# PROTECTING THE 340B DRUG PRICING PROGRAM FOR COMMUNITY HEALTH CENTERS

Providing Predictable and Flexible Funding for Community Health Centers

**Recommendations**

1. **Preserve the 340B Program.**
2. **Protect high-priced pharmaceutical drugs** from being carved out of Medicaid Managed Care.

## What is the 340B Drug Pricing Program?

For over 30 years, the 340B Drug Pricing Program has provided an estimated 20–50% cost savings on prescription drug purchases for qualifying hospitals and health centers,[1] including Indian healthcare providers. These savings result in accessible prescriptions for patients and are passed on to clinics to fund programming, salaries, and operations.

## What are the benefits from the 340B Program?

Since 2019, the Health Resources and Services Administration (HRSA) has reported there are 211 340B tribal pharmacies operated by 111 different tribes and organizations. In addition to these, 45 urban Indian organization (UIO) 340B pharmacies are operated by 20 different UIOs. These 340B cost savings allow Indian healthcare providers to maximize limited federal resources by reinvesting savings into culturally attuned health services for patients who are low-income, uninsured, and ineligible for Medicaid or Medicare.

340B programs also increase access to affordable prescriptions, which supports medication adherence and improved long-term health outcomes[2,3] for Indian healthcare beneficiaries and other eligible patient populations.[4]

Program integrity and compliance are central components of the 340B Drug Pricing Program, including eligibility recertification, and routine participation in Health Resources and Services Administration (HRSA) and drug manufacturer audits.

## Envisioning healthcare without the 340B program

Without 340B programs, high prescription costs for providers would result in barriers to affordable prescriptions for patients, and a reduction in services among culturally attuned healthcare providers. Coupled with this, shifts towards increased authority of Pharmacy Benefit Managers to negotiate drug pricing and pharmacy contracts would bring conflict of interest concerns and undermine providers that have established managed care contracts.

**Case Studies on 340B State Reforms: California and Washington**

In attempts to avoid duplicate discounts, states complicate the ability of Indian healthcare providers to maximize 340B cost savings.

A mandatory carve-in policy for Medicaid patients in California switches pharmacy benefits from managed care to fee-for-service, resulting in the state—rather than Indian healthcare providers—capturing federal cost savings. Washington state has carved out high-cost oncology, cystic fibrosis, and HIV antiviral medications from managed care rates, eliminating flexible funding streams previously used to enhance culturally attuned services for patients.

### References


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