SENIOR CARE PHARMACY COALITION

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January 26, 2026

Via Electronic Submission

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-4212-P
7500 Security Boulevard
Baltimore, MD 21244-8013

RE: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program and Medicare Cost Plan Program; CMS-4212-P, RIN 0938-AV63

To Whom it May Concern:

The Senior Care Pharmacy Coalition (SCPC) appreciates the opportunity to comment on the CMS Proposed Rule entitled "Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program and Medicare Cost Plan Program," Agency Docket Number CMS-4212-P (the Proposed Rule).[1] SCPC is the only Washington-based organization exclusively representing the interests of long-term care (LTC) pharmacies. SCPC's membership includes 80% of all unaffiliated LTC pharmacies and serves one million residents daily in skilled nursing facilities and assisted living communities across the country.[2] Given the distinct characteristics of the LTC patient population and the enhanced clinical responsibilities of LTC pharmacies, we offer unique perspectives on CMS' initiatives and proposals, particularly how Medicare Prescription Drug Benefit and corresponding MA-PD program, collectively referred to as "Part D" policies and requirements impact Part D enrollees with institutional level of care needs and the LTC pharmacies that serve them.

While SCPC has no specific comments on the new recommendations in the Proposed Rule, we note that there are proposals that remain open from the Contract Year 2026 Proposed Rule ("Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs for All-Inclusive Care for the Elderly" Agency Docket Number CMS-4208-P) that we urge CMS to finalize in the Final Rule for Contract Year 2027. More specifically, we urge CMS to finalize the following pending proposals from the Contract Year 2026 Proposed Rule:

[1] 90 Fed. Reg. 54894 (Nov. 28, 2025).
[2] This figure is based on pre-pandemic facility occupancy rates. Our members also serve an increasing number of individuals with LTC needs, including Medicare beneficiaries living in community settings and at home.

- Network Transparency for Pharmacies, which would require Plans to complete all network pharmacy agreements and notify pharmacies as to whether they will be in network by October 1 prior to the initiation of the Plan year.
- Part D Sponsors Must Provide Network Pharmacies Reciprocal Rights to Terminate Contracts Without Cause, which would prohibit Plans and the Pharmacy Benefit Managers (PBMs) that negotiate on behalf of Plans from creating different termination rights for the Plan and the network pharmacy. Network pharmacy agreement termination rights should be reciprocal as between the PBM/Plan and the pharmacies.

RELEVANT BACKGROUND ON LTC PHARMACIES

LTC pharmacies are distinct from retail or mail-order pharmacies in three ways. First, LTC pharmacies primarily serve Medicare beneficiaries who need LTC. This patient population is significantly more complex and more reliant on prescription drugs than Medicare beneficiaries who do not need LTC. Second, and as a function of patient need, LTC pharmacies are legally and professionally required to provide more clinical and specialized services than retail or mail order pharmacies. Third, the economics of LTC pharmacies differ substantially from retail or mail-order pharmacies.

The LTC Patient Population[3]

There are 4.2 million Medicare beneficiaries who need LTC, 25% of whom reside in LTC facilities, including skilled nursing facilities (SNFs), nursing facilities (NFs), intermediate care facilities for people with intellectual and developmental disabilities (ICF/IIDs), and assisted living facilities (ALFs). Medicare beneficiaries who need LTC – especially those residing in LTC facilities – have significantly greater needs than Medicare beneficiaries who do not need LTC. Those who need LTC by definition have two or more impairments in activities of daily living (ADLs). Residents in NFs average impairments in six ADLs, and those in ALFs average impairments in five ADLs. LTC facility residents also have a significantly higher prevalence of chronic conditions, with the average resident suffering from four or more chronic conditions.

Three-quarters (75%) of Medicare beneficiaries residing in federally defined LTC facilities suffer from Alzheimer's disease and other cognitive impairments. In ALFs, the rate for Medicare beneficiaries is 59%.

This patient population uses health care resources far more frequently than Medicare beneficiaries who do not need LTC, with hospital admission rates 22% higher, hospital

[3] The data referenced in this subsection are taken from the following reports: ATI Advisory & SCPC, "Functional and Clinical Complexities of Medicare Beneficiaries in Nursing Facilities and Assisted Living," (July 15, 2024); ATI Advisory & SCPC, "The Role of Long-Term Care Pharmacy in Supporting Individuals with Long-Term Services and Supports Needs," (July 25, 2023); ATI Advisory & SCPC, "Medicare Beneficiaries with LTC Needs By Setting," (May 19, 2023); and ATI Advisory & SCPC, "Understanding the Long-Term Care Needs of the Medicare Population and the Role of Long-Term Care Pharmacy in Addressing this Need," (July 2021).

emergency department use rates 102% higher, and average annual Medicare spending 22% higher. This group also averages 12-14 prescription drugs, compared to eight for Medicare beneficiaries who do not need LTC. Given the degree and complexity of patient need, the enhanced clinical and specialized services LTC pharmacies provide are fundamental to the quality of care and life for Medicare beneficiaries living in LTC facilities.

LTC Pharmacy Services

LTC pharmacies routinely provide extensive clinical and specialized services that go well beyond the services retail or mail order pharmacies are equipped to provide. These services include:

- Direct and ongoing consultation with residents and their families.
- Participation in resident care management teams, including direct interactions with and recommendations to the facility medical director, nursing staff, and administration. This engagement requires familiarity with the resident's medical records and complete prescription drug profile.
- Drug utilization review to prevent over-or-under-utilization of prescription drugs and to improve outcomes and reduce costs when medically appropriate.
- Medication therapy management, including comprehensive medication reviews and targeted medication reviews for all LTC beneficiaries.
- Medication reconciliation, including at least daily reconciliation for opioids.
- Direct and ongoing training and contact with facility nursing staff.
- Pharmacist availability to provide medication and patient care services 24/7/365.
- Direct placement of peripherally inserted central catheters and insertion of Midline and PICC lines.
- Antibiotic stewardship and infection control.
- Specialized packaging to improve adherence and reduce medication errors.
- Access to prescription medications at all times pursuant to which patients must receive medications as soon as two hours after the pharmacy receives the prescription.
- 24/7/365 access to pharmacy services and emergency delivery of prescription drugs.

CMS incorporates many of these elements in the LTC Pharmacy Network Adequacy standards imposed on Part D Plans. [4] Similarly, the Medicare and Medicaid Requirements of Participation for federally defined LTC facilities include Pharmacy Services provisions that,

[4] Medicare Prescription Drug Benefit Manual, Chapter 5, §50.5.2.

as interpreted by CMS, mirror the services described above.[5] Indeed, both Congress and CMS have acknowledged these differences in the design of the Part D program. CMS has established separate LTC Pharmacy Network Adequacy Standards with which Part D Plans (Plans or PDPs) must comply and has interpreted the convenient access standard differently when applied to Part D beneficiaries residing in LTC facilities. These standards are designed to assure that Part D beneficiaries who require an institutional level of care (i.e., who require LTC) – as well as all other residents of LTC facilities - receive prescription drugs from LTC pharmacies capable of providing the required services.

CMS also has recognized that a large and growing number of Medicare beneficiaries who need LTC reside in assisted living facilities or live at home, and that they would benefit from access to LTC pharmacy services.[6] In particular, CMS has issued guidance clarifying that, if a Medicare beneficiary has institutional level of care needs (i.e., needs LTC) but resides in an assisted living facility or at home, then a Part D Plan may, but is not required, to pay a higher dispensing fee to pharmacies that provide LTC pharmacy services in addition to dispensing prescription drugs to such beneficiaries.[7]

Unfortunately, this clarification has proven insufficient to expand access to LTC pharmacy services for all Part D beneficiaries who need LTC regardless of the setting in which they live. While beyond the scope of these comments, CMS could – and should – clarify the convenient access standard to assure that these Part D beneficiaries have unfettered access to LTC pharmacy services and LTC pharmacies receive dispensing fees commensurate with the costs of providing these services regardless of patient setting.

LTC Pharmacy Economics

LTC pharmacies rely disproportionately on reimbursement from Part D for economic viability.

[5] Long-term care (LTC) facilities participating in Medicare and Medicaid must provide pharmacy services to all facility residents. Medicare requires that skilled nursing facilities (SNFs), and Medicaid requires that nursing facilities (NFs) and intermediate care facilities (ICF/IIISs), provide "pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident." 42 U.S.C. § 1395i-3 (pertaining to SNFs participating in the Medicare program) and 42 U.S.C. § 1396r(b)(4)(a)(iii) (pertaining to NFs participating in the Medicaid program). For purposes of these comments and recommendations, the term "federally defined LTC facility" will include SNFs, NFs, and ICF/IIDs, and will be used to distinguish between residents of these facilities and community-dwelling individuals, including those residing in assisted living facilities, other congregate settings, or in private homes. CMS has promulgated extensive regulations implementing these pharmacy services requirement, State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 208, 10-21-22). The Pharmacy Services provisions are delineated in § 483.45. In the State Operations Manual, CMS describes those services as essential to patient care.

[6] Most Medicare beneficiaries with LTC needs – 75% - live at home. Only 25% live in federally defined LTC facilities and assisted living facilities. *See supra note 3, ATI Advisory & SCPC July 2021 Report.*

[7] Medicare Prescription Drug Benefit Manual, Chapter 5, § 2.7, Table 2.

On average, 75% of LTC pharmacy revenues are from Part D.[8] Another 20% of revenues are paid by SNFs for Medicare beneficiaries during a Part A stay at the facility. Medicaid, other government insurance programs (e.g., TRICARE, Federal Employee Health Benefits program), commercial insurance, and patient out-of-pocket payments account for the remaining 5% of revenues.

Nearly 75% of Medicare beneficiaries in LTC facilities are dually eligible for Medicaid as well.[9] This has important implications for LTC pharmacy economics. A disproportionate percentage of LTC facility residents with Part D coverage are enrolled in benchmark plans, which must be stand-alone PDPs rather than MA-PD plans. Given the dramatic reduction in benchmark plans recently, as well as the consolidation of benchmark plan management in ESI, one of the three market-dominant PBMs, this is especially problematic for LTC pharmacies. We comment extensively on these problems in our comments on abusive and predatory PBM practices below.

Under the current market structure, PDPs and PBMs have exploited their oligopolistic and anticompetitive market power and LTC pharmacy reliance on Part D revenues to impose a perverse and unsustainable reimbursement model. There are three components to this model: ingredient cost reimbursement for brand name drugs (brands), ingredient cost reimbursement for generic drugs (generics), and dispensing fees.

PDPs and PBMs set LTC pharmacy dispensing fees for brands and generics at a fraction of the actual cost LTC pharmacies must incur to dispense prescription drugs and provide the services that Part D requires of LTC pharmacies. The average cost for an LTC pharmacy to dispense one prescription is about $15.50, while the average PDP/PBM LTC pharmacy dispensing fee is about $4.00. Every time a LTC pharmacy dispenses a prescription – brand or generic – its reimbursement is only 26% of its actual costs to meet Medicare requirements, which creates a substantial operating loss that would be unsustainable absent offsetting revenues in excess of costs. Essentially, PDPs and PBMs demand that LTC pharmacies lose more than $11.00 for each of the more than 200 million prescriptions LTC pharmacies dispense to Medicare Part D beneficiaries each year, which forces LTC pharmacies to rely on revenues from brands to more than offset this loss. [10]

Roughly 10% of drugs dispensed by LTC pharmacies are brands, yet LTC pharmacies must rely on high margins from brands, particularly high-cost brands, for profitability. This

[8] By contrast, the National Community Pharmacists Association has reported that Part D accounts for 35% of retail pharmacy revenues from dispensing prescription drugs. Retail pharmacies, of course, also sell convenience items that LTC pharmacies do not. Sales from convenience items and other health care services that retail pharmacies provide diminish the importance of both revenues and profitability from dispensing drugs. In fact, for many retail pharmacies, dispensing drugs may be a "loss leader" to attract consumers to purchase more profitable items. LTC pharmacies rely solely on revenues from dispensing prescription drugs and providing the services described in the text.

[9] *See supra note 3,* ATI Advisory & ATI Reports.

[10] We note that, due to the impact of Medicare drug price negotiations discussed below, LTC pharmacies will incur additional losses with respect to MFP drugs. Adjusting for these additional losses, and without addressing the substantial differential between LTC pharmacy dispensing/service costs and Plan/PBM dispensing fees, LTC pharmacies would require as much as an additional $30 per MFP prescription simply to compensate for the substantial losses associated with Medicare negotiated price drugs.

payment model aligns with the business interests of PDPs/PBMs. Since they earn substantial rebates from manufacturers of brands, they encourage LTC pharmacies to dispense these drugs by formulary manipulation and managing reimbursement for ingredient costs.

While generics account for roughly 90% of drugs dispensed by LTC pharmacies, the PDP/PBM reimbursement methodology for generics becomes a zero-sum game in which LTC pharmacies receive generic ingredient cost reimbursement that either barely covers acquisition costs or results in modest losses. [11] In recent years, reimbursement for generics has worsened steadily, a trend that likely will accelerate due to policy changes that are reducing PDP/PBM revenues.[12]

Negotiated Medicare Part D prescription drug prices, as required by relevant provisions of the Inflation Reduction Act (IRA),[13] unintentionally pushed the perverse reimbursement model PDPs/PBMs have imposed on LTC pharmacies closer to collapse than ever before. LTC pharmacies strongly support policy initiatives to lower prescription drug costs for all consumers, including Part D beneficiaries, but doing so should not threaten patient access to prescription drugs or LTC pharmacy economic viability. Because negotiated Part D prices understandably focus on the costliest brands for the program, they necessarily focus on the drugs crucial to the LTC pharmacy reimbursement model. Eight of the ten drugs with negotiated prices for 2026 (Maximum Fair Price or MFP drugs) and 12 of the 25 drugs subject to such negotiations for 2027 are prescribed frequently for LTC patients. These drugs account for 25-30% of total LTC pharmacy revenues.

While all pharmacies share concerns regarding the administrative burdens and additional costs associated with implementing the Medicare price negotiation provisions of the IRA, the collapse of the Part D reimbursement model is unique to LTC pharmacies. Retail pharmacies and mail-order pharmacies are far less dependent on Medicare Part D for their pharmacy

[11] PDPs and PBMs earn substantial revenues from manufacturers through rebates, which primarily impact brands. PDPs and PBMs also earn substantial revenues from generics, but they do so because they are partners in large generic purchasing groups which sell generics to pharmacies that are part of the same corporate families. These different revenue models create different financial incentives for PDPs/PBMs regarding ingredient cost reimbursement for brands versus ingredient cost reimbursement for generics. Since PDP/PBM revenue from brands is based on the volume prescribed and dispensed through PDPs, the PDP/PBM incentive is to encourage LTC pharmacies to dispense brands on each PDP's formulary. Since PDP/PBM revenue from generics comes from volume drug sales to owned or affiliated pharmacies, however, the PDP/PBM incentive is to squeeze unaffiliated pharmacies by continuing to lower generic ingredient cost reimbursement to make it harder for unaffiliated pharmacies to compete with affiliated pharmacies because the former cannot participate in the PDP/PBM-owned purchasing groups that offer the lowest generic acquisition costs exclusively to affiliated pharmacies.

[12] Since PDPs/PBMs earn revenues based on drug prices, when prices decrease revenues and profits decrease. PDPs/PBMs routinely shift their losses to LTC pharmacies through lower ingredient cost reimbursement rates and higher "administrative" fees. In 2021, as part of the American Rescue Plan Act, Congress changed the way Medicaid manufacturer rebates were calculated. In response, manufacturers substantially reduced prices for some prescription drugs, which has had a direct impact on LTC pharmacy revenues and profitability and has caused PDPs/PBMs to reduce reimbursement – particularly for generics – and engage in abusive and predatory practices more aggressively. Similarly, although the negotiated drug prices in Medicare will not begin to take effect until 2026, PDPs/PBMs already are engaged in shifting their loss of manufacturer rebates to LTC pharmacies.

[13] 42 U.S.C. §1320.

revenues, and both retail and mail-order pharmacies have lower costs because they do not provide the additional services LTC pharmacies are legally required to provide. Retail pharmacies also sell convenience items that provide alternative revenue sources that LTC pharmacies lack.

We recommend that CMS implement proposals pending from the Proposed 2026 Rule to level the negotiating playing field between LTC pharmacies and Plans/PBMs. Otherwise, CMS risks an even greater likelihood of market collapse in 2027 than it faced in 2026.

PROPOSALS FROM THE 2026 PROPOSED RULE

- **CMS Should Assure Reciprocal Contractual Termination Rights.**

We applaud CMS for proposing that Part D Plans (and their PBMs) afford termination rights to pharmacies, including LTC pharmacies, reciprocal to the rights consistent with the rights Plans give themselves. CMS correctly noted in the Contract Year 2026 Proposed Rule that Part D Plans and PBMs have abused their contracting rights for years and routinely present "take it or leave it" contracts to pharmacies containing unfair and predatory contract provisions, including clauses that give Plans and PBMs unbridled authority to keep pharmacies in network and restricting pharmacies' ability to terminate a contract. CMS in November 2024 was correct that "pharmacies – particularly small pharmacies unaffiliated with larger chains – [do not] have the ability to negotiate" terms and conditions in network agreements,[14] and that observation extends to all LTC pharmacies except those that are subsidiaries or affiliates of conglomerates that own both PBMs and LTC pharmacies.[15] Although CMS did not finalize the proposal for Plan Year 2026, it remains pending, and we urge CMS to finalize this proposal for Plan Year 2027.[16]

We appreciate that Part D Plans and their PBMs are likely to challenge the agency's authority to promulgate this regulation, claiming that the "non-interference" clause prohibits CMS from dictating contract terms. CMS previously – and correctly – has recognized that the Medicare Part D statute allows the agency to require reasonable and relevant contract terms, including terms designed to assure that contract terms are reasonable and fair to pharmacies.[17] Therefore, CMS should finalize the regulation as proposed.

- **CMS Should Require PBMs to Provide Network Pharmacy Notification By October 1 Each Year.**

SCPC strongly supports the proposal from the 2026 Proposed Rule that Plans/PBMs provide pharmacies notice no later than October 1 that they will be network pharmacies for the Plan Year beginning the following January 1.[18] CMS is correct that Part D Plans, through their

[14] 89 Fed. Reg. at 99383.
[15] There are two LTC pharmacy companies that are part of PBM-driven health care conglomerates. CVS Health owns Omnicare, the largest LTC pharmacy company, and Caremark, the largest PBM. United Healthcare owns Pharmscript, the fourth largest LTC pharmacy company, and Optum, the second largest PBM.
[16] Proposed § 423.404(i).
[17] 42 U.S.C. § 1395w-112(b)(3)(D).
[18] 89 Fed. Reg. at 99381.

PBMs, regularly extend contract negotiations beyond October 1, such that pharmacies do not know their network status for the coming year. Further, because Part D Plans and their PBMs are not transparent, pharmacies often do not know the Part D Plans in whose networks they will participate until the Plan year begins and beneficiaries are unable to make informed Plan selections during open enrollment given that they do not know if their preferred pharmacy will be in network.

More importantly, and as both CMS and the Federal Trade Commission have recognized, PBMs routinely refuse to negotiate network agreements fairly, and often merely amend existing agreements with "take it or leave it" contractual terms that give pharmacies the Hobson's choice of accepting predatory contract amendments or rejecting such amendments, thereby disqualifying themselves from network participation for dozens of Part D Plans, given that a single PBM typically offers one contract on behalf of multiple Part D Plans. The oligopolistic structure of Part D Plans and PBMs creates financial incentives that precipitate these exploitative and predatory practices, which have forced pharmacies that are independent of these oligopolies, including LTC pharmacies, into financial distress at an alarming rate.

The PDP network pharmacy negotiations for Plan Year 2026 – which remain incomplete as of this writing – are instructive. Several major contracts between PBMs/Plans and leading Pharmacy Services Administrative Organizations (PSAOs) representing LTC pharmacies remained in flux until December 31, and at least one Plan/PBM has not finalized contracts with a number of LTC pharmacies, posing a risk of convenient access to tens of thousands of Medicare beneficiaries in LTC facilities. CMS certainly understood this challenging situation, since it issued two Memoranda to Plans in December regarding LTC pharmacy network adequacy and convenient access. SCPC's December 24, 2025 letter to CMS, a copy of which is attached to these comments, reviews relevant circumstances in detail. By finalizing the November 2024 proposal, CMS could help to level the negotiating playing field for 2027 contract negotiations and provide certainty for both beneficiaries that their preferred pharmacy will be in network, and for pharmacies that they will be in network, before the open enrollment period.

Basic fairness demands that Part D Plans and their PBMs provide pharmacies with timely notice of network participation, which also would provide substantial benefits to beneficiaries. We therefore urge CMS to finalize its proposal that Plans and their PBMs must notify pharmacies by October 1 of their network status for the subsequent Plan Year.

- **CMS Should Require PDPs to Assure Timely and Accurate Updates to Plan Finder by October 1 Each Year.**

SCPC again urges CMS to expand its network contract notification proposal to require that Part D Plans and their downstream entities include all LTC pharmacies that are in network on Plan Finder by October 1 of each year so that beneficiaries and their authorized representatives will know that the LTC pharmacy is in network when entering a LTC facility. CMS notes its awareness of situations where a pharmacy believes it is out of network and

does not fill prescriptions even though Plan Finder lists the pharmacy as in network.[19] The converse also occurs with great frequency – a pharmacy, and especially a LTC pharmacy, is in network and prepared to offer LTC pharmacy services to facility residents who are Part D beneficiaries yet the Part D Plan fails to include the pharmacy in Plan Finder, instead erroneously misrepresenting the pharmacy as "out of network."

In both the 2026 Proposed Rule and in previous Proposed Rules, CMS proposed to amend 42 C.F.R. §§ 422.111 & 422.2265 to require that MA Plans be added to Plan Finder to assure that network providers are listed correctly both in provider directories and on Plan Finder.[20] CMS in the 2026 Plan Year Proposed Rule accurately noted that: "it is important that, when Medicare beneficiaries are exploring their options, they have the information they need to make the best choice for their needs." [21] The same logic clearly applies to stand-alone Part D Plans, yet the 2026 Proposed Rule only applied to MA Plans. This gap is particularly problematic for Part D beneficiaries residing in LTC facilities since these residents are disproportionately dually eligible for Medicare and Medicaid. Dual eligibles disproportionately enroll in benchmark plans, which in turn are exclusively stand-alone Part D Plans. We therefore urge CMS to include that both MA Plans and stand-alone Part D Plans be listed in Plan Finder in the 2027 Final Rule.

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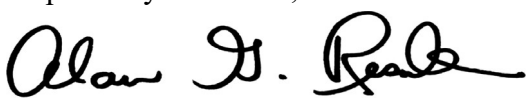
Thank you for your consideration of these comments, and we welcome any questions you may have. Please feel free to contact me at arosenbloom@seniorcarepharmacies.org or (717) 503-0516 if we can provide any additional information.

Respectfully submitted,



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[19] 89 Fed. Reg. at 99383.
[20] 89 Fed. Reg. at 99430.
[21] Id.