COA Submits Patient-Centered Recommendations on Sen. Cassidy's 340B Reform Discussion Draft

Comments Urge Congress to Make Discounts Follow Patients and Strengthen Accountability of Covered Entities

Community Oncology Alliance Logo

WASHINGTON, DC, UNITED STATES, August 19, 2026 /EINPresswire.com/ -- The Community Oncology Alliance (COA) has submitted comments to Senate Committee on Health, Education, Labor, and Pensions Chairman Bill Cassidy, MD, on the 340B Drug Pricing Integrity and Affordability for Patients Act discussion draft. COA called the proposal a serious and constructive foundation for reform while urging Congress to strengthen it so the 340B program delivers direct, measurable benefits to vulnerable patients.

COA supports several provisions in the discussion draft, including patient-affordability requirements, public reporting of drug margins, stronger standards for hospital child sites, direct accountability for contract pharmacies, limits on percentage-based middleman compensation, stronger enforcement, and greater oversight of the Prime Vendor Program. However, COA warns that transparency alone will not ensure that patients benefit from the discounts associated with their care.

“340B reform should be judged by a simple test: does the discount actually follow the patient, lower their costs, and preserve access to affordable cancer care in the community?” said Ted Okon, executive director of COA. “Congress has an opportunity to increase access to care for our most vulnerable patients while closing loopholes that reward middlemen, institutional arbitrage, and consolidation into higher-cost hospital settings.”

COA emphasized that it is not asking Congress to extend 340B eligibility to independent community oncology practices. Instead, the organization urged lawmakers to refocus the program on eligible patients and genuine safety-net providers while preserving adequate reimbursement for the clinical, operational, inventory, and financial risks of furnishing cancer treatment.

COA's eight recommendations include:
1. Make the discount follow the patient. Strengthen the affordability provisions so all low-income and medically vulnerable patients, including Medicare beneficiaries, receive a direct and measurable benefit tied to the actual 340B discount.
2. Rewrite the patient definition. Determine eligibility for each prescription or drug order based on a contemporaneous, clinically relevant relationship with the patient. A years-old encounter or referral alone should not establish patient status.
3. Require comprehensive and proportionate transparency. Require covered entities to report gross 340B spread, separately itemized expenses, net margin, patient savings, charity care, and other data. Streamlined reporting may be appropriate for genuinely small, low-volume, mission-based providers.
4. Preserve and strengthen child-site reforms. COA supports the bill's shortage-area, charity-care, Medicaid, ownership, and provider-based requirements, while applying absolute safety-net thresholds separately to each location.
5. Limit contract pharmacies to demonstrated access needs and close pharmacy benefit manager (PBM) loopholes. Require a documented patient-access need and periodic review of whether each arrangement actually improves access. PBM-owned mail-order pharmacies should be excluded from serving as 340B contract pharmacies.
6. Use a single federal claims process and authoritative data standards. Create one federal repository for claims processing and review. Covered entities should not face a patchwork of manufacturer-specific portals, duplicative audits, and conflicting vendor rules.
7. Reform hospital eligibility and permissible uses of retained revenue. Base hospital eligibility on meaningful, auditable outpatient safety-net performance. After eligible patients receive the direct benefit, remaining revenue should be limited to documented services for low-income, uninsured, and medically vulnerable patients.
8. Make reduced consolidation an outcome measure. A successful bill should be judged partly by whether it reduces incentives for hospital acquisition of independent community oncology practices and shifts of care into higher-cost hospital outpatient settings.

For patients with cancer, COA noted that drug affordability cannot be separated from the site where treatment is delivered. Hospitals that acquire independent practices may gain both a 340B acquisition advantage and higher site-of-service payment, increasing incentives to move the same care into more expensive hospital outpatient settings. COA urged Congress to evaluate whether the final bill reduces total patient and taxpayer costs, preserves competition, and keeps high-quality cancer care close to home.

"The unprecedented growth of 340B is not aligned with the program's original intent to serve

vulnerable patients," Okon said. "A durable reform package must make patient benefit measurable, target resources to providers performing a genuine safety-net mission, prevent middlemen from capturing the discount, and reduce, not reinforce, the forces driving cancer care into higher-cost settings."

340B reform is especially important to community oncology because hospital 340B margins can combine with higher site-of-service payments to encourage acquisitions of independent practices and shifts into more expensive hospital outpatient settings. HRSA reports that 340B drug purchases reached $100 billion in 2025, more than 50 percent above 2023, with disproportionate share hospitals accounting for nearly four-fifths of the total. The number of 340B contract pharmacy locations also grew from 789 in 2009 to 25,775 in 2022, while the Federal Trade Commission reports that pharmacies affiliated with the three largest PBMs now account for nearly 70 percent of specialty drug revenue.

COA thanked Chairman Cassidy and the Committee for confronting longstanding weaknesses in 340B and said it looks forward to working with Congress on meaningful, durable, and patient-centered reform that reduces costs, preserves competition, and keeps high-quality cancer care close to home.

Read the full comment letter here: https://mycoa.communityoncology.org/news-updates/press-releases/coa-submits-patient-centered-recommendations-on-sen-cassidys-340b-reform-discussion-draft

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About the Community Oncology Alliance
The Community Oncology Alliance (COA) is a nonprofit organization dedicated to ensuring that patients have access to the highest-quality, most affordable, cutting-edge cancer care close to home. COA is the only national organization focused exclusively on community oncology, where the majority of Americans with cancer receive treatment. Through policy, advocacy, and community, COA works to support independent community oncology practices and advance access to high-quality cancer care for patients nationwide. Learn more at www.communityoncology.org.

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