October 26, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services

Re: CMS-4217-NC, Request for Information; Medicare Part D Reasonable and Relevant Pharmacy Contracting Standards (91 FR 60568)

Dear CMS Administrator:

On behalf of Northeast Pharmacy Service Corporation (NPSC) and our participating pharmacies, we appreciate the opportunity to submit comments concerning reasonable and relevant pharmacy contracting standards under Medicare Part D.

Based in Framingham, Massachusetts, NPSC is a pharmacy services administrative organization representing independent community pharmacies across New England. Our network exists to support the business, operations, and long-term viability of independent pharmacies through contracting, advocacy, and direct engagement with payors. From that vantage point, we have watched the PBM market evolve over time, and the conclusion is straightforward. The issue is not simply a lack of transparency. The issue is that the system itself has become structurally imbalanced.

NPSC has a longstanding interest in the ability of independent community pharmacies to remain competitive and continue serving Medicare beneficiaries. Our concern is not simply whether pharmacies are allowed to participate in Medicare Part D networks. It is whether the terms of participation allow those pharmacies to remain financially viable while providing the services their patients depend upon.

Congress recognized this issue in the Consolidated Appropriations Act, 2026, by directing CMS to establish standards for reasonable and relevant pharmacy contracting terms. We believe CMS now has an opportunity to address several longstanding problems that have weakened independent pharmacy participation in Medicare Part D.

At its core, this is a question of fairness, competition, and patient access. A pharmacy should not have to accept unreasonable financial terms simply to remain available to its Medicare patients.

1. Pharmacy reimbursement must bear a reasonable relationship to the cost of dispensing medications (Section II.A).

One of the most significant concerns for independent pharmacies is the disconnect between reimbursement and the actual cost of purchasing and dispensing prescription medications.

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Pharmacies cannot continue to dispense medications when reimbursement falls below acquisition cost, particularly when the dispensing fee does not adequately account for the cost of operating the pharmacy.

Those costs include pharmacists, technicians, prescription processing, inventory management, regulatory compliance, patient counseling, and the many other responsibilities involved in safely dispensing medications.

CMS should establish standards that address both ingredient cost reimbursement and professional dispensing fees. A reimbursement methodology that considers only the acquisition cost of the medication, without adequately accounting for dispensing services, does not reflect the economics of pharmacy operations.

We recognize that reimbursement methodologies may vary by pharmacy type, product, and service. However, those differences should be supported by objective considerations rather than the relative negotiating power of the parties.

The minimum reimbursement for a drug's acquisition cost, separate from any dispensing fee, administration fee, or other separately payable fee, must be sufficient to cover the price at which a pharmacy can reasonably acquire the drug in its regional geographic marketplace. Reimbursement methodologies for drug ingredient costs must be based on transparent, publicly available, and verifiable benchmarks that accurately reflect current marketplace pricing and reasonably available acquisition costs in the applicable geographic region.

Pharmacies should not be required to disclose their actual drug acquisition costs directly to Part D plan sponsors or their pharmacy benefit managers (PBMs), particularly where such entities own or control competing pharmacies, including retail, specialty, or mail order pharmacies, through vertical integration. Disclosure of proprietary cost information may create conflicts of interest and place independent pharmacies and any non-vertically integrated pharmacy at a competitive disadvantage.

CMS should also require timely updates to maximum allowable cost (MAC) pricing and a meaningful appeals process when reimbursement does not reflect available acquisition costs.

A pharmacy should have a mandatory appeals mechanism to challenge a reimbursement rate, obtain an explanation, and receive a timely decision. The appeal mechanism must provide recourse for pharmacies when the PBMs pricing decision results in reimbursement that continues to be below the acquisition costs from accessible suppliers in the pharmacy's geographic marketplace.

CMS should require that Dispensing Fees and Administration Fees should be based on the actual cost of providing these services, taking into consideration the geographic location of the pharmacy. Myers & Stauffer, a national CPA firm, is contracted by multiple state Medicaid programs to conduct "Cost of Dispensing" (COD) surveys, that collect actual pharmacy cost data necessary to establish fair and appropriate reimbursement rates in the Medicaid program. For retail pharmacies, Medicare Part D dispensing fees

should be subject to a minimum floor no lower than the Medicaid fee-for-service dispensing fee for the corresponding pharmacy type in that state.

2. Pharmacy contracts must be understandable, transparent, and fairly administered (Sections II.B and II.C).

For many independent pharmacies, Part D contracting is not a negotiation in the traditional sense. Pharmacies are presented with standardized agreements that offer little opportunity to change financial or operational provisions.

When pharmacies decline a PBM's non-negotiable terms, patients/consumers frequently lose access to the local pharmacy that they have relied on for years.

This imbalance becomes more concerning when reimbursement provisions can be modified through provider manuals, rate sheets, policy bulletins, or other documents outside the original agreement.

We believe CMS should require Part D sponsors and their PBMs to provide pharmacies with all material contract terms, including reimbursement methodologies, dispensing fees, performance requirements, and applicable payment adjustments, before a pharmacy is required to accept an agreement.

Material changes should require adequate advance notice and an opportunity for review. Silence should not automatically constitute acceptance of a significant financial change. CMS must set minimum contract review periods, restrict any unilateral mid-year changes, and require clear disclosure of intended changes in the form of a written contract amendment. CMS must also prevent changes to reimbursement rates or other material contract changes from being done via provider manual updates, bulletins, or portal notices. CMS should also make it clear that all contact changes require affirmative acceptance by the pharmacy and cannot be automatically implemented by requiring the pharmacy to file an opt-out declaration.

CMS should also prohibit contract provisions that allow reimbursement to be adjusted through aggregate guarantees, reconciliation arrangements, or other mechanisms that prevent pharmacies from knowing their final payment when a prescription is dispensed. CMS should require that PBMs and Part D plans disclose the final adjudicated price, including patient copays, at the point of sale. Once a prescription claim has been adjudicated and the patient has paid the copay established through that adjudication, the reimbursement amount and patient copay must not be retroactively altered. All "clawbacks" and other post-adjudication reconciliations that reduce pharmacy reimbursement or increase, decrease, or otherwise change the patient's copay after payment has been made should be expressly prohibited.

Pharmacies need to know what they are being paid. That should not be an unreasonable expectation in a federally funded prescription drug program.

3. Any-willing-pharmacy protections must provide meaningful access to pharmacy networks (Section II.B).

Medicare's any-willing-pharmacy requirement was intended to preserve competition and ensure that beneficiaries have access to qualified pharmacies.

However, network participation alone does not necessarily mean a pharmacy can compete on equal terms.

We are particularly concerned about circumstances in which an independent pharmacy may participate in a standard network but has little realistic opportunity to participate in a preferred network, even when it can satisfy the same objective requirements as other participating pharmacies.

CMS should clarify that network participation criteria must be transparent, consistently applied to all pharmacies, and reasonably related to the services being provided.

This is especially important when preferred network arrangements create significant financial incentives for beneficiaries to use particular pharmacies.

PBMs must also be prohibited from conditioning a pharmacy's participation in any Part D plan on its participation in other PBM networks. A pharmacy that declines any other PBM contract must still be offered participation in all Part D plans administered by that PBM.

If a pharmacy meets the objective requirements concerning licensing, accreditation, dispensing capabilities, and service standards required for network participation, CMS should prohibit the PBM from denying that pharmacy an opportunity to participate at the same terms, conditions and reimbursement rates established for all other pharmacies in that network.

The objective should be genuine competition among qualified pharmacies, not simply a larger list of pharmacies that are technically included in a network.

4. Vertical integration deserves particular attention (Section II.B).

The ownership relationships among health plans, PBMs, and pharmacies create concerns that CMS should address as it develops these standards.

When a PBM or its parent company also owns pharmacies, the entity establishing network participation requirements may be competing directly with the independent pharmacies subject to those requirements.

That does not mean every contract involving an affiliated pharmacy is improper. It does mean CMS should examine whether affiliated and unaffiliated pharmacies are treated equally and consistently.

Independent pharmacies should not face different reimbursement, performance, accreditation, or participation requirements simply because they are not owned by the company administering the pharmacy benefit.

CMS must require that PBMs and plans hold PBM-affiliated and unaffiliated pharmacies that meet the published objective criteria for network participation to the same contract terms, conditions, and reimbursement rates.

The same principles should apply to specialty pharmacy networks where qualified independent pharmacies may be excluded despite possessing the capabilities necessary to serve patients.

5. Pharmacy performance measures should reflect what pharmacies can reasonably control (Section II.D).

We support appropriate quality measures that improve medication use and patient outcomes.

However, pharmacy performance requirements should be clinically relevant, transparent, and based on factors that a pharmacy can reasonably influence.

Pharmacies should not face financial penalties or network restrictions based on measures that are affected substantially by circumstances outside their control.

CMS should require that pharmacies receive the methodology, underlying data, performance thresholds, and a reasonable opportunity to challenge inaccurate assessments. Quality Measure payments should not be calculated as a percentage of the top performers in a pharmacy network reaching an established performance criteria but should be awarded to all pharmacies that meet the performance thresholds disclosed in the program methodology.

A quality measurement program should encourage better patient care. It should not become another unpredictable means of reducing pharmacy reimbursement.

6. Pharmacy audits should protect program integrity without becoming a disproportionate financial burden (Section II.E).

Pharmacy audits are an important component of Medicare program integrity. We recognize the need to identify fraud, inappropriate billing, and conduct that may affect patient safety.

At the same time, an audit should distinguish between genuine billing or compliance violations and minor administrative or clerical errors that do not establish improper dispensing or financial harm. Audit standards should not allow for recoupment for errors in otherwise properly dispensed prescriptions that cause no financial harm. Extrapolation of audit findings should be prohibited in the absence of evidence of fraud.

CMS should establish reasonable standards governing audit notice, documentation requests, recoupment, extrapolation, corrective action, and appeals.

Pharmacies should receive clear explanations of audit findings and have a fair opportunity to respond to any and all findings through an independent appeal process before substantial payment recoupments or other adverse actions occur.

The goal should be accurate payment and compliance, not imposing unnecessary financial consequences for errors that can be corrected.

7. CMS should establish enforceable standards, not simply additional guidance (Sections II.G and II.H).

Finally, we encourage CMS to ensure that its new reasonable and relevant contracting standards can be meaningfully enforced.

Providing general guidance without an effective compliance mechanism would leave many of the underlying concerns unresolved.

CMS should require Part D sponsors to demonstrate that their standard contract terms comply with federal requirements. Pharmacies should also have access to a reasonable process for raising concerns when those standards are not followed.

CMS should prohibit PBMs and Part D plan sponsors from requiring pharmacies to resolve all disputes exclusively through mandatory arbitration, particularly where such provisions limit pharmacies' access to the courts, restrict available legal remedies, or impose unreasonable costs and procedural barriers. Pharmacy contracts should preserve pharmacies' ability to pursue judicial relief and participate in appropriate collective legal actions to challenge unlawful or unfair PBM practices.

The standards should include clear expectations concerning contract disclosure, reimbursement transparency, network participation, audit procedures, and dispute resolution.

We also encourage CMS to coordinate these standards with the new PBM disclosure and remuneration requirements established by Congress. These provisions should work together rather than create overlapping requirements that leave pharmacies unable to determine their actual contractual rights.

Conclusion

Independent community pharmacies remain an important part of the Medicare prescription drug delivery system. They provide continuity of care, personal relationships, medication counseling, and access to prescriptions in communities that cannot always depend on larger pharmacy chains.

The continued loss of independent pharmacies should concern policymakers, particularly when Medicare beneficiaries may have fewer convenient options for obtaining their medications.

We believe the standards CMS develops should reflect a simple principle: pharmacy contracts should be fair, understandable, and economically reasonable, with participation requirements that are applied consistently.

Medicare beneficiaries benefit when qualified pharmacies can compete, and when patients have a meaningful choice about where to obtain their medications.

NPSC appreciates CMS's consideration of these comments and welcomes the opportunity to continue contributing to this discussion as the agency develops its proposed standards.

Sincerely,

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