

December 24, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue S.W.
Washington, D.C. 20201

RE: Medicare Negotiated Drug Prices and LTC Pharmacies

Dear Administrator Oz,

I am writing on behalf of the Senior Care Pharmacy Coalition (SCPC) regarding the Memorandum dated December 23 from Vanessa Duran, the Director of the Medicare Drug Benefit and C&D Data Group, to All Medicare Prescription Drug Plans (Plans) reminding them of their obligation to provide convenient access and reasonable dispensing fees for selected drugs (drugs subject to Medicare price negotiations or “MFP” drugs) to long-term care (LTC) pharmacies. Beginning in 2024, we have had ongoing discussions with CMS concerning the unique problem Medicare price negotiations create for LTC pharmacies and are grateful for the agency’s ongoing efforts – particularly the memoranda issued on August 25, December 5, December 23 - to persuade Plans to address these unique economic issues through market-based solutions. We also appreciate the statutory limitations on the agency’s ability to direct Plans regarding contract negotiations with LTC pharmacies.

Despite the agency’s best efforts to encourage Plans and the PBMs that represent them to achieve market-driven solutions, Plans and their PBMs simply have not responded effectively, such that the market has failed. CMS has the statutory authority to save LTC pharmacies from catastrophic market failure and protect Medicare beneficiaries living in LTC facilities from the consequences of such failure. For the reasons explained below, we respectfully submit that the time has come for CMS to exercise this authority and urge CMS to act now.

The financial viability of LTC pharmacies depends on appropriate reimbursement from Plans for brand name drugs. 75% of LTC pharmacy revenues are from the Part D program. Plans reimburse ingredient costs for generic drugs at break-even rates and pay dispensing fees that on average cover only 25% of the costs LTC pharmacies must incur to meet the LTC pharmacy service requirements imposed by federal law. These losses are more than two billion dollars annually, since LTC pharmacies lose roughly \$11 on each prescription of the more than 200 million prescriptions they dispense to Part D beneficiaries each year. Hence, LTC pharmacies must rely on appropriate reimbursement for brand name drugs to offset these losses and to provide sufficient operating margin so LTC pharmacies can manage debt service, pay taxes, and reinvest to maintain and grow their businesses. We note that Plans and their PBMs have imposed this perverse payment model on LTC pharmacies to align with their own financial incentives.

The Medicare drug price negotiation provisions of the Inflation Reduction Act (IRA) are designed to eliminate all LTC pharmacy margin on brand name drugs subject to price negotiations. Eight of the ten drugs subject to price negotiations for 2026 and twelve of the fifteen drugs subject to price negotiations for 2027 are frequently prescribed to Medicare beneficiaries in LTC facilities. As a result, the impact of MFPs on the LTC pharmacy sector will be devastating over the next two years.

The agency's ongoing efforts regarding this problem demonstrate that both CMS and the LTC pharmacy community agree that we are on the cusp of a crisis in the LTC delivery system next year. As of today, one week before negotiated prices take effect, SCPC understands that several LTC pharmacy negotiating entities (either large LTC pharmacy companies capable of direct negotiations with PBMs on behalf of Plans or Pharmacy Services Administrative Organizations [PSAOs] representing large groups of smaller LTC pharmacy companies in such negotiations) have been unable to negotiate acceptable contracts with at least one of the four major PBMs – Caremark, Optum, ExpressScripts, and Humana – for 2026. As a result, hundreds of thousands of Medicare beneficiaries in LTC facilities are at risk of losing access to network LTC pharmacies next week.

The December 5 Memorandum asked Plans to confirm to CMS no later than December 20 that they had contracts in place with pharmacies that are members of the SPS Health PSAO. Given the need for the December 23 Memorandum, it is evident that many of the Plans failed to meet the December 20 deadline. It also seems likely that CMS knows this problem is not unique to the SPS Health PSAO.

The current situation underscores that a LTC delivery system crisis is looming for the new year, which will impact not only LTC pharmacies, but Medicare beneficiaries, LTC facility residents, and LTC facilities. Moreover, if Plans violate Part D requirements by failing to demonstrate that they meet LTC pharmacy network adequacy and convenient access standards, CMS would be forced to consider Plan terminations consistent with codified enforcement actions, which could further threaten the stability of the entire Part D program.

SCPC and its sister organization, the American Society of Consultant Pharmacists (ASCP), completed a survey of their joint memberships this month. We plan to release the results publicly next week. The results paint a bleak picture for 2026:

- The survey respondents represent almost 20% of the estimated 1,400 closed-door LTC pharmacies serving patients in LTC facilities.
- The survey respondents serve about 40% of all patients in LTC facilities across the country. About 35% of these patients live in facilities in rural areas of the country.
- 84% of respondents will reduce services or stop serving facilities or regions entirely. This will disproportionately impact Medicare beneficiaries in rural areas. In some cases, lack of access to LTC pharmacy services could lead to closure of skilled nursing facilities, nursing facilities, and intermediate care facilities.

- 78% of respondents will lay off essential LTC pharmacy staff. These layoffs have already started.

Put simply, reliance on market-driven solutions has failed. The government has intervened in the market through direct price negotiations with manufacturers and by capping Plan ingredient cost reimbursement for MFP drugs but has not addressed the adverse impact of the resultant market distortions on LTC pharmacies. The need for ongoing CMS admonitions to Plans demonstrates that the market is failing and that reminders, while appreciated, are not sufficient to prevent a LTC market crisis in 2026.

In this regard, we note that negotiating power dynamics between LTC pharmacies and market-dominant PBMs, which negotiate on behalf of large groups of Plans in a single contract negotiation, disproportionately and often unfairly favor the PBMs. Unlike retail pharmacies, LTC pharmacies cannot simply decline participation in Part D networks. A LTC pharmacy is legally obligated to serve every patient in a LTC facility, whether or not the LTC pharmacy has a contract with the relevant payer. In addition, if a LTC pharmacy does not serve every patient in a facility, the LTC pharmacy contract with the facility is at risk. PBMs and Plans understand and exploit these dynamics to force LTC pharmacies to accept inadequate reimbursement terms (e.g., dispensing fees that cover only 25% of costs). Before Medicare drug price negotiations, cost-shifting from break-even ingredient cost reimbursement for generics and substantial losses from inadequate dispensing fees to reimbursement for brand ingredient costs has allowed LTC pharmacies to survive. The Medicare drug price negotiation provisions, however, will break the precarious LTC pharmacy reimbursement model that Plans and their PBMs have created.

The December 23 Memorandum reminds Plans that they must contract with “any willing pharmacy.” “Any willing pharmacy” contracts will not prevent market failure. Plans routinely offer “any willing pharmacy” contract terms that are worse than the terms they otherwise negotiate or would have negotiated with LTC pharmacy negotiating entities, and pharmacies rarely sign such contracts. If Plans rely on the “any willing pharmacy” provision in an attempt to satisfy the LTC pharmacy network adequacy and convenient access requirements, LTC pharmacies either will be forced to accept unsustainable “any willing pharmacy” contract terms or will refuse to accept those terms. Either outcome – both of which could occur next year– would precipitate the very crisis both CMS and SCPC seek to avoid.

We understand, of course, that the IRA created an exception to the non-interference clause to implement the Medicare price negotiation program, but not to assure adequate LTC pharmacy reimbursement. Fortunately, CMS does have separate statutory authority to waive the non-interference clause. Section 402 of the Medicare statute, 42 U.S.C. § 1395b-1(a)(1), grants the Department of Health and Human Services broad authority to engage in demonstration projects – including system-wide demonstration projects – encompassing changes to “methods based on negotiated rates,” provided that a demonstration meets certain statutory criteria. Since the inception of the Part D program in 2006, CMS has invoked this authority four times to address issues regarding the effective operation of the program. This authority has been used under both Republican and Democratic Administrations, most recently by the Trump Administration earlier

this year. We respectfully submit that CMS must use this provision once again to resolve the looming LTC delivery system crisis.

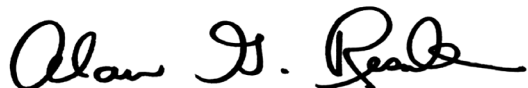
We also understand that the entire pharmacy community – retail as well as LTC – have deep concerns regarding implementation of the drug pricing program, including concerns that the process will not roll out smoothly and concerns regarding the cash flow issues associated with manufacturer reconciliation payments. Due to significant market differences between LTC and retail pharmacies, the implications of potential implementation problems are more severe for LTC pharmacies than for retail pharmacies.

Nonetheless, the certain impact of negotiated price drugs dwarfs the potential impact of implementation problems for LTC pharmacies. The impact of negotiated prices is unique to LTC pharmacies and has ramifications that threaten stability of the entire Part D program. This unique problem requires a targeted solution, and our proposed solution has the support of LTC pharmacies and community retail pharmacies alike.

We therefore respectfully and urgently renew our request that CMS exercise its authority to implement a two-year, nationwide Part D demonstration project that will provide LTC pharmacies with an additional supply fee for drugs subject to Medicare price negotiations. This is a solution that many Congressional leaders support, and that will avoid an imminent LTC delivery system crisis. CMS has the clear statutory authority to act, and we urge the agency to do so promptly.

Thank you for your ongoing attention to this crucial issue.

Respectfully submitted,



Alan G. Rosenbloom
President & CEO
Senior Care Pharmacy Coalition

cc: John Brooks, Deputy Administrator and Chief Policy and Regulatory Officer
Lara Strawbridge, Deputy Director for Policy, Medicare Drug Rebate Negotiations Group
Chris Klomp, Director, Medicare, and Deputy Administrator
Vanessa Duran, Director, Medicare Drug Benefit and C&D Data Group