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Vanessa Duran, Director, Medicare Drug Benefit and C & D Data Group
Craig Miner, Director, Division of Part D Policy
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-8013

Re: Reasonable and Relevant LTC Pharmacy Considerations

Dear Ms. Duran and Mr. Miner:

On behalf of the Senior Care Pharmacy Coalition (SCPC), I am writing today to share some of our thoughts and considerations, especially those specific to long-term care (LTC) pharmacy gathered by our members based on their experiences with Part D Plans and their pharmacy benefit managers (PBMs), as the CMS team finalizes the Request for Information related to Part D pharmacy contracting terms required by Section 6223 of the Consolidated Appropriations Act of 2026. As CMS is aware, LTC pharmacy is a fundamentally distinct class of pharmacy, recognized as such in both Part D regulation and the Medicare Prescription Drug Manual (Chapter 6, Section 50.5.2), and we urge you to consider those differences and ask for information specific to the LTC pharmacy sector different and apart from retail and home infusion pharmacy when establishing standards for reasonable and relevant terms.

We particularly appreciate the several meetings we have had with CMS Administrator Dr. Oz and his team on these issues over the past eight months and hope the upcoming RFI reflects the principles we have shared regarding steps CMS can take to improve PBM contracting dynamics with LTC pharmacies. In addition to those exchanges, however, we wanted to share with you some additional specific examples of unreasonable and irrelevant contracting provisions that our LTC pharmacy members have experienced over the past several years, so that the upcoming RFI can speak to these issues and address them with granularity.

As CMS understands, LTC pharmacies do far more than fill prescriptions. They provide medication management, emergency access, specialized packaging, consultant pharmacist support, and care team coordination for seniors in nursing homes, assisted living facilities, and other long-term care settings. When Part D contracting fails to reflect these services, patients, facilities, and pharmacies all face unnecessary risk. For that reason, we propose the following issues be addressed in the upcoming reasonable and relevant RFI and subsequently in the standards CMS develops to implement the reasonable and relevant requirement:

1. Reasonable and Relevant LTC Pharmacy Contracts Must Ensure Reimbursement Reflects Specialized Service Costs

CMS has defined the specialized services that LTC pharmacies must provide in the Medicare Drug Benefit Manual, Chapter 6, Section 50.5.2. Historically, however, Plans and PBMs have refused to provide LTC pharmacies with an appropriate dispensing fee covering the costs of those services. As CMS is aware, Part D dispensing fees range from \$1 or less for generics (90% of the drugs dispensed) and around \$4.50 for branded drugs. Yet, the true cost to dispense for long-term care pharmacies, measured before additional economic pressures went into effect from the Inflation Reduction Act, was approximately \$17.65.¹ CMS can establish a minimum payment standard or cost survey specific to LTC dispensing fees, or clarify that unreasonably low reimbursement, potentially defined as reimbursement lower than pharmacy cost, is not "reasonable and relevant."

2. Plans that Fail to Maintain Adequate Networks Should be Penalized

As CMS has experienced, over the past several years PBMs and Plans have either terminated LTC pharmacy networks mid-plan year (such as Optum, which terminated a large number of LTC pharmacy agreements effective July 1, 2026) or refused to enter into network agreements prior to the beginning of the Plan year (such as ESI, which did not reach agreement with a large number of LTC pharmacies on a network agreement until the end of January 2026 for coverage of drugs dispensed as of January 1). Given statutory network adequacy standards, CMS can clarify that all Plans must have all LTC pharmacies in network by a date certain (we propose October 1, as described further below), and that in the event a Plan does not, all affected beneficiaries (not just duals and SNF residents) may use a Special Enrollment Period to switch plans. Further, CMS should also propose, potentially as a reasonable and relevant contract standard, that Plans be required to provide fair out-of-network reimbursement until a new contract is finalized. CMS should also set parameters around when it is reasonable for a Plan to notify a beneficiary about a possible disruption in their pharmacy service; often Plans exploit beneficiary notices to pressure pharmacies into signing unfavorable contract terms to avoid notices being sent to facilities or patients regarding their network status.

3. It is both Reasonable and Relevant for Plans to Provide "LTC" Reimbursement Across Similar Care Settings

Over the years, and in direct contradiction to CMS Manual (Chapter 6, Section 20.7) and Policy Guidance (including December 15, 2021 Memorandum to Plans), many Plans have attempted to reimburse LTC pharmacies at an "LTC Rate" for LTC pharmacy services provided in SNFs and Nursing Facilities, but pay a lower dispensing fee for the very same LTC pharmacy services provided in other congregate residential facilities such as assisted living facilities, group homes, and intermediate care facilities. CMS should solicit comments on whether an LTC pharmacy network contract would only be reasonable and relevant if it requires Plans and PBMs to pay the same LTC pharmacy dispensing fees wherever an LTC pharmacy dispenses a medication so long as the patient receiving the care has a long-term care pharmacy level of need.

¹ See "Long-Term Care Pharmacy Cost Analysis" at https://seniorcarepharmacies.org/wp-content/uploads/CLA_Long-Term_Care_Pharmacy_Cost_Analysis.pdf (2024)

Similarly, PBMs routinely demand that LTC pharmacies sign both LTC contracts and retail contracts, and then the PBM moves beneficiaries from the LTC contract to the retail. CMS should inquire whether this is a reasonable or relevant practice.

4. Ensure Non-Compliance with Contract Terms is Viewed as Violation of Any Willing Pharmacy Requirement and Penalized as Such

Even in cases when LTC pharmacies have contract agreements in place with Part D Plans and their PBMs for a given Plan year, during the Plan year itself LTC pharmacies have found that Plans and their PBMs repeatedly violate or otherwise fail to adhere to contract terms, often leaving pharmacies with the choice of protracted litigation or acquiescence. For that reason, we recommend that CMS establish that for a network pharmacy contract to be reasonable and relevant, it must provide for timely and resource-conscious adjudication of any claims of non-compliance with contract terms. CMS must establish that a contract can only be reasonable and relevant if it is adhered to.

5. Protect LTC Residents from Inappropriate Cost-Sharing

CMS should establish a reasonable and relevant standard such that LTC beneficiary cost-sharing be no worse than a Plan's preferred pharmacy cost-sharing. This is needed because Plans offer beneficiaries in LTC facilities preferred retail/mail-order cost sharing even though the beneficiary cannot access mail-order given the nature of the facility in which they reside. Medications for LTC residents must be dispensed and administered in accordance with the requirements of the applicable care setting. Beneficiaries should not be penalized with cost-sharing simply because they need to reside in a SNF, Nursing Facility or other Congregate living facility.

6. Plans Must Reimburse Based on the Brand or Generic Drug Actually Dispensed

Plans should be required to reimburse LTC pharmacies based on the drug actually dispensed at the time of service. For example, a pharmacy may purchase an inventory of a branded drug and dispense that branded drug, but between the time the drug is dispensed and the time the pharmacy is paid, a generic drug may come onto the market, and the Plan refuses to reimburse any more than the generic rate. CMS should propose a reasonable and relevant standard requiring Plans to honor the pharmacy designation of the type of drug actually dispensed and prohibiting Plans from redefining drugs after they have been dispensed.

7. Require Reasonable & Reciprocal Termination Provisions

CMS has previously recognized in the 2024 Plan Year Proposed Rule that it is not reasonable or relevant for Plans to have punitive contract termination provisions and CMS previously called for Plans to require reciprocal termination without-cause provisions in network pharmacy contracts. Building on this idea, SCPC suggests it is not reasonable or relevant for any network pharmacy contract to include termination notice periods greater than 60 days. We thus urge the Agency to finalize its proposal in the context of the reasonable and relevant standard setting process.

8. Define the LTC Pharmacy "Class of Trade"

PBMs and Plans do not have a consistent or uniform definition of the LTC pharmacy class of trade. CMS should solicit comments on what such a uniform definition should be and how it could be defined around the services the pharmacy provides to the patient with an LTC level of need, in order to ensure that pharmacy network contract terms and conditions are reasonable and relevant for the LTC pharmacy business model and practice functions.

9. Ensure Timely and Accurate Network Information on Plan Finder

As part of the Plan contract review process, CMS requires Plans to accurately list retail network pharmacies on Plan Finder but does not require Plans to list LTC pharmacies in the same way. Unfortunately, this results in Plans listing their preferred affiliate pharmacies on Plan Finder (for example, Caremark used to only list Omnicare when CVS owned the LTC pharmacy), at best confusing beneficiaries and their families and at worst causing beneficiaries and their families to consider switching out of facilities altogether when pharmacies appear to be out of network or unavailable. All LTC pharmacies should be listed on Plan Finder, and it should be a reasonable and relevant contractual standard that Plan Sponsors/PBMs accurately identify LTC pharmacy network status and cost-sharing information on Medicare Plan Finder before each enrollment period.

10. Ban Unfair Plan Contracting Methods/Practices

Passive Amendments: CMS should solicit comments on reasonable and relevant contracting methods/practices. For example, it should not be reasonable for PBMs to send “passive amendments” – proposed contract amendments that spring into place unless the pharmacy objects within some abbreviated timeframe. Similarly, PBMs and Plans for years have “faxed” contract amendments to individual pharmacies rather than to the corporate headquarters or designated recipient of contracts. Particularly in this digital age, CMS should inquire whether contract amendments should be emailed, whether pharmacies should be permitted to designate a specific recipient for contract amendments, whether a minimum timeframe (such as 30 days) is reasonable for acceptance of any contract, and whether the acceptance must be through written agreement rather than passive non-objection.

Unfair Incorporation by Reference of Provider Manual: Another misuse of contracting practices by PBMs is the incorporation by reference of the pharmacy manual as a contract document. While pharmacy manuals should explain the procedures and policies of how the pharmacy should operate and work with the Plan, many Manuals have been unilaterally amended by Plans to contain their own set of legal requirements (such as arbitration provisions) which often conflict with the Plan contracts themselves. Pharmacy Manuals should be guides – not binding contractual documents that include contract terms that better belong in the network contract itself.

Inappropriate Amendment Documents and Practices: In addition to the faxes addressed above, PBMs frequently issue changes through “policy updates,” provider portals, or other means such as undefined updates to pharmacy manuals (also noted above) which can exceed 100 pages and contain complex, highly technical language. Contracts often specify that these manuals and

policy documents control in the event of a conflict with the “negotiated” agreement, allowing material contract provisions to be effectively modified or overridden outside of the original contracting process. This lack of transparency prevents pharmacies from making informed business decisions and creates uncertainty regarding their contractual rights and obligations. The ability of one party to unilaterally alter material contract terms after execution, while simultaneously limiting the other party's ability to reject those changes without severe consequences, runs counter to fundamental principles of transparency, fairness, and informed consent. These practices effectively permit PBMs to rewrite key terms of participation after a contract has been signed, leaving pharmacies with little meaningful recourse. These practices should be deemed unreasonable.

Audit Standards: Similarly, many Plan and PBM contracts contain unreasonable and irrelevant audit standards, permitting Plans and PBMs to extrapolate based upon unreasonably small sample sizes, or permitting unreasonably broad and unworkable audit requirements. Plans and PBMs should be prohibited from relying on such practices to routinely deny pharmacies fair reimbursement for the proper dispensing of medications.

While legitimate program integrity efforts are necessary, many PBM audit processes appear designed to generate recoupments rather than identify true fraud, waste, or abuse. Pharmacies are frequently subjected to audit standards that are inconsistent, overly technical, and disconnected from whether a prescription was appropriately dispensed to an eligible patient. A common concern is the use of minor clerical, typographical, or documentation discrepancies as justification for denying claims and demanding full repayment, even when there is no evidence of patient harm, inappropriate dispensing, fraud, or financial loss to the PBM or plan sponsor. In many cases, a prescription was valid, medically necessary, dispensed correctly, and received by the patient, yet the pharmacy is still required to repay the entire claim amount due to an administrative technicality that had no impact on the underlying transaction.

Additionally, PBMs often conduct audits using vague or inconsistently applied standards, making it difficult for pharmacies to understand expectations and maintain compliance. Audit findings may be based on interpretations of contract language, pharmacy manual provisions, or policies that were not clearly communicated to the pharmacy beforehand. The lack of standardized audit criteria creates uncertainty and exposes pharmacies to substantial financial liability without adequate notice or transparency.

Excessive or punitive audit practices divert resources away from patient care, increase administrative costs, and threaten the sustainability of pharmacies that serve vulnerable and underserved populations. A reasonable and relevant audit process should focus on identifying fraud, waste, and abuse while recognizing the difference between intentional misconduct and harmless administrative errors. Ensuring that audit practices are transparent, consistent, and proportionate would reduce unnecessary administrative burden and waste.

PSAO Participation: PBMs often unreasonably and actively discourage pharmacy choice by limiting a pharmacy's ability to join a PSAO or by creating uncertainty around future network participation if the pharmacy chooses to terminate its direct contract and transition to PSAO representation. This places independent pharmacies in a difficult position and may deter them from pursuing the contracting model that best supports their business and patients and leaves them in a more vulnerable negotiating position. Two of the largest PBMs require pharmacies to maintain direct contractual relationships for certain lines of business while permitting PSAO participation for a limited subset of plans or claims. This fragmented contracting structure creates ongoing administrative complexity, increases compliance burdens, and exposes pharmacies to risk via inefficient and ineffective contracting limitations.

Because the PBMs retain the ability to modify reimbursement terms, fees, or contract provisions under the direct agreement, pharmacies remain vulnerable to unfavorable changes that can effectively undermine the protections and negotiating benefits provided through the PSAO arrangement. These practices limit pharmacy autonomy and restrict the ability of pharmacies to choose the representation model that best meets their operational and financial needs. Pharmacies must have the freedom to participate in a PSAO across all applicable lines of business without fear of network exclusion, retaliation, or mandatory dual-contracting arrangements that diminish the value of PSAO representation.

Post-Termination Requirements: Finally, PBMs have recently begun including provisions in network agreements that, in the event the pharmacy leaves the network but still must bill the PBM (as an out-of-network claim) the pharmacy will be deemed to accept the new lower payment rate that the PBM submits in response to the claim. This is an illegal contract of adhesion and should be evaluated under the reasonable and relevant standards.

Other Areas to Consider:

Network Pharmacy Contracts Must Be Finalized by October 1

CMS carefully requires Part D plans to finalize numerous Plan benefit details by October 1 so that beneficiaries understand the offerings they will select when open enrollment begins on October 15. There are no such requirements that Plans finalize network LTC pharmacy agreements by that date so that beneficiaries can use their open enrollment period to ensure their Plan has their LTC pharmacy in network. We suggest it would be reasonable to require Plan Sponsors/PBMs to complete all LTC pharmacy contracts by that date.

Maintain Uniform and Fair Pharmacy Enrollment, Credentialing and Certification Services

Plans routinely adopt unreasonable and irrelevant enrollment, credentialing and pharmacy certification practices. For example, some PBMs charge up to a \$2,500 "application fee" just to enroll in a network that the PBM is already contractually required to build. Similarly, Plans each use different types of enrollment forms, when a standardized form would suffice for each. Further, although CMS readily relied on the NCPDP pharmacy database for purposes of IRA implementation, the PBMs and Plans rarely use the NCPDP data although it is available to them

and instead each requires idiosyncratic information. To meet the reasonable and relevant standard, PBMs must adhere to standardized pharmacy enrollment forms and use NCPDP data for such purposes to eliminate duplicative requirements, reduce unnecessary administrative burden and costs, and streamline pharmacy network enrollment.

Prohibit PBM “Processing Fees,” “Switch Fees” and “Audit Fees.”

Many PBMs and Plans impose a “processing” or “switch” fee of \$3.00 per transaction to process any claim. Thus, while a pharmacy may receive a \$4 dispensing fee for a brand drug, a \$3 “switch fee” charged by the PBM or Plan to process the claim effectively reduces the pharmacy’s net dispensing fee to just \$1. Similarly, for generics, the cost of the drug and the \$1 dispensing fee may be less than the switch fee. These fees are neither reasonable nor relevant, and CMS should propose eliminating them. Other PBMs charge pharmacies \$5 for each claim audited. It should not be reasonable or relevant for PBMs to charge pharmacies when the PBM audits the pharmacy (or when the pharmacy audits the PBM). CMS should prohibit Plans/PBMs from imposing fees that do not reflect the fair market value of actual services provided by the plan/PBM on behalf of the pharmacy.

Thank you for your consideration of our recommendations and suggestions. If you have questions or wish to discuss our recommendations, please feel free to contact me at egrewal@seniorcarepharmacies.org.

Respectfully submitted,

A handwritten signature in grey ink, appearing to read "Esmé Grewal".

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