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April 13, 2026

The Honorable Thomas J. Engels, Administrator
Health Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20852

Re: Request for Information: 340B Rebate Model Pilot Program, HHS Docket No. HRSA-2026-03042

Dear Administrator Engels:

I am writing on behalf of the Alliance of Safety-Net Hospitals (ASH), a network of hospitals dedicated to helping American families stay healthy, working, and independent. ASH would like to offer feedback in response to the Request for Information the Health Resources and Services Administration (HRSA) published in the *Federal Register* on February 17, 2026 presenting a potential 340B Rebate Model Pilot Program.

ASH member community safety-net hospitals and others like them serve a high proportion of Medicaid and uninsured patients and often operate 340B drug purchasing programs to help them stretch scarce federal resources to provide care to their patients. Community safety-net hospitals are the health care backbone of these hard-working communities and have built a foundation of services and community outreach activities based on the specific needs of their communities. Many of these services and activities are funded in part from the savings they derive from the 340B discount program and safety-net hospitals have come to rely on these savings when planning to meet new community needs.

If HRSA changes the 340B program to a rebate model, these community safety-net hospitals will quickly face financial pressure to reduce or even eliminate some of these services and to stop innovating in response to new and emerging challenges. For the reasons outlined below, ASH asks HRSA to withdraw its plan to shift the 340B program to a rebate model and to investigate other, better, less damaging ways to prevent the duplicate discounts that are HRSA's reason for proposing such a change.

The Importance of 340B to Community Safety-Net Hospitals

It is impossible to overstate the importance of the 340B program to community safety-net hospitals—and more significant—to the patients those hospitals serve. The 340B program enables community safety-net hospitals to reinvest the savings they gain through the program into their communities: in new services those communities need, such as outreach programs, even including some services that safety-net hospitals know will lose money but they introduce them anyway because they know their communities need them; 24/7 pharmacies; new community clinics; subsidizing the medical practices of physicians who otherwise would not choose to establish their practices in these communities; and other efforts that, without the

savings 340B makes possible, these hospitals simply would not be able to afford. Large swaths of the communities these hospitals serve are healthier today than they would have been without the savings the 340B program generates—savings these hospitals consistently, effectively, and resourcefully reinvest in their communities.

Safety-Net Hospitals Cannot Pay Up Front for 340B-Covered Prescription Drugs

Congress created the 340B program to provide direct support to safety-net hospitals that need to stretch every penny they have to care for their Medicaid and uninsured patients. Most of these hospitals operate on extremely thin margins and for them, changing to a rebate model would fundamentally alter the 340B program—for the worse. It would change the 340B program from the direct support that Congress intended when it enacted the program in 1992 into an indirect, delayed support that Congress never contemplated, hurting the hospitals that care for low-income patients in their communities.

ASH does not believe Congress had this in mind when it created the 340B program and finds it difficult to believe that HRSA would turn its back on such a successful program to prioritize the needs of drug manufacturers over the needs of low-income prescription drug consumers. Changing to a rebate model would do this—it would place enormous pressure on community safety-net hospitals and others to find the money they would need to pay for these prescription drugs up front. To afford those up-front costs, community safety-net hospitals and other 340B providers like them would have to divert money from services designed specifically for their hard-working communities—services that fulfill the very purpose of the 340B program.

Community Safety-Net Hospitals Would Be Disadvantaged by a Rebate Model

A rebate structure in the 340B program could place low-margin safety-net hospitals and other 340B participants at a significant disadvantage in comparison to the large drug manufacturers that are expected to pay rebates in a timely manner. In the RFI, HRSA asked for feedback on how a rebate payment timeline such as 10 calendar days would affect covered entities' cash flow. As described above, most community safety-net hospitals and other 340B providers would struggle greatly to fund upfront drug acquisition costs—purchases that would effectively amount to short-term loans to pharmaceutical companies. At best, this model gives manufacturers interest-free loans and at worst it enables manufacturers to seek investment returns on the payments they receive from covered entities prior to issuing the rebates that are due. ASH urges HRSA to consider this imbalance of purchasing power in any future rebate model structure by imposing interest penalties on manufacturers that fail to pay within the required time. If providers meet all documentation requirements for rebates and manufacturers do not deliver payment within 10 days, they should be charged a 10 percent interest fee to compensate for the financial strain they have placed on the low-margin providers that participate in the 340B program.

Program Integrity Protections

ASH and other national provider voices, alongside the Centers for Medicare & Medicaid Services (CMS), have worked over the last several years to eliminate unnecessary paperwork and bureaucratic delays in obtaining health care and ensuring prompt payment to providers. If HRSA moves forward with the transition to a rebate model for 340B drug purchases, the agency must prioritize clear administrative standards and keep paperwork burdens low to help balance the needs of the 340B entities and the interests of manufacturers while protecting seamless access to covered outpatient drugs.

We expect covered entities would be required to submit distinct data elements that manufacturers need to process rebate requests, so manufacturers must be required to respond in a timely manner either with payment or requests for missing information. We recommend that HRSA set strict limits on the types of additional documentation requests and reasons for payment denial that manufacturers can use in administering any future rebate model. Without such protections, 340B providers will be forced to dedicate their scarce staffing resources to running down paperwork instead of reconciling their financial outlays and focusing on patient care. Similar to the penalty if a manufacturer fails to pay covered entities within 10 calendar days, ASH recommends that HRSA charge manufacturers interest penalties for any rebate requests that go unanswered within five calendar days and any additional documentation requests or denials that are not sufficiently specific for the entities to respond. ASH urges HRSA to keep in mind the imbalance of power involved when large for-profit drug manufacturers are processing financial requests from small, rural, and safety net 340B covered entities.

Patient Perspective

From ASH's perspective, the potential benefits of transitioning to a rebate model are dwarfed by the potential damage the proposed change could wreak on the health care safety net because covered entities would need to redirect resources away from providing care to go chasing after their rebates. We are particularly concerned about the future viability of 24/7 pharmacies and the community benefit programs that are often funded by the savings generated by the current 340B program.

The cost savings 340B hospitals experience allows them to care for more working families, including those eligible for Medicaid. Safety-net providers should never be forced to attempt to weigh the high cost of establishing and staffing outpatient clinics in low-income areas against the future cost of adding to their administrative staff to ensure their ability to collect the rebates due to them. For these reasons, ASH urges CMS to abandon the plan to turn the 340B upfront drug discount program into an after-the-fact rebate model.

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The Alliance of Safety-Net Hospitals appreciates the opportunity to submit feedback in response to the RFI and welcomes any questions HRSA may have about the views we have expressed in this letter.

Sincerely,

Ellen Kugler, Esq.
Executive Director