Submitted electronically to regulations.gov

Jan 26, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-4212-P
7500 Security Boulevard
Baltimore, MD 21244–1850

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

Dr. Oz,

The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide comments to CMS' proposed rule *Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program.*

NCPA represents America's community pharmacists, including 18,900 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care (LTC) settings. Together, our members employ 205,000 individuals, and provide an expanding set of healthcare services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers. NCPA submits these comments on behalf of both community and LTC independent pharmacies.

Requirement for Point-of-Sale Discounts (§§ 423.505 and 423.2736): Pharmacy Prompt Payment

Consistent with section 1860D–14C(c)(1)(B) of the Social Security Act and CMS's policies in section 60.3 of the Manufacturer Discount Program Final Guidance, CMS proposes at § 423.2736(c) that Part D sponsors be required to reimburse network pharmacies for the manufacturer discount amount on applicable drugs within established prompt payment timeframes. Specifically, CMS would require sponsors to pay pharmacies no later than 14 calendar days after the dispensing date for electronic claims, or no later than 30 calendar days for non-electronic claims, consistent with CMS pharmacy prompt payment requirements at § 423.520. **NCPA supports this proposal.** Clear prompt-payment timelines for the applicable discount will promote consistent administration of the Manufacturer Discount Program and reduce payment delays that can create operational burdens at the pharmacy counter. This

approach supports continuity of care for Part D beneficiaries and strengthens the integrity of the redesigned Part D benefit. **NCPA supports CMS' proposal to require pharmacy prompt pay timeframes in the Part D Manufacturer Discount Program.**

LTC pharmacy concerns with CMS' proposals and input requests regarding: 1) clarifying the "date of dispensing" for LTCPs and home infusion pharmacies as the date the pharmacy submits the discounted claim for reimbursement; 2) soliciting public input on ways to simplify and strengthen network adequacy oversight for MA plans; 3) not finalizing from the CY 2026 Medicare Part D proposed rule the requirement that all Part D sponsors, including all first tier, downstream, or related entities notify network pharmacies which plans will be in-network prior to October 1 of the year prior to the upcoming plan year; and 4) ways to simplify and modify the Star Rating Methodology for CY 2027 and the addition of new outcome measures that promote prevention and wellness:

Overview

Long-term care pharmacies (LTCPs) provide comprehensive medication management and clinical services to patients who reside in LTC settings. They navigate complex Medicare Part D requirements,[1] and play a critical role in ensuring LTC facilities remain compliant with CMS medication-related requirements.[2] To meet these demands, LTCPs maintain a comprehensive inventory of formulary drugs and secure storage capacity, provide pharmacist-led services, such as drug utilization reviews, and offer on-call pharmacist support and reliable delivery services, including emergency access.[3]

However, LTCPs are often not adequately reimbursed for the services they provide. PDPs and pharmacy benefit managers (PBMs) reimburse LTCPs primarily in two ways. First, LTCPs generate revenue based on the difference between (a) the ingredient or acquisition cost of the drug (generic or brand), which is the amount that LTCPs pay to wholesalers or pharmaceutical manufacturers to acquire the drug and (b) the reimbursement they receive for that drug, at a rate negotiated between the LTCP and the PBM, who acts on behalf of the PDPs and other payers. Second, Part D requires PDPs to pay LTCPs a separate dispensing fee that is meant to cover administrative and professional services.[4] According to a recent survey of LTCPs, the average cost to dispense a prescription in compliance with regulations is approximately four times higher than

[1] Cynthia G. Tudor, "Chapter 5: Benefits and Beneficiary Protections," *Medicare Prescription Drug Benefit Manual*, Centers for Medicare & Medicaid Services, September 20, 2011, https://www.cms.gov/files/document/chapter-5-benefits-and-beneficiary-protection-v92011.pdf.

[2] Under federal law, Medicare and Medicaid certified LTC facilities, including SNFs and nursing homes, must comply with the Pharmacy Services Requirements of Participation at 42 CFR 483.85 which mandate pharmacist consultation, monthly drug-regimen review, and ensuring proper dispensing and administration of medications. LTCPs serving these facilities must agree by contract to support compliance with these statutory and regulatory obligation.

[3] Centers for Medicare & Medicaid Services, *Long-Term Care Guidance*, CMS, March, 16 2005 https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/ltcguidance.pdf

[4] *Part D Dispensing Fees and Institutional-Level Care Needs*, December 2021, https://cdn.ymaws.com/www.ascp.com/resource/resmgr/docs/news/partddispfeeinstlevelcarenee.pdf

the average dispensing fee paid by PDPs, which is typically about $4 per prescription.[5] This reimbursement gap highlights a significant shortfall in LTCP's operating costs, which threatens their financial sustainability and thus beneficiary access.

Therefore, to promote the Administration's goal to lower drug prices and promote access to drugs for all Americans, NCPA urges CMS to:

- Convene key stakeholders and explore alternative reimbursement models with stand-alone and MA PDPs to shift away from reimbursement methods based on the cost of drugs and instead reimburse LTCPs for the services they provide and health outcomes they achieve;
- Strengthen CMS oversight by requiring PDPs to report data on LTCP beneficiaries to ensure they have adequate networks that meet LTCP standards; and
- Stratify Part D star measures by LTCP beneficiary to ensure fair comparison across different care environments and demonstrate the distinct care pattern LTCP beneficiaries receive.

Explore Alternative Reimbursement Models in Medicare Part D and Medicare Advantage

For CY 2027, CMS proposes a number of clarifying provisions for the Medicare Part D Manufacturer Discount Program. Among those relevant to LTCPs is the proposal to clarify the "date of dispensing" for LTCPs and home infusion pharmacies as the date the pharmacy submits the discounted claim for reimbursement. CMS also proposes to reinforce point-of-sale requirements, specifying that Part D sponsors must reimburse network pharmacies applicable manufacturer discounts within the applicable timeframe after the date of dispensing.

NCPA advises CMS to explore new payment models for LTCPs, built around the unique services and value they provide: optimizing medication regimens, preventing adverse drug events, reducing hospitalizations, and improving overall patient outcomes. CMS can take specific regulatory actions to facilitate the movement towards a new paradigm for LTCP reimbursement that does not rely on the cost of drugs.

To truly safeguard medication access for vulnerable beneficiaries, CMS should act as a convener of stakeholders – Part D sponsors, LTCPs, Pharmacy Services Administrative Organization (PSAO), LTC facilities, nursing homes and patient advocates – to explore new reimbursement models in stand-alone and MA prescription drug plans that compensate LTCPs for their value-added services, e.g., clinical expertise, medication management, drug delivery, compliance packaging, 24/7 availability and collaborative care efforts.

There are many alternative reimbursement models that should be explored to replace the current methodology, e.g., access to LTCP services based on patient characteristics/need for LTC

[5] Senior Care Pharmacy Coalition, *The Impact of Drug Price Negotiations on Seniors in Long-Term Care*, SCPC, July 2024, https://seniorcarepharmacies.org/wp-content/uploads/The-Impact-of-Drug-Price-Negotiations-on-Seniors-in-Long-Term-Care.pdf The cost estimates are based on 2024 contract and payment data, which may not fully reflect future plan negotiations and market conditions.

services; enhanced service fees; capitated payments and other performance-based arrangements where LTCPs are responsible for quality of care and patient outcomes.

While the non-interference clause may prohibit CMS from defining future payment arrangements, CMS could hold a series of Open-Door Forums or Technical Expert Panels with industry stakeholders to make recommendations for future payment models and pursue opportunities to use the CMS Innovation Center's waiver authority to test new payment models. Simultaneously, CMS should move forward with the recommendations described below to create the conditions for the development of more sophisticated value-based payment arrangements. These models must be designed for long-term sustainability so that LTCPs can remain financially stable and continue to provide essential services to vulnerable beneficiaries.

Supplemental Request for Information: How CMS Can Simplify and Strengthen Network Adequacy Oversight for MA Plans

In the CY 2027 proposed rule, CMS solicits public input on ways to simplify and strengthen network adequacy oversight for MA plans, including streamlining provider and facility network review process and exception protocols.

Recommendation: **NCPA advises CMS to increase oversight by requiring PDPs to report data on LTCP beneficiaries and ensure they have adequate networks that meet LTCP standards.**

One of CMS' strongest regulatory authorities over PDPs is the requirement under 42 CFR § 423.120(a)(5) for PDP sponsors to maintain a pharmacy network that ensures convenient access to LTCPs for residents in LTC facilities, thereby demonstrating network adequacy. To be compliant, PDP sponsors must satisfy four requirements:[6]

1) *Workplan submission*: Include a strategic plan in their application detailing outreach, contracting milestones, and tracking progress.
2) *Performance and Service Criteria*: Ensure contracts incorporate CMS-defined performance and service standards.
3) *Contract with Any Willing Provider*: Attest to offering contracts to qualified pharmacy meeting network terms and CMS criteria.
4) *Convenient access requirements:* Attest that institutionalized enrollees can routinely access Part D benefits through in-network LTC pharmacies, not relying on out-of-network benefits to meet the convenient access standard.

However, CMS currently only requires PDPs to attest that LTC residents routinely receive Part D benefits through in-network pharmacies, without relying on out-of-network options. Plans must only submit a list of contracted network LTCPs and describe how these pharmacies will ensure access to Part D benefits for all institutionalized beneficiaries. CMS evaluates plan compliance by

[6] Centers for Medicare & Medicaid Services, *Long-Term Care Guidance*, CMS, March 16, 2005 https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/downloads/ltcguidance.pdf

analyzing enrollment and disenrollment trends among institutionalized beneficiaries, reviewing complaints and utilization data and identifying patterns that may indicate inadequate access. CMS also uses the Minimum Data Set (MDS) and enrollment files to link institutionalized beneficiaries to LTCPs within each plan network. There is no requirement for PDPs to report LTCP-specific network data. This lack of granular data limits CMS' ability to audit or enforce compliance with the "convenient access" standard, thus creating a regulatory blind spot.

NCPA urges CMS to focus on strengthening network adequacy oversight of PDPs to ensure all LTC beneficiaries have convenient access to their medications. Specifically, CMS needs to see whether beneficiaries in nursing homes or those included in a 1915(c) waiver have access to a LTCP for their medication needs. Current PDP reporting for network adequacy does not differentiate retail pharmacies from LTCPs. Given their health status, LTCP beneficiaries cannot simply substitute a retail pharmacy for their medication needs.[7] Visibility into network adequacy for LTCPs will provide CMS with additional enforcement opportunities to ensure these Medicare beneficiaries receive proper services.

CMS should finalize LTCP Networks Annually Before Open Enrollment

Additionally, CMS should require that adequate LTCP networks be finalized annually prior to the start of open enrollment. In the CY 2026 Medicare Part D proposed rule, CMS proposed requiring all Part D sponsors, including all first tier, downstream, or related entities (FDRs), to notify network pharmacies which plans will be in-network prior to October 1 of the year prior to the upcoming plan year**.** As we previously asked CMS in our comments on the CY 2026 Medicare Part D proposed rule,[8] **NCPA asks CMS to finalize this proposal as part of the CY 2027 final rule.** Allowing network negotiations to continue during open enrollment creates unnecessary disruption for beneficiaries who already rely on an LTCP provider. When plans issue "out-of-network" notices during open-enrollment, LTC facilities face undue burden scrambling to identify new "in-network" LTCPs to ensure continuity of services.

NCPA applauds several memorandums CMS issued on August 25, 2025, December 5, 2025 and December 23, 2025 to all Part D plan sponsors reminding them of the requirement under C.F.R. § 423.120 that LTC facility residents must have routine access to Part D drugs dispensed directly to patients. This includes the requirement that a PDP's pharmacy network has a sufficient number of LTCPs to comply with CMS' LTC convenient access standard. These repeated reminders underscore ongoing challenges with network adequacy compliance. To make the guidance more meaningful, CMS should require:

- **LTCP-specific Network Reporting:** PDP sponsors should be required to submit detailed data identifying which pharmacies in their networks are LTCPs, including the number, geographic distribution, and facility affiliation. This will allow CMS to distinguish LTCPs from retail pharmacies and truly assess beneficiary access to LTCPs.

[7] Under 42 CFR § 483.45 and § 483.70(f), federally defined LTCFs must contract with pharmacies capable of meeting LTC-specific service requirements, effectively prohibiting beneficiaries from using retail pharmacies.
[8] See ncpa-comments-cms-part-d.pdf.

- **Routine Audits and Data Validation:** CMS should conduct routine audits of PDPs to verify the accuracy of LTCP access attestations.
- **Enforcement Mechanism:** CMS should establish penalties for PDPs that fail to maintain adequate LTCP networks or misrepresent access in their attestation.
- **Public Disclosure Requirement:** CMS should require PDPs to publicly disclose the LTCP network information they submit to demonstrate compliance with CMS guidance. This transparency would enable beneficiaries, LTC facilities, and other stakeholders to monitor access and hold plans accountable.

The additional oversight of PDPs will not only safeguard patient access to needed medication but also ensure that PDPs and PBMs work more collaboratively with LTCPs to sustain access.

Stratify Part D Star Measures by LTCP Beneficiary

CMS seeks feedback on ways to simplify and modify the Star Rating Methodology for CY 2027 and the addition of new outcome measures that promote prevention and wellness.

NCPA believes that CMS can leverage Medicare Advantage and Part D Star Ratings to influence plan behavior and improve care quality. Each year, CMS evaluates MA and Part D plans across a range of performance measures which assess clinical outcomes, patient experience, medication adherence and operations efficiency. Plans are rated from one to five stars, and these ratings impact consumer choice, plan enrollment and financial incentives such as quality bonus payments. Currently, there is a significant gap in how the Star Ratings system addresses the role of LTCPs that provide specialized services, including medication regimen reviews, emergency dispensing, and compliance packaging among others. Moreover, the current Star Ratings framework does not adequately capture or reward the quality and complexity of these services, nor does it capture the complexity of the LTCP population. As a result, LTCPs are often excluded from performance-based incentives that drive plan behavior, despite their contributions to medication adherence and beneficiaries' outcomes. Without metrics specific to the LTCP population or incentives tied to LTCPs performance, PDPs and PBMs lack the data and infrastructure to deploy alternative reimbursement models with LTCPs that reward value over volume.

NCPA recommends that CMS should stratify Part D Star measures by LTCP beneficiaries to monitor their quality of care. LTCP beneficiaries have distinct clinical profiles and unique care delivery models compared to other Medicare beneficiaries. Therefore, CMS should have a separate evaluation for this sub-population. CMS could achieve that without adding new measures by simply stratifying existing Star measures. This would also enable more accurate comparison across PDPs serving LTCP populations.

Addition of Depression Screening and Follow-Up Measure to Star Ratings

CMS is proposing to add the depression screening and follow-up as a new individual Star Rating measure for performance periods beginning on or after January 1, 2027:

TABLE 2: SUMMARY OF NEW INDIVIDUAL STAR RATING MEASURES FOR PERFORMANCE PERIODS BEGINNING ON OR AFTER JANUARY 1, 2027

Measure	Measure Description	Domain	Measure Category and Weight	Data Source	Measurement Period	CMIT ID	Statistical Method for Assigning Star Rating	Reporting Requirements (Contract Type)
Part C Measures								
Depression Screening and Follow-Up	The average percentage of eligible MA plan members who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days.	Managing Chronic (Long Term) Conditions	Process Measure Weight of 1	HEDIS	The calendar year 2 years prior to the Star Ratings year	Not available	Clustering	MA-PD and MA-only

NCPA supports this addition. Pharmacies are essential touchpoints for mental health care, providing a convenient venue to assess well-being and an established, trusting patient-provider relationship. NCPA has also gathered some anxiety and depression screening tools for its members to help identify where mental health interventions can be helpful for certain patients and appropriate treatment measures.[9] **To help achieve success on this measure, and others, NCPA urges CMS to adopt payment policies that leverage the inclusion of a wider range of professionals, especially pharmacists.**

Streamlining the Methodology, Further Incentivizing Quality Improvement, and Suggestions for New Measures

NCPA supports CMS' goals to effectively incentivize quality improvement and consider future outcomes measures to promote prevention, health, and wellness, in alignment with healthy aging, to include priorities like nutrition and wellbeing. Chronic diseases continue to pose a major threat to the health, wellbeing, and resiliency of the American people. NCPA urges CMS to leverage pharmacies in Medicare to reduce harmful chronic diseases in America, including by asking CMS to:

- **Formally recognize pharmacists as providers to claim reimbursement under Medicare Part B.[10]**
- **Expand pharmacists' role in medication therapy management in Medicare Part D**
    - NCPA opposes further broadening coverage of MTM services without increasing payment to pharmacies, as doing otherwise will create an "unfunded mandate" on pharmacy.
    - MTM payments should be commensurate with the care and expertise provided to the patient, not based on generating additional revenue for the plans and the PBMs.
    - NCPA supports Congress advising CMS to require Part D contracts to contain "any willing pharmacy" language to allow pharmacies to participate in MTM services.

[9] See Tools to screen patients for anxiety and depression | NCPA.
[10] 42 U.S.C. 1395w-4.

- **Address challenges for pharmacists and pharmacies to deliver diabetes self-management training ("DSMT") services**
    - Clarify that pharmacists and pharmacies can provide DSMT services.
    - Provide education and training materials for staff and information for patients and other stakeholders about the program and its benefits.
    - Clarify that a DSMT accredited pharmacy can bill for services without sign-off from a Part B DSMT accredited provider—a position reinforced by the fact that CMS and national accreditation organizations ("NAOs") allow pharmacists to be DSMT certified instructors.
    - Ease barriers to DSMT access by allowing pharmacists working within an accredited program to be able to bill as a provider with their own NPI number.
    - Clarify in the Medicare Benefit Policy Manual, Chapter 15, Section 300[11] that DSMT services are already permitted at pharmacies that meet CMS' and NAOs' requirements.[12]
    - Allow pharmacists to order laboratory testing like a provider.
- Allow pharmacists to bill for the device unit and the corresponding counseling of continuous glucose monitoring (CGM) in Medicare
    - **Expand access to needed diabetes services, specifically by covering CGM that is delivered by pharmacists and other qualified practitioners under direct or general (preferable) supervision.**
- **Allow Annual Wellness Visits to be delivered under general supervision.**

Strengthening Current Medicare Advantage and Medicare Prescription Drug Benefit Program Policies (Operational Changes) - Coordination of Election Mechanisms for MA and Part D (§§ 422.62, 422.66, 423.32, 423.36, and 423.38) - Special Elections Period

CMS is proposing to codify its current policy that for elections that are made based on certain special election periods, the beneficiary at issue must either have CMS approval for the use of that SEP through the use of a CMS-operated election mechanism (for example, 1–800–MEDICARE or the Online Enrollment Center (OEC)) or other means, such as enrollee receipt of a notice. CMS proposes this change to codify longstanding guidance and practice requiring CMS approval for certain SEPs. This policy allows for control over election periods and mechanisms to ensure appropriate use and allows us to delineate a clear process for each election. To accomplish this, CMS would propose to establish at §§ 422.66(g), 423.32(k), and 423.36(g) the requirement that

[11] See CMS. Medicare Policy Benefit Manual. Chapter 15, Section 300. May 22, 2022, available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.

[12] In accordance with § 410.144, a CMS-approved NAO may accredit an individual, physician or entity to meet one of three sets of DSMT quality standards: CMS quality standards; the National Standards for Diabetes Self-Management Education Programs (National Standards); or the standards of an NAO that represents individuals with diabetes that meet or exceed our quality standards. Currently, CMS recognizes the American Diabetes Association and the American Association of Diabetes Educators as approved NAOs, both of whom follow National Standards. Medicare payment for outpatient DSMT services is made in accordance with §414.63.

elections may require CMS approval based on the use of specified SEPs. CMS approval would be provided for plan elections either through the use of a CMS-operated election mechanism or through the individual's receipt of a notice which explains eligibility for the SEP and election instructions. As CMS approval would be an eligibility criterion of the SEP, MA organizations and Part D plan sponsors may not transmit elections to CMS using the specified SEPs without prior CMS approval.

NCPA asks CMS to clarify if current regulations allow CMS to open up the SEPs for re-doing networks in the event that PBMs and plans provide false information. NCPA has had an ongoing issue of PBMs and plans either reporting that pharmacies are in network when they are not, or that they are still in network when they have dropped out.

Limit on Specialty-Tier Cost Threshold Adjustment (§ 423.104(d)(2)(iv)(B))

In this proposed rule, CMS is proposing to revise § 423.104(d)(2)(iv)(B)(1) and (2) to allow CMS to reduce the specialty-tier cost threshold under certain circumstances, in addition to the current authority to increase the threshold. NCPA is concerned with this proposal. While we recognize the intent to align policy with evolving market dynamics, lowering the specialty-tier cost threshold would expand the number of drugs subject to specialty-tier placement, increasing the number of opportunities for vertically integrated Pharmacy Benefit Managers (PBMs) to inappropriately steer beneficiaries toward PBM affiliated pharmacies at significant cost to government programs and beneficiaries, as well as increasing coinsurance and creating unpredictable out-of-pocket costs for beneficiaries. The latter impacts would be especially harmful for residents of long-term care settings, who disproportionately rely on specialty medications to manage complex, chronic, and progressive conditions. Beneficiaries should benefit from declining drug prices, not be shifted into benefit designs that impose greater financial risk. **CMS should therefore maintain a stable specialty-tier cost threshold methodology, allow for cost exceptions on the specialty tier, and ensure that any future authority to lower the threshold is paired with clear guardrails, including anti-steering provisions, beneficiary impact analysis, advance notice, and meaningful stakeholder input.**

NCPA thanks CMS for the opportunity to provide feedback, and we stand ready to work with the agency to offer possible solutions and ideas. Please let us know how we can assist further, and should you have any questions or concerns, please feel free to contact me at steve.postal@ncpa.org or (703) 600-1178.

Sincerely,

Steve Postal, JD
Senior Director, Policy & Regulatory Affairs
National Community Pharmacists Association