



ADVOCATES FOR  
COMMUNITY  
HEALTH

April 20, 2026

Tom Engels  
Administrator  
Health Resources and Services Administration  
5600 Fishers Ln, Rockville, MD 20852

**HHS Docket No. HRSA-2026-03042**

Dear Administrator Engels,

Thank you for the opportunity to provide feedback on the 340B Rebate Model Pilot Program as announced by the Health Resources and Services Administration (HRSA) in the Federal Register on February 17, 2026. On behalf of Advocates for Community Health (ACH), a member organization focused on advocacy initiatives to affect positive change for community health centers (CHCs), the patients they serve, and the entire nation's health care system, **we encourage HRSA to consider an alternative option in order to prevent duplicate discounts and improve 340B program oversight: create a neutral claims clearinghouse operated by HHS to which covered entities submit relevant claims data.**

ACH's 51 members serve over 4 million patients across 22 states, Puerto Rico, and the District of Columbia. ACH is a longstanding proponent of reform of the 340B program, calling for increased accountability and transparency from all covered entities, authority for HRSA to institute stronger guardrails to protect against diversion and duplicate discounts, and protections for CHCs to leverage the program to reinvest savings directly into patient care.

With regards to the specific questions posted in the RFI, we refer you to the comment submitted by the National Association of Community Health Centers (NACHC), which has done extensive work tracking the projected impacts on health centers across the United States, and the hundreds of community health centers that have taken the time to enumerate the burden on their organizations and their patients. Through a nationwide survey, NACHC found that CHCs report an average loss of \$50,000 to \$4 million from entity-owned pharmacy operations, \$5,000 to \$720,000 for contract pharmacy arrangements due to the administrative hurdles of manual reconciliation, and an average of \$3 million in additional costs annually simply to manage the pilot. For rural CHCs, these

costs are even more devastating. Rural centers invest nearly one-quarter (25%) of their 340B savings in rural-specific infrastructure. From a NACHC survey, nearly 75 percent of rural health centers spent at least five percent of their 340B savings on mobile clinics, with nearly eight percent spending 20 percent or more. Rural health centers also reported utilizing 340B savings for mental health services, nutrition programs, and capital investment.

It is difficult to justify this kind of fiscal and administrative burden on CHCs, the entities that best exemplify the original intent of the 340B program, which is “to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.” (H.R. Rep. No. 102-384(II), at 12 (1992)). In fact, federal law prohibits these funds from being used for any purpose other than advancing the objective of the health center project. Subsection 330(e)(5)(D) of the Public Health Service Act requires health centers to reinvest all savings into activities that promote the purpose of their grant, and advance their mission of providing care to medically underserved populations. Further, 45 CFR 75.307 requires that program income be actively used either to further the objectives of the health center project, or to reduce the amount of the Federal grant. A [recent survey of ACH members found that](#) one out of every four dollars in 340B savings goes to support rural patients, including maintaining rural clinic sites, providing telehealth services, mobile access clinics, and school-based clinics in rural areas.

CHC purchases under the 340B program represent just 5.8% of overall covered entity purchases ([OPA](#)), and do not pose a significant compliance risk. Since 2012, CHCs have undergone regular oversight audits from HRSA, and consistently conduct their own internal audits for compliance with all federal guidance and regulations. Even if one accepts the premise that a rebate model might achieve marginal compliance improvement, it’s outweighed by the significant risk it poses to the financial stability and operations of thousands of safety net providers across the country.

CHCs are already facing workforce shortages, forthcoming expected losses of Medicaid revenue, and other challenges. The increased administrative burden and financial risk CHCs would have to undergo to participate in the pilot is expected to be significant and will limit their ability to provide high quality and comprehensive care using 340B savings.

Health centers will have to add senior level staff with experience and sophistication to track rebates across multiple different models, third party administrators (TPAs), and contract pharmacies. They will need to submit data reports, and submit disputes when manufacturers ultimately do not comply. **Resource estimates have increased based on initial interactions with the Beacon system, which has mismanaged the roll-out of the IRA refund process this year, issuing inappropriate refunds to entities and accruing a backlog of**

**resolution requests.** Resources needed to hire these staff and set up these processes take away from resources that could be dedicated to patient care.

Furthermore, the Pilot Program may impact uninsured access to affordable medications. If the program transitions to a rebate program, CHCs may also face difficulty offering a sliding fee scale to uninsured patients. More specifically, if a CHC assumes a 340B eligible drug and provides a sliding fee scale based on that purchase price, but a rebate isn't paid, CHCs cannot go back to charge the patient more; they will have to absorb that cost. CHCs may have to restructure how they are offering sliding fee scales depending on their cash flow reserves.

If required to participate in the rebate model, community-based providers will have to invest in costly overhaul of their internal and external systems without guarantee that their rebate requests – to which they are legally entitled – will be paid. The rebate model clearly prioritizes the convenience and financial success of large, for-profit corporations, rather than health centers working in underserved communities, whose sole goal is to invest 340B savings back into care for the patients they serve.

To be clear, ACH understands – and supports – the intent behind the rebate model pilot. There is a potential duplicate discount between Maximum Fair Price in the Medicare program and the 340B discount that covered entities receive, and the government needs a system in place to comply with the law preventing this. Rather than impose a burdensome, risky rebate model, instead, HRSA should require covered entities to submit claims to a neutral clearinghouse operated by HHS. A clearinghouse would maintain HHS as the ultimate arbiter of proper 340B discounts, and provide a neutral, centralized model free of conflict of interest. Testing this model is an ideal way to develop a duplicate discount prevention approach that can minimize administrative burden, and decrease risk for community health centers and other covered entities, while complying with federal law.

The idea has clear precedent. The Centers for Medicare & Medicaid Services (CMS) is using a claims data repository to identify 340B units for the calculation of Medicare inflation rebates required under the Inflation Reduction Act (IRA); this repository could be used for the purposes of this pilot. In addition, this model is currently underway in the state of Oregon to prevent duplicate discounts in Medicaid, and has received bipartisan support from Congress through various legislative proposals.

Should HRSA ultimately decide that the agency needs to pilot a rebate model program, we urge the agency to consider exempting smaller entities from the rebate model given the wide range of concerns. Instead, we recommend testing a clearinghouse concept with

entities with lower operating revenue, allowing two concepts for 340B program oversight to be piloted while minimizing administrative burden on small organizations.

Thank you again for the opportunity to provide feedback. ACH welcomes the opportunity to serve as a resource and partner in supporting the development of a model that fully considers the best interests of CHCs and the patients they serve. For more information, please contact me at [apearskelly@advocatesforcommunityhealth.org](mailto:apearskelly@advocatesforcommunityhealth.org) and/or Stephanie Krenrich, Senior Vice President of Policy and Government Affairs, at [skrenrich@advocatesforcommunityhealth.org](mailto:skrenrich@advocatesforcommunityhealth.org).

Sincerely,

A handwritten signature in black ink, appearing to read 'Amanda Pears Kelly', with a stylized, flowing script.

Amanda Pears Kelly  
Chief Executive Officer  
Advocates for Community Health