

February 15, 2018

The Honorable Bill Cassidy
703 Hart Senate Office Building
Washington, DC 20510

The Honorable Larry Bucshon
1005 Longworth House Office Building
Washington, DC 20515

The Honorable Scott Peters
1122 Longworth House Office Building
Washington, DC 20515

Dear Senator Cassidy, Congressman Bucshon, and Congressman Peters,

The undersigned organizations thank you for your leadership and introduction of the 340B PAUSE Act (H.R. 4710) and 340B HELP Act (S. 2312), and we encourage your colleagues to sign-on as cosponsors. These important pieces of legislation are a crucial step to ensuring that the 340B program gets back on track and meets its original goal of helping vulnerable patients. At the same time, and importantly, H.R. 4710 and S. 2312 exempt rural hospitals (critical access hospitals, sole community hospitals, and rural referral centers) and Health Resources and Services Administration (HRSA) grantees (such as community health centers and Ryan White clinics, to name a few) from the temporary freeze and requirements to report data on types of patients served and charity care provided, allowing these smaller safety-net providers to continue to use the program with no interruption and without changes. Cancer hospitals and children's hospitals are also exempt from the temporary freeze on enrollment in the program.

Over the past two decades, hospital use of the 340B program has grown significantly with little oversight and an unclear direct benefit to patients. Pausing new disproportionate share hospital (DSH) registration in the 340B program presents Congress with the opportunity to improve program oversight and integrity, which is key to ensuring the program is benefitting patients and will be sustainable in the long-term. Currently, the 340B program does not require that hospitals pass the discount on to lower patients' out-of-pocket costs. In fact, a 2014 report by the Office of Inspector General (OIG) found that the hospitals it studied often did not offer the reduced 340B prices to uninsured patients – the very patients 340B was designed to help. This means patients were paying full price, 100% out of pocket, while the hospitals benefitted from the monetary windfall at their expense. What's more, revenue from 340B incentivizes many hospitals to purchase independent community physician groups, especially oncology practices. This acquisition trend has caused a shift in site of care from community settings to hospitals for many patients who are then forced to pay higher out of pocket prices in a more expensive hospital setting, while hospitals get to pocket the profit.

The 340B program is a vital safety net for uninsured and vulnerable patients who rely on the safety net facilities that participate. Unfortunately, a lack of program oversight and lax regulations have led not to 340B revenue being used to increase charity care for patients, but instead to greater profits for hospitals and higher costs for patients. 340B DSH hospitals are not required to demonstrate that the funds generated by the program are used to provide benefits to vulnerable or uninsured patients. In contrast, grantees face a range of reporting responsibilities, including requirements to provide information on how they reinvest 340B and other revenue into care for vulnerable communities. Given this, we support the language in your legislation that would impose new reporting requirements for DSH hospitals to provide HRSA with more visibility into how the program is being used and whether patients are benefitting through additional charity care. We do not believe the reporting requirements in your

legislation are overly burdensome on those entities, as they are in line with just some of the wide range of reporting requirements grantees are subject to. This information will provide decisionmakers with insights into whether the billions of dollars received from 340B discounts are being reinvested in charity care for vulnerable and low-income patients.

We appreciate that Congress has taken an interest in ways to realign the 340B program with the interests of patients and that your legislation takes steps toward this goal by increasing transparency and accountability, while also enabling HRSA to collect the data and information necessary to provide better oversight. At the same time, we also appreciate that the legislation protects rural hospitals and grantees who are vital to serving some of our nation's most vulnerable patients.

It is long past time that changes were made to the 340B program to better protect uninsured, vulnerable patients, as well as the providers who serve them. Thank you for putting those interests first; we look forward to working with you on our common goals.

Sincerely,

AIDS Drug Assistance Programs Advocacy Association
Alliance for Patient Access
American Autoimmune & Related Diseases Association
American Behcet's Disease Association
CancerCare
Colorectal Cancer Alliance
Community Access National Network
Connecting Families Urea Cycle Disorders Foundation
Council for Citizens Against Government Waste
Cutaneous Lymphoma Foundation
Gay and Lesbian Medical Association
Guillain-Barre Syndrome, Chronic Inflammatory Demyelinating Polyneuropathy Foundation International
International Foundation for Autoimmune & Autoinflammatory Arthritis
Lupus and Allied Diseases Association
National Grange
National Hispanic Medical Association
National Infusion Center Association
Oncology Institute of Hope and Innovation
RetireSafe
Rheumatology Nurses Society
Texas Oncology
U.S. Rural Health Network