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Tiered 340B Transparency for Oklahoma: Protecting Rural Providers While Advancing Program Integrity

Policy Brief

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Executive Summary

In the wake of H.R. 1 eliminating $5.3 billion in rural Oklahoma Medicaid spending over the next decade, the 340B Drug Pricing Program is one of the few remaining mechanisms keeping rural entities solvent. Since its creation in 1992, 340B has grown into the second largest prescription drug program in the nation, saving each of Oklahoma's 930 340B entities between $564,000 and $8.9 million annually. The program's growth prompted 20 states and Congress to propose or pass 340B transparency legislation, but uniform reporting mandates risk disproportionately increasing administrative costs for rural 340B entities, eliminating critical 340B savings. Oklahoma can proactively adopt Minnesota's successful 340B tiered reporting framework that adjusts reporting requirements based on entity size to protect financially strained rural entities while promoting program integrity.

Introduction

As of January 2026, 48 of Oklahoma's 74 rural hospitals are at risk of closing, with 20 likely to close within the next two to three years.[1] The financial strain will worsen as H.R. 1 removes $5.3 billion in rural Oklahoma Medicaid spending over the next decade,[2] which cannot be offset by the state's five-year $223.5 million Rural Health Transformation Program (RHTP) grant.[3] In a limited federal resource landscape, the 340B Drug Pricing Program remains a major source of financial support for Oklahoma's rural providers. 340B requires pharmaceutical manufacturers to provide six types of qualifying hospitals and clinics, or "entities," with 20–50% discounts on outpatient drugs, helping covered entities maintain services, expand access to care, and in some cases, reduce patient cost sharing or cash prices.[4]

Oklahoma's legislators already recognize the 340B program's role as a lifeline for rural health. HB 2048, the 340B Nondiscrimination Act,[5] passed both chambers with bipartisan support and would have protected covered entities from discrimination by manufacturers, insurers, and pharmacy benefits managers (PBMs) while preserving patients' pharmacy choice. Due to the law's attempt to modify contract pharmacy regulations, a federal court injunction enjoined the law due to preemption by federal HRSA law.[6]

Key Statistics

- 340B covered entities purchased $66.3 billion in outpatient drugs in 2023.[7]
- Oklahoma has 930 registered 340B covered entities.[8]
- Estimated annual 340B savings per Oklahoma entity range from $564,000 to $8.9 million.[9]

Since 2023, 20 states[10] and Congress[11] have proposed or passed 340B transparency legislation

1 https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

2 https://www.mcafeetaft.com/oklahomas-rural-healthcare-faces-new-era-under-the-one-big-b eautiful-bill-act/

3 https://oklahoma.gov/governor/newsroom/newsroom/2025/oklahoma-lands-historic-funding-t o-reimagine-rural-health-care.html

4 https://www.npcnow.org/topics/health-spending/340b-drug-pricing-program

5 https://www.billtrack50.com/billdetail/1788248

6 https://www.ca4.uscourts.gov/opinions/251054.P.pdf

7 https://www.hrsa.gov/opa/updates/2023-340b-covered-entity-purchases

8 https://340bopais.hrsa.gov/SearchCe

9 https://340binformed.org/2020/04/340b-data-show-how-savings-help-patients-with-low-inco mes-and-protect-access-in-rural-areas/

10 https://rwc340b.org/state-340b-covered-entity-reporting-laws-roundup

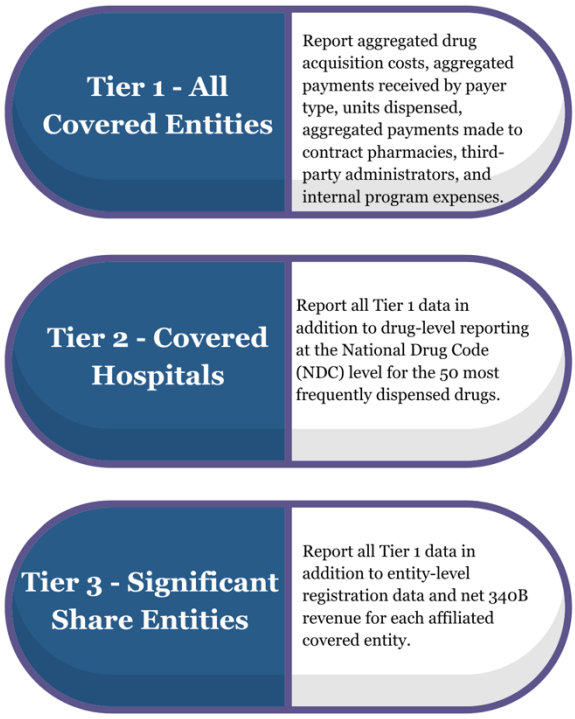
11 https://www.congress.gov/bill/118th-congress/house-bill/3290

in response to the program's explosive growth, concerns about savings utilization, and lack of existing oversight. Uniquely, Minnesota uses a tiered framework to protect rural 340B entities from burdensome reporting requirements,[12] providing a valuable template for designing future Oklahoma 340B transparency laws.

See Appendix A for definitions, additional background, and legal context.

Policy Proposal - Tiered Reporting Requirements by Entity Size

A tiered reporting framework that scales reporting requirements based on an entity's share of statewide 340B revenue can protect financially vulnerable small and rural entities by minimizing reporting administrative burdens while improving 340B transparency by collecting essential data that may inform future legislation. Compared to a uniform reporting mandate, tiered reporting reframes transparency as a fiscal responsibility and fairness argument to protect rural health while minimizing new costs on taxpayers and entities.



Drawing on Minnesota's approach,[13] entities would be classified by the State Commissioner of Health as either Significant Share Entities (SSEs) or aggregated reporters. SSEs are entities whose net 340B revenue accounts for a significant share of Oklahoma's total net 340B revenue. Aggregated reporters are all entities that are not determined to be SSEs and report data as a group rather than as individual entities. Covered hospitals face unique reporting requirements, creating three tiers of 340B entity reporting:

Stakeholder Analysis & Political Feasibility

Large Hospital Systems and High-Revenue Covered Entities

Large disproportionate share hospitals (DSHs), academic medical centers, and any other 340B-covered entities likely to be designated as an SSE due to high net 340B revenues face the heaviest administrative burdens from reporting requirements.[14] The American Hospital Association (AHA) broadly represents their interests and has opposed transparency mandates, arguing that they do not reflect the intent of the 340B program.[15]

Manufacturers

AbbVie, Eli Lilly, AstraZeneca, Novartis, and other manufacturers generally represented by the PhRMA lobbying group fund the 340B program and strongly support transparency,[16] arguing that the absence of reporting requirements enables program abuse. As the 340B program operates on a much larger scale in Oklahoma than in Minnesota (930 versus 204 entities),[17, 18] transparency requirements will advance their interests in reducing program costs through oversight and reform.

12 https://www.revisor.mn.gov/statutes/cite/62J.461

13 https://www.revisor.mn.gov/statutes/cite/62J.461

14 https://www.appliedpolicy.com/the-340b-drug-pricing-program-origins-and-ongoing-questio ns/

15 https://340breport.com/aha-tells-house-panel-it-opposes-new-340b-hospital-reporting-requ irements/

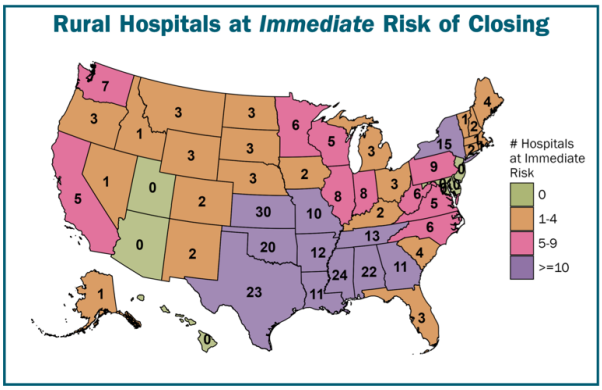
16 https://www.phrma.org/resources/phrma-statement-on-the-340b-drug-pricing-program

17 https://340bopais.hrsa.gov/SearchCe

18 https://www.health.state.mn.us/data/340b/docs/2025report.pdf

Rural and Safety-Net Covered Entities

Critical access hospitals, sole community hospitals, Federally Qualified Health Centers (FQHCs), and other safety-net grantees are the primary concern of the tiered framework. On average, rural hospitals allocate 18% more of their total expenses to administrative salaries than urban hospitals,[19] despite operating on a much lower median overall profit margin (2.7% versus 5.6%).[20] In Minnesota, 25 covered entities were responsible for 90% of the state's net 340B revenue[21] while FQHCs and other safety net providers generated less than 1% of statewide net 340B revenue.[22] Tiered requirements would protect low-revenue rural entities from reporting obligations relevant to large systems, garnering strong support compared to uniform reporting mandates.



Source: Center for Healthcare Quality and Payment Reform, "Rural Hospitals at Risk of Closing," January 2026.[23]

State Government

The state government bears the cost of developing, implementing, and enforcing a reporting framework through the Oklahoma Legislature and the Oklahoma State Department of Health (OSDH). The OSDH already administers complex health programs, indicating sufficient administrative capacity to minimize implementation and enforcement costs. The state benefits from appearing fiscally responsible and pro-transparency, aligning with conservative legislative priorities.

If Oklahoma legislators pursue 340B transparency, Minnesota's tiered reporting framework provides guidance on development, implementation and enforcement. Transparency reporting requirements have faced minimal litigation compared to contract pharmacy laws[24] and do not restrict program participation, avoiding conflict with federal HRSA law.

Timeline & Implementation

The following outline provides a detailed roadmap to operationalize a tiered 340B transparency reporting framework that collects 340B entity data within 12 months of enactment.

Phase 1 (Months 1–6): Commissioner Designation & Rulemaking

The OSDH Health Economics Division and the Commissioner formally designate the Health Economics Division as the administering body. The Commissioner identifies and designates SSEs, and the OSDH initiates administrative rulemaking to define tier-specific requirements, reporting standards, submission timelines, and enforcement procedures. The OSDH should open a 30-day public comment period on the proposed rules.

Phase 2 (Months 6–9): Portal Development and Tiered Template Build

The OSDH IT department procures or deploys a data submission portal with a submission template for each tier hosted on the existing OSDH IT infrastructure. To ensure efficient and uniform data collection, the OSDH should provide technical training on data collection and portal use.

Phase 3 (Months 10–13): First Reporting Cycle

All Oklahoma 340B Covered entities submit their first annual reports of 340B activity. The OSDH reviews submissions through automated and

19 https://pmc.ncbi.nlm.nih.gov/articles/PMC12359134/

20 https://www.healthaffairs.org/content/forefront/covid-19-and-financial-viability-us-rural-hospit als

21 https://www.health.state.mn.us/data/340b/docs/2025report.pdf

22 https://www.fiercehealthcare.com/providers/one-state-large-hospitals-dominate-340bs-net-s avings

23 https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf

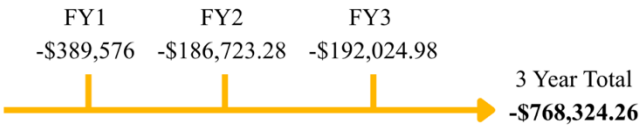
24 https://essentialhospitals.org/state-340b-legislation-protects-drug-access-sets-reporting-req uirements/

manual checks to ensure data quality. Should any issues arise, the OSDH should seek follow-up within 10 business days of receiving a submission.

Phase 4 (Months 13–17): Legislative Review and Refinement
The OSDH compiles the initial results into the first annual Oklahoma 340B Transparency Report for legislative review. Legislators review the findings, identify amendments to the Commissioner's reporting framework, and use the data to inform future 340B legislation.

See Appendix B for further implementation outline.

Fiscal Note



The proposal's 3-year net fiscal impact was projected at $768,324.26. The majority of the cost consists of initial staffing, portal development, rulemaking, and implementation in FY1 ($389,576). Ongoing annual costs are lower, at $186,723.28 in FY2 and $192,024.98 in FY3. A sensitivity analysis projected the 3-year net fiscal impact to range from $483,187.71 to $883,572.90.

Oklahoma's 930 340B entities face an estimated $3,775,000 in annual compliance costs, which are not covered by the state budget. However, this cost is likely lower than the administrative burden of a uniform reporting mandate. The tiered framework only requires SSEs to report affiliated-entity data, reducing the administrative burden on non-SSE entities.

Oklahoma has not previously implemented a 340B reporting system, so a fiscal analysis of a uniform reporting mandate would be speculative. A precise comparison would require assumptions about entity-level reporting volume, data validation needs, and staff time for both the state and covered entities. The tiered framework limits the most detailed reporting obligations to SSEs, thereby imposing lower administrative costs on both the state and covered entities than a uniform reporting mandate. The proposal would not generate new state revenue and would not directly affect Medicaid revenues or other existing state healthcare expenditures.

See Appendix C for detailed fiscal methodology.

Legislative Landscape & Limitations

The 340B program is facing significant proposed changes, with federal reform efforts split between expanding access, expanding oversight, and changing entity eligibility. No approach has gained momentum, and significant litigation over contract pharmacy policy has created legal uncertainty about the program.[25] Overall, the landscape faces stalemates over the program's original purposes, such as whether it was intended to primarily benefit providers or patients.[26]

At the state level, transparency has been the main focus, which may inform future state and federal reform. As of 2025, nine states have enacted reporting requirements, and eleven states have introduced similar legislation but have not yet passed it.[27] Oklahoma's HB 2048 shows strong bipartisan support for protecting covered entities, but highlights the limits of state action in 340B due to federal preemption. 340B transparency is not, nor is it intended to be, a comprehensive solution to problems in the 340B program. 340B reform is part of broader state and federal efforts to rebalance financial relationships in healthcare. As federal action becomes more likely, Oklahoma can proactively shape state and federal 340B policy through transparency legislation.

See Appendix D for detailed legislative background.

25 https://www.pharmacytimes.com/view/updates-to-340b-and-what-pharmacists-need-to-k now

26 https://schaeffer.usc.edu/research/misaligned-incentives-340b

27 https://rwc340b.org/state-340b-covered-entity-reporting-laws-roundup

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Technical Appendix

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Technical Appendix

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Table of Contents

This technical appendix to *Tiered 340B Transparency for Oklahoma: Protecting Rural Providers While Advancing Program Integrity* provides detailed empirical, legal, fiscal, and legislative foundations for the 340B program and reform efforts, focusing on a tiered 340B transparency reporting framework modeled on Minnesota's approach.

Appendix A. Background and Policy Context

A1. Federal Financing Context, Rural Provider Stress, and Its Consequences

H.R. 1, the 2025 budget reconciliation law, reshaped the federal health financing environment by modifying Medicaid, the Affordable Care Act, Medicare, and Health Savings Accounts. The Congressional Budget Office (CBO) estimates that Medicaid will lose nearly $1 trillion in funding over the next 10 years and lead to 10 million people losing coverage.[1] For Oklahoma, H.R. 1 will reduce rural Oklahoma Medicaid spending by $5.3 billion over the next decade, jeopardizing a key funding source for already financially stressed rural providers.[2]

- $5.3B projected rural Oklahoma Medicaid spending reduction over 10 years
- 48 of 75 rural inpatient hospitals at risk of closure
- 20 of 75 rural inpatient hospitals at immediate risk
- 47 of 77 counties with four or fewer rural health facilities

Oklahoma has faced 7 rural hospital and 5 inpatient service closures since 2015, averaging more than 1 facility closure per year. Of the 75 remaining rural inpatient hospitals, 45 (61%) operate at a loss. 48 rural hospitals (65%) are at risk of closing due to losses on patient services and low financial reserves. 20 (27%) rural hospitals are at immediate risk of closing due to inadequate revenues to cover expenses and only enough financial reserves to offset losses for 2-3 years at most. The risk of closure is highest for the smallest rural hospitals, where almost 50% of all rural hospitals with less than $45 million in annual expenses are at risk of closure, with 16% at immediate risk, while only 20% of those with annual expenses above 45 million are at risk of closure, with 10% at immediate risk. [3]

Due to the geographic distribution of rural hospitals and facilities, any closure has severe consequences on service availability and patient access to care. Oklahoma has an average of 4.87 rural health facilities per county, which include Critical Access Hospitals (CAH), Federally Qualified Health Centers (FQHC), Rural Emergency Hospitals (REH), and Short-Term/PPS Hospitals. 47 of Oklahoma's 77 counties have 4 facilities or fewer, with 19 having 2 or fewer.[4] Closures in these counties can create healthcare deserts with severely limited service availability, increased patient travel times, and higher prices at remaining facilities, worsening rural health outcomes.[5, 6]

1 https://www.kff.org/medicaid/a-closer-look-at-the-50-billion-rural-health-fund-in-the-new-reconciliation-law/

2 https://www.mcafeetaft.com/oklahomas-rural-healthcare-faces-new-era-under-the-one-big-b eautiful-bill-act/ https://pmc.ncbi.nlm.nih.gov/articles/PMC9633454/

3 https://ruralhospitals.chqpr.org/Solutions.html#the-need-for-rapid-action-to-prevent-closures-and-sustain-rural-healthcare

4 https://www.ruralhealthinfo.org/rural-maps/healthcare-facilities

5 https://www.ruralhealthinfo.org/topics/healthcare-access

6 https://www.sph.umn.edu/news/rural-hospital-closures-led-to-higher-prices-at-nearby-surviving-hospitals/

A2. Oklahoma's Rural Health Transformation Program Award and Its Limits

The Rural Health Transformation Program (RHTP) was added to H.R. 1 through Section 71401 of Public Law 119-21 in recognition of its impact on rural hospitals, providing $50 billion in state grants over five years that offsets 37% of the estimated $137 billion in federal rural Medicaid spending cuts. Half of the funding ($25 billion) will be distributed equally to each state by the Centers for Medicare and Medicaid Services (CMS), and the other half will be distributed at CMS's discretion, subject to broad requirements. States can use the funding to support a broad range of rural health initiatives, such as expanding the rural health workforce, modernizing health infrastructure, and paying for healthcare services.

Oklahoma was awarded a $223,476,948.62 for the first budget period through the five-year RHTP grant.[7] The funding will be used to invest in local care infrastructure, chronic disease prevention, workforce pipelines, regional care collaboration, shifts to value-based care, and improve data interoperability.[8] These initiatives will mitigate declines in rural health outcomes, but the funding is limited to 5 years and tied to specific programmatic uses that may not cover the day-to-day operations of financially struggling rural hospitals. If the $223 million grant were renewed each year for five years and used to offset the $5.3 billion in rural Oklahoma Medicaid spending cuts, it would offset $1.115 billion (21%).

A3. The 340B Program, Its Controversies, and Growing Importance

The 340B Drug Pricing Program is a federal outpatient drug discount program established under Section 340B of the Public Health Service Act, 42 U.S.C. § 256b in 1992.[9] Under the program, manufacturers participating in Medicaid must provide covered outpatient drugs at a 20–50% discount to eligible covered entities.[10] Hospital-covered entities defined by Section 340B(a)(4)(L), (M), (O) include disproportionate share hospitals, sole community hospitals, rural referral centers, critical access hospitals, children's hospitals, and free-standing cancer hospitals. Non-hospital covered entities defined by Section 340B(a)(4)(A-K) include federally supported safety-net providers, such as federally qualified health centers, Ryan White providers, family planning clinics, and tribal or urban Indian health centers.[11]

Manufacturers distribute drugs to wholesalers who sell them at the 340B discount price to covered entities for use in clinical settings or dispensed through in-house pharmacies. Covered entities may form contracts with one or more pharmacies, such as CVS, to provide pharmacy services and 340B drugs to authorized patients. Generally, the savings from participating in the 340B program are used to sustain services, expand access, and in some cases, reduce patient cost-sharing or cash prices.[12]

Controversies over a lack of oversight, contract pharmacy arrangements, and the utilization of 340B savings remain key issues for primarily state legislators. The 340B program has seen explosive growth

7 https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/health-promotion/rhtp/webinar/20260421%20RHTP%20Virtual%20Touchpoint%20vFinal.pdf

8 https://oklahoma.gov/health/rhtp.html

9 https://www.congress.gov/crs-product/IF12232

10 https://www.340bhealth.org/members/340b-program/overview/

11 https://www.federalregister.gov/documents/2015/08/28/2015-21246/340b-drug-pricing-program-omnibus-guidance

12 https://www.commonwealthfund.org/publications/explainer/2025/aug/340b-drug-pricing-program-how-it-works-and-why-its-controversial

since, with 340B purchases growing from $13.9 billion in 2014[13] compared to $81.4 billion in 2024.[14] The program was not intended to grow to such a scale and, accordingly, was not created with strict oversight mechanisms for how 340B savings are used, contract pharmacy arrangements, and practices such as duplicate discounting and discrimination by manufacturers, PBMs, and insurers.[15] Duplicate discounting is prohibited by 42 USC 256b(a)(5)(A)(i), in which eligible providers obtain a 340B discount and a subsequent Medicaid reimbursement from drug manufacturers. In 2021, duplicate discounts accounted for an estimated 25% of all 340B sales, raising concerns that Health Resources & Services Administration (HRSA) lacks sufficient oversight to stop the practice.[16] Price and contract discrimination by manufacturers, PBMs, and insurers against 340B entities involves a variety of practices. PBMs and insurers may identify claims as a "340B claim" for the purposes of setting reimbursement, reducing payment rates, or penalizing covered entities or their contracted pharmacies due to acquiring drugs through 340B. Manufacturers limit 340B entities' ability to use contract pharmacies or restrict access to discounted 340B drugs dispensed through contract pharmacies by refusing to ship 340B drugs to contract pharmacies, mandating the use of manufacturer-designated pharmacies, limiting covered entities to a single contract pharmacy, limiting upfront 340B discounts, and imposing distribution contracts that exclude contract pharmacy arrangements. State law, such as Maine's Title 24-A §7754 and Rhode Island's Senate Bill 114, protects 340B entities from reimbursement discrimination. 340B pharmacy access laws, such as Colorado Senate Bill 25-07 and South Dakota's Senate Bill 154, prevent manufacturers from restricting contract pharmacy arrangements, but such laws continue to be contested.[17] Between 2021 and 2025, PhRMA and manufacturers, such as AstraZeneca, AbbVie, Novartis, have legally contested 340B contract pharmacy access laws in Arkansas, Colorado, Hawaii, Kansas, Michigan, Missouri, Mississippi, Nebraska, Oklahoma, Oregon, Rhode Island, Vermont, and West Virginia.[18]

Manufacturer contentions over contract pharmacy arrangements reflect broader debates over whether 340B savings were intended to benefit vulnerable patients or to help entities maintain margins. The HRSA describes the program's intent as helping providers "stretch scarce federal resources as far as possible," indicating that the program is meant to help entities maintain margins.[19] Manufacturers argue that 340B's intent was to benefit low-income, uninsured, and vulnerable patients by passing savings to them through reduced co-pays or cash prices, but 340B entities currently prioritize profit maximization instead.[20] The American Hospital Association (AHA), representing numerous 340B entities,[21] argues that 340B statute does not dictate how savings should be utilized, and the program is intended to help providers maintain margins that enable them to continue providing services to benefit low-income, vulnerable populations.[22] Congressional action can clarify the program's intent, potentially changing 340B savings utilization practices that may affect entity participation in the program.

13 https://www.drugchannels.net/2019/08/340b-program-purchases-reach-243.html

14 https://www.hrsa.gov/opa/updates/2024-340b-covered-entity-purchases

15 https://www.drugchannels.net/2025/12/340b-hit-81-billion-in-2024-23-why-cms.html

16 https://www.edgeworthеconomics.com/antitrustprescription-340B-duplicate-discounts

17 https://www.frierlevitt.com/articles/340b-price-discrimination-state-laws-contract-pharmacy-protections/

18 https://www.mintz.com/insights-center/viewpoints/2146/2025-09-09-mintz-ira-update-340b-roundup-states-and-manufacturers

19 https://www.hrsa.gov/opa

20 https://www.help.senate.gov/imo/media/doc/final_340b_majority_staff_reportpdf.pdf

21 https://www.aha.org/2021-03-15-setting-record-straight-340b-fact-vs-fiction

22 https://virtue340b.com/glossary-term/340b-savings-utilization-use-of-savings-2/

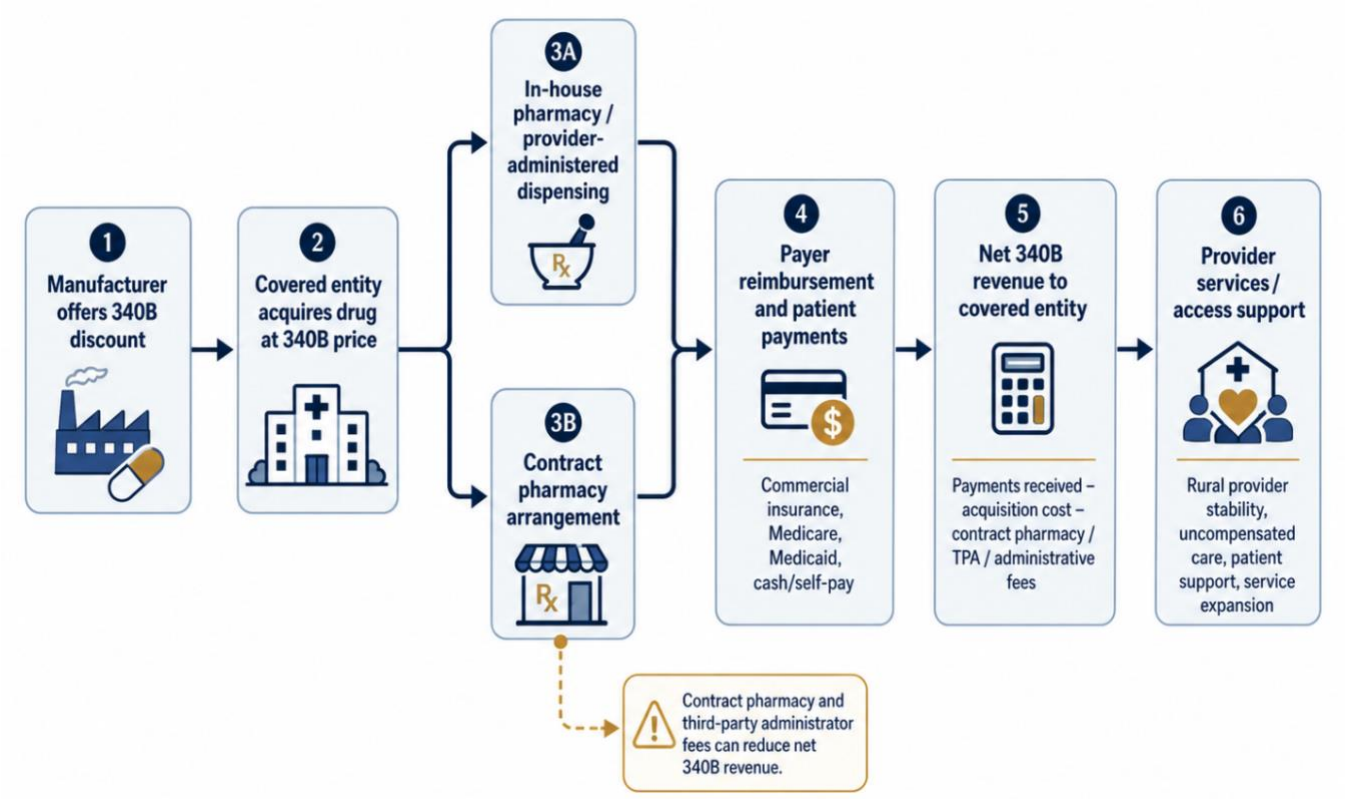

Figure 1. How 340B Savings Flow. The 340B pathway begins with discounted drug acquisition and ends with net revenue that may support provider services after acquisition and program-related costs.

Due to the $1 trillion in Medicaid cuts from H.R. 1, 340B remains a key federal funding mechanism to help financially struggling providers remain solvent. The large scale of 340B in Oklahoma reflects its role as a lifeline in a limited federal resource environment, with 930[23] registered 340B entities compared to Minnesota's 204,24 despite Minnesota having a 40% larger population.[25] While the RHTP grant assists vulnerable rural populations, it does not necessarily directly fund provider care as 340B does.

A4. Litigation & Legal Vulnerability

Recent state and federal 340B legislation has focused on three areas: contract pharmacy arrangement reform, transparency mandates, and changes to entity eligibility.[26] As previously mentioned, manufacturers have filed numerous lawsuits challenging state 340B pharmacy access laws, including Oklahoma's HB2048. On October 31st, 2025, a US district court issued a preliminary injunction of HB2048 due to the unconstitutionality of forcing sales at confiscatory prices and preemption of the law's delivery requirement and parallel enforcement provision (see Appendix D for further information on HB2048).[27] The litigation suggests that some forms of state 340B regulation may face substantial legal

23 https://340bopais.hrsa.gov/SearchCe

24 https://www.health.state.mn.us/data/340b/docs/2024report.pdf

25 https://www.nationsonline.org/oneworld/US-states-population.htm

26 https://www.pharmacytimes.com/view/updates-to-340b-and-what-pharmacists-need-to-know

27 https://law.justia.com/cases/federal/district-courts/oklahoma/okwdce/5:2025cv00727/131727/59/

vulnerability, particularly those directed at reimbursement, contract pharmacy arrangements, manufacturer control over 340B arrangements protected by the Takings Clause, and enforcement.

Oklahoma's continued interest in 340B reform requires careful design to minimize further litigation. Notably, transparency frameworks have faced minimal challenge from manufacturers and 340B entities, enabling higher implementation success rates than nondiscrimination mandates and other restrictions on manufacturer control. Reporting requirements are not necessarily devoid of legal risk, but can be minimized by emphasizing legislative oversight and data generation rather than direct market control provisions.

A5. Minnesota's Reporting Model as a Template

Minnesota offers one of the clearest current state models for 340B transparency. Its 2023 reporting law requires covered entities to register with the state and annually report aggregated purchase, payment, dispensing, and program-expense data. Reporting must also be stratified by payer type, and hospitals must report National Drug Code-level data for their 50 most frequently dispensed or administered drugs. The law authorizes penalties for late reporting and requires the Minnesota Department of Health to submit annual findings to the legislature.[28] Specific reporting requirements are listed below:

1. Aggregated acquisition costs for drugs obtained under 340B.
2. Aggregated payment received for drugs obtained, administered, and dispensed under 340B.
    a. Must be reported by payer type (private insurance, Medicare, etc.) in the form and manner determined by the commissioner.
    b. Must reflect the net of the contracted price for insurance claims payments and the portion of payment received from grants, cash or payment types that relate to the dispensing of drugs obtained under the 340B program
3. The number of pricing units dispensed or administered to patients as described in (2).
4. Aggregate payments made:
    c. to contract pharmacies to dispense drugs obtained under 340B;
    d. to any non-covered entity that is not a contract pharmacy for managing any aspect of the covered entity's 340B program;
    e. for any internal, direct administration expenses for the 340B program.
5. For covered hospitals, they must report all of the above (Elements 1–3) at the national drug code level for the 50 most frequently dispensed drugs by the covered hospital entity under the 340B program.
6. For significant share entities, they must report the name, ID, service address, and entity type of each 340B covered entity to maintain current registration with the commissioner. For each 340B entity defined, that entity's net 340B revenue must be calculated and reported from data from (Elements 1–3). Net 340B revenue is calculated as (2) - (1 + 4).

These requirements can be consolidated to create three reporting tiers, defined below:

- **Tier 1 - All covered entities**

28 https://www.revisor.mn.gov/statutes/cite/62J.461

Report aggregated drug acquisition costs, aggregated payments received by payer type, pricing units dispensed, and aggregated payments made to contract pharmacies, third-party administrators, and internal program expenses (Elements 1–4).

- **Tier 2 - Covered Hospitals**
  All Tier 1 requirements, in addition to drug-level reporting at the National Drug Code (NDC) level for the 50 most frequently dispensed drugs (Element 5).
- **Tier 3 - Significant Share Entities (Commissioner-Designated)**
  All Tier 1 requirements, in addition to entity-level registration data and calculated net 340B revenue for each affiliated covered entity under their umbrella, derived from calculations involving Elements 1–4 (Element 6).

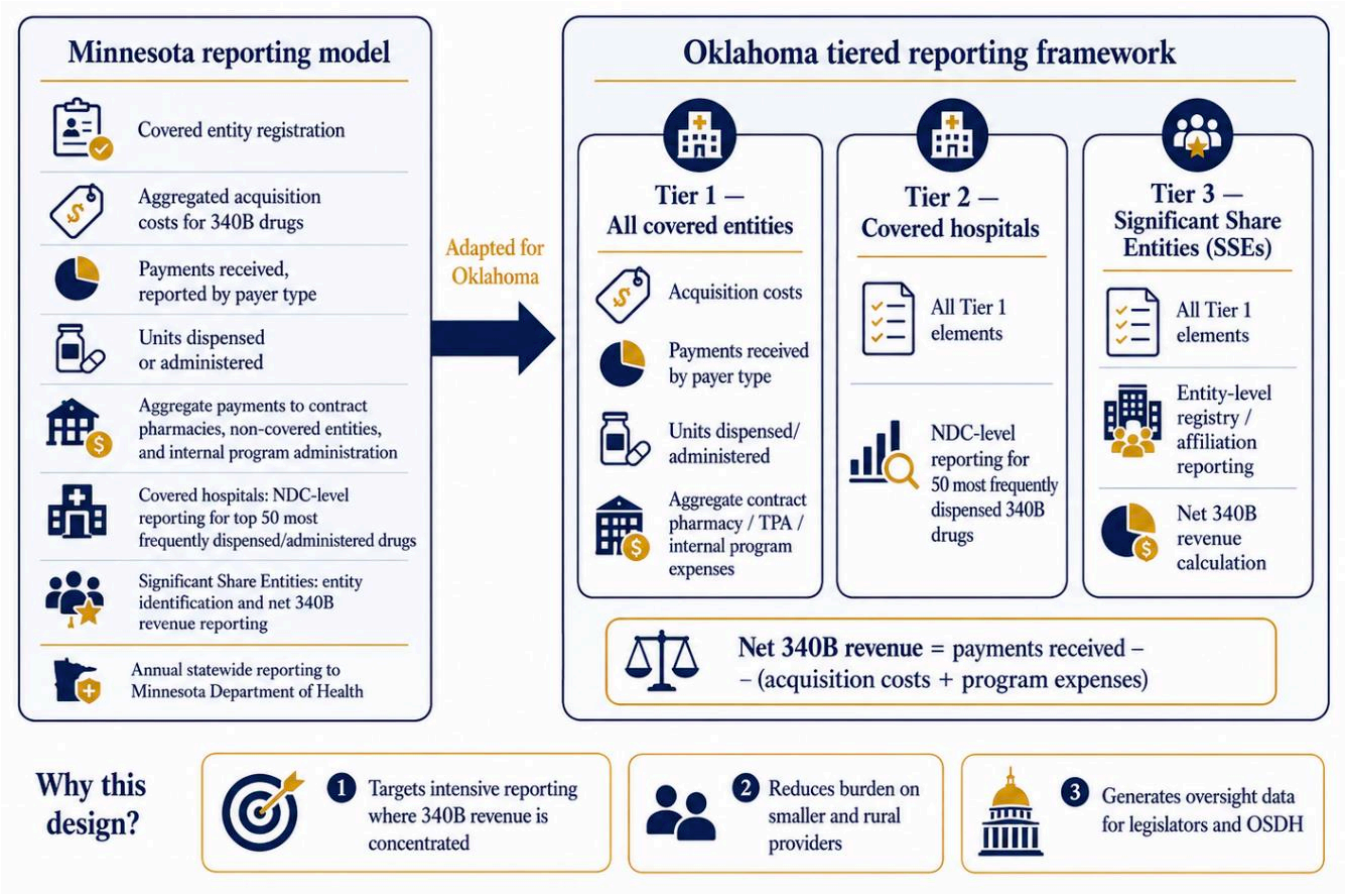

Figure 2. Minnesota Model to Oklahoma Tiered Framework. The proposed Oklahoma framework adapts Minnesota's reporting model into three tiers based on entity type and reporting intensity.

Minnesota's model achieved a 92.6% (189 out of 204) covered-entity response rate across 2 years of released data, demonstrating the feasibility of its design.[29] Oklahoma can adapt the model and include an additional provision to determine the effectiveness of a tiered transparency model:

- To determine policy effectiveness and support iteration, all 340B covered entities must report the administrative burden of complying with the reporting requirements. Tier 1 administrative

29 https://www.health.state.mn.us/data/340b/docs/2024report.pdf

burdens would be aggregated, while Tier 2 and Tier 3 entities must report their administrative burdens independently.

Reports from the Minnesota Department of Health (MDOH) overseeing the tiered reporting model revealed net 340B revenue growth from $630 million in 2023 to $1.34 billion in 2024, but these revenues were highly concentrated among large hospital systems. 25 covered entities accounted for 90% of the state's net 340B revenue, suggesting that limited savings were passed on to vulnerable patients. The registration data suggested that pharmacy contracts primarily benefit out-of-state residents: 204 parent sites managed 2,472 contracts with 574 unique pharmacies, but only 1,284 contracts were in Minnesota. Additional concerns include 45% of net 340B revenue driven by commercial payers, raising questions for employers regarding high costs.[30]

Data quality issues led the MDOH to follow up on 90% of reports at least once due to unclear statutory language that caused inconsistent entity reporting for office-administered versus pharmacy-dispensed drugs, inconsistent entity methodologies for reporting contract pharmacy fees, entity inability to disaggregate payer type, and child sites reporting independently of parent sites. If Oklahoma seeks to implement reporting requirements, these data quality issues should be proactively addressed in statutory language and training.[31]

30 https://www.health.state.mn.us/data/340b/docs/2025report.pdf

31 https://www.health.state.mn.us/data/340b/docs/2024report.pdf

Appendix B. Timeline & Implementation

The following outline provides a detailed roadmap to operationalize a tiered 340B transparency reporting framework that collects 340B entity data within 12 months of enactment. Between months 13–17 post-enactment, reported data will be compiled and presented to relevant legislative committees for program refinement.

Phase 1: Commissioner Designation & Rulemaking (Months 1–6)

The OSDH Health Economics Division and the OSDH Commissioner formally designate the Health Economics Division as the administering body. Additional staff should be utilized to assist in implementation, including a 1.0 FTE Health Economist and a 0.5 FTE IT/Data Systems position. The OSDH Commissioner initiates two parallel workstreams:

First, the Commissioner identifies and designates SSEs based on their judgment and the definition of an SSE: a 340B entity whose aggregate revenue from 340B program operations constitutes a significant portion of all 340B net revenue among all 340B entities in the state. The designation process requires the Commissioner to review current HRSA registration data, existing 340B purchasing records, and entity financial filings. In Minnesota, this designation process identified 25 entities responsible for 90% of statewide 340B revenue.[32] The same phenomena can be expected to occur in Oklahoma's designation process, given that its largest health systems, OU Health, Saint Francis Health System, and Integris Health, likely constitute the majority of statewide 340B purchasing volume.

Second, OSDH initiates administrative rulemaking under the Oklahoma Administrative Procedures Act and publishes the proposed rules in the Oklahoma Register by the third month of implementation. These rules should define the following:

1. The three-tier structure and Commissioner designation criteria for SSEs
2. Reporting elements required by tier
3. The form and manner of payer-type disaggregation for payment data
4. Submission deadlines
5. Enforcement mechanisms

The fourth month can be utilized as a 30-day public comment period on the proposed rules. SSE designations can be issued in month five, and final rules are adopted by month six.

The public comment period can surface opposition from entities that are likely to be designated as SSEs. They may challenge the Commissioner's designation criteria or the methodology used to calculate net 340B revenue. OSDH should document its designation methodology in the rulemaking record using HRSA registration data and publicly available financial disclosures to withstand administrative challenge. Minnesota's designation process and the accompanying Department of Health methodology report provide a template, but it can be adapted to Oklahoma's own health systems based on the commissioner's judgment.

Phase 2: Portal Development & Tiered Template Build (Months 6–9)

32 https://www.health.state.mn.us/data/340b/docs/2025report.pdf

The OSDH IT department should collaborate with the Oklahoma Hospital Association and the Oklahoma Primary Care Association to procure or develop and deploy a data submission portal based on existing OSDH data infrastructure, with three distinct submission pathways corresponding to each tier. Three reporting templates should be developed:

- **Tier 1 template:** Five data fields covering aggregated acquisition costs, aggregated payments received (total and by payer type), pricing units dispensed, and the four categories of aggregated payments made. Entities already collect the data and maintain records for HRSA compliance, simplifying reporting.
- **Tier 2 template:** All Tier 1 fields plus an NDC-level drug table for the 50 most frequently dispensed drugs, pre-populated with NDC codes where possible to reduce manual entry burden. Hospitals already maintain dispensing records at the NDC level for Medicare cost reporting, simplifying reporting.
- **Tier 3 template:** All Tier 1 fields plus an entity registry table requiring the name, ID, service address, and entity type of each affiliated covered entity, and a net 340B revenue calculation worksheet structured as:

  Net Revenue = Aggregated Payments Received – (Aggregated Acquisition Costs + Aggregated Payments Made).

To ensure uniform data collection and reporting across entities, the OSDH should publish a supplemental guidance document outlining how to derive payer-type data from existing claims systems and report it accurately. Additionally, the OSDH should conduct outreach to all 340B entities by contacting entity administrators responsible for 340B program operations through mail and an online webinar to ensure proper notification and technical training for administrators to use the portal and enter the correct information. A direct hotline for OSDH technical assistance should be established.

By month nine, the OSDH should have made the portal live with the three published templates, completed all outreach sessions, and set up an active IT hotline.

Phase 3: First Reporting Cycle (Months 10–13)

All Oklahoma 340B covered entities submit their first annual reports of 340B activity by month 12. The OSDH will review submissions as they arrive through automated and manual checks, flagging missing or discrepant information for follow-up. Some discrepancies may be automatically detected to improve efficiency, which include, but are not limited to, the following:

1. Missing payer type disaggregation in Tier 1 submissions
2. Missing or incomplete NDC drug tables in Tier 2 submissions
3. Net 340B revenue calculation discrepancies in Tier 3 submissions
4. Inconsistent reporting between HRSA databases and submissions

The OSDH should seek follow-up with incomplete and discrepant filers for clarification within 10 business days of receiving a submission. The OSDH should compile all validated data into a statewide 340B transparency dataset disaggregated by tier, entity type, and geography by month 13. This dataset should be used to create a report that includes all mandated data and presents the completion rate by tier, Tier 3 net 340B revenue totals as a share of statewide 340B purchasing volume, and administrative

burdens through a post-submission survey. Tier 1 entity compliance burdens would be averaged, while Tier 2 and Tier 3 entities would report their administrative burdens independently.

Potential reporting issues may arise from data quality issues. The Minnesota Department of Health (MDH) was required to follow up on 90% of reports at least once due to five types of data quality issues:

1. Reporting of office-administered versus pharmacy-dispensed drugs

   The reporting requirements applied to all 340B drugs, whether they were office-administered or pharmacy-dispensed. However, ambiguous statutory language led most covered entities to report only pharmacy-dispensed drugs purchased through the 340B program, a small number to report only office-administered drugs, and a small number to report both. Stakeholders additionally indicated that office-administered drugs were more difficult to identify.

2. Inconsistent methodologies for reporting contract pharmacy fees

   Covered entities were required to report fees paid to contract pharmacies for dispensing 340B drugs, as these fees can significantly cut into net 340B revenues. Covered entities used multiple methodologies to report fees. Some reported the total payments they made to contract pharmacies, including acquisition costs, while others reported the net payments to contract pharmacies and reimbursements to pharmacies from payers. Follow-up was required to allocate contract pharmacy fees to the appropriate category.

3. Payer type

   The statute required entities to report costs and revenues by payer type, but some entities were unable to disaggregate by payer type (commercial insurance, Medicare, Medical Assistance, MinnesotaCare, and Other). For hospital covered entities, the MDH applied their annual payer mix by patient days to allocate totals. Payer mix was calculated using existing standardized hospital report data from the most recent available year.

4. Child versus parent site

   Covered entities were required to report data at the 340B parent level, meaning all child-site and contract-pharmacy data should have been included in the parent report. Some child sites and contract pharmacies reported independently, prompting the MDH to follow up to determine whether the data were in the parent report or needed to be added.

5. Other

   Multiple entities had unique data issues not specified in the Minnesota legislative report, but required follow-up for clarification or resubmission.

Phase 4: Legislative Report & Program Iteration (Months 13–-17)

The OSDH should publish the first annual Oklahoma 340B Transparency Report by month 14, which should include the following information:

1. Statewide 340B net revenue by tier and entity type, where Tier 1 and 2 data are aggregated, and Tier 3 data is reported independently
2. Payer-type distribution of 340B payments
3. Charity care and uncompensated service allocation rates

4. Geographic distribution of 340B activity across rural and urban Oklahoma
5. Administrative burden for compliance by tier, consisting of aggregated Tier 1 data and individual Tier 2 hospital and 3 SSE entity data

The OSDH will present its findings to the House and Senate Health and Human Services Committees during the interim period. Legislature reviews findings and identifies any amendments to Commissioner designation criteria, tier thresholds, or reporting elements warranted for a future session.

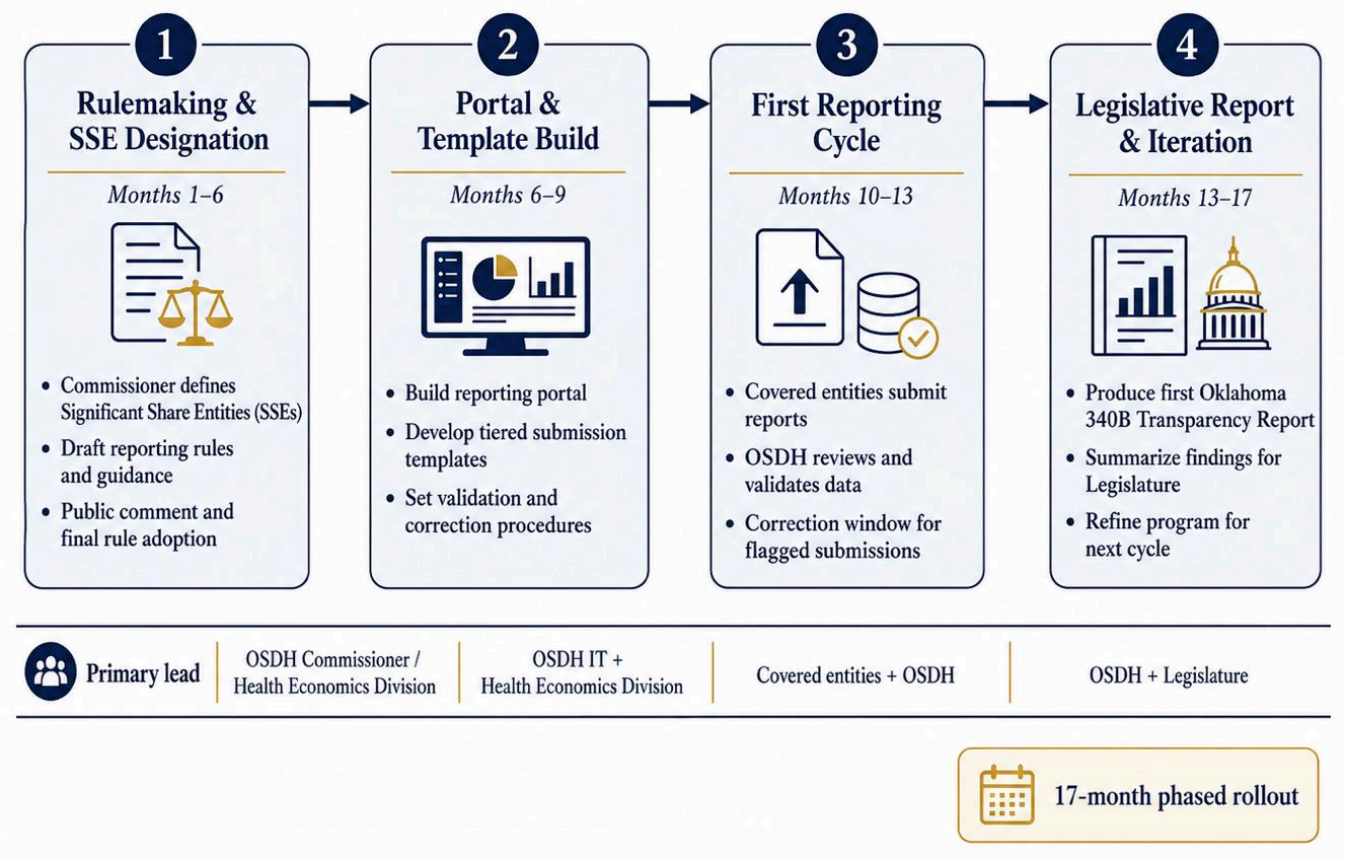

Figure 3. Implementation Roadmap. The proposed framework would move from rulemaking and SSE designation to portal development, first reporting, and legislative review over 17 months.

Appendix C. Fiscal Note

C1. Net State Fiscal Impact

The net state fiscal impact is summarized in the table below. FY1 indicates the first fiscal year after implementation, FY2 indicates the second fiscal year, and FY3 indicates the third fiscal year.

FY1	FY2	FY3	3-Year Total
-$389,576	-$186,723.28	-$192,024.98	-$768,324.26

The fiscal impact was calculated using five assumptions outlined below:

1. Three fiscal years of operations are required to assess continued fiscal stability.
2. Oklahoma has 930 registered 340B covered entities, and the number of entities remains unchanged between FY1 and FY3.
3. Entity distribution is estimated from Minnesota data and HRSA registration records.
   a. Tier 3 SSEs: ~20 health systems
      i. Minnesota found that the top 25 covered entities were responsible for 90% of the state's net 340B revenue.[33]
   b. Tier 2 covered hospitals: 60 hospitals[34]
   c. Tier 1 all other covered entities: ~850 entities, including FQHCs, Ryan White grantees, STD/TB clinics, and hemophilia treatment centers.
4. The FTE salary for an OSDH Health Economist is approximately $119,844 and increases by 3% each year.[35] The 0.5 FTE salary for an IT and data systems engineer was estimated at $51,732 and increases by 3% each year.[36]
5. Based on the scale and complexity of the data portal, the cost to develop and deploy it was estimated at $150,000.

33 https://www.health.state.mn.us/data/340b/docs/2025report.pdf

34 https://cdn.aglty.io/phrma/fact-sheets/340b/%20Fact%20Sheet%20-%20340B%20State%20Profiles%20-%20Oklahoma%20-%202024.pdf

35 https://www.salary.com/research/salary/recruiting/health-economist-salary/ok

36 https://www.indeed.com/career/system-engineer/salaries/Oklahoma-City--OK

Direct Expenditures - State (OSDH)

Item	FY1	FY2	FY3
1.0 FTE Health Economist	$119,844	$123,439.32	$127,142.50
0.5 FTE IT/Data Systems	$51,732	$53,283.96	$54,882.48
Data portal development & deployment (Y1 only)	$150,000	$0	$0
Legal/rulemaking support (Y1 only)	$30,000	$0	$0
Commissioner designation process (Y1 only)	$10,000	$0	$0
Tiered outreach & training (higher in Y1)	$20,000	$10,000	$10,000
Supplemental guidance development (Y1 only)	$8,000	$0	$0
Total State Cost	$389,576	$186,723.28	$192,024.98

Revenue Impact

This policy generates no state revenue and does not affect Medicaid revenues or existing state healthcare expenditures.

C2. Sensitivity Analysis

The policy's 3-year total fiscal impact to the state ranges from $483,187.71 to $883,572.90. The sensitivity analysis utilized three scenarios to calculate a total 3-year range:

1. The OSDH repurposes 0.5 FTE of existing Health Economist capacity rather than hiring a full new FTE.
2. The OSDH develops and deploys the data portal on existing OSDH data infrastructure without procurement.
3. The OSDH faces a 15% increase in costs due to unforeseen delays and expenditures.

Scenario	FY1	FY2	FY3	3-year total
State cost	$389,576.00	$186,723.28	$192,024.98	$768,324.26
Scenario 1 — 0.5 FTE repurposed from existing OSDH capacity (3% annual salary escalation)				
FTE savings	−$59,992.00	−$61,647.56	−$63,496.99	−$185,136.55
Adjusted state cost	$329,584.00	$125,075.72	$128,527.99	$583,187.71
Scenario 2 — Portal deployed on existing OSDH infrastructure (FY2028 one-time savings only)				
IT savings — low (−$75,000.00)	−$75,000.00	—	—	−$75,000.00
Adjusted state cost (low IT)	$314,576.00	$186,723.28	$192,024.98	$693,324.26
IT savings — high (−$100,000.00)	−$100,000.00	—	—	−$100,000.00
Adjusted state cost (high IT)	$289,576.00	$186,723.28	$192,024.98	$668,324.26
Total 3-year cost range by scenario				
Low estimate (Scenario 1 + high IT savings)	$229,584.00	$125,075.72	$128,527.99	$483,187.71
Base estimate (no adjustments)	$389,576.00	$186,723.28	$192,024.98	$768,324.26
High estimate (base + 15% contingency)	$448,012.40	$214,731.77	$220,828.73	$883,572.90

C3. Estimated Covered Entity Administrative Burden

Compliance cost estimates are derived from the complexity differential between tiers and are based on the AHA's $150,000–$500,000 estimate for a complex rebate pilot model, adjusted downward proportionally for a reporting-only obligation. As the policy requires reporting on administrative burden, the estimate is needed only to assess initial implementation.

Tier	Estimated Entities	Per-Entity Annual Cost	Annual Sector Total
Tier 3 (Significant Share)	~20	~$40,000	~$800,000
Tier 2 (Covered Hospitals)	60	~$15,000	~$900,000
Tier 1 (All Other Entities)	~830	~$2,500	~$2,075,000
Total Covered Entity Burden			~$3,775,000/year

These costs are borne entirely by covered entities and represent a small fraction of the $564,000–$8.9M in annual 340B savings per entity.[37]

37 https://340binformed.org/2020/04/340b-data-show-how-savings-help-patients-with-low-incomes-and-protect-access-in-rural-areas/

Appendix D. Legislative Landscape & Legal Limitations

D1. Legislative & Legal Landscape Summary

The 340B program is facing significant proposed changes, often driven by debates over the program's original purpose. Federal reform efforts are split between expanding access, rebuilding program integrity, expanding oversight, and changing eligibility.[38] No single approach has gained momentum, and significant litigation over contract pharmacy policy has created legal uncertainty about the program.[39] Overall, the landscape faces stalemates over the program's original purposes, such as whether it was intended to primarily benefit providers or patients.[40]

At the state level, transparency has been the main focus, which may inform future state and federal reform. As of 2025, Colorado, Hawaii, Idaho, Indiana, Maine, Minnesota, Ohio, Rhode Island, Vermont, and Washington have passed 340B transparency laws. 11 additional states have introduced similar legislation, but have not yet passed it.[41] Oklahoma's HB 2048 showed strong bipartisan support for protecting covered entities but also highlighted the limits of state action in 340B due to the unconstitutionality of regulating how manufacturers handle 340B entity contract pharmacy arrangements and federal preemption challenges to enforcement and to regulating manufacturer 340B drug delivery.

Overall, 340B reform is part of a larger effort to rebalance financial relationships across the healthcare system. As federal action becomes more likely, Oklahoma can proactively shape state and federal 340B policy through transparency legislation.

D2. Federal Legislative Landscape

The 119th Congress has demonstrated active, bipartisan engagement on 340B reform, introducing several bills ranging from expanding rural access to increasing transparency and accountability.

H.R. 5256, the 340B Affording Care for Communities and Ensuring a Strong Safety-Net Act (340B ACCESS Act), was introduced by Rep. Earl L. "Buddy" Carter (R-GA-1) in the 119th Congress on September 10, 2025. It imposes new covered entity oversight and reporting requirements for 340B savings use and includes more stringent criteria for program participation, such as a minimum charity care amount, contract pharmacy restrictions, and sliding-scale discounts to patients. The bill also includes civil monetary penalties for noncompliance by entities.[42]

H.R. 4581, the 340B Patients Act of 2025, was introduced by Rep. Doris Matsui (D-CA-7) in the 119th Congress on July 22, 2025. The bill would require manufacturers to offer 340B discount prices to covered entities regardless of how a drug is dispensed and prevent them from imposing conditions on a covered

38 https://www.pharmacytimes.com/view/updates-to-340b-and-what-pharmacists-need-to-know

39 https://www.pharmacytimes.com/view/updates-to-340b-and-what-pharmacists-need-to-know

40 https://schaeffer.usc.edu/research/misaligned-incentives-340b

41 https://rwc340b.org/state-340b-covered-entity-reporting-laws-roundup

42 https://www.billtrack50.com/billdetail/1905639

entity's ability to purchase and use 340B drugs. The bill also imposes civil monetary penalties for noncompliance by manufacturers.[43]

H.R. 44, the Rural 340B Access Act of 2025, was introduced by Rep. Jack Bergman (R-MI-1) in the 119th Congress on January 3, 2025. The bipartisan bill would expand 340B program eligibility to rural emergency hospitals (REH), a Medicare provider category established by Congress in 2020 for rural hospitals that deliver emergency care and outpatient services to patients who typically stay for less than 24 hours, but were not originally included in the 340B program.[44]

D3. State Legislative Landscape

Transparency requirements for 340B-covered entities have become a major focus of state legislative activity.

Idaho's S1390 was introduced on March 16, 2026, by the Senate State Affairs Committee.[45] It would require 340B covered entities to report how 340B savings are used and the number of prescriptions dispensed through contract pharmacies not owned by a 340B-affiliated entity. It would also require reporting aggregate acquisition costs for drugs dispensed through contract pharmacies not owned by a 340B affiliated entity, the 340B savings from these dispensed drugs, and aggregate payments made to these contract pharmacies.[46]

Oklahoma's HB2048, the 340B Nondiscrimination Act, was introduced on February 3, 2025, and sponsored by Sen. Brent Howard (R-OK-38), Rep. Preston Stinson (R-OK-096), Rep. Nick Archer (R-OK-055), Rep. Jared Deck (D-OK-044), Rep Ellyn Hefner (D-OK-087), and Rep. Anthony Moore (R-OK-057). It passed both chambers of the Oklahoma Legislature on March 26, 2025, with strong bipartisan support, but was vetoed by Governor Kevin Stitt on May 17, 2025. The veto was overridden on May 29, 2025, and HB2048 became law. The bill would have prohibited insurers, PBMs, and manufacturers from engaging in discriminatory reimbursement practices against 340B entities and empowered the Attorney General and Insurance Commissioner to enforce compliance through civil penalties. Discriminatory practices include reimbursing 340B entities at lower rates than non-340B entities, imposing additional fees or conditions, limiting covered entities' contract pharmacy arrangements, and interfering with the acquisition or delivery of 340B drugs.[47] On June 30 1, 2025, AbbVie, Novartis, and AstraZeneca filed a lawsuit against Attorney General Drummond in the US District Court for the Western District of Oklahoma, arguing that it violates federal law and the Supremacy Clause in the US Constitution.[48] On October 31st, 2025, the court issued a preliminary injunction of HB2048 due to the unconstitutionality of forcing sales at confiscatory prices and preemption of the law's delivery requirement and parallel enforcement provision.[49] Legislation has yet to address transparency reporting requirements.

43 https://www.billtrack50.com/billdetail/1902109

44 https://www.congress.gov/bill/119th-congress/house-bill/44

45 https://legiscan.com/ID/sponsors/S1390/2026

46 https://www.billtrack50.com/billdetail/1989806

47 https://fastdemocracy.com/bill-search/ok/2025-2026/bills/OKB00033235/

48 https://www.courtlistener.com/docket/70683628/novartis-pharmaceuticals-corporation-v-drummond/#:~:text=Jun%2030%2C%202025,Main%20Doc

49 https://law.justia.com/cases/federal/district-courts/oklahoma/okwdce/5:2025cv00727/131727/59/

Appendix E. Glossary of Terms

The following terms are used throughout the brief and appendix. Definitions reflect their specific meaning in the context of the 340B program, Oklahoma health policy, and the proposed tiered transparency framework.

Term	Definition
340B Drug Pricing Program	A federal outpatient drug discount program established under Section 340B of the Public Health Service Act (42 U.S.C. § 256b) in 1992. It requires pharmaceutical manufacturers participating in Medicaid to sell covered outpatient drugs to eligible covered entities at discounts of 20–50% below market price.[50]
340B ID	The HRSA-assigned identification number for a covered entity registered in the federal 340B program database (OPAIS). Used to track purchasing activity, designate covered entities, and administer program compliance. Child sites and contract pharmacy arrangements operate under the parent entity's 340B ID.[51]
Administrative Rulemaking	The formal process by which the OSDH Commissioner would establish binding regulations governing tier definitions, reporting elements, submission timelines, and enforcement procedures under the Oklahoma Administrative Procedures Act. Includes a mandatory public comment period and publication in the Oklahoma Register. Distinct from statutory drafting, rulemaking enables an agency to refine technical standards without requiring a return to the full Legislature.[52]
AHA (American Hospital Association)	The primary national lobbying organization representing hospital-covered entities, including large disproportionate share hospitals and academic medical centers. The AHA has opposed 340B transparency mandates, arguing that they do not reflect the program's statutory intent.
Child Site	A subordinate clinic, unit, or location associated with a covered entity's primary (parent) site, operating under the parent's 340B ID. Transparency frameworks typically require child site activity to be reported at the parent level rather than independently.[53]
CMS (Centers for Medicare and Medicaid Services)	The federal agency within the Department of Health and Human Services that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the ACA marketplace. CMS oversees hospital cost reporting, sets reimbursement rates under the Prospective Payment System, and distributes Rural Health Transformation Program grant funds to states. CMS data are used by covered entities to satisfy certain 340B reporting obligations.
Contract Pharmacy	A retail or specialty pharmacy that is in a contractual arrangement to dispense 340B drugs in exchange for a fee charged to a covered entity under a contractual arrangement, rather than through the entity's in-house pharmacy.

50 https://www.hrsa.gov/sites/default/files/hrsa/rural-health/phs-act-section-340b.pdf

51 https://www.340bpvp.com/Documents/Public/340B%20Tools/340b-glossary-of-terms.pdf

52 https://oklahoma.gov/education/about/administration/office-of-legal-services/administrative-rules.html

53 https://www.hrsa.gov/opa/faqs#:~:text=Outpatient%20clinics/departments%20within%20the,separately%20as%20a%20child%20site.

Term	Definition
Covered Entity	An organization or facility eligible to participate in the 340B program as defined by Section 340B(a)(4) of the Public Health Service Act. Hospital covered entities include disproportionate share hospitals, sole community hospitals, rural referral centers, critical access hospitals, children's hospitals, and freestanding cancer hospitals. Non-hospital covered entities include federally supported safety-net providers such as FQHCs, Ryan White providers, family planning clinics, and tribal or urban Indian health centers. Oklahoma has 930 registered entities.[54]
Critical Access Hospital (CAH)	A rural hospital designation under Medicare that must maintain 25 or fewer acute care inpatient beds, be located more than 35 miles from another hospital (or 15 miles in areas with mountainous terrain or only secondary roads), and provide 24-hour emergency care. CAHs receive cost-based Medicare reimbursement and are eligible 340B covered entities. Oklahoma has 39 CAHs.[55]
Discount (340B)	The price reduction manufacturers are statutorily required to provide to 340B entities on covered outpatient drugs. The discount is calculated as the difference between a drug's market price and the 340B ceiling price (the maximum price a manufacturer may charge a covered entity), which the HRSA derives by subtracting the unit rebate amount (URA) from the average manufacturer price (AMP). Discounts typically range from 20–50% off the market price.[56]
Disproportionate Share Hospital (DSH)	A hospital that serves a disproportionately high share of low-income or uninsured patients and receives additional Medicare and Medicaid reimbursement under the DSH adjustment. DSH status is one of the primary qualifying criteria for hospital participation in the 340B program. Large DSH hospitals, including academic medical centers, are among the highest-volume 340B purchasers.[57]
Duplicate Discounting	A practice prohibited under 42 U.S.C. § 256b(a)(5)(A)(i) in which a covered entity obtains a 340B discount from a manufacturer on a drug and subsequently claims a Medicaid rebate on the same drug transaction, effectively collecting two separate price reductions. Estimated to account for approximately 25% of all 340B sales in 2021.[58]
Federally Qualified Health Center (FQHC)	A community-based outpatient clinic that receives grants under Section 330 of the Public Health Service Act by serving medically underserved populations on a sliding-fee basis regardless of ability to pay. Eligible to participate in the 340B program as a non-hospital covered entity. FQHCs and other safety-net providers typically generate a small fraction of statewide 340B net revenue.59 Oklahoma has 140 FQHCs in the rural facility database.[60]
H.R. 1 (One Big Beautiful Bill Act)	The 2025 Federal Budget Reconciliation Law (Public Law 119-21) that restructured Medicaid, the Affordable Care Act, Medicare, and health savings accounts. The Congressional Budget Office estimated it will reduce Medicaid spending by nearly $1 trillion nationally over ten years and lead to 10 million people losing coverage.[61] For Oklahoma, H.R. 1 is projected to reduce rural Medicaid spending by $5.3 billion over the next decade.[62]

54 https://www.federalregister.gov/documents/2015/08/28/2015-21246/340b-drug-pricing-program-omnibus-guidance

55 https://www.ruralhealthinfo.org/topics/critical-access-hospitals

56 https://www.340bhealth.org/members/340b-program/overview/

57 https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/disproportionate-share-hospital-dsh

58 https://www.hrsa.gov/opa/program-requirements/medicaid-exclusion

59 https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers

60 https://www.ruralhealthinfo.org/states/oklahoma

61 https://www.kff.org/medicaid/health-provisions-in-the-2025-federal-budget-reconciliation-law/

62 https://www.mcafeetaft.com/oklahomas-rural-healthcare-faces-new-era-under-the-one-big-b eautiful-bill-act/ https://pmc.ncbi.nlm.nih.gov/articles/PMC9633454/

Term	Definition
HB2048 (Oklahoma 340B Nondiscrimination Act)	Oklahoma legislation introduced in February 2025 and passed with strong bipartisan support that would have prohibited insurers, PBMs, and manufacturers from engaging in discriminatory practices against 340B entities. Vetoed by Governor Kevin Stitt, overridden by the Legislature, and subsequently enjoined by a federal district court on October 31, 2025, due to unconstitutionality (Takings Clause) and federal preemption of its delivery requirement and parallel enforcement provision.
HRSA (Health Resources and Services Administration)	A federal agency within the Department of Health and Human Services that administers the 340B program, maintains the covered entity registration database (OPAIS), establishes ceiling prices, and issues program guidance and oversight. HRSA's administrative authority over 340B creates federal preemption constraints on state legislation.[63]
Insurers (role in 340B)	Commercial health insurance companies and managed care organizations that pay for drugs dispensed to their enrollees, including drugs acquired at the 340B discount price. Insurers' reimbursement practices are a key source of financial conflict, as some insurers identify claims involving 340B-acquired drugs and reimburse covered entities at reduced rates, impose additional administrative conditions, or exclude 340B entities from preferred networks.[64]
Manufacturers (role in 340B)	Pharmaceutical companies that participate in Medicaid are required by statute to participate in 340B by providing covered outpatient drugs at discounted ceiling prices. Manufacturers fund the 340B discount by forgoing revenue from covered entity sales.
Medicaid	A joint federal-state health insurance program that provides coverage to low-income individuals, families, pregnant women, people with disabilities, and certain other groups. Medicaid is the primary payer for many patients served by 340B covered entities, and manufacturer participation in Medicaid obligates them to provide 340B discounts.
MDOH / MDH (Minnesota Department of Health)	The Minnesota state agency responsible for administering and overseeing the state's 340B transparency reporting program under Minn. Stat. § 62J.461.[65]
Minn. Stat. § 62J.461	Minnesota's 2023 340B transparency reporting statute, which established the tiered reporting framework the proposed Oklahoma transparency framework is modeled on. It required covered entities to register and annually report aggregated purchase, payment, dispensing, and program-expense data, with additional requirements for hospitals and significant share entities.[66]
National Drug Code (NDC)	A unique 10- or 11-digit identifier assigned by the FDA to every drug product, used to standardize identification across dispensing, billing, and reporting systems.[67]
Net 340B Revenue	The financial return a covered entity realizes from the 340B program, calculated as aggregated payments received from payers minus the sum of aggregated 340B acquisition costs and aggregated payments made to contract pharmacies, third-party administrators, and internal program administration.
OPAIS (Office of Pharmacy Affairs Information System)	HRSA's federal database of registered 340B covered entities, accessible to the public at 340bopais.hrsa.gov. Used to verify entity eligibility, confirm 340B IDs, track purchasing activity, and administer program oversight.[68]

63 https://www.hrsa.gov/opa/340b-opais

64 https://www.frierlevitt.com/articles/340b-price-discrimination-state-laws-contract-pharmacy-protections/

65 https://www.revisor.mn.gov/statutes/cite/62J.461

66 https://www.revisor.mn.gov/statutes/cite/62J.461

67 https://www.fda.gov/drugs/drug-approvals-and-databases/national-drug-code-directory

68 https://www.hrsa.gov/opa/340b-opais

Term	Definition
OSDH (Oklahoma State Department of Health)	The state agency proposed to administer the tiered 340B transparency reporting framework, specifically through its Health Economics Division. The agency would be responsible for SSE designation, administrative rulemaking, portal development, entity outreach, data validation, and production of the annual Oklahoma 340B Transparency Report for legislative review.
Parent Site	The primary registered 340B covered entity that holds the 340B ID and is responsible for all affiliated child sites and contract pharmacy arrangements. Transparency reporting frameworks typically require parent-level consolidation of all affiliated activity, meaning child site and contract pharmacy data must be rolled into the parent's report rather than submitted independently.[69]
Payer Type Disaggregation	A data process by which entities specify payments received by payer category, such as commercial insurance, Medicare, Medicaid, and uninsured or self-pay, rather than reporting aggregate totals only.
PBM (Pharmacy Benefits Manager)	A third-party company that manages prescription drug benefits on behalf of health insurers, employers, and government programs, acting as an intermediary between payers, pharmacies, and manufacturers. In 340B, PBMs may identify claims as "340B claims" to set lower reimbursement rates, impose additional fees or administrative conditions on 340B dispensing, and penalize covered entities, or their contracted pharmacies, for participating in 340B.[70]
PhRMA (Pharmaceutical Research and Manufacturers of America)	The principal lobbying organization representing major drug manufacturers, including AbbVie, Eli Lilly, AstraZeneca, and Novartis, in 340B policy debates and federal regulatory proceedings. PhRMA and its member companies have consistently supported 340B transparency legislation and federal oversight requirements, arguing that the absence of reporting mandates enables program abuse and misdirection of savings away from low-income patients.[71] PhRMA members have also funded litigation against state 340B contract pharmacy access and nondiscrimination laws, including Oklahoma's HB2048.
Preemption (Federal)	A constitutional doctrine derived from the Supremacy Clause of Article VI of the U.S. Constitution, providing that valid federal law supersedes conflicting state law. In the 340B context, federal preemption has been the primary legal mechanism used to enjoin state 340B legislation that conflicts with HRSA's regulatory authority or manufacturer obligations under federal statute.[72]
Price Discrimination (340B)	A variety of methods by which manufacturers, PBMs, or insurers treat 340B-covered entities differently from non-340B entities in financially disadvantageous ways. Common methods include reimbursing 340B claims at lower rates than equivalent non-340B claims, imposing additional administrative fees or conditions on 340B dispensing, restricting covered entities to a single contract pharmacy, limiting upfront 340B discounts, and imposing distribution contracts that exclude contract pharmacy arrangements.[73]

69 https://www.hrsa.gov/opa/faqs#:~:text=Outpatient%20clinics/departments%20within%20the,separately%for enjoining state 340B legislation that conflicts with HRSA's regulatory authority or manufacturers'20as%20a%20child%20site.

70 https://www.nachc.org/wp-content/uploads/2024/01/340B_Discriminatory-Contracting.pdf

71 https://www.phrma.org/resources/phrma-statement-on-the-340b-drug-pricing-program

72 https://www.congress.gov/crs-product/R48696

73 https://www.frierlevitt.com/articles/340b-price-discrimination-state-laws-contract-pharmacy-protections/

Term	Definition
Prospective Payment System (PPS)	The Medicare reimbursement methodology under which hospitals are paid a fixed, predetermined amount per discharge based on the patient's diagnosis-related group (DRG), regardless of actual costs incurred. Short-term general acute care hospitals operating under PPS are a distinct category of 340B-eligible provider type from critical access hospitals, which receive cost-based reimbursement. Oklahoma has 43 Short Term/PPS hospitals.[74, 75]
Public Health Service Act (PHSA)	The foundational federal statute enacted in 1944 governing the organization and funding of public health programs in the United States. Section 340B of the PHSA (42 U.S.C. § 256b) establishes the 340B drug pricing program. Section 330 of the PHSA establishes and funds Federally Qualified Health Centers. The PHSA provides HRSA with its administrative and rulemaking authority over the 340B program, and its statutory framework defines both covered entity eligibility criteria and the manufacturer obligations that fund the program.[76]
Rebate (Medicaid Drug Rebate Program)	A payment manufacturers make to state Medicaid programs after the fact, calculated as a percentage of the Average Manufacturer Price (AMP) of a covered drug. Unlike discounts, which reduce the price at the point of sale, rebates are retrospective payments processed after claims are adjudicated.[77]
Rural Emergency Hospital (REH)	A Medicare provider designation established by Congress in 2020 for rural hospitals that deliver emergency care and outpatient services, with patient stays typically under 24 hours.[78] REHs are not present in the original 340B statute. Oklahoma has 5 REHs.[79]
Rural Health Clinic (RHC)	A clinic certified by CMS to provide primary care services in rural, medically underserved areas. RHCs receive enhanced Medicare and Medicaid reimbursement rates but are not currently eligible for the 340B program.80 Oklahoma has 148 RHCs.[81]
Rural Health Transformation Program (RHTP)	A five-year, $50 billion federal grant program added to H.R. 1 (Public Law 119-21, Section 71401) to partially offset rural Medicaid spending cuts. Half of the funding is distributed equally across all states; the other half is distributed at CMS discretion.[82]
Short Term / PPS Hospital	A general acute care hospital reimbursed by Medicare under the Prospective Payment System (PPS), which pays a fixed amount per inpatient discharge based on the patient's diagnosis-related group. These hospitals may qualify for 340B participation if they meet disproportionate share hospital criteria.[83] Oklahoma has 43 such hospitals.[84]
Significant Share Entity (SSE)	A covered entity designated by the State Commissioner of Health as accounting for a significant portion of total statewide net 340B revenue. Oklahoma's largest health systems, such as OU Health, Saint Francis Health System, and Integris Health, are most likely to be designated as SSEs.

74 https://www.cms.gov/medicare/payment/prospective-payment-systems

75 https://www.ruralhealthinfo.org/states/oklahoma

76 https://www.hrsa.gov/sites/default/files/hrsa/rural-health/phs-act-section-340b.pdf

77 https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program

78 https://www.ruralhealthinfo.org/topics/rural-emergency-hospitals

79 https://www.ruralhealthinfo.org/states/oklahoma

80 https://www.ruralhealthinfo.org/topics/rural-health-clinics

81 https://www.ruralhealthinfo.org/states/oklahoma

82 https://www.kff.org/medicaid/a-closer-look-at-the-50-billion-rural-health-fund-in-the-new-reconciliation-law/

83 https://www.ruralhealthinfo.org/topics/healthcare-payment

84 https://www.ruralhealthinfo.org/states/oklahoma

Term	Definition
Takings Clause	The final clause of the Fifth Amendment to the U.S. Constitution, which provides that private property shall not be "taken for public use, without just compensation." In the 340B context, manufacturers have invoked the Takings Clause to challenge state laws that compel them to sell drugs at 340B discount prices to contract pharmacies, arguing that mandatory below-market sales at "confiscatory prices" constitute an unconstitutional taking of property. This argument was partially accepted by the federal district court that enjoined Oklahoma's HB2048 in October 2025.[85]
Value-Based Care	A health care reimbursement and delivery model that ties provider payment to patient health outcomes and care quality rather than the volume of services delivered. In contrast to fee-for-service payment, value-based care models, including accountable care organizations, bundled payment arrangements, and quality-linked contracts, create incentives to reduce unnecessary utilization and improve population health.[86]

85 https://www.congress.gov/crs-product/R47682

86 https://www.ama-assn.org/practice-management/payment-delivery-models/what-value-based-care