**Summary of NACHC Response to Hill Republicans’ Request for 340B Input**

**As of 10/20 AM**

# Background on FQHCs and the 340B program

* Overview of what FQHCs are
* FQHCs are already required – by Federal law, regulation, and mission -- to invest every penny of 340B savings into activities that advance their charitable mission.
* How FQHCs use 340B savings -- both to make drugs affordable for their low-income patients, and to support other important services. While FQHCs are a tiny part of the 340B program -- accounting for just 6% of sales -- 340B plays a huge part in FQHCs’ ability to achieve their mission.
* FQHCs are already subject to extensive Federal oversight and detailed reporting. To FQHCs are widely recognized as being good stewards of 340B, complying with both the letter and the spirit of the 340B statute

# GENERAL COMMENTS

1. PROGRAM PURPOSE: 340B has always been – and must remain -- much more than a program for providing drug discounts for low-income uninsured and underinsured individuals. Replacing 340B with such a program would both:
* reduce patient access to affordable medications, and
* be financially destabilizing to FQHCs, who are the backbone of our country’s primary care safety net.
1. PICK-POCKETING:
* For FQHCs, the most important change needed to the 340B statute is a prohibition on pick-pocketing.
* To increase their understanding of 340B “pick-pocketing”, Congress should conduct or request research into these practices.
1. CONTRACT PHARMACIES
* The 340B statute should explicitly state that ensure that FQHCs may dispense drugs purchased under 340B via contract pharmacies.
* Restricting FQHCs to a single in-house or contract pharmacy significantly reduces FQHC patients’ access to pharmaceuticals and other services.
* Any potential restrictions on contract pharmacies should be done with a scalpel rather than a sledgehammer, recognizing the various factors that influence contract pharmacy decisions.

4. ELIGIBLE PRESCRIPTIONS/ PATIENTS (aka “Patient definition”)

* Any changes to the “patient definition” must not be one-size-fits-all, meaning that they would apply uniformly to all types of CEs. Rather, each category of Covered Entity should have a “patient definition” that appropriately reflects its statutory goals, organizational structure, program requirements, and Federal oversight.
* “FQHC patient” should be defined under 340B the same way it is defined for FQHC oversight purposes – namely, by using the long-standing definition used under the Uniform Data System.
1. REPORTING REQUIREMENTS: Any new reporting requirements under 340B should be coordinated and aligned with other Federal reporting requirements on FQHCs.
2. AVOIDING “DUPLICATE DISCOUNTS” THAT ARE PROHIBITED UNDER STATUTE: FQHCs are willing to consider a standardized national system to avoid duplicate discounts under Medicaid – but it is not our responsibility to help manufacturers avoid paying rebates that they voluntarily offered to PBMS as marketing incentives.
3. MAINTAINING THE UP-FRONT DISCOUNT STRUCTURE: FQHCs must always be able to pay the discounted price up front – not to wait to get the savings in the form of a rebate.