



■ 1700 Pennsylvania Avenue, NW
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February 25, 2026

Dear Dr. Oz,

We appreciated the opportunity to meet you and your team in January. During our discussion, you invited us to provide recommended actions CMS could take within the agency's existing statutory authority that would level the negotiating playing field between long term care pharmacies (LTC pharmacies) and Part D Plan Sponsors (Plan Sponsors) and the pharmacy benefit managers (PBMs) that represent them in Part D contract negotiations. Your invitation arose from our discussion of the precarious state of the LTC pharmacy sector due to years of PBM abuse and the ways in which the Medicare Drug Price Negotiation Program (MDPNP) threatens LTC pharmacy market collapse, which could jeopardize access to LTC pharmacy services for Medicare beneficiaries who need LTC in both LTC facilities and other care settings.

In response to your invitation, we offer eight actionable recommendations that would level the contractual playing field, allow LTC pharmacies to negotiate sustainable contracts with Plan Sponsors/PBMs, and protect beneficiary access to essential services that only LTC pharmacies provide.

We recognize that, since our meeting, Congress enacted the Consolidated Appropriations Act of 2026, which directed CMS to define "reasonable and relevant" Part D contract terms in regulation and establish penalties for Plan Sponsor/PBMs that do not offer such terms.¹ We believe that CMS would have had the statutory authority to adopt our recommendations without Congressional action, and therefore that CMS has the authority to implement our recommendations independent of the regulatory process to determine "reasonable and relevant" contract terms. In particular, for reasons discussed in each recommendation, we believe CMS can and should implement our recommendations sooner than the timeline for developing "reasonable and relevant" regulations. At minimum, however, CMS should include these recommendations in its proposed regulations to implement this provision of the Consolidated Appropriations Act.

The recommendations below are presented in order of implementation timeline, beginning with solutions we believe CMS can implement most quickly to provide immediate relief, followed by those that may require a longer implementation timeframe. Our ordering does not indicate level of priority or importance, which we have instead tried to capture in the description of the recommendation.

¹ Consolidated Appropriation Act, 2026, Sections 6223, available at <https://www.congress.gov/bill/119th-congress/house-bill/7148/text>.

1. Incentivize or Require that Plan Sponsors/PBMs Complete Contract Negotiations with LTC Pharmacies by October 1 for Next Contract Year (CY)

Problem

As the two most recent contracting cycles have demonstrated, Part D sponsors, including their first tier, downstream, or related entities (FDRs) – particularly PBMs (collectively, Plan Sponsors/PBMs) consistently do not enter into network participation agreements with LTC pharmacies before the start of the annual open enrollment period for the next Contract Year, which begins annually on October 15. In fact, Plans/PBMs often do not enter into such agreements before the end of the annual enrollment period, which occurs annually on December 7 for the next Contract Year. For both Contract Years 2025 and 2026, at least one Plan Sponsor/PBM did not conclude agreements with a significant number of LTC pharmacies until January for the then-current Plan Year.

There is no deadline by which Plans/PBMs must enter into agreements with LTC pharmacies, and current regulations give Plan Sponsors/PBMs no incentive to finalize contracts with LTC pharmacies before the annual enrollment begins. Absent such incentives, Plan Sponsors/PBMs delay finalizing contracts to exploit already existing unfair market advantage. This practice creating significant uncertainty for beneficiaries – particularly beneficiaries in LTC facilities – regarding access to care, and forces LTC pharmacies to choose between accepting unsustainable contract terms or risking the loss of all the patients it serves in LTC facilities, not only those patients covered by plans which a particular plan sponsor/PBM offers, because a LTC pharmacy is contractually obligated to serve all patients in a given LTC facility.

Recommended CMS Action

Timing: Plan Year 2027 (Immediate Finalization)

Priority/Impact: Very High

We strongly recommend that, as part of the CY 2027 Medicare Advantage and Part D Final Rule (the CY 2027 Rule), CMS finalize a provision included in the CY 2026 Medicare Advantage and Part D Proposed Rule (the CY 2026 Propose Rule) which would have required “Part D sponsors (or first tier, downstream, or related entities (FDRs), such as pharmacy benefit managers (PBMs), on the sponsors’ behalf) to notify network pharmacies which plans the pharmacies will be in-network for in a given plan year by October 1 of the year prior to that plan year and to require sponsors to provide pharmacies a list of these plans to network pharmacies on request after October 1.”² In proposing this

² CY 2026 Medicare Advantage and Part D Proposed Rule (CMS-4208-P), 89 Fed. Reg. 99340, 99342 (December 10, 2024). See also 89 Fed. Reg. at 99381.

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provision, CMS stated that these changes are “necessary to ensure that pharmacies can provide their customers with accurate information about which plans the pharmacy is participating in.”³ Since Plan Sponsors/PBMs could not comply with these provisions unless contracts with LTC pharmacies were final by October 1, finalizing this proposed regulation would create strong incentives for Plan Sponsors/PBMs to complete contracts with LTC pharmacies by October 1. We also recommend that CMS specifically require Plan Sponsors/PBMs to finalize contracts with LTC pharmacies by October 1 for the next CY.

2. Reasonable and Reciprocal Term and Termination Provisions

Problem

Plan Sponsors/PBMs often lock pharmacies into long-term, multi-year contracts that have unilateral or otherwise onerous termination provisions. The most egregious include unilateral provisions allowing **only** the Plan Sponsor/PBM to terminate the contract without cause or bilateral termination without cause that require LTC pharmacies to provide notice of cancellation as long as 12 months in advance. In the CY 2026 Proposed Rule, CMS observed that such practices as PBM abuse, noting that they skew negotiation dynamics and leave pharmacies with limited recourse during major market shifts.⁴ The inability to renegotiate these multi-year contracts has exacerbated the financial impact of the MDPNP on LTC pharmacies.

Recommended CMS Action

Timing: Plan Year 2027 (Immediate Finalization)

Priority/Impact: High

We strongly recommend that CMS, as part of the Final Rule for CY 2027, CMS finalize another provision in the CY 2026 Proposed Rule which would require reciprocal termination without cause provisions in all contracts between LTC pharmacies and Plan Sponsors/PBMs. We also recommend that CMS require that Plan Sponsors/PBMs include termination notice provisions no longer than 60 days in contracts with LTC pharmacies.

3. Assure that LTC Pharmacy Network Status and Related Information on Medicare Plan Finder is Timely and Accurate

³ Id. at 99381.

⁴ See the CY 2026 Medicare Advantage and Part D Proposed Rule (CMS-4208-P) (the reference concerns only unilateral without cause termination rights).

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Problem

Plan Sponsors/PBMs consistently fail to identify whether LTC pharmacies are “in-network” on Medicare Plan Finder (MPF) frequently fails to identify whether LTC pharmacies are in-network, often automatically classifying LTC pharmacies as out-of-network unless they are also included in a retail pharmacy network. In addition, when Plan Sponsors/PBMs accurately identify LTC pharmacies as in-network, they often mistakenly state that beneficiaries who select in-network LTC pharmacies would have a 100% co-pay. By including such inaccurate information on MPF, beneficiaries - particularly those in LTC facilities who are disproportionately dually eligible with complex needs – must make plan choices and select LTC pharmacies based on inaccurate information, potentially leading to gaps in access to necessary care.

Some Plan Sponsors/PBMs have recently attempted to weaponize such inaccurate information and their own unwillingness to reach contract agreements with LTC pharmacies by informing beneficiaries after they have enrolled in their Part D plan that the LTC pharmacy partnering with the facility in which they reside is out-of-network. These beneficiaries are left confused and distressed over the possibility of losing access to affordable drug coverage, with few, if any, options available post-open enrollment. While relevant to this recommendation, it is also relevant to the first recommendation. If contracts were finalized before the open enrollment period begins, Plan Sponsors/PBMs would not be able to weaponize the process as they have in recent years.

Recommended CMS Action

Timing: Plan Year 2027

Priority/Impact: Very High

We recommend that CMS update MPF requirements to explicitly require Plan Sponsors/PBMs to identify which pharmacies are in their LTC pharmacy networks and to assure the accuracy of information concerning each in-network LTC pharmacy, and to do so before the beginning of each enrollment period. Ensuring that this information is displayed accurately and timely is essential for beneficiaries, particularly those residing in LTC facilities, to make informed choices regarding competing Part D plans. Addressing this problem aligns with recent CMS initiatives to improve provider directories and would ensure that beneficiaries have the information they need to choose plans that provide access to necessary medications and services.

Historically, CMS has not required that Plan Sponsors/PBMs display accurate and timely information concerning LTC pharmacy network status on MPF because LTC pharmacies are not public-facing pharmacies that beneficiaries access directly (e.g., like “walk-in” pharmacies). However, beneficiaries in LTC facilities or who choose to use LTC pharmacies in other settings must choose their Part D plans annually, and, consistent with

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the agency's other initiatives to assure that consumers have timely and accurate information on which to base health care decisions, CMS should address this issue. Rather than inadvertently allowing Plan Sponsors/PBMs to use this CMS practice to create additional leverage in negotiations with LTC pharmacies, to the detriment of beneficiaries. Beneficiaries should be able to choose the plan that best fits their needs, including in-network coverage of Part D benefits.

4. Penalty for Plans Failing to Contract with LTC Pharmacies

Problem

In the last two years, as market dynamics have adapted to the Medicaid drug manufacturer rebate changes in the American Rescue Act⁵ and the MDPNP in the Inflation Reduction Act,⁶ Plan Sponsors/PBMs have become more intransigent in contract negotiations with LTC pharmacies. For CY 2026, CMS issued three extraordinary guidance memoranda to Plan Sponsors concerning the need to contract with LTC pharmacies to meet convenient access and LTC pharmacy network adequacy requirements.⁷ While CMS requires Part D Plans to maintain convenient access to LTC pharmacies, the agency seemingly has not established penalties for Plan Sponsors/PBMs that fail to meet this requirement. Plan Sponsors/PBMs exploit the lack of enforcement and potential penalties for non-compliance to delay contracting to the detriment of beneficiaries and LTC pharmacies, as described more fully in our prior recommendations.

Recommended CMS Action

Timing: Plan Year 2027 or 2028

Priority/Impact: Very High

CMS can address this in two ways:

1. **Enrollment Flexibility:** Clarify that Medicare beneficiaries who need long-term care, particularly those residing in skilled nursing facilities (SNFs), nursing facilities (NFs), intermediate care facilities (ICFs), and assisted living facilities (ALFs) - may use a Special Enrollment Period (SEP) to change Part D plans if the Plan Sponsor/PBM which owns or operates their current Part D plan fails to enter into a

⁵ P.L. 117-169, available at <https://www.congress.gov/bill/117th-congress/house-bill/5376/text>.

⁶ P.L. 117-2, available at <https://www.congress.gov/bill/117th-congress/house-bill/1319>.

⁷ See CMS Memo to Plans, August 25, 2025 ("we expect Part D plan sponsors' dispensing fees to sufficiently compensate network pharmacies so that enrollees can be assured network access to selected drugs"); CMS Letter to Health Plans, December 5, 2025 (reminding plans that "all of a Part D sponsor's enrollees who reside in an LTC facility must be able to routinely receive their Part D benefits through the plan's network of LTC pharmacies"); CMS Memo to Plans, December 23, 2025 (reminding Plans of "obligation to work with long-term care (LTC) pharmacies and LTC facilities to provide beneficiaries residing in LTC facilities required access to Part D drugs"); SCPC Letter to Dr. Oz, December 24, 2025 (noting crisis in LTC pharmacy).

LTC network pharmacy agreement by the beginning of the Contract Year. Furthermore, such a clarification would be consistent with previous CMS guidance pertaining to dispensing fees for Part D beneficiaries who need LTC and reside in ALFs or in the community.⁸

- 2. Reimbursement Protection:** Clarify that if a beneficiary resides in an LTC setting and the available LTC pharmacy is out-of-network because the Plan Sponsor/PBM fails to contract with the LTC pharmacy by the beginning of the Contract Year, the Plan Sponsor/PBM must reimburse the LTC pharmacy its full usual and customary rate until such time as the beneficiary has transition to an in-network LTC pharmacy or the Plan Sponsor/PBM finalizes a contract with the LTC pharmacy in question. This ensures the pharmacy is paid fairly while deemed out-of-network, thereby reducing the current incentive for Plan Sponsors/PBMs to delay finalizing contracts into a new Contract Year to create undue market pressure on LTC pharmacies to accept unsustainable reimbursement rates.

CMS has the authority to implement this recommendation through guidance or under 42 CFR § 423.124. The out-of-network regulation, 42 C.F.R. § 423.124(b), already provides CMS with discretion to direct how payments to out-of-network pharmacies operate, but the regulation does not clearly state whether the plan sponsor/PBM must pay the pharmacy in full and then reconcile with the beneficiary, or whether the beneficiary must pay the pharmacy and seek reimbursement from the Plan Sponsor/PBM should the plan's out-of-network benefit requires the latter. The regulation also provides Plan Sponsors/PBMs considerable flexibility to determine how much of an out-of-network charge they will cover. We recommend that CMS clarify § 423.124 to require that the plan allowance must be at least 75% of the pharmacy's usual and customary price, aligning the regulation with the statutory requirement that all Part D plans must offer at least the standard benefit (i.e., 75% coverage of costs in the initial coverage phase).

5. Address Inadequate Reimbursement for LTC Pharmacy Costs to Comply with Federal Service Requirements

Problem

Due to their unfair and disproportionate market power, Plan Sponsors/PBMs have created a perverse LTC pharmacy reimbursement model that forces LTC pharmacies to rely on high margins from ingredient cost reimbursement for brand name drugs to offset substantial losses on the cost of LTC pharmacy services. Both Medicare Part D standards⁹ and

⁸ See Medicare Prescription Drug Manual, Chapter 6, Section 20.7; CMS Memo to Plans, December 15, 2021, available at <https://ncpa.org/sites/default/files/2021-12/partddispfeeinstlevelcareneed.pdf> (each authorizing payment of LTC dispensing fee for any beneficiary with a long-term care level of need, irrespective of where that beneficiary resides).

⁹ Medicare Prescription Drug Manual, Chapter 5, Section 5.2.

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Medicare and Medicaid Pharmacy Services Requirements of Participation for LTC facilities, impose substantial service obligations on LTC pharmacies, the latter of which devolve to LTC pharmacies through contracts with LTC facilities. On average, it costs a LTC pharmacy roughly \$15.50 to dispense one prescription drug in compliance with these legal obligations.¹⁰ By contrast, dispensing fees – the only reimbursement for services that LTC pharmacies receive – average about \$4.00 per prescription. Essentially, LTC pharmacies lose about \$11.00 on the cost of services for each of the more than 200 million prescriptions they dispense to Part D beneficiaries each year. Given the MPDNP and other government-led efforts to reduce drug prices for Part D beneficiaries and other consumers, LTC pharmacies can no longer sustain a loss of more than \$2 billion annually on the provision of services. It is essential that CMS assure adequate reimbursement for the costs of compliance with LTC pharmacy service obligations.

Recommended CMS Action

Timing: Plan Year 2027 or 2028

Priority/Impact: Very High

We recommend that CMS assure that Plan Sponsors/PBMs adequately reimburse LTC pharmacies for the cost of compliance with their legally mandated service requirements, while giving Plan Sponsors/PBMs appropriate flexibility to negotiate contracts with LTC pharmacies. In particular, we recommend that CMS should require that Plan Sponsors/PBMs establish a floor for LTC pharmacy dispensing fees or other payment for LTC pharmacy services. While the "non-interference" clause prevents CMS from instituting a specific price structure, setting a floor for LTC ingredient costs or dispensing fees – or clarifying that unreasonably low rates are *not* "reasonable and relevant" – is a necessary guardrail to ensure market viability. It should be noted that CMS has previously provided that the agency can create such standards notwithstanding the non-interference clause, in implementing the statutory any willing pharmacy requirements¹¹ and has even clarified that unreasonably low reimbursement terms for specialty drugs would contravene the any willing pharmacy requirements.¹² We believe defining price floors would fit within those prior statements on CMS's authority and application of the any willing pharmacy requirements.

We recognize that the Consolidated Appropriations Act of 2026 created broader authority for CMS to regulate PBM practices, CMS has separate authority under its existing "reasonable and relevant" regulatory guidance authority to address this problem before finalizing regulations required by the Consolidated Appropriations Act. Should the agency decide against acting immediately, however, we urge that CMS include this

¹⁰ https://seniorcarepharmacies.org/wp-content/uploads/CLA_Long-Term_Care_Pharmacy_Cost_Analysis.pdf.

¹¹ 83 FR 16440, 16590.

¹² Medicare Prescription Drug Benefit Manual, Chapter 5, Section 50.3.

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recommendation in the proposed regulations implementing the new PBM oversight provisions.

6. Assure Good Faith Plan Sponsor/PBM Adherence to Contract Terms

Problem

Plan Sponsors/PBMs often do not adhere to contract terms. Plan Sponsors/PBMs consistently reimburse LTC pharmacies less than their contracts require, forcing LTC pharmacies into costly arbitration and litigation processes that delay full reimbursement to LTC pharmacies for years. Moreover, such cases settle shortly before hearings or trials. Plan Sponsors/PBMs routinely demand that settlement agreements be confidential, such that LTC pharmacies cannot demonstrate to CMS that Plan Sponsors/PBMs fail to comply with the contract terms to which they have agreed.¹³ Relevant regulations include the “any willing provider” requirement and the existing “reasonable and relevant” requirement become meaningless when PBMs routinely flout contract terms that inform such regulatory provisions, and given that taxpayer dollars designed to assure that Part D beneficiaries who need LTC have access to LTC pharmacy services, CMS should become better stewards of the public fisc by actively and directly assuring that Plan Sponsors/PBMs comply in good faith with contract terms regarding LTC pharmacy reimbursement.

Recommended CMS Action

Timing: Plan Year 2027

Priority/Impact: Very High

We recommend that CMS implement robust audit mechanisms to ensure that Plan Sponsors/PBMs adhere to the terms of their contracts and comply with all relevant Part D regulatory requirements. “Paper verification” has proven insufficient. CMS must actively assure that Plan Sponsors/PBMs are complying with their contracts and comply with Part D regulations. As with prior recommendations, while we believe CMS may implement this recommendation within the statutory authority that existed before the 2026 Consolidated Appropriations Act, at minimum CMS should include an active audit process to assure good faith contractual compliance in its proposed regulations implementing the new PBM reform provisions.

¹³ See, e.g., MHA Long Term Care Network, Inc. v. Express Scripts, Inc., Case No. 4:23-cv-01436-JAR (E.D. Mo.), Complaint filed February 24, 2024) (alleging ESI chronic and bad faith under-reimbursement practices); Albertsons v. Express Scripts, Inc., Case No. N25C-12-001-KMMCCLD (Superior Court DE), Complaint filed January 6, 2026 (alleging bad faith reclassification by ESI of branded drugs after dispensing to “generic” for purposes of reducing reimbursement).

7. SNF-ALF Equalization

Problem

Plan Sponsors/PBMs consistently reimburse LTC pharmacies lower dispensing fees, and in some cases lower amounts for ingredient costs lower for services provided to Part D beneficiaries living in ALFs that for Part D beneficiaries with similar care needs living in SNFs, NFs, or ICFs, despite the fact that the drug costs and the level of specialized LTC pharmacy services the beneficiary needs are identical regardless of residential setting. Plan Sponsors/PBMs justify this differential by citing the outdated regulatory definition of a LTC pharmacy, 42 C.F.R. § 423.100, which excludes ALFs and other congregate settings, while ignoring CMS guidance pertaining to higher dispensing fees if a beneficiary needs LTC regardless of the setting in which they live.¹⁴ Despite this guidance, PBMs continue to rely on a literal reading of the regulatory LTC pharmacy definition to treat LTC pharmacies as “retail” pharmacies when serving ALF and other non-SNF residents, resulting in inadequate reimbursement and undermining CMS’s stated policy intent.

Recommended CMS Action

Timing: Plan Year 2028

Priority/Impact: High

CMS should update its regulations to clarify that the definition of "LTC facility" for purposes of Part D administration includes ALFs, other congregate living facilities, and pharmacies located in mental health clinics, consistent with definitions in the Older Americans Act. The preamble to this regulation should explicitly state that reimbursing LTC pharmacies differentially for ingredient costs and costs of services for Part D beneficiaries who need LTC based on the setting in which they live is not "reasonable and relevant" under applicable law. CMS has the authority to do so under the existing “reasonable and relevant” regulatory and guidance provisions or as part of the regulations implementing the PBM reform provisions in the 2026 Consolidated Appropriations Act.

8. Preferred Network Pharmacy Cost Sharing for LTC Residents (ALF / IDD / SNF)

Problem

Many Part D beneficiaries living in the community are members of Plans with “preferred network pharmacy” cost-sharing provisions for retail or mail order pharmacies. Unfortunately, when a beneficiary develops a need for LTC and enters an LTC facility, particularly an ALF, the financial incentive to use a preferred network pharmacy conflicts with the best clinical interests / quality of the beneficiary because Plan Sponsors/PBMs

¹⁴ See Medicare Prescription Drug Manual, Chapter 5, § 20.7 and December 15, 2021 CMS Memorandum to Plans.

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treat LTC pharmacies differently because they are not in preferred pharmacy networks. Beneficiaries who need LTC take 12 or more prescription drugs a day and nearly 60% of Medicare beneficiaries in ALFs suffer from dementia or other cognitive impairments.¹⁵ These beneficiaries clearly benefit from the extensive services LTC pharmacies provide, most of which retail and mail order pharmacies do not and cannot provide. Of utmost consideration is that LTC pharmacies help facilities reduce the operational and safety challenges of managing polypharmacy, including higher risk of adverse events and hospitalization, inappropriate prescribing, and harmful drug interactions. For such beneficiaries, Part D financial incentives, which encourage such beneficiaries to continue using retail or mail order pharmacies in preferred pharmacy networks, are misaligned with clinical care incentives, which encourage such beneficiaries to use the LTC pharmacy with which the ALF has relationships. As a result, Part D beneficiaries who need LTC and reside in ALFs risk polypharmacy complications, adverse drug interactions, medication errors, and other potentially serious clinical complications.

Recommended CMS Action

Timing: Plan Year 2028

Priority/Impact: High

We recommend that CMS require Plan Sponsors/PBMs to ensure that the patient cost share shall be no worse than the cost share of a “preferred pharmacy.” For any Part D plans that offer coverage for Part D beneficiaries who need LTC and who enter or already reside in a LTC facility, including SNFs, NFs, ICFs, and ALFs. Alternatively, and consistent with the previous recommendation concerning SNF/ALF equalization, CMS could require that, when a Part D beneficiary resides in a LTC facility, preferred pharmacy network provisions – which are limited to retail and mail-order pharmacies – no longer apply to the beneficiary. Either approach would appropriately align clinical and financial incentives. CMS has the statutory authority to implement this change through its current “reasonable and relevant” regulation or in implementing the PBM reform provisions of the 2026 Consolidated Appropriations Act.

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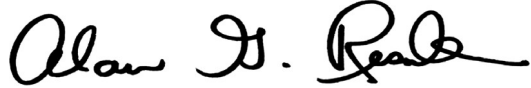
We appreciate your willingness to consider our recommendations and believe that CMS has the statutory authority to implement all of them promptly and alternatively could include them as part of the process of implementing the PBM reform provisions in the 2026 Consolidated Appropriations Act. If you have any questions or concerns, please let us know.

¹⁵ <https://seniorcarepharmacies.org/wp-content/uploads/ATI-SCPC-Nursing-Facility-and-Assisted-Living-Facts-2021-20240712.pdf>.

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We look forward to continuing dialogue regarding our recommendations and other relevant aspects of the Part D program.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Alan G. Rosenbloom". The signature is fluid and cursive, with a long horizontal stroke at the end.

Alan G. Rosenbloom
President & CEO
Senior Care Pharmacy Coalition

cc: Chris Klomp, Director of Medicare and Deputy Administrator of CMS, and Senior
Advisor to the Secretary
Alec Aramanda, Deputy Director of Medicare
Joe Albanese, Medicare Director of Policy
Chris Ritter, Acting Deputy Director of Medicare