

Research Report:

Pharmacy Services in a Changing 340B Landscape

Critical Issues and Emerging Opportunities for
FQHCs and Lookalikes Across Episcopal
Health Foundation's Service Area

September 2026

I. Executive Summary

Background

The Episcopal Health Foundation retained Health Equity Outcomes (HEO) to conduct the analysis summarized in this report to assist its plans for supporting FQs in its service area, to protect and (where feasible) expand pharmacy services, access, and revenues. This analysis included three phases: (1) a literature scan to assess the national perspective on pharmacy structures, services, and revenues among FQHCs and Look-Alikes and relevant trends in 340B (2) an e-survey of leaders of FQs and Look-Alikes in EHF's district and (3) semi-structured qualitative interviews of FQ and Look-Alike Leaders in EHF's District and TACHC.

Key Findings

Pharmacy Structures

- FQs in EHF's service area report positive perceptions of entity-owned/in-house pharmacies.
- The majority of responding FQs (78%) have at least one entity-owned pharmacy. Participating leaders expressed positive experiences associated with the impact of entity-owned pharmacies on revenue stability and continuity of care.
- FQs that do not have an entity-owned pharmacy expressed interest in opening one. However, barriers to opening one included the upfront financial costs, required physical and electronic infrastructures, and required staff.
- FQs have mixed perceptions of contract arrangements with retail pharmacies; they are becoming increasingly costly but are still necessary for rural patient populations.
- FQs and a state professional association have positive perceptions of contract arrangements with independent pharmacies, but recognize these arrangements are not likely to grow as independent pharmacies in Texas are closing rapidly.

Pharmacy Services

- Texas FQs are interested in providing clinical pharmacy services, and some are already doing so. Insurance coverage, which is currently limited in Texas, is a key factor in expanding these services.
 - Half of FQs surveyed offer at least one clinical pharmacy service; of those, over half offer at least two. The most common services offered related to diabetes management and prescription refill management under a Collaborative Practice Agreement (CPA).

- Most FQs surveyed who do not currently offer clinical pharmacy services would consider adding them if insurance coverage expanded to cover more of them in Texas.
- Half of interviewed FQs intended to add or expand their clinical pharmacy services in the next year, in order to better compete with other providers, increase opportunities for direct patient engagement, and meet the heightened demand for chronic disease management.

Pharmacy Revenues

- 340B pharmacy revenues vary greatly across FQs in Texas; FQs use them to subsidize a wide variety of services for their patients.
 - Most interviewed FQ leaders did not know what their organization's annual 340B revenue/savings were. Of the four that reported their 340B savings, it ranged from approximately \$30,000 to \$25.5M on an annual basis. Nationally, FQs' pharmacy revenues range from 5% to 30% of their total revenues.
 - Nearly all (89%) of FQs surveyed used their 340B savings to subsidize sliding fee scales for patients. Over half also used their 340B savings to subsidize case management (72%), outreach and enrollment/eligibility services (67%), and prescription delivery services (56%).

Managing 340B

- While 340B revenues enable FQs to provide essential services for their patients at reduced or no cost, FQs are concerned about reductions in these revenues. Many have experienced reductions already and expect this trend to continue in coming years.

340B Advocacy

- Interviewed FQ leaders expressed concern about how several existing and impending regulatory changes to the 340B program have already and/or will reduce their 340B pharmacies' footprint and revenue.
 - Manufacturer restrictions on contract pharmacies
 - Pharmacy Benefit Manager (PBM) and third-party payor fees, reduced reimbursements, and other restrictions, especially at contract pharmacies
 - Increased data/reporting requirements
 - The rebate model
- All interviewed FQ leaders expressed support for legislative protection against existing and future regulatory restrictions to 340B.

- The Texas Association of Community Health Centers (TACHC) supported Texas House Bill 3265—which imposes a civil penalty on “discriminatory practices” against 340B entities—in the 2025 legislative session, and will do so again in the 2026 session in hopes of getting it passed.

Implications for Texas FQs, Pharmacies, and their Patients

As leaders of FQs anticipate the continued evolution of the 340B Drug Discount Program and the resulting impact on the financial viability for their organizations, it will be critical to rapidly identify and execute strategic investments to protect this crucial component of the safety net across the state of Texas. When integrated into health center operations, pharmacy services can provide an important revenue stream for FQs, and support greater patient engagement and continuity of care with providers. However, the provision and expansion of these services have been limited by existing staff capacity and internal expertise. This report highlights specific opportunities for collaboration among innovative FQs, supporting stakeholders, and subject matter experts to drive high-quality, affordable, accessible care for patients and communities across the state of Texas.

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II. Background

In 1992, the 340B Drug Pricing Program (340B) was established to help safety-net providers collect savings from medicines they dispensed and to use those savings to support services for disadvantaged patients. The program requires pharmaceutical manufacturers to sell drugs used for safety-net patients at 50% less than market prices. The program also gave federally qualified health centers (FQHCs) great flexibility in their use of these savings as there are no reporting requirements for their uses. The intention of the legislation was that these funds could be used to support care for the uninsured, sliding fee scales, and other unfunded or underfunded services.

340B applies to all safety net providers, not just FQHCs who together receive only an estimated 5% of 340B covered drugs. Safety-net hospitals receive more than 85% of 340B drugs and a large majority of the revenue savings. 340B remains a vital avenue for FQHC patients to receive prescription drugs and for FQHCs to generate savings to fund additional services for their disadvantaged patients, such as sliding fee scales, behavioral health services, dental services, enrollment assistance, and case management. However, as drug manufacturers, other third parties, and the federal government increasingly put restrictions on 340B, FQHCs' 340B savings, pharmacy services, and patient outcomes are at risk.

There are a total of **53** community health centers in EHF's service area, of which **40** are federally qualified health centers (FQHCs) and **13** are Look-Alikes. In this report, the term "FQ" will be used to denote both federally qualified health centers and Look-Alikes. The Episcopal Health Foundation contracted with a non-profit research organization, Health Equity Outcomes, to understand where and how EHF can support FQs' 340B pharmacy services in its service area. Health Equity Outcomes conducted a national literature scan, and survey and interviews of FQ leaders in order to understand the status, barriers, and facilitators of their pharmacy services.

Defining FQHCs and Look-Alikes

What is a Federally Qualified Health Center?

A Federally Qualified Health Center – or “FQHC” – is a federally funded nonprofit health center or clinic that serves medically underserved areas and populations. FQHCs provide primary care services regardless of ability to pay. Services are provided on a sliding scale fee.

What is a Look-Alike?

Health center program look-alikes – or “Look - Alikes” – are community-based health care providers that meet the requirement of HRSA’s Health Center Program, but don’t receive Health Center Program funding. They provide primary care services in underserved areas, provide care on a sliding fee scale based on ability to pay, and operate under a governing board that includes patients.

The need for this support has become more critical as FQs are negatively impacted by anticipated 2027 cuts in Texas Medicaid benefits, and by federal and state restrictions as well as restrictions by bio-pharmaceutical firms to the 340B Drug Pricing Program, limiting savings that have since 1992 been a key source of financing for care of uninsured and underinsured populations. The Texas Association of Community Health Centers (TACHC) provided valuable advice concerning the needs of its members, and ongoing trends in the state landscape impacting 340B activity and the delivery of care.

The primary goals of this research are as follows:

Goal: Expand Awareness

Identify the key operational facilitators, barriers, and innovations for pharmacy services among FQHCs and Look-Alikes in both rural and urban settings in the EHF service area



Goal: Strategize on Support

Determine how EHF can support FQHCs’ and Look-Alikes’ arrangements for pharmacy services to enhance patient access and assist health centers in protecting revenue streams



To assist in this effort, the Health Equity Outcomes team identified five research domains to ensure a comprehensive understanding of the existing pharmacy landscape among FQs. These domains are as follows:

Domain 1: Pharmacy Structures	- Mix of entity-owned and contract pharmacies - Plans for expansion or revision of pharmacy sites & access - Incentives and barriers	
Domain 2: Pharmacy Services	- Current services offered - Desired services - Plans, incentives, and barriers	
Domain 3: Pharmacy Revenues	- Overall revenues 340B revenues	
Domain 4: Managing 340B	- Approach to managing 340B under current regulations - Anticipated changes under proposed regulations	
Domain 5: 340B Advocacy	Strategies to limit negative impacts of 340B reforms	

To provide a comprehensive assessment of the national and state landscape across these domains, the Health Equity Outcomes team conducted research across three key phases:

Phases for Research	
	Key Goals
Phase One: Literature Scan	Gain a national perspective on pharmacy structures, services offered (with a particular focus on clinical pharmacy services), and revenues among FQs and relevant trends in 340B
Phase Two: E-Survey	Identify specific experiences, needs, impact of 340B changes, and strategic intentions of FQs in EHF's district
Phase Three: Semi-Structured Interviews	Define current and planned pharmacy services, the impacts of 340B changes on FQ services, and what direct assistance and policy initiatives would be most valuable to FQ leaders in preserving their services and financial stability

III. Key Learnings

National Insights from Literature Review

Pharmacy Ownership and Contracting Models

There are four basic models for the legal and financial structures of FQ Pharmacies:

- 1) **In-house/Entity-owned Pharmacy:** the pharmacy is often located within or proximate to a clinic site and the pharmacy license is held by the FQ
- 2) **Contract with community pharmacies:** the FQ contracts with a community pharmacy (privately owned by individual or corporation that has three or less pharmacy sites in the immediate area).
- 3) **Contract with retail pharmacies:** the FQ contracts with a retail chain of pharmacies or big box or grocery stores that have pharmacies.
- 4) **Hybrid:** combination of in-house and contracting with community and/or retail pharmacies.

The trend nationally is for FQs to increase their number of pharmacy sites. FQs and that can afford the set-up costs and increased staffing in recent years added in-house pharmacies—often in combination with retaining & expanding their contract pharmacies (hybrid models). NACHC's survey of its members found that **55%** maintained at least one in-house pharmacy. That same survey found that **65%** of NACHC members reported having one or more contract pharmacies, suggesting that the dominant model nationally is hybrid with a mixture of entity-owned and contract pharmacies.

In-house pharmacies are believed to have substantial advantages over contract pharmacies. They offer closer coordination with clinical staff and generate more pharmacy revenues for the clinic because no fees are paid to a contract pharmacy or pharmacy benefit manager (PBM). Contract pharmacies are reported in the national literature to require 30% to 50% of pharmacy revenues. In-house pharmacies also retain more of 340B savings and avoid some of the restrictions recently added by drug manufacturers to 340B discounts through contract pharmacies (National Association of Community Health Centers 2022).

Service Area-Specific Insights from Surveys and Interviews

Pharmacy Structures

Reported Experiences with Entity-Owned Pharmacies

The majority of surveyed organizations in EHF's service area (**78%**) (14/18) report having at least one entity-owned pharmacy for their organization, in line with national trends for community health centers across the country. Of these organizations, **43%** (6/14) report adding an entity-owned pharmacy within the last 12 months and several indicated strategic plans for adding an entity-owned pharmacy. Taken together, these data suggest a consistent and growing recognition among senior leaders that entity-owned pharmacies are essential to the financial viability of community health centers in the rapidly evolving regulatory landscape in Texas and to improving quality of care.

Of those organizations with entity-owned pharmacies who participated in interviews, **100%** report positive experiences in owning and operating these pharmacies, noting benefits of more coordinated patient care, improved patient and provider communication, and long-term financial viability.

"The majority of the uninsured patients do come to our pharmacy in-house. We're able to service them because we...control the flow as far as how much we offer in pricing...We're also able to assist with enrolling patients in assistance programs and...connecting them to resources that can help them afford their medications a little better."

- Interviewee 2, Director of Pharmacy

This sense of the value of entity-owned pharmacies is consistent with both the findings of research findings and with the position of the NACHC which encourages – and tries to assist its members—the establishment of entity-owned pharmacies. The NACHC also encourages its members to take steps to increase the “penetration rate” or portion scripts written that are filled in the entity-owned pharmacy. Several of our interviewees indicated a strategic goal of increasing penetration for their entity-owned pharmacy and an interest in gaining advice and assistance in doing so.

Several organizations in EHF's service area noted the particular benefit of outsourcing management of their entity-owned pharmacies to external vendor organizations, such as Maxor and Cardinal, with expertise in staffing and the ability to engage with additional staff in the local area when additional capacity is required on site. They also indicated that using such firms to set up and do initial operations of a new entity-owned pharmacy and then turn over to the FQ management was an efficient approach.

“We have a management contract with Maxor, which is a pharmacy management company. So, the pharmacist and the techs are actually employed by Maxor, which is great for us because they’re much better than we are at finding pharmacists and techs. And they have some other contracts locally, so they can even pull a pharmacist or tech if in an emergency situation.”

- Interviewee 4, Director of Special Projects

Reported Experiences with Contract Pharmacies

Patterns in engagement with contract pharmacies vary widely across participating organizations, in alignment with the size of their geographic service areas, the type of area served (i.e., urban vs. rural locations), and the insurance mix of their patient population served. **39%** (7/18) of surveyed organizations report at least one contract with an independent pharmacy currently, while **83%** (15/18) report at least one contract with a retail pharmacy. The mix of contract pharmacies is actively evolving alongside changes in the number of entity-owned pharmacies, with **43%** (3/7) and **27%** (4/15) reporting that they have added at least one contract with an independent or a retail pharmacy in the past year, respectively. One interviewee noted engaging outside support to monitor their organization’s portfolio of contract pharmacy relationships.

“For our Accredo and Express Scripts and all of those are managed by... Nuvem [Rx] now. They used to be called 340Basics. Anyway, I meet with them and...we go over the financials...Because of all the changes that have occurred with the manufacturers, we block some of the NDCs...I meet with them monthly.”

- Interviewee 6, Director of Pharmacy

Perceptions of the success and long-term viability of contract pharmacies are mixed among participating community health centers. The primary benefits described by interviewed leaders include the ability to more readily serve their rural populations with their contract pharmacy partnerships, through multiple access points and services such as mail-order delivery offered by retail stores, and additional flexibility offered to patients for the purposes of convenience.

“Why we’re onboarding some of these contract pharmacies now is, you know, not everybody comes to our pharmacy. And even though they’re our patients, they have freedom to choose whatever pharmacy that they want. We want to capture some of that leakage that we’re not able to service in-house.”

- Interviewee 2, Director of Pharmacy

“So, we have multiple contracts with various Walgreens in rural areas. That way, our patients who live further out don’t have to stress on medication. They can just go to their local Walgreens and pick it up.”

- Interviewee 5, Chief Operating Officer

The challenges described for contract pharmacies are largely connected with two key concerns related to their long-term operational and financial viability. First, interviewees report the growing proportion of revenues taken by contract pharmacies (e.g., concerns of increased administrative fees such as dispensing fees). Second, multiple organizations noted the growing manufacturer restrictions that add complexity to their internal workflows relative to entity-owned pharmacies. **58%** (7/12) of interviewees described negative experiences and concerns related to their organization's experiences with contract pharmacies.

"At Walgreens...if the pharmacist has a question or a problem, they're not very likely to call. It's hard for them to get in touch with our providers...It's not been a negative relationship. It's just been kind of a no relationship. But of course, our in-house pharmacist knows every provider personally. When we get a new provider, they meet with them and train them on how to submit the prescriptions."

- Interviewee 4, Director of Special Projects

"Manufacturer restrictions and distribution costs have made it very difficult for us to continue our contract with a retail pharmacy (Walgreens)."

- Survey Respondent

Some community health centers, as well as TACHC, also mentioned that contracts with independent pharmacies can come with fewer fees than retail pharmacies, and tend to be more mutually beneficial for the FQ and pharmacy.

"Our center utilizes an independent contract pharmacy that has a location in our building but also will ship out to patients from their other sites if needed. This is the BEST relationship for our center. There is buy-in with them and they support us in so many ways."

- Survey Respondent

"Although I will say in some situations, you know, those contract arrangements, particularly with our independent pharmacies that are going under right and left across our state, it can be really beneficial arrangements for both that community pharmacy and the health center."

- Interviewee 12, Professional Association Executive

However, as independent pharmacies close across Texas, contract arrangements with them are not likely to grow. Largely as a result of lower reimbursement rates from PBMs, independent pharmacies are closing at an alarming rate. Between 2023 and 2025, at least one independent pharmacy in Texas closed every week (Texas Pharmacy Association 2025). Both FQHCs and independent pharmacies operating with razor-thin margins have been negatively impacted by PBM practices that decrease organizational revenue.

Anticipated Changes in Pharmacy Structures

The vast majority of interviewees (91%) report that their organization intends to change the mix of entity-owned and contract pharmacies over the next 12 months, with many organizations actively working toward the launch of a new entity-owned pharmacy and / or the termination of existing contract pharmacy relationships over the next six months. The primary rationale described for these changes was linked to the financial viability for community health centers in relation to the current and anticipated changes in the 340B regulatory landscape, with entity-owned pharmacies providing greater flexibility for health center leaders in responding to the needs of their patients and providers.

“We currently operate only one pharmacy, even though our agency has multiple locations across a 25-mile footprint in the greater Houston area. Establishing a pharmacy at each site would improve patient access and service. However, limited funding, reimbursement changes and manufacturer requirements has caused a shift in finances that requires us to stretch our resources to provide services in multiple service lines.”

- Survey Respondent

Further, the growing limitations on engaging with contract pharmacies implemented by multiple manufacturers and the decreased revenue resulting from these relationships have negatively impacted the perception of these partnerships among participating organizations. Opportunities to facilitate the operational efficiency and resulting increased penetration rate among entity-owned pharmacies were noted as particularly valuable by multiple interviewees.

Figure 1. Current Pharmacy Structures ($n = 18$)

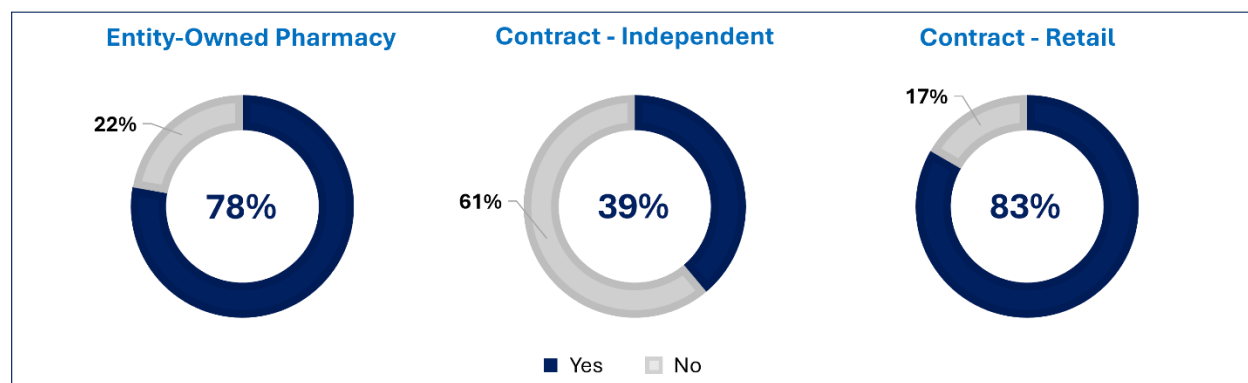


Figure 2. Pharmacy Types Added in Past 12 Months ($n = 18$)



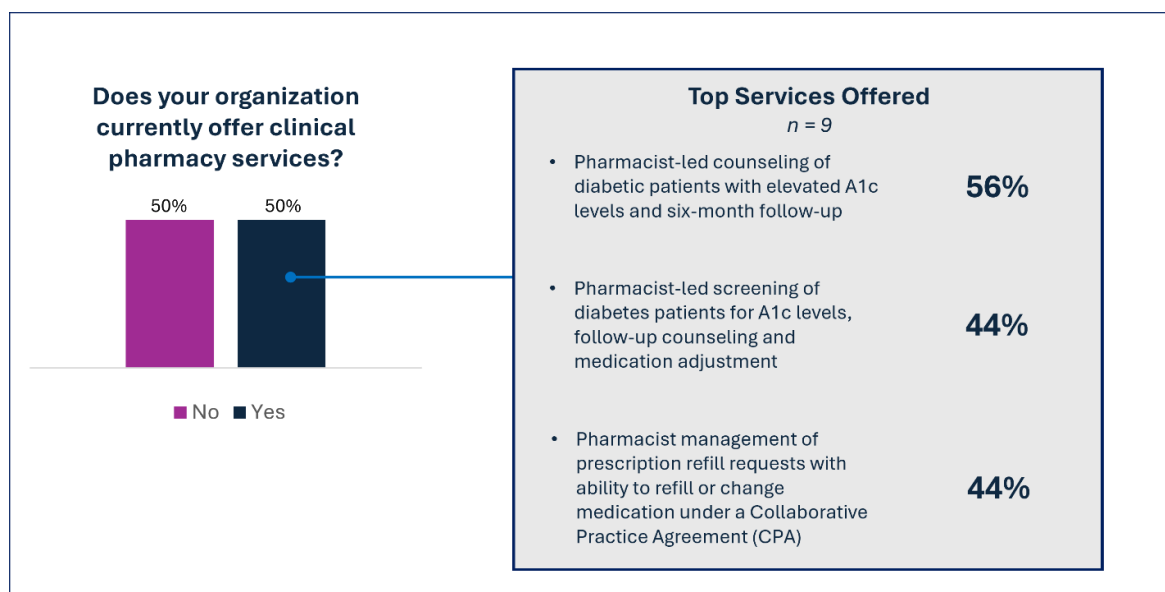
Pharmacy Services

In national data, clinical pharmacy services (i.e., pharmacist-led interventions in medication and disease management) provide an opportunity for community health centers to support limited clinician capacity, and improve patient access to care, and follow-up support. A recent national survey of FQs found that all (100%) respondents reported revenue shortages and most (70%) reported clinical staffing shortages (Horstman et al. 2024). Clinical pharmacy services are seen as a means of reducing work burdens on doctors, nurses, and community health care workers. In many states—unlike in Texas—Medicaid programs offer coverage for clinical pharmacy services as well as some private insurers, so clinical pharmacy services also are a source of additional pharmacy revenues.

Patient and clinician acceptance is reported to be high for many of the most common services along with positive outcomes data on the impact for patients (Abou-Karam 2022; Moczygemba et al. 2024; Salama et al. 2025). Clinical pharmacy services can provide an opportunity for FQs across EHF's service area to address persistent and growing gaps in care for uninsured and underinsured populations.

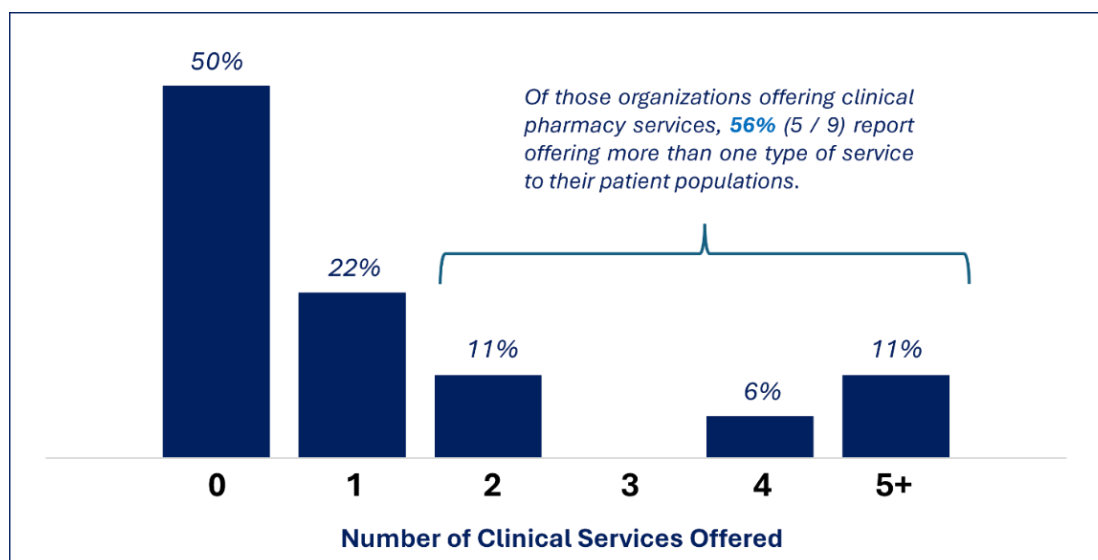
Of the organizations surveyed, half (9/18) report offering at least one type of clinical pharmacy service for their patients. The most common services reported were linked to diabetes care, given the growing needs among the patient populations served by participating health centers (see **Figure 3**).

Figure 3. Current Landscape of Clinical Pharmacy Services ($n = 18$)



As noted in the February 2026 EHF report on “Highlighting Lived Experiences of People Living with Pre-Diabetes & Type 2 Diabetes”, both diabetes and pre-diabetes have reached crisis levels in Texas. One of the most well-studied and documented areas of successful clinical pharmacy services is for diabetes care. Pharmacist-led initiatives such as counseling patients on use of medications, screening patients for A1c levels and counseling those with elevated levels, approving medication refills, and advising patients on use of continuous glucose monitoring devices are reported to have positive outcomes.

Figure 4. Range of Clinical Pharmacy Services Offered ($n=18$)



For those organizations currently offering clinical pharmacy services, more than half (**56%**) reported offering more than one type of service to their patient populations (**Figure 4**). For those organizations who do not currently offer clinical pharmacy services, availability of insurance coverage and existing staff capacity were cited as the most common barriers to these services to date. A majority (**78%**) of surveyed organizations who do not currently offer clinical pharmacy services reported that their organizations would consider adding clinical pharmacy services if insurance coverage could be expanded to cover more clinical pharmacy services. However, these services were perceived to be valuable to patients and to clinicians even among those who did not cite insurance coverage as a primary barrier to offering clinical pharmacy services.

“As far as the interactions that we have with our doctors, they’re calling us all day for questions and treatment options anyways. And the pharmacists that I have on staff are PharmDs, so they do have the clinical knowledge and are able to provide advice and management as well.”

- Interviewee 2, Director of Pharmacy

In qualitative interviews, **45%** (5/11) of participating leaders described a specific intent to add or expand clinical pharmacy services over the next 12 months. The underlying rationale as described by interviewees for adding or expanding these services included:

- The potential for competing more effectively with other providers in their local and regional markets
- The increased opportunity for direct patient engagement and more transparent disclosure with pharmacists relative to other clinician types
- The outsized demand for supporting patients in chronic disease management through these services.

“If clinical pharmacy could really put FQs as a higher probability of being a provider of choice, because we’re really competing with the Kelsey-Seybolds and...everybody else in the Medicare Advantage and Medicare managed care market in greater Houston. It’s the largest medical center in the country, or in the world! So you have a lot more competition with other private providers that are trying to capture that same market with you.”

- Interviewee 3, Chief Executive Officer

“I think there’s a different trust level with the pharmacist because sometimes the patients are not always honest with their providers...I think that they’re a little bit more honest with the pharmacist. And then that pharmacist just has that, I guess, overall a unique relationship with the patient because the pharmacist is so accessible.”

- Interviewee 6, Director of Pharmacy

Taken together, these findings suggest that there is an appetite for and potential ability to provide these services among FQs even under the current limited insurance coverage available.

Pharmacy Revenues

Across the country, pharmacy revenues for FQs reportedly range from **5%** to **30%** of the earned-from-billings revenues¹, with the variability attributable to differences in pharmacy ownership, range of pharmacy contracting models, and insurance mix of patients.

Given the sensitivity around this topic, data on overall and 340B-related revenues were collected via semi-structured interviews to allow health center leaders to provide relevant context on their organization’s financial performance to date and anticipated changes across the next 12 months. Of the 12 interviews conducted, 5 interviewees provided more detailed estimates of their organization’s 340B revenues in 2025 for consideration in this research report. For comparison, these data are summarized as described with the organization’s 2024 operating revenue in **Table 1** below. One response has been omitted for accuracy.

Table 1. 340B Revenue and Total Revenue Among Participating Organizations

FQHC	Reported 340B Revenue	Total Revenue (2024)
FQ #1	\$30,000	\$15.9M
FQ #2	\$4M - \$5M	\$35.7M
FQ #3	\$3M - \$4M	\$36.7M
FQ #4	\$25.5M	\$124.9M

“Our pharmacy profits have declined, again, as a result of changes in the manufacturer environment and the Medicare contracted rate. I don’t know if anybody else has talked to you about the fact that the Medicare contracted rate affected prices, 340B prices, particularly for diabetes drugs. And so, we have had increased cost of our drugs related to that that has impacted our profitability.”

- Interviewee 4, Director of Special Projects

“Like before, we were dispensing medications and...we would adjudicate through the pharmacy benefits manager. And so, the drug manufacturers are like, well we’re not here to make FQHCs rich. And so, they have their own little process that they go through with their own benefits manager...We went from say a \$3,000 drug where we would probably get, you know, maybe \$2,000 in revenue to \$82.75 plus cost...the revenue is gone.”

¹ Earned-from-billings revenues for FQs and Look-Alikes refers to only the income generated from billings for patient care services and exclude their income from grants, donations, and sponsored programs (Watts et al 2024)

- Interviewee 6, Director of Pharmacy

As previously summarized, the 340B Drug Pricing Program was originally established to assist safety-net providers in collecting savings from medicines they dispense and subsequently using those savings to support services for disadvantaged patients. To date, specific knowledge on how FQs across the state of Texas leverage 340B savings to support their patient populations has been limited by challenges in data collection, staff capacity, and the variability in services offered across health centers of different sizes and in different markets.

The Health Equity Outcomes team included specific prompts to assess the range of services supported by 340B savings in both the quantitative survey and the set of qualitative interviews conducted across health center leaders. Across the options provided, sliding fee scales were noted as the most common use for 340B savings across all health centers surveyed (see **Table 2**).

Table 2. Summary of Programs / Services Supported by 340B Savings²

Program / Service	Percentage
Sliding fee scales	89% (16/18)
Case management	72% (13/18)
Outreach and enrollment / eligibility services	67% (12/18)
Prescription delivery services	56% (10/18)
Behavioral health services	50% (9/18)
Nutrition education and assistance	50% (9/18)
Transportation	44% (8/18)
Laboratory / x-ray services	39% (7/18)
Dental services	39% (7/18)
Other (please specify) ³	22% (4/18)
Emergency housing services	0% (0/18)

² Respondents were asked, “Which of the following services or programs does your organization try to direct 340B savings to support? (Check all that apply)” and provided with a list of ten discrete options along with the option to describe additional services in an open-text field.

³ Additional options provided included “Pharmacist-led clinic-based injectable medications”, “Medication Therapy Management, Prescription Assistance Programs”, “Medication and Medical Consultation”, and “We have launched an MTM Pharmacy team with plans to expand into the services listed above”

In qualitative interviews, participating leaders described the potential changes they anticipate if 340B savings continues to decrease for their organizations.

“It would definitely be a ripple effect. Transportation would probably be one of the first things I would have to trim down just because, I mean, fuel, the cost of fuel and the pay of the drivers. I could see that being a thing that would be cut. Assistance with, you know, every now and then if somebody needs an x-ray and they don’t have the copay, we’ve covered x-ray costs before. So some of the extra things we do may, you know, those are going to be some of the first things that go.”

- Interviewee 5, Chief Operating Officer

Managing 340B

Interviewees largely report negative sentiments as it relates to changes in the 340B program, with 83% (10/12) describing a negative impact on their organization’s revenues and overall financial viability. No interviewees participating in qualitative interviews described a positive sentiment pertaining to the changes in 340B (0/12). The consequences of these changes are reported to have not only a negative impact on the individual health centers, but also the potential to shift the broader healthcare landscape across the state.

In response to the changes experienced to date and the anticipation of additional changes to come, participating health center leaders describe executing shifts in their day-to-day operations as well as in their future strategic planning for the organizations. These changes include critical staff capacity diverted away from pharmacy operations and delayed plans to open entity-owned pharmacies due to capital limitations. FQ leaders express the paradox of the growing administrative burden required to comply with complex 340B requirements that is distributed across their staff, with the limited capacity this administrative burden creates for a forward-looking strategic assessment of potential organizational opportunities and risks related to 340B and subsequent implementation.

“At each level, each staff is doing something related to 340B because they have to review patients’ charts to make sure that they’re eligible. They’ve seen the provider within the designated time frame. They’ve completed their registration. So pretty much, each staff at every level of their day is doing something related to 340B compliance.”

- Interviewee 2, Director of Pharmacy

“On our current plan, opening an in-house pharmacy was my goal. That is ultimately what I want. But with everything going on, with the changes in the 340B landscape and the rebate model proposal and the manufacturer restrictions, it put a major halt on my plan just because of the unknown costs. Having to have that nice chunk of change in capital to purchase all the medications ourselves and...we’ve seen a decrease in revenue from some of the manufacturer restrictions.”

- Interviewee 5, Chief Operating Officer

340B Advocacy

The policy and regulatory environment surrounding 340B has continued to intensify at both the state and national levels across 2026. Health center leaders participating in qualitative interviews were generally enthusiastic about the potential for EHF to engage in advocacy efforts in support of FQs, and noted several concrete opportunities that would directly benefit their organization's long-term sustainability.

Interviewees expressed concern about contract pharmacy restrictions, additional fees, and 340B revenue reductions imposed by drug manufacturers, pharmacy benefit managers (PBMs), and other third parties (**Table 3**). While there are no federal protections against these restrictions, many states have enacted laws protecting 340B entities, and especially contract pharmacies.

“Several states have adopted their own legislation, and we hope that Episcopal Health can work with the FQHCs and with our state organization to include that legislation in Texas.”

- Interviewee 4, Director of Special Projects

Interviewees were generally supportive of Texas HB 3265 (**Table 3**) but also noted that some 340B covered entities should be exempt from additional requirements and restrictions. Some states have imposed certain restrictions or reporting requirements on 340B hospitals only, so it is possible that a similar bill could be introduced in Texas.

“That bill will help, but I really think if people like Episcopal Health and other big entities that pour into the community, if we could advocate for, you know, leave the FQHCs alone. Leave the rural hospitals alone. Leave us small fish alone that are just trying to take care of the people in the towns we live in.”

- Interviewee 5, Chief Operating Officer

The rebate model (**Table 3**), which will take effect on January 1, 2027, continues to create significant concerns for FQ leaders. It is not clear which manufacturers and which drugs will be included in the program, and how FQs will manage the ensuing cash flow restrictions.

“The rebate program is absolutely one thing which can be a huge impact. Of course, the 340B contract pharmacy carveouts is not super impactful to us...today right away, but it can be and it will be as different manufacturers try to...create more administrative burden.”

- Interviewee 3, Chief Executive Officer

Table 3. Common 340B Issues & Policy/Advocacy Efforts to Address Them

340B Regulatory Issues ⁴	Non-Texas Policy/Advocacy Efforts	Texas Policy/Advocacy Efforts
Manufacturer restrictions on contract pharmacies (distance, single location)	Opposing: 21 states have <u>passed</u> laws preventing manufacturers from imposing such restrictions (all with contract pharmacy-specific provisions)	Opposing: HB 3265⁵ , <u>introduced</u> to the Texas State House in 2025. Would impose a civil penalty for “discriminatory practices” by health benefit plan issuers, PBMs, third-party payors, and manufacturers as it relates to 340B entities.
PBM and third-party payor fees, reimbursement rates, shares of 340B revenue, and other restrictions; especially at contract pharmacies	Opposing: 33 states have <u>passed</u> laws preventing PBMs and other third parties from imposing such restrictions (9 with contract pharmacy-specific provisions)	HB 3265 did not pass, but it will be re-introduced in the next session.
Increased data/reporting requirements	Supporting: 7 states have <u>passed</u> laws increasing reporting requirements for 340B covered entities, including FQs/LALs. 3 states have imposed reporting only on 340B-covered hospitals.	
Rebate model	Supporting: HRSA announced the Revised 340B Rebate Model Pilot Program, taking effect on January 1, 2027.	N/A

⁴ Mentioned by interviewees

⁵ TACHC lobbied/advocated for this bill in the 2025 legislative session, and plans to do so again.

IV. Implications for Texas Stakeholders

FQs serve as an essential safety net for underinsured and underinsured populations across the country, and are particularly critical across the state of Texas as the state with the highest number of uninsured individuals in the United States (Tolbert et al. 2026). An August 2026 report highlighted the growing demand for both Medicaid and SNAP enrollment, leaving more Texans vulnerable to requiring unplanned emergency care and increased dependence on safety net providers for survival. Together, these realities will drive an increased demand for the services provided by FQs in EHF's service area. Leaders of FQs, alongside critical partnering organizations, will need to collaborate on new paths to achieving long-term financial sustainability and operational scale.

The learnings summarized in this report point to two concrete opportunities to better serve patients and communities served by FQs.

- (1) **Exchange of real world practices for efficiently launching and operating entity-owned pharmacies within FQs:** In responding to the needs of patients and communities, many leaders of FQs learn the nuances of pharmacy operations while executing these plans for their organizations. Along the way, there are efficiencies gained in approaches to staffing, patient and provider engagement, and marketing and communications to increase the entity-owned pharmacy penetration rate. These efficiencies can be shared with other peer FQs across the state, to support financial viability and staff retention.
- (2) **Dedicated, centralized support for tracking and responding to key regulatory changes associated with the 340B program:** Participating leaders noted the administrative burden required to keep pace with relevant changes – and how these changes directly impact their staff's workflows – at an individual organizational level. Opportunities to engage with accessible subject matter experts can support continued focus among FQ leaders, and help to readily identify opportunities and potential risks.

Alignment with Current EHF Priority Areas

Across the course of this research, participating organizations were also invited to share their ongoing and / or planned pharmacy initiatives pertaining to EHF's priorities in the following areas:

- Food insecurity
- Diabetes care
- Maternal health services
- Home delivery, telemedicine, and / or mail-order delivery

Across the 12 leaders participating in qualitative interviews, **83%** (10/12) reported at least one ongoing or planned pharmacy initiative in one or more of these priority areas for their organization. Some leaders who reported not having pharmacy initiatives in a priority area were already addressing that area, but not through their pharmacy. In fact, some reported already receiving non-pharmacy grants from EHF to support food insecurity and nutrition.

Table 4. Ongoing or Planned Pharmacy Initiatives Across EHF's Priority Areas

EHF Priority Area	Percentage
Patients with diabetes	67% (8/12)
Home delivery, telemedicine, and / or mail-order delivery	58% (7/12)
Food insecurity	42% (5/12)
Maternal health services	25% (3/12)

The findings in this report reflect the perspectives of the organizations participating in both the e-survey and / or the qualitative interviews conducted across 2026. Additional follow-up research is required to assess whether these perspectives reflect the general sentiments of the 53 community health centers across EHF's service area.

Given the regularly changing landscape for 340B and for FQs in Texas, this research would benefit from annual updates to assess the changes across EHF's service area and how the evolution of the 340B program is impacting financial viability for FQs.

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VI. Appendices

Appendix Document 1: Methodology

To complete this analysis, the Health Equity Outcomes team conducted research across three distinct phases:

- **Phase One: Literature Review** to gain a national perspective on pharmacy structures, services offered (with a particular focus on clinical pharmacy services), and revenues among FQs and relevant trends in 340B as identified from a search of peer-reviewed journals, reports, and news media publications. The intent of the literature review report was to offer a backdrop against which EHF can judge how its FQs' pharmacy services and revenues and initiatives are similar to or diverge from national trends. The literature report can be found in Appendix Document 2. A spreadsheet listing, summary and link to identified articles is submitted as a companion report.
- **Phase Two: E-Survey of leaders of FQs in EHF's Service Area** to identify specific experiences, needs, impact of 340B changes, and strategic intentions of FQs in EHF's district
- **Phase Three: Semi-Structured Qualitative Interviews of FQ Leaders in EHF's District and a Statewide Healthcare Organization** to define their current and planned pharmacy services, the impacts of 340B changes on their services, and what direct assistance and policy initiatives would be most valuable to them in preserving their services and financial stability.

Phase One: Literature Review

To identify relevant resources pertinent to the research domains outlined in the Project Overview, the HEO team conducted a thorough search of both peer-reviewed literature and grey literature (**Figure 5**).

A search was conducted on PubMed using the following search terms:

("FQHC" OR "federally-qualified health center" OR "community health center" OR "CHC") AND ("pharmacy services" OR "pharmacy" OR "pharmacist") AND ("2021/01/01"[Date - Publication] : "3000"[Date - Publication])

To identify relevant grey literature, the HEO team identified a list of key stakeholder organizations pertinent to the domains of interest (e.g., National Association of Community

Health Centers, Commonwealth Fund, Episcopal Health Foundation). The team then conducted targeted searches on Google and reviewed each of the stakeholder websites for relevant reports and resources (**Figure 6**). Where relevant, the team referenced footnotes contained therein to identify additional relevant sources.

Figure 5. PubMed Search Yield

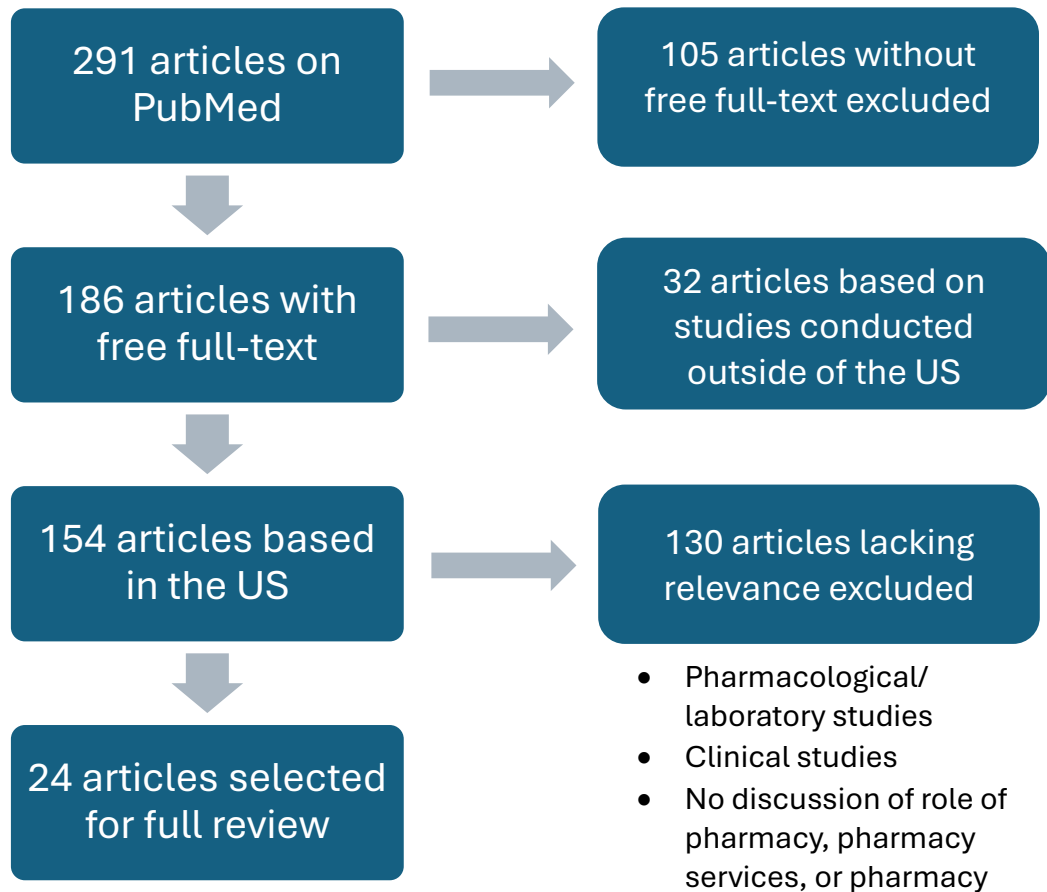


Figure 6. Grey Literature Search Yield



Phases Two and Three: E-Survey and Semi-Structured Interviews

Respondents

Health Equity Outcomes developed an initial list of executives from the FQs in EHF's service area from public sources. This draft list was then edited and prioritized by EHF and TACHC. After editing by EHF and TACHC, a final list including CEOs, COOs, Pharmacy Directors from 35 FQs was prepared for survey dissemination. All survey respondents who indicated interest would be invited to an interview.

Outreach & Data Collection

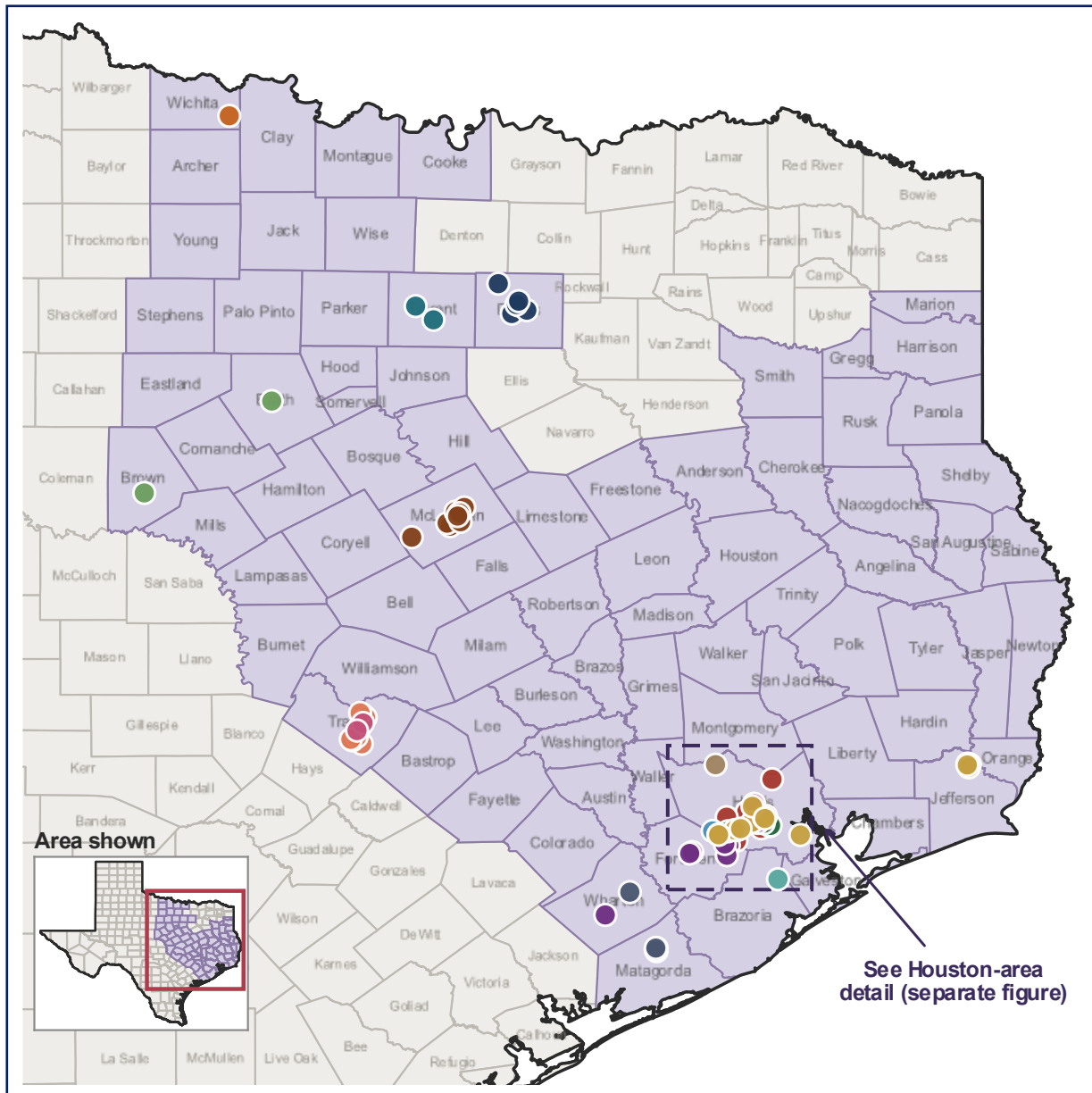
The survey was developed by HEO in collaboration with EHF and TACHC and can be found on page 46 of the appendix. HEO programmed and administered the survey on the JotForm platform. The semi-structured interview guide was developed in collaboration with EHF and can be found on page 50 of the appendix.

Health Equity Outcomes drafted invitation email language and received feedback and approval from EHF and TACHC. EHF invited agreed upon organizations to complete the survey via email (see **Appendix Document 4** on page 49 for invitation language), with HEO staff cc'ed. Non-respondents received 3 waves of follow-up reminders (approximately 1 week apart) after invitation.

Interviews were conducted by three members of the Health Equity Outcomes team on Microsoft Teams or Zoom, and lasted 30-45 minutes each. Interviews were recorded with interviewee consent, and transcripts were sent to interviewees for comment. Interview participants were remunerated with a \$100 honorarium, offered in the form of a digital gift card.

A total of 35 organizations were invited to the survey, and 18 completed the survey, yielding a response rate of **51.4%**. A total of 11 individuals from 10 FQ organizations were interviewed, yielding a response rate of **55.5%**. A 12th individual was recruited from the Texas Association of Community Health Centers (TACHC) and interviewed.

Figure 7. Participating Health Centers in EHF Service Area



Participating Organizations

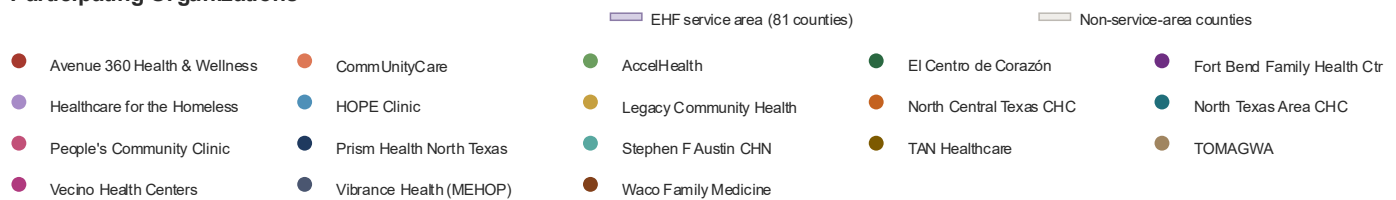


Figure 8. Participating Health Centers in EHF Service Area – Houston Metro Area

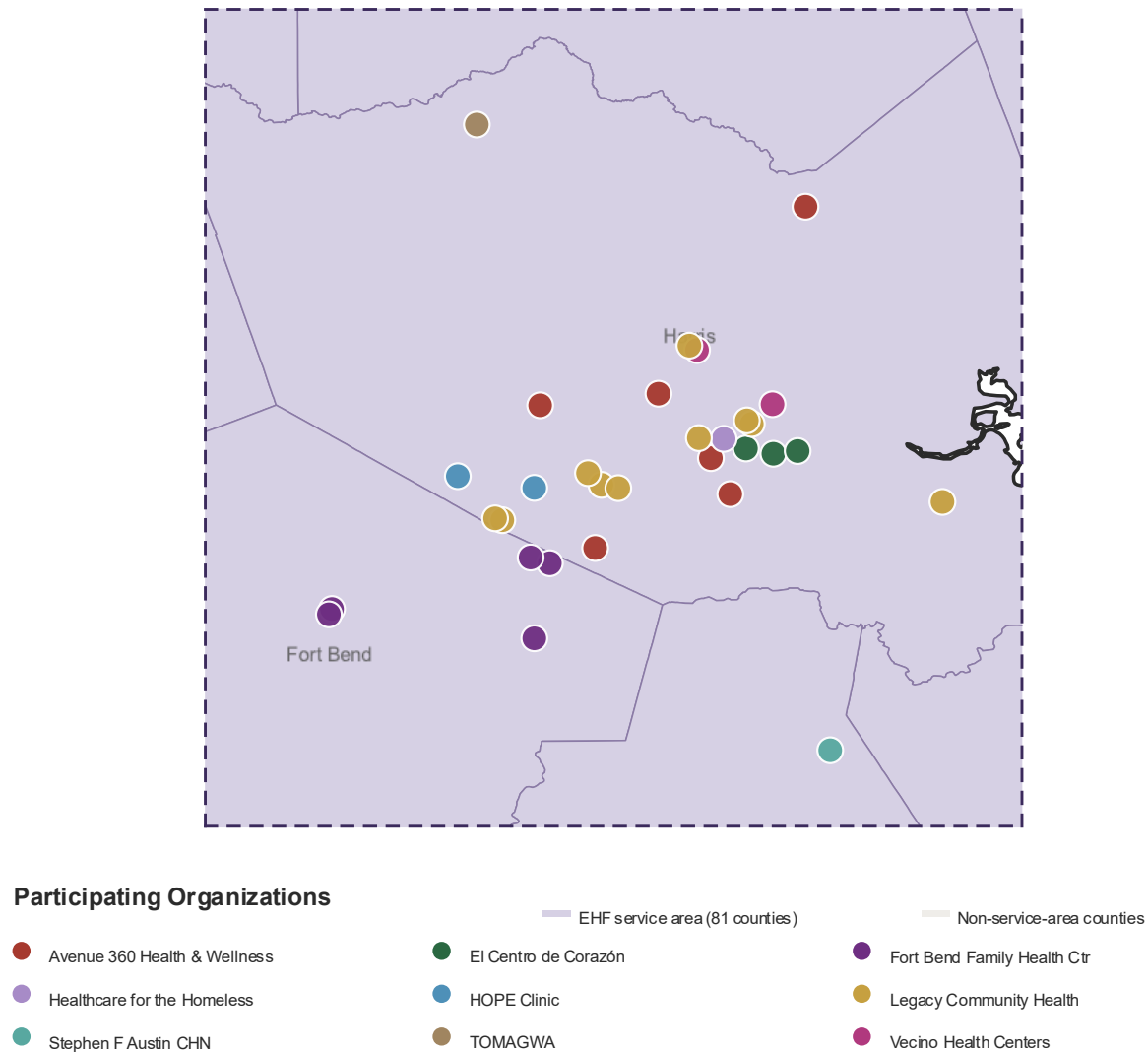


Table 5. Overview of Participating Organizations

Organization	Reported # of Clinical Sites	Reported # of Pharmacy Sites ⁶	# of Patients Served ⁷	# of Surveys Collected	# of Interviews Conducted
AccelHealth (Cross Timbers Health Clinics, Inc.)	3	5	12,891	1	0
Avenue 360 Health & Wellness	5	105	11,973	1	1
CommUnityCare	30	103	148,234	1	0
El Centro de Corazon	3	3	11,979	1	1
Fort Bend Family Health Center	6	5	19,263	1	2
Healthcare for the Homeless - Houston	3	2	2,965	1	0
HOPE Clinic (Asian American Health Coalition)	5	13	31,061	1	0
Legacy Community Health	63	172	192,777	1	0
North Central Texas Community Health Center (Community Healthcare Center)	12	48	32,842	1	1
North Texas Area Community Health Center	3	7	11,326	1	1
People's Community Clinic	3	19	21,946	1	0
Prism Health North Texas	7	163	17,735	1	1
Stephen F Austin Community Health Network Inc	22	18	48,727	1	0
TOMAGWA HealthCare Ministries	2	2	1,984	1	0
Triangle Area Network (TAN Healthcare)	3	10	1,390	1	1
Vecino Health Center (Houston Community Health Centers)	2	1	12,104	1	1
Vibrance Health	3	35	14,003	1	1
Waco Family Medicine	13	3	76,946	1	1

⁶ Data reflects information shared by respondents about total number of entity-owned *and* contract pharmacy sites in the quantitative survey and / or qualitative interviews administered July 2026. These figures may vary from other publicly available sources, given the inherent time lag in printed records and discrepancies in the inclusion of specialized pharmacy sites. Where there were discrepancies, the Health Equity Outcomes team has deferred to the number shared directly from participating organizations via the e-survey and / or qualitative interviews in this table.

⁷ Data reflects 2025 numbers publicly reported through HRSA's Health Center Program Uniform Data System (UDS)

Appendix Document 2: Literature Review Summary

Project Overview

The overarching goal for this engagement with the Episcopal Health Foundation (EHF) is to identify the facilitators, barriers, and innovations for pharmacy services within FQHCs (Federally Qualified Health Centers, FQs) and Look-Alikes that will increase support for non-medical drivers of public health (NMDPH) and diversify revenue streams. This project also seeks to identify initiatives that EHF may undertake to help FQs and Look-Alikes to augment their services and to protect their pharmacy revenues sources from erosion from revisions in 340 B regulations and practices. To accomplish these goals, the project undertook three activities in sequential phases:

- **Phase One: Literature Review**, a national perspective on pharmacy structures, services, and revenues among FQHCs and look-alikes and relevant trends in 340B as identified from a search of peer-reviewed journal and report publications.
- **Phase Two: E-Survey of leaders of FQs and Look-Alikes in EHF's District** to identify specific experiences, needs and strategic intentions of FQHCs and Look-Alikes in EHF's district.
- **Phase Three: Semi-Structured Qualitative Interviews of FQ and Look-Alike Leaders in EHF's District and TACHC** to define their current and planned pharmacy services, the impacts of 340B changes on their services, and what direct assistance and policy initiatives would be most valuable to them in preserving their services and financial stability. Across each phase of the project, the Health Equity Outcomes (HEO) team will focus on the core set of domains outlined below to guide the research.

**Domain 1:
Pharmacy Structures**

- Mix of in-house and contract pharmacies
- Plans for expansion
- Incentives and barriers



**Domain 2:
Pharmacy Services**

- Current services offered
- Desired services
- Plans, incentives, and barriers



**Domain 3:
Pharmacy Revenues**

- Overall revenues
- 340B revenues



**Domain 4:
Managing 340B**

- Approach to managing 340B under current regulations
- Anticipated changes under proposed regulations



**Domain 5:
340B Advocacy**

- Strategies to limit negative impacts of 340B reforms



Report Summary

To execute **Phase One** (**Literature Review**), HEO staff conducted a review of journal articles and reports concerning findings for FQHCs and Look-Alikes across the country. The focus of this phase is to identify published findings at the national level across Domains 1 – 4. The following report summarizes the key takeaways from this literature review, and implications for Phases Two (E-Survey) and Three (Semi-Structured Interview).

Defining FQHCs and Look-Alikes

What is a Federally Qualified Health Center?

A Federally Qualified Health Center – or “FQHC” – is a federally funded nonprofit health center or clinic that serves medically underserved areas and populations. FQHCs provide primary care services regardless of ability to pay. Services are provided on a sliding scale fee.

What is a Look-Alike?

Health center program look-alikes – or “look-alikes” – are community-based health care providers that meet the requirement of HRSA’s Health Center Program, but don’t receive Health Center Program funding. They provide primary care services in underserved areas, provide care on a sliding fee scale based on ability to pay, and operate under a governing board that includes patients.

*Across the 81 counties in the Episcopal Health Foundation’s service areas, there are currently **40 FQHCs** and **13 Look-Alikes**.*

Overview of Literature Review

a. Search Strategy

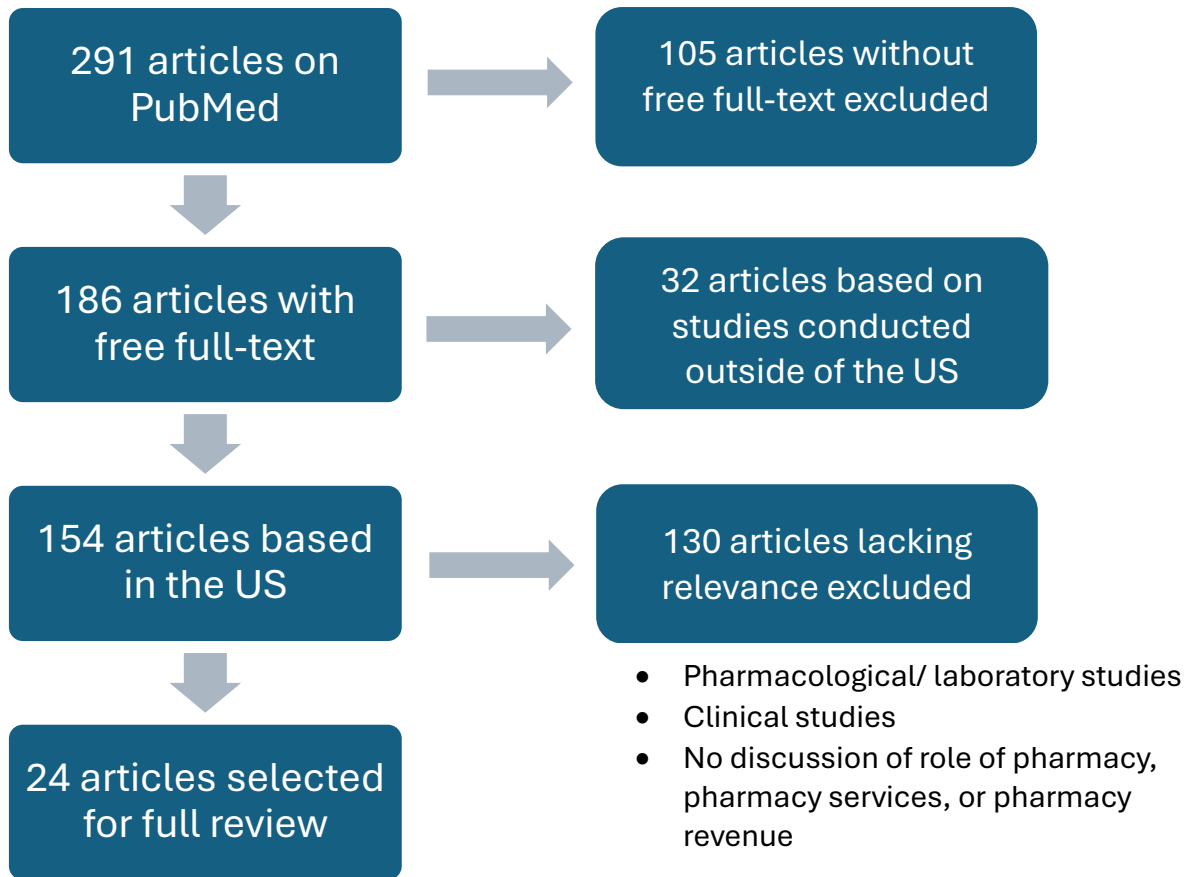
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A search was conducted on PubMed using the following search terms:

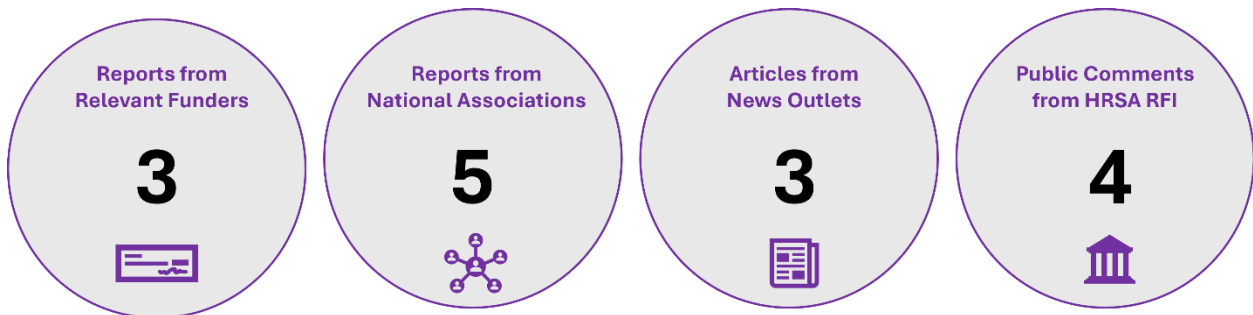
("FQHC" OR "federally-qualified health center" OR "community health center" OR "CHC") AND ("pharmacy services" OR "pharmacy" OR "pharmacist") AND ("2021/01/01"[Date - Publication] : "3000"[Date - Publication])

To identify relevant grey literature, the HEO team identified a list of key stakeholder organizations pertinent to the domains of interest (e.g., National Association of Community Health Centers, Commonwealth Fund, Episcopal Health Foundation). The team then conducted targeted searches on Google and reviewed each of the stakeholder websites for relevant reports and resources. Where relevant, the team referenced footnotes contained therein to identify additional relevant sources.

b. PubMed Search yield:



c. Grey Literature Search Yield



d. Literature Review Spreadsheet

K	L	M	N	O	P	Q	R	S	T	U	V
DOI	Web URL	Include In Review (Y/N)	Exclude Reason	Priority?	Key Relevant Findings	Notes	Research Q Addressed	340B? (Y/N)	Facilitators? (Y/N)	Barriers? (Y/N)	Innovations? (Y/N)
10.24926/iip.v15i1.6081	https://pmc.ncbi.nlm.nih.gov/articles/PMC11107967/	Y		Y	prospective study in an FQ of pharmacists counseling and follow up with continuous glucose monitoring found improved time in range and added reimbursement to the FQ pharmacy			N			Y
10.1016/j.sapharm.2021.08.002	https://pmc.ncbi.nlm.nih.gov/articles/PMC9063767/	Y		Y	pharmacist delivered HPV vaccines had similar completion rates as clinic delivered and high patient satisfaction with reports of greater convenience. Barriers to pharmacist follow up vaccinations were difficulty in keeping in stock and lack of insurance coverage for dispensing.			N	Y	Y	Y

	A	B	C	D	E	F	G	H	I	J
1	PMID	Title	Authors	Citation	First Author	Journal	Publication Year	Create Date	PMCID	NIHMS
2	3.9E+07	Clinical and Financial Outcomes of a Pilot Pharmacist-Led Continuous Glucose Monitoring Clinic	Ballard L, York AL, Skelley JW, Sims M.	Innov Pharm. 2024 Mar 18;15(1):10.24926/iip.v15i1.6081. doi: 10.24926/iip.v15i1.6081. eCollection 2024.	Ballard L	Innov Pharm	2024	5/23/24	PMC11107967	
3	3.4E+07	The feasibility and acceptability of a pilot randomized controlled trial testing pharmacy-based HPV vaccine completion	Koskan A, Zittel ME, Lee C, Sanchez O, Alvarez L, Helitzer DL.	Res Social Adm Pharm. 2022 Jun;18(6):3038-3045. doi: 10.1016/j.sapharm.2021.08.002. Epub 2021 Aug 8.	Koskan A	Res Social Adm Pharm	2022	8/14/21	PMC9063767	NIHMS1788393

Key Literature Findings for FQHCs' and Look- Alikes' Pharmacies

Pharmacy Ownership and Contracting Models

There are four basic models for the legal and financial structures of FQHC and Look-Alike Pharmacies:

- 1) **In-house/FQHC-owned Pharmacy:** the pharmacy is often located within or proximate to a clinic site and the pharmacy license is held by the FQHC or Look-Alike
- 2) **Contract with community pharmacies:** the FQHC or Look-Alike contracts with a community pharmacy (privately owned by individual or corporation that has three or less pharmacy sites in the immediate area).
- 3) **Contract with retail pharmacies:** the FQHC or Look-Alike contracts with a retail chain of pharmacies or big box or grocery stores that have pharmacies.
- 4) **Hybrid:** combination of in-house and contracting with community and/or retail pharmacies.

The trend nationally is for FQHCs and Look-Alikes to increase their number of pharmacy sites. FQHCs and Look-Alikes that can afford the set-up costs and increased staffing in recent years added in-house pharmacies—often in combination with retaining & expanding their contract pharmacies (hybrid models). NACHC's survey of its members found that **55%** maintained at least one in-house pharmacy.

In-house pharmacies are believed to have substantial advantages over contract pharmacies. They offer closer coordination with clinical staff and generate more pharmacy revenues because for the clinic because no fees are paid to a contract pharmacy. In-house pharmacies also retain more of 340B savings and avoid some of the restrictions recently added to 340B discounts through contract pharmacies (see below). The NACHC encourages members to acquire in-house pharmacies when possible.ⁱ

Contract pharmacies, however, are easier and less costly to establish and, unlike in-house pharmacies—do not require additional staff to operate. They also offer a way to provide multiple pharmacy locations. Smaller and rural FQHCs and Look-Alikes tend to rely more on contract pharmacies, often with multiple pharmacy contracts and no in-house pharmacy. The NACHC survey of its members found that **65%** reported having at least one contract pharmacy.

Clinical Pharmacy Services: offsetting gaps in clinical care

FQHC and Look-Alike pharmacies all dispense medication and frequently sell durable medical equipment and over the counter (OTC) drugs and supplies. Nationally, many also provide “clinical pharmacy” services (also called “advanced practice services”), that is pharmacist-led interventions in medication and disease management. Clinical pharmacy services can help FQHCs and Look-Alikes to supplement staff shortages in primary care.

A national survey of Community Health Centers by the Commonwealth Fund found that all (100% of respondents) reported revenue gaps and that most (70%) reported shortages in clinical staff.ⁱⁱ Clinical services offered by pharmacists and pharmacy technicians may bring in additional revenues (where payer coverage permits billing) and also relieve strained clinical staffing. Clinical pharmacy services also are found to yield improved coordination between primary care clinicians (PCPs) and pharmacists and to increase patient access to care and follow-up support.ⁱⁱⁱ

The published literature reports positive patient acceptance and outcomes and high clinical staff acceptance for many of the most common clinical pharmacy services. A number of peer-reviewed studies were found that evaluated pharmacist-led services for specific patient populations, including those groups of strategic interest to EHF—particularly diabetes.

Positive outcomes evaluations of clinical pharmacy services delivered by pharmacists for FQHC or Look-Alikes patients were found for the following:

- Pharmacist-led **screening of diabetes patients** for A1c levels, follow-up counseling and medication adjustment.^{iv}
- Pharmacist-led follow-up and **counseling to diabetic patients given continuous glucose monitoring** devices.^v
- Pharmacist-led **counseling of diabetic patients with elevated A1c** levels and six-month follow-up.^{vi}
- Pharmacist-led reminders and **counseling to diabetic patients with elevated A1c levels** through medium of texting and of tele-video meetings.^{vii}
- Pharmacist-conducted **cardiovascular risk clinic for diabetic patients**.^{viii}
- Pharmacist conducting **annual wellness visits**.^{ix}
- Pharmacist **prescriptions and coupons to local food banks**.^x
- Pharmacist-led **tobacco cessation counseling** with pharmacist prescribing of supporting medications.^{xi}

- Pharmacist **management of prescription refill requests** with ability to refill or change medication under a Collaborative Practice Agreement (CPA).^{xii}
- Pharmacist **dispensing and management of Methadone prescriptions**.^{xiii}
- Pharmacist-led **hypertension management clinics**.^{xiv}

A study by the Community Pharmacy Enhanced Services Network (CPESN) and supported by EHF noted the potential value of clinical pharmacy services by community pharmacists to address key deficits faced by community health centers in Texas. These deficits included non-medical drivers of health (NMDH), shortages of primary care services, and access to care.^{xv} The recommended clinical pharmacy services needed in Texas were found to be pharmacist-led prescribing of hormonal contraception screening for NMDH deficits; delivering pediatric vaccines; home visits; educational programs; and test-and-treat (POC testing with prescribing as indicated by test results). The CPESN report also recommended measures to increase clinical pharmacy services in Texas such as training pharmacy technicians as community health workers (CHWs) and creating sustainable financing for clinical pharmacy services through improved payer coverage.^{xvi}

Pharmacy Revenues

FQHC and Look-Alike pharmacy revenues vary greatly but are believed to range nationally from **5%** to **30%** of their overall earned-from-billings revenues (separate from grant income).^{xvii} The broad range is explained in part by the variation in ownership or contracting models. As noted above, in-house pharmacies generate more revenue because they do not share margins with the contracted pharmacy. The contract pharmacy share may be as high as 30%- 50% of margins. For FQHCs and Look-Alikes with both in-house pharmacies and contract pharmacies (hybrid model), revenues will vary depending on their “penetration rate,” meaning the portion of scripts written that are filled at in-house pharmacy. The NACHC strongly recommends that its members take steps to increase penetration such as prominent location in the building, signage, and adequate staffing to ensure prompt refills.^{xviii}

Other reasons for variations in pharmacy revenues include patient payer mix and whether payers cover clinical pharmacy services. One national study of FQHCs found that on average **29%** of their patients are uninsured and 42% receive Medicaid. Medicare pays for Medication Therapy Management (MTM) by pharmacists, but Medicaid programs vary by state from broad clinical services coverage—often limited to specific patient groups or only when a Collaborative Practice Agreement with physicians applies to the service—to little or no coverage. Pharmacy Benefit Managers (PBMs)—if used—may also take a share of margins. The size of a FQHC or Look-Alike will determine volume of prescriptions and, therefore, pharmacy revenues. Finally, pharmacy revenues may vary by the impacts of 340B discounts and requirements. Texas requires that Medicaid drugs be acquired through a PBM.

Key Literature Findings for 340B's Impact on FQHC and Look-Alike Pharmacies

In 1992, the 340B Drug Pricing Program was established to help safety-net providers collect savings from medicines they dispensed and to use those savings to support services for disadvantaged patients. The program requires pharmaceutical manufacturers to sell drugs used for safety-net patients at 50% less than market prices. The program also gave FQHCs and Look-Alikes great flexibility in their use of these savings and there are no requirements for their reporting savings or their uses. The intention of the legislation was that these funds could be used to support care for the uninsured, sliding fee scales, and other unfunded or underfunded services.

The 340B Drug Pricing Program covers all safety net providers, not just FQHCs and Look-Alikes who together receive only an estimated **5%** of 340B covered drugs. Safety-net hospitals receive more than **85%** of 340B drugs and a large majority of the revenue savings.

340B-Generated Revenues or “Savings” for FQHCs and Look-Alikes

Because 340B recipients are not required to report 340B savings, there are no validated estimates of the amounts received. However, a study based on analysis of the Health Resources and Services Administration's (HRSA) Uniform Data System and the Office of Pharmacy Affairs Information System (OPAIS) found that for each 340B registered pharmacy site held by an FQHC, 340B revenues grew by \$17,600.^{xix} Thus on average, an FQHC's annual 340B revenues might be estimated by multiplying their number of registered pharmacy sites (“covered entities”) by \$17,600. The same study posited that because the median number of pharmacy locations per FQ in 2020 was 19, the average 340B income per FQ in that year was approximately **\$334,400**. (Note: Look-Alikes were apparently not included in this analysis and may have lower per registered pharmacy 340B revenues.)

Forces behind efforts to reform and limit 340B

- **Growth of 340B registered entities and volume of discounted 340B drugs.** The size of the 340B Program has grown substantially. Spending on drugs purchased through the 340B Program increased from \$6.6B in 2010 to \$43.9B in 2021; spending increased by over \$4B between 2020 and 2021 alone^{xx}.
- **Hospitals and their off-site outpatient clinics consistently account for the vast majority of 340B spending** (87% in 2021). In 2021, FQHCs accounted for only 6% of spending on drugs through 340B.
- **For FQs nationally, the average number of registered pharmacy locations participating in 340B per FQ rose** from two in 2004 to 35 in 2021.

- **Lack of transparency for 340B savings and their uses.** Because the 340B Program does not require hospitals or FQHCs to report their 340B utilization or revenues, there is no clear evidence of how these savings are used. Safety-Net hospitals (by far the largest recipients of 340B drugs) have been widely accused of using these funds not to assist uninsured patients or improve services as intended, but instead to increase margins. To some extent, accusations of FQ and Look-Alike diversion of savings from intended uses may be raised because of hospital practices.
- **Suspected “double billings” for 340B scripts.** Double billings occur when a drug is purchased at the discounted 340B price, and a Medicaid rebate is incorrectly claimed for the same script. Law requires that “Covered entities must have mechanisms in place to prevent duplicate discounts”^{xxi}.

What reforms are being proposed and/or implemented and their reported impacts?

Reforms in 340B procedures and eligibility include:

- **Claims-Level Data Requirements:** Manufacturers Novo Nordisk and Eli Lilly now require covered entities to submit claims-level data for both contract and in-house pharmacies for access to 340B discount pricing. This is a change in practice, not a government regulation change. These two manufacturers have implemented this change nationally and in Texas. Some FQHCs have reported that submitting claims-level data for all 340B scripts will require one or more additional full-time employees.
- **Rebate on 340B drugs to replace purchase at discount:** A shift to a back-end (and, therefore, delayed) rebate in place of discount at time of purchase was to have been tested in a HHS (Health and Human Services) pilot program. That pilot program was prevented by a Maine US District Court and HHS in April 2026 requested comments concerning a revised model of that pilot program. The shift to rebates is believed to have severe financial and administrative implications for FQs and Look-Alikes including cash flow problems while waiting for payment of the rebates.
- **Restricting FQHCs and Look-Alikes 340B drugs to only in-house and one contract pharmacy:** Several manufacturers have started only providing 340B priced drugs at one in-house and one contract pharmacy per 340B covered entity. Some have also started requiring 340B covered entities, including FQHCs and Look-Alikes, to provide claims-level data on all 340B drugs dispensed at each contract pharmacy^{xxii}. The administrative burden associated with these requirements could significantly reduce the number of contract pharmacies FQHCs are able to have in practice.

Feedback on Proposed 340B Changes for EHF FQs

Several FQs within EHF's district submitted comments to HHS which pointed to consequences such as¹

*"We estimate it would cost \$2,480,934.83 annually to purchase the 10 drugs under the proposed rebate model. Currently, our organization spends \$881,654.06 to purchase these same drugs at the 340B ceiling price. This represents a **181% increase** in upfront capital required for medication procurement."*

*"North Central Texas Community HealthCare Center anticipates needing an **additional 2 – 3 FTEs**, costing our organization an estimated **\$200,000 per year** in additional costs."*

- Severe cash flow issues coupled with already small margins: The Maximum Fair Price (MFP) rebate program for Medicare also boasts a 10-day rebate payment timeframe, but participants have reported waiting 30-90 days for payment.
- Additional staff required: nationwide, CHCs estimate they would need 0.5-1 additional FTE staff and between \$30k and \$200k to pay these staff needed to comply with rebate model requirements.
- Administrative Burden: new software at CHCs and contract pharmacies need to be adopted and integrated to meet reporting requirements and be eligible for rebates
- Increased medication costs for uninsured and underinsured patients
- Significant net losses from denials
- Significant increased cost of 10 selected drugs
- Increased reliance on and cost of Third Party Administrators for contract pharmacies (and potential loss of contract pharmacies as a result)
- Reduction or elimination of sliding fee scales
- Reduction or elimination of specific non-revenue-generating services currently funded by 340B savings, including behavioral health services, laboratory testing, dental services, case management, nutrition education and assistance, emergency housing, and other social services

Efforts being made to protect FQHCs' and Look-Alikes' access to 340B savings

As of October 2025, 37 states have enacted laws to protect 340B savings.

- Some states have passed laws preventing manufacturers from limiting 340B discounts to one or any specified limit of contracted pharmacies. At last count there were 21 such states. Texas was not among them; House Bill 3265^{xxiii} was introduced to the state legislature in early 2025, but was not passed. Courts in Minnesota and Mississippi have upheld these state protective laws.^{xxiv}
- Some advocates for preserving FQHC and Look-Alike savings from 340B suggest adding reporting requirements for the uses of 340B savings in order to document that funds are being used consistently with the intent of providing care for the uninsured and other disadvantaged patients.

An example of such positive findings defending FQHC and Look-Alikes' was published in a study based on analyses of Federal data sources (HRSA's Uniform Data System and OPAIS) found that:

"FQHC 340B participation was associated with increased provision of low-profit, high community value preventive services...<which> contrasts sharply with recent studies showing no increase in the provision of low-profit services for certain 340B hospitals."^{xxv}

- Recent laws in 11 states (including Idaho, Hawaii, Ohio, Minnesota and Maine) have added requirements for such reporting with the intent of making more specific documentation possible.

Implications and Next Steps

Given the national findings reported in the literature for FQHCs and Look-Alikes as described above, **Phase Two** of this project will address the following key questions for FQs and Look-Alikes in EHF's districts:

Sample Topics for E-Survey

Domain 1: Pharmacy Structures	• How many pharmacies do the FQs currently maintain? • What mix of in-house & contract pharmacies do they have? • How will the number or mix evolve over the next year?	
Domain 2: Pharmacy Services	• What services beyond dispensing medicines and medical equipment do their pharmacies offer?	
Domain 3: Pharmacy Revenues	• What are total estimated pharmacy revenues? What portion is from 340B savings? • What services or programs are supported by 340B savings?	
Domain 4: Managing 340B	• What staffing is currently used to support 340B?	

The survey will necessarily be brief to encourage responses—and request descriptive information with closed response options.

Phase Three Interviews will collect broader perspectives concerning the impact of 340B changes on FQHCs and Look-Alikes in EHF's District and what assistance they most need in protecting and expanding their pharmacy services and revenues. For Phase Three, interviews will be more expansive and will attempt to collect opinions, strategic plans, and preferences.

Sample Topics for Semi-Structured Interviews

Domain 1: Pharmacy Structures

- Do FQHC managers intend to change their mixture of in-house and contract pharmacies? If yes, why? What assistance do they need?



Domain 2: Pharmacy Services

- Do FQHC managers want or plan to offer more clinical pharmacy services? If yes, what are the priorities? If no, why?



Domain 3: Pharmacy Revenues

- Annually, how much savings from 340B do pharmacies currently realize? Is this a change from last year?
- How do changes in 340B savings impact pharmacy services?



Domain 4: Managing 340B

- If 340B requirements were changed, how would that change your staffing requirements for 340B?



Domain 5: 340B Advocacy

- In your view, what policy initiatives would most effectively protect your pharmacy services and 340B revenues?



Appendix Document 3. Final Survey Instrument

Survey Introduction: Thank you for your participation in this survey to learn more about current approaches to pharmacy services among federally qualified health centers (FQHCs) and Look-Alikes in the Episcopal Health Foundation’s [service area](#). This survey will take approximately **10 minutes** to complete. We will share a brief executive summary of findings following the completion of the survey.

For any questions, please contact **Liyana Ido** (Lido@atlasclarity.com).

Section I. Demographic Information

- **Q1.** Organization Name: _____
- **Q2.** Number of Health Center Sites: _____
- **Q3.** Your Role: _____
- **Q4.** City & County: _____

Section II. Structural Arrangements for Pharmacy Services

Q5. Please indicate which types of **pharmacy arrangements your organization currently has** by checking either yes or no for each. **The pharmacy arrangement names refer to ownership, not location.** If you check yes, please specify the number of such pharmacies in the text box that appears.

Type of Pharmacy Arrangement	No	Yes, please specify how many sites of this type
Entity-owned pharmacy (e.g., a pharmacy owned & operated by your organization)		
Contract with independent pharmacy (e.g., a formal contractual arrangement with an outpatient pharmacy that is privately owned by an individual or corporation that has no more than 3 locations)		
Contract with retail pharmacy (e.g., a formal contractual arrangement with an outpatient pharmacy that is privately owned by an individual or corporation that has more than 3 locations)		

Q6. Please indicate which types of **pharmacies your organization has added in the past 12 months** by checking either yes or no for each. **The pharmacy arrangement names refer to ownership, not location.** If you check yes, please specify the number of such pharmacies in the text box that appears.

Type of Pharmacy Arrangement	No	Yes, please specify how many of this type have been added
Entity-owned pharmacy (e.g., a pharmacy owned & operated by your organization)		
Contract with independent pharmacy (e.g., a formal contractual arrangement with an outpatient pharmacy that is privately owned by an individual or corporation that has no more than 3 locations)		
Contract with retail pharmacy (e.g., a formal contractual arrangement with an outpatient pharmacy that is privately owned by an individual or corporation that has more than 3 locations)		

Q7. Which of the following clinical pharmacy services does your organization currently offer? (Check all that apply)

- ☐ Pharmacist-led screening of diabetes patients for A1c levels, follow-up counseling and medication adjustment.
- ☐ Pharmacist-led follow-up and counseling to diabetic patients given continuous glucose monitoring devices.
- ☐ Pharmacist-led counseling of diabetic patients with elevated A1c levels and six-month follow-up.
- ☐ Pharmacist-led reminders and counseling to diabetic patients with elevated A1c levels through medium of texting and of tele-video meetings.
- ☐ Pharmacist-conducted cardiovascular risk clinic for diabetic patients.
- ☐ Pharmacist-conducted annual wellness visits.
- ☐ Pharmacist prescriptions and coupons to local food banks.
- ☐ Pharmacist-led tobacco cessation counseling with pharmacist prescribing of supporting medications.

- ☐ Pharmacist management of prescription refill requests with ability to refill or change medication under a Collaborative Practice Agreement (CPA).
- ☐ Pharmacist dispensing and management of Methadone prescriptions.
- ☐ Pharmacist-led hypertension management clinics.
- ☐ None of the above
- ☐ Other, please specify : [short text]

Section III. Health Center Experiences with 340B

Q8. Which of the following services or programs does your organization try to direct 340B savings to support? (Check all that apply)

- ☐ Sliding fee scales
- ☐ Case management
- ☐ Outreach and enrollment/eligibility services
- ☐ Behavioral health services
- ☐ Dental services
- ☐ Nutrition education and assistance
- ☐ Emergency housing services
- ☐ Transportation
- ☐ Laboratory/x-ray services
- ☐ Other, please specify [short text]

Section IV. Scheduling Follow-Up Discussions

Q9. Would you or a colleague be open to scheduling a follow-up interview with the Atlas Clarity team, in order to better understand how EHF might help organizations like yours to protect and expand pharmacy services and revenues? Honoraria will be provided for interviews.

- ☐ Yes
- ☐ No
- **(If YES):** Please enter your preferred contact information below:
 - Email: _____
 - Phone: _____

Q10. Is there anything else you would like to share about your organization's pharmacy arrangements? [Open text response]

Appendix Document 4: Survey Invitation Language

Dear Community Health Center Leaders,

The Episcopal Health Foundation is committed to protecting and expanding Texas's pharmacy services and 340B savings' revenues. In alliance with the Texas Association of Community Health Centers (TACHC) we are seeking to understand how our FQHCs and Look-Alikes can be protected from 340B revisions. To that end, we have retained our research partner [Atlas Clarity](#) to better understand the pharmacy services and 340B landscape for FQHCs in Texas. **Your perspectives are essential for us at EHF and TACHC to better support your pharmacy services and 340B revenue through grant funding and policy advocacy.**

In order to gather your input, we are asking that you or a colleague at your organization complete this brief (~ 10 minute completion time) survey [insert link]. At the end of the survey, you will be asked whether you would also be willing to participate in a semi-structured interview for which there will be an honoraria of \$100. You will receive an email from Atlas Clarity Research Manager Liyana Ido (lido@atlasclarity.com) in the coming weeks regarding your survey status or interview scheduling. We appreciate any information you are able to share with us to strengthen our financial, strategic, and advocacy support for FQHC pharmacy services.

Thank you,

Briana Martin (she/her), MSPE
Research and Policy Officer
BMartin@EpiscopalHealth.Org
Episcopal Health Foundation

Appendix Document 5: Semi-Structured Interview Guide

Phase Three: Semi-Structured Interviews

Interview Introduction: Thank you for your participation in today's discussion. We welcome feedback from your perspective to better understand patterns in existing pharmacy services and the impact of the 340B program across health centers in the state of Texas. This interview will take approximately **30 minutes** to complete.

Your comments in this interview will help us prepare a report for the Episcopal Health Foundation on how they can best support Community Health Centers (CHC), like yours, in their service area to enhance and protect their pharmacy services. The report will not identify any comments you make as coming from you or from your CHC. Do you have any questions before we get started?

Do we have your consent to audio record and transcribe today's interview for our notetaking purposes? The recording will be stored on the Atlas Clarity servers and only available to our internal team members. All transcripts will be destroyed after our report is submitted.

I. Introduction

- Can you briefly describe your role and responsibilities at your organization?

NOTE: Interviewer to refer to information compiled from the submitted survey, Uniform Data System and the organization's public-facing website where available to confirm accuracy for the next three questions.

- How many clinical sites (community healthcare sites) does your organization have?
- On average, how many patients does your organization treat annually across all sites?
- Roughly what would you say is the mix of insurance held by your patient population?

II. Pharmacy Structures

First, we would like to ask a few questions about your current pharmacy structure and services. We would like to confirm information from your survey for your organization's numbers and locations of entity-owned and contract pharmacies. We are using these terms to refer to a pharmacy owned and operated by your organization and / or a formal contractual arrangement with an outpatient pharmacy.

NOTE: Interviewer should refer to survey responses and ask if this information is correct.

- Can you describe the staff you currently have to support these pharmacies?

- **Probe:** Roughly, how many pharmacists and pharmacy techs and other staff devoted to pharmacy administration and services do you have across all pharmacies?
- **Probe:** How many staff members currently support the financial or administrative work required to fulfill 340B requirements?
- In your view, is your current staffing sufficient for your organization's needs/ to keep up with current 340B requirements?
 - **Probe:** Has the number of FTEs supporting 340B changed in the last year? If so, how?

(If respondent reports having an entity-owned pharmacy)

- How long have you maintained an entity-owned pharmacy?
- What advantages have you experienced with having an entity-owned pharmacy, if any?
- What disadvantages have you experienced with having an entity-owned pharmacy, if any?
- How would you estimate the penetration rate of your entity-owned pharmacy? (that is, the percentage of scripts written that are filled in your entity owned pharmacy)
 - **Probe:** Is your organization currently implementing any tactics to increase this penetration? If yes, briefly describe.
 - **Probe:** Are there any resources or support that would help you to take desired measures to increase penetration?
- Have you observed any patterns in patients using the entity-owned pharmacy vs contract pharmacies? (e.g., trends in age, gender, insurance status, chronic disease status)

(If respondent reports not having an entity-owned pharmacy)

- *(Time permitting)* What advantages have you experienced in working with contract pharmacies, if any?
- *(Time permitting)* What disadvantages have you experienced in working with contract pharmacies, if any?
- From your perspective, would there be interest from your organization in adding an entity-owned pharmacy? Please describe your rationale.
 - **(If yes) Probe:** What would be the goals in adding an entity-owned pharmacy? (e.g., higher pharmacy revenues that are not shared with contract pharmacy, better coordination with clinicians, more clinical pharmacy services, more 340B savings, protection from 340B changes)
 - **Probe:** In your view, what assistance would be most helpful for adding an entity-owned pharmacy? (e.g., dedicated training, planning / start up grant)

NOTE: Interviewer should include the final question in this section for all interviewees, regardless of whether or not the organization currently has an entity-owned pharmacy.

- Across the next twelve months, does your organization plan to change the mixture of entity-owned and contract pharmacies?
 - (If **yes**) Can you describe what the change(s) are and what is motivating this planned change?
 - (If **no**) Can you describe why there is no change planned across the next twelve months?
 - **Probe:** No need to change the existing mix? (e.g., pharmacy resources and access are perceived as adequate)
 - **Probe:** Barriers preventing the organization from changing the existing mix?

III. Pharmacy Services

- Do your pharmacies offer services beyond dispensing? (i.e., clinical pharmacy services)
 - **NOTE:** Interviewer should refer to survey response and ask interviewee to confirm or revise what is listed on the survey responses.
 - (Time permitting) **Probe:** In your experience, how does the pharmacist engage with the larger patient care team?

(If respondent reports organization does offer clinical pharmacy services)

- In your view, what do you see as the benefits to your **patients** of offering clinical pharmacy services?
- (Time permitting) Does your organization have any patient outcomes data for clinical pharmacy services?
- In your view, what are the benefits to your **clinicians** of offering clinical pharmacy services?
- Are you able to get coverage and reimbursement for these services? Do you use collaborative care agreements to get coverage?

(If respondent reports organization does not offer clinical pharmacy services)

- In your view, why does your organization not offer clinical pharmacy services today?
 - **Probe:** No unmet needs among patient population?
 - **Probe:** Sufficient staffing by PCPs, NPs, and CHWs?
 - **Probe:** Lack of Medicaid coverage in Texas for clinical pharmacy services?

NOTE: Interviewer should include the final question in this section for all interviewees, regardless of whether or not the organization currently offers clinical pharmacy services.

- Across the next twelve months, does your organization plan to offer (additional) clinical pharmacy services?
 - (If **yes**) What assistance would be most helpful in expanding clinical pharmacy services?

IV. Pharmacy Revenues

- To the best of your knowledge, roughly how much savings does your organization earn from the 340B program on an annual basis?
- Has this changed over the last twelve months?
 - (If **yes**) What would you attribute this change to?
- Do you anticipate any changes in 340B revenue across the next twelve months?
 - (If **yes**) Can you describe what changes in revenue you anticipate and why?
- How do changes in 340B savings impact your pharmacy and clinical services?

V. Managing 340B Under Current and Proposed Changed Regulations

- Has your organization experienced any changes related to the 340B program? If yes, please describe the changes and the impact on your organization.
- Of the potential additional changes to 340B, which would have the greatest impact on your organization?
 - **Prompt:** Impact of claims-level data requirements?
 - **Prompt:** Impact of replacing discounts at the time of purchase with back-end rebates?
 - **Prompt:** Impact of limiting your organization to accessing 340B drugs at one in-house pharmacy and one contract pharmacy?
 - Any others?

VI. 340B Advocacy

- In your view, what policy initiatives would most effectively protect your pharmacy services and 340B revenues in Texas?
- The Episcopal Health Foundation has identified some priority areas for their grant portfolio. Do you have any ongoing or planned pharmacy initiatives to support these areas/groups?
 - **Probe:** Food insecurity
 - **Probe:** Patients with diabetes
 - **Probe:** Expanding maternal health services
 - **Probe:** Improving access through services like home delivery, telemedicine, or mail-order delivery

Interview Closing:

Please share any additional details that you think would be helpful in better understanding your perspective on the current status of pharmacy services and 340B implementation in your organization.

Thank you again for your participation in today's discussion. If it is of interest, we are happy to share an unedited version of today's transcript so that you can amend any of the information you shared with our team.

To process the honorarium for today's interview, you will receive a \$100 Amazon digital gift card within **72 hours** of today's interview. This honorarium will come from Jeffrey Berko on the Atlas Clarity team. Feel free to email him at JBerko@atlasclarity.com if there is any delay in receipt, or if you have any questions on this interview.

ⁱ National Association of Community Health Centers. *Pharmacy Services in CHCs: A Cornerstone of Comprehensive Care*. Bethesda, MD: National Association of Community Health Centers, January 22, 2026.

ⁱⁱ Horstman, Celli, et al. *Community Health Centers' Progress and Challenges in Meeting Patients' Essential Primary Care Needs: Findings from the Commonwealth Fund 2024 National Survey of Federally Qualified Health Centers*. New York: The Commonwealth Fund, August 8, 2024. <https://doi.org/10.26099/wmta-a282>

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^{iv} Abou-Karam, Nada M., Melissa E. Jump, Jingying Jiao, and Andrew N. Schmelz. "Pharmacist-Physician Split-Shared Visits in a Federally Qualified Health Center: Lessons Learned from a Novel Reimbursement Model Using Telehealth." *Innovations in Pharmacy* 13, no. 1 (2022). <https://doi.org/10.24926/iip.v13i1.4451>.

^v Moczygemba, Jackie R., Kelly E. Meyers, Lauren C. Williams, et al. "Clinical and Financial Outcomes of a Pilot Pharmacist-Led Continuous Glucose Monitoring Clinic." *Journal of the American Pharmacists Association* 64, no. 4 (2024): 102150. <https://doi.org/10.1016/j.japh.2024.102150>.

^{vi} Rochester-Eyeguokan, Charmaine D., Kathleen J. Pincus, Olufunke M. Sokan, and Hyunuk Seung. "The Impact of a Pharmacist-Led Comprehensive Diabetes Management Program in a Federally Qualified Health Center." *Journal of the American Pharmacists Association*, 2025. <https://doi.org/10.1016/j.japh.2025.102399>.

^{vii} Ekenga, Veronica, Carla White, Julie M. Akers, et al. "Impact of Collaborative Chronic Care Management with Remote Patient Monitoring in Federally Qualified Health Centers." *Journal of the American College of Clinical Pharmacy* 7, no. 3 (2024): 262–270. <https://doi.org/10.1002/jac5.1967>.

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^{xi} Gallegos, Nancy, Laura Fitzgerald, Andrea Versackas, et al. "Improving Organizational Sustainability of an Urban Indian Health Clinic with an Innovative Pharmacy Model." *Journal of Primary Care & Community Health* 13 (2022): 1–7. <https://doi.org/10.1177/21501319211069750>.

^{xii} Tab 2/#17 and 20 and 23

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- ^{xviii} National Association of Community Health Centers. *A Primer on Health Center Pharmacy Operations*. Bethesda, MD: National Association of Community Health Centers, 2023. <https://www.nachc.org/wp-content/uploads/2023/03/A-primer-on-health-center-pharmacy-operations.pdf>.
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- ^{xxiv} National Association of Community Health Centers. *State-Level 340B Laws and Legislation Tracker*. Bethesda, MD: National Association of Community Health Centers, April 15, 2026. https://www.nachc.org/wp-content/uploads/2026/04/4_15_26_nachc_state-level-340b-laws-and-legislation_tracker.pdf.
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