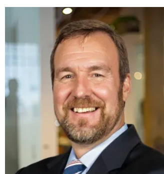
- **Model your exposure with precision**. Quantify the impact of varying Medicaid disenrollment scenarios on each hospital's DSH percentage. Stress-test financials under a "loss of 340B" scenario and translate the results into service-line, capital, and liquidity implications.
- **Optimize Medicaid inpatient day capture.** Enhance real-time eligibility verification, strengthen documentation practices, and audit patient classification processes to ensure all Medicaid-eligible inpatient days are accurately recorded on the cost report.
- **Reevaluate site-of-care strategy and build strategic partnerships.** Where appropriate, realign 340B-eligible practices or infusion services toward facilities with stronger DSH positioning. Explore care-at-home and long-term care strategies that preserve appropriate inpatient Medicaid volume.Also, evaluate partnerships with federally qualified health centers (FQHCs) or FQHC look-alikes to expand Medicaid access and strengthen community alignment.
- **Stand up cross-functional governance.** Leading health systems are coordinating DSH and 340B strategy with a single executive sponsor overseeing joint work groups across strategy, finance, and pharmacy.
- **Engage early at the state level.** Work with Medicaid agencies as work requirements and redetermination processes are implemented to minimize avoidable coverage loss in your markets.

*The health systems that act now—treating DSH percentage and 340B participation as strategic levers rather than technical compliance issues—will be best positioned to protect margin and mission.*

## Call to action

**We can help.** Contact us to learn more about how to assess your organization's 340B exposure, optimize DSH performance, and build a proactive strategy to withstand Medicaid reform while protecting the communities you serve.

## Authors

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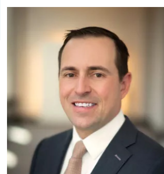

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