November 21, 2026

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

RE: Medicare Part D Reasonable and Relevant Pharmacy Contracting Standards

Dear CMS Administrator:

Founded in 1882, the Arkansas Pharmacists Association represents more than 2,000 pharmacists, student pharmacists, pharmacy technicians, associate members, and pharmacy owners across Arkansas. Our members serve patients in communities throughout the state and have a direct interest in fair pharmacy contracting, sustainable reimbursement, and reliable access to medications and pharmacy services.

On behalf of the Arkansas Pharmacists Association, we are very pleased that Congress enacted legislation requiring the Centers for Medicare & Medicaid Services (CMS) to define and enforce reasonable and relevant Medicare Part D contract terms, including pricing, between pharmacy benefit managers (PBMs), health plans, and pharmacies. This important federal reform presents an opportunity to address longstanding pharmacy pricing problems by establishing transparent standards that account for the actual cost of acquiring medications, the professional cost of dispensing them, and other necessary expenses of operating a pharmacy and providing pharmacist professional services. We strongly support meaningful, enforceable standards that protect Medicare beneficiaries, reduce avoidable taxpayer spending, and sustain access to pharmacies and the essential services they provide.

Pharmacy benefit managers (PBMs) and health plans often control network participation through contracts offering little meaningful negotiation. Vertically integrated PBMs and insurers may also own pharmacies receiving prescription volume and reimbursement. CMS should ensure contract terms are economically sustainable, transparent, genuinely negotiable, and protected from conflicts of interest.

1. Require Meaningful Negotiation and Eliminate Take It or Leave It Contracts
CMS should require a genuine opportunity for active, good faith negotiation between pharmacies and Part D sponsors or their PBMs. Pharmacies should not have to accept financially unsustainable reimbursement, unilateral amendments, arbitrary fees, or unreasonable operational requirements merely to serve Medicare patients.

Contracts should contain transparent reimbursement methodologies, safeguards against retroactive payment reductions, reasonable notice of changes, and an independent dispute resolution process. Any willing pharmacy protections are undermined when payment terms effectively exclude pharmacies by reimbursing below acquisition and operating costs.

CMS should adopt a measurable five-part test: a reasonable and relevant term must (1) support the cost of acquiring and dispensing each drug (2) be fully disclosed and affirmatively accepted; (3)

remove conflicts of interest for PBM affiliated pharmacies; (4) relate to the services actually furnished under Part D; and (5) be independently verifiable and enforceable. Objective differences in payment should reflect services, patient needs, or documented operating costs, not corporate ownership.

Complete contract offers should disclose all rates, fees, guarantees, performance requirements, and the applicable IIN, BIN, PCN, group, and network identifiers. CMS should require a meaningful review period, affirmative written consent for material amendments, and a stand-alone Part D schedule. Participation in Part D should not be conditioned on accepting unfavorable commercial contracts or blended guarantees and not be tied or required for participation in other or non-Medicare contracts managed by the same PBM or health plan. Contract changes affecting reimbursement, audit standards, or network status should not be imposed through unsigned provider manuals or unilateral bulletins.

Any willing pharmacy protections should extend to pharmacies meeting published objective services. The same principle must protect patients served by unaffiliated independent, chain, mail order, hospital, FQHC, specialty, infusion, and other pharmacies. Network termination should require documented cause, notice, and an independent appeal, rather than functioning as an indirect means of excluding a competing pharmacy.

2. Eliminate Conflicts of Interest and Protect Taxpayers

The Federal Trade Commission's July 2024 and January 2025 PBM Section 6(b) reports documented striking disparities in reimbursement to vertically integrated PBMs' affiliated pharmacies. The July 2024 report identified nearly $1.6 billion in dispensing revenue above the National Average Drug Acquisition Cost (NADAC) for just two generic cancer medications, abiraterone for prostate cancer and imatinib for leukemia, at PBM-affiliated pharmacies from 2020 through part of 2022 across commercial insurance and Medicare Part D. In the Medicare Part D program specifically, the FTC reported that 2022 reimbursement to affiliated pharmacies for these drugs was approximately 23 times NADAC for abiraterone and 36 times NADAC for imatinib. The January 2025 report found more than $7.3 billion in affiliated-pharmacy specialty generic dispensing revenue above NADAC during 2017 through 2022, including approximately $1.4 billion attributable to Medicare Part D. They demonstrate why reasonable and relevant Medicare Part D terms must address excessive affiliate pricing, apply objective and transparent reimbursement standards, and protect patients from the conflicts of interest inherent when PBMs set reimbursement for pharmacies they also own. [1, 2]

CMS should prohibit discriminatory reimbursement favoring affiliated pharmacies, require disclosure and independent review of related party transactions, prevent financially motivated steering, and evaluate total spending to Medicare and beneficiaries. A PBM should not be able to set payment terms that disadvantage independent, chain, mail order, hospital, federally qualified health center (FQHC), specialty, infusion, and other pharmacies not owned by or affiliated with the PBM or health plan while enriching its own pharmacy business.

CMS should compare payment for the same drug and service across affiliated and unaffiliated pharmacies, require disclosure of related-party payments and patient steering arrangements, and use claim-level data to detect preferential pricing. Specialty network limitations should be justified by documented clinical or manufacturer requirements, not by the identity of the pharmacy owner.

We recommend a stronger policy to eliminate conflicts of interest for the protection of patients nationwide. Prohibit PBM and health plan ownership of competing network pharmacies. Reasonable and relevant Medicare Part D contract terms cannot include the fundamental conflict of interest that arises when a PBM or health plan serving Medicare also owns or operates pharmacies participating in the same network. A PBM should not be allowed to determine network access, reimbursement, specialty-drug distribution, or audit treatment for pharmacies with which it competes. Disclosure and payment parity are important safeguards, but they do not eliminate this structural conflict. CMS should establish and enforce a prohibition on PBMs and health plans owning or operating pharmacies in the Medicare networks they administer and support federal legislation where additional statutory authority is necessary.

Arkansas legislators addressed this conflict in Act 624 of 2025, which prohibits PBM pharmacy ownership, although its implementation has been subject to federal litigation. Tennessee has also enacted restrictions addressing PBM pharmacy ownership. On April 14, 2025, Arkansas Attorney General Tim Griffin helped lead a bipartisan coalition of 39 state and territory attorneys general urging Congress to prohibit PBMs, their parent companies, and affiliates from owning or operating pharmacies. Their appeal reinforces that this is a national patient-access and consumer-protection concern, not merely a disagreement over pharmacy contracting. [3]

This conflict carries direct patient health and safety consequences. Steering patients away from their chosen pharmacy, imposing unaffordable prices, or delaying access to specialty medications can interrupt time-sensitive treatment for patients with cancer, transplant recipients, and others with complex conditions. A systematic review and meta-analysis published in The BMJ examined seven common cancer types and found that each four-week delay in cancer treatment was associated with increased mortality; for surgery, the increase was approximately 10% on average, and certain radiotherapy and systemic treatment indications showed larger increases. The study did not examine PBM steering directly, but it demonstrates why avoidable treatment delays are a serious patient-safety issue. [4]

Medicare patients deserve timely access to lifesaving therapy at the pharmacy they choose, without financially motivated steering to an affiliated pharmacy at substantially higher reimbursement. Reasonable and relevant terms cannot excuse blatant conflicts of interest that threaten access, affordability, patient health, and safety.

3. Establish Public, Sustainable Reimbursement Benchmarks

CMS should establish a transparent reimbursement methodology modeled on state Medicaid acquisition cost principles: NADAC plus 4% plus a survey established professional cost to dispense. When NADAC is unavailable, Wholesale Acquisition Cost (WAC) should serve as the publicly available alternative benchmark, with clearly specified rules for its application.

The 4% factor would provide a modest incentive for investment in technology, clinical innovation, and pharmacy openings in rural and underserved communities. The dispensing fee should be established by a statistically valid, independent cost to dispense survey, regularly updated, and never lower than the applicable state Medicaid cost to dispense. CMS should prohibit hidden fees or adjustments that reduce effective reimbursement below the established standard.

This is an index based, market based allowable reimbursement methodology, not a fixed price or a guaranteed payment amount. The publicly available benchmark establishes an objective allowable amount, while preserving genuine price competition. Pharmacies must remain free to submit their usual and customary charges below that allowable amount, including a lower ingredient cost and dispensing fee when their purchasing efficiencies and operating model allow them to offer a lower total price.

This approach rewards pharmacies that purchase medications efficiently, innovate, and deliver high quality services at lower prices. At the same time, a transparent, consistently applied allowable methodology would help prevent excessive reimbursement to PBM owned pharmacies (as it exists today) and replace arbitrary, discriminatory pricing terms that can distort competition, threaten independent, chain, mail order, hospital, federally qualified health center (FQHC), specialty, infusion, and other pharmacies not owned by or affiliated with the PBM or health plan. The objective is a genuine market-based price that encourages lower overall spending without sacrificing sustainable pharmacy access.

A public index-based allowable amount is a market-oriented ceiling for the standard methodology, not a mandated transaction price. Pharmacies remain free to offer a lower usual and customary cash price, including a lower ingredient charge and dispensing fee, and the plan should pay the lower applicable amount. CMS should define usual and customary as the pharmacy's own price offered to the general public, rather than prices imposed by third-party discount card or PBM programs. This preserves real price competition while preventing inflated reimbursement to conflicted PBM-owned pharmacies and opaque below-cost pricing imposed on their competitors.

The professional dispensing fee must stand on its own and cover surveyed dispensing costs, independent of any assumed ingredient-cost margin. It should be updated regularly, with annual inflation adjustments and periodic new cost surveys, and reflect documented differences in long-term care, compounding, specialty handling, infusion, and other resource-intensive services. The state Medicaid cost-to-dispense amount should be a minimum reference point for the applicable pharmacy service. A pharmacy should not have to subsidize losses on one drug class with gains on another.

NADAC is based on surveyed pharmacy acquisition invoices and offers a transparent, regularly updated market reference. When NADAC is unavailable or unsuitable, CMS should specify a transparent WAC-based fallback and permit confidential invoice verification by CMS or a neutral third party. A vertically integrated PBM should not obtain a competitor's confidential acquisition invoices to set that competitor's reimbursement. Modeled or algorithmic acquisition estimates should not displace observed costs without transparent validation and appeal rights.

CMS should expressly apply its pricing-standard update so that every claim should have a final, understandable point-of-sale reimbursement amount, without downward post-adjudication reconciliation or disguised recoupments. Any participation fees or adjustments should count when testing the actual net reimbursement against the applicable standard. Remittance advice should show claim-level payments, adjustments, and reason codes.

Arkansas has developed protections through Act 3 of 2018, Act 994 of 2019, Rule 128, and subsequent PBM legislation, but the framework continues to evolve and has not fully solved below-cost reimbursement or access losses. Kentucky, Louisiana, Montana, West Virginia, and other states

have adopted or advanced differing acquisition-cost-index, dispensing-fee, or fair-reimbursement approaches. CMS should evaluate the operative provisions and implementation of these state models, rather than rely on an unenforceable general statement of fairness. A federal standard should provide a clear, measurable baseline while respecting applicable state patient health and safety protections.

4. Address Pharmacy Closures and Rural Access in Arkansas

Our compiled records identify 61 Arkansas pharmacy closures from 2023 through November 2026: 21 in 2023, 19 in 2024, 10 in 2025, and 11 in 2026. These include closures in Bearden, Calico Rock, Carlisle, DeWitt, Dumas, Forrest City, Mena, Newport, and Palestine.

Arkansas communities including Holiday Island, Bearden, Plainview, Gillette, Cedarville, and others have lost all local pharmacy access, according to our association's assessment. Little River, Miller, and Woodruff Counties have lost all independent pharmacies. These losses extend beyond prescription dispensing: patients and facilities may also lose access to durable medical equipment, long term care and assisted living pharmacy services, hospice, customized compounding, pediatric medication flavoring, same day delivery, screenings, comprehensive vaccine services, community health worker support, and other services traditionally provided by community pharmacies. Residents, particularly older adults and people with limited transportation, have to travel farther for prescriptions, immunizations, counseling, and medication management. CMS should consider these service losses, rural network adequacy, pharmacy deserts, and financial sustainability when evaluating whether Part D contracting terms are reasonable and relevant.

Network adequacy must be measured by actual patient access and a pharmacy's ability to maintain an adequate inventory of essential medications, including cancer therapies, HIV treatments, transplant medications, and other brand name and specialty drugs, rather than merely by a signed network agreement or a pharmacy appearing in a directory. CMS should closely monitor essential rural pharmacies and communities with limited pharmacy access, evaluate whether below-cost reimbursement and anticompetitive network restrictions contribute to medication shortages or pharmacy closures, and require corrective action when contract terms jeopardize patient care.

Access to essential medications is not only a matter of patient health and safety but also a matter of national security, emergency preparedness, and disaster resilience. Rural communities in states like Arkansas must maintain reliable local access to lifesaving medications during natural disasters, disruptions to transportation, satellites and distribution systems, and potential attacks against the United States. Medicare beneficiaries should not be forced to rely exclusively on PBM-owned mail order specialty pharmacies for critical treatments, including medications for multiple myeloma, when qualified local pharmacies are willing and capable of providing those therapies. The FTC's PBM investigations have documented extraordinary markups on certain specialty generic medications and significant conflicts of interest involving vertically integrated PBMs. CMS must prohibit anticompetitive steering and network restrictions that exploit these conflicts, inflate medication costs, delay treatment, and leave vulnerable patients without timely access to lifesaving therapies. **A Medicare network that exists on paper but fails to deliver medications when patients need them is neither adequate nor reasonable and relevant.**

The consequences of unaffordable cancer medications and restrictive specialty pharmacy networks are not hypothetical. In March 2026, KAIT Region 8 News reported that Jen Holifield, a Medicare beneficiary from Gosnell, Arkansas, diagnosed with multiple myeloma, had gone more than two

months without her prescribed lenalidomide (generic Revlimid) because her 30-day copayment was an unaffordable $3,271.66 [5]. In a subsequent April 2026 investigation, KAIT documented how Hyde Pharmacy in Paragould, Arkansas, was unable to obtain authorization to dispense Revlimid or its generic because the restricted distribution network was closed to additional pharmacies, forcing a patient to rely on mail order despite having a qualified local pharmacy willing to provide treatment [6]. These examples expose what is fundamentally broken in Medicare Part D: patients facing life-threatening cancers can be denied timely, affordable access to essential medications while restrictive pharmacy networks limit patient choice and prevent local pharmacists from providing care. CMS must prohibit anticompetitive pharmacy steering and unjustified network restrictions, ensure that qualified pharmacies can dispense lifesaving specialty medications, and measure network adequacy by actual patient access rather than pharmacies listed on paper. A Medicare program that allows cancer patients to go without prescribed treatment while qualified local pharmacies are excluded from dispensing those medications is failing the very patients it was created to serve.

5. Require State Licensure and Independent, Uniform Pharmacy Audits

CMS should require PBMs administering Medicare Part D benefits in Arkansas to maintain applicable licensure with the Arkansas Insurance Department and comply with Arkansas pharmacy audit protections and oversight standards to the fullest extent permitted by federal law. Medicare contracting should not become a vehicle for evading valid state safeguards.

Audits are essential for preventing fraud, waste, and abuse, but should be performed by qualified, independent companies without ownership or competitive interests in the pharmacies being audited. A PBM or plan that owns competing pharmacies should not control audits of independent, chain, mail order, hospital, federally qualified health center (FQHC), specialty, infusion, and other pharmacies not owned by or affiliated with the PBM or health plan.

All pharmacy types, including independent, chain, mail order, hospital, federally qualified health center (FQHC), specialty, infusion, and other pharmacies not owned by or affiliated with the PBM or health plan, as well as PBM affiliated pharmacies should be audited under the same objective criteria, documentation rules, and enforcement methods. CMS should prohibit selective targeting, disproportionate recoupments for minor clerical errors, retaliation, and audit practices designed to force independent, chain, mail order, hospital, federally qualified health center (FQHC), specialty, infusion, and other pharmacies not owned by or affiliated with the PBM or health plan out of networks or redirect patients to PBM owned competitors.

Pharmacies should receive reasonable notice, opportunities to correct or explain discrepancies, and independent appeals. CMS should coordinate with state insurance regulators and impose meaningful consequences for abusive or discriminatory audits. In rural Arkansas, audit abuse can threaten the viability of a pharmacy and eliminate local access to care.

Audit contracts should require advance notice, a defined look-back period, claim-by-claim findings, disclosure of the legal or contractual basis for each finding, a meaningful correction period, and independent appeals before recoupment. Harmless clerical errors that cause no financial loss should not justify full-claim recovery. Extrapolation should be tightly restricted and supported by a disclosed, statistically sound method and substantive program-integrity findings. Auditors must not be compensated based on recoupment amounts.

PBM affiliated pharmacies and unaffiliated pharmacies should face identical audit criteria and scrutiny. Automated tools used to select claims, determine payment, or flag pharmacies for audit

should be explainable and contestable. CMS should require sponsors to independently validate the pricing and audit information supplied by their PBMs, particularly where the PBM owns competing pharmacies. Arkansas's pharmacy audit bill of rights and subsequent enforcement legislation provide useful state experience for developing federal safeguards.

6. Enforce Compliance and Accountability

CMS should require Part D sponsors and PBMs to demonstrate compliance through transparent reporting, independent audits, disclosure of PBM and health plan affiliate pharmacy payment arrangements, accessible complaint processes, and meaningful penalties. Oversight should assess whether contracts increase total prescription drug spending, promote steering, or threaten access in underserved areas.

Each sponsor should annually certify compliance and submit complete model contracts, reimbursement schedules, affiliate payment comparisons, audit policies, and reimbursement-to-NADAC analyses by pharmacy type. CMS should provide a protected allegation and dispute process, prohibit retaliation or confidentiality provisions that impede reporting to CMS, and publish meaningful enforcement outcomes. Pharmacy performance programs should be transparent, based on validated and appropriately risk-adjusted measures, and offer upside incentives above a sustainable base payment rather than creating new below-cost reimbursement through unattainable guarantees. Contractual average pricing guarantees are often gamed to guarantee below cost prices to unaffiliated pharmacies and guarantee massive markups at PBM affiliated pharmacies. "Guarantees" add an unnecessary level of opaqueness and complexity that PBMs use to game pricing in an anticompetitive way for both patients and for local unaffiliated pharmacies (pharmacies not owned or operated by PBMs) in rural communities.

These reasonable and relevant standards should apply to both stand-alone Part D and Medicare Advantage prescription drug plans. Implementation should allow adequate lead time for pharmacy review and execution of complete agreements before the applicable plan year. CMS should also address long-term care and assisted living dispensing, selected drugs subject to maximum fair prices, and separately reimbursable clinical services so that complex care is not forced into an unsuitable retail payment structure.

Conclusion

CMS should define reasonable and relevant terms to require genuine negotiation, prohibit coercive contracting, address vertically integrated conflicts of interest including banning PBMs from acting as both a PBM in Medicare and also operating affiliated pharmacies in its own networks, and establish reimbursement based on NADAC or WAC, a 4% acquisition cost adjustment, and a survey established dispensing fee no lower than the applicable state Medicaid cost to dispense.

CMS should also preserve applicable state PBM licensure and pharmacy audit protections, and require independent, consistent audits that cannot be weaponized against competing pharmacies. A contract is not reasonable if it forces a pharmacy to operate at a loss, and an audit is not fair if it is used to eliminate competition rather than protect patients and taxpayers.

Thank you for considering these comments.

Sincerely,

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References

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[2] Federal Trade Commission. Specialty Generic Drugs: A Growing Profit Center for Vertically Integrated Pharmacy Benefit Managers. January 2025. https://www.ftc.gov/system/files/ftc_gov/pdf/PBM-6b-Second-Interim-Staff-Report.pdf

[3] National Association of Attorneys General. Letter Urging Prohibition of Pharmacy Benefit Managers from Owning or Operating Pharmacies. April 14, 2025. https://www.naag.org/policy-letter/letter-urging-prohibition-of-pharmacy-benefit-managers-from-owning-or-operating-pharmacies/

[4] Hanna TP, et al. Mortality due to cancer treatment delay: systematic review and meta-analysis. BMJ. 2020;371:m4087. https://doi.org/10.1136/bmj.m4087

[5] Davis M. Medication Cost Prevents Cancer Patient from Accessing Treatment. KAIT Region 8 News. March 2026. https://www.kait8.com/2026/03/09/medication-cost-prevents-cancer-patient-accessing-treatment/

[6] Davis M. Continued Coverage: Pharmacies Struggle Accessing Life-Extending Cancer Drug. KAIT Region 8 News. April 2026. https://www.kait8.com/2026/04/10/continued-coverage-pharmacies-struggle-accessing-life-extending-cancer-drug/

Appendix A. Arkansas Pharmacy Closures, 2023–2026

Compiled pharmacy closure list provided for this comment. Total: 61 locations. Names are retained as supplied, with minor city spelling standardization. This list has not been independently verified.

2026 (11)

No.	City	Pharmacy
1	Bearden	Bearden Pharmacy
2	Benton	Finley's / Allcare
3	Danville	Walgreens
4	De Queen	Harris Drug
5	DeWitt	Tommy's Rexall
6	Forrest City	St. Francis Pharmacy
7	Jonesboro	Camp's Medical Pharmacy
8	Malvern	Millers Drug Store
9	Marked Tree	Southern Pharmacy
10	Mena	Walgreens
11	Pine Bluff	Flowers Pharmacy

2025 (10)

No.	City	Pharmacy
1	Carlisle	Medskers
2	Dumas	Lees Super
3	Fayetteville	Walgreens
4	Forrest City	Price Harris
5	Glenwood	Phil's Eastside Pharmacy
6	Monette	Southern Pharmacy
7	Newport	Walgreens
8	Palestine	Palestine Family Pharmacy
9	Van Buren	Super Sav 3
10	White Hall	Doctors Orders Dollarway

2024 (19)

No.	City	Pharmacy
1	Ashdown	Walgreens 21500
2	Conway	Turbare
3	Dumas	Meador
4	El Dorado	Mid-South
5	Fort Smith	Chaffee Pharmacy
6	Jonesboro	Walgreens 01952
7	Little Rock	Cash Saver Colonel Glen
8	Little Rock	Walgreens 03412 Baseline
9	Little Rock	Walgreens 11345 Cantrell
10	Little Rock	Walgreens 15792 Stagec.
11	Marshall	Baker Pharmacy
12	Maumelle	Fresenius
13	McCrory	Best Drug
14	Morrilton	Lemons
15	North Little Rock	PharMerica
16	North Little Rock	Walgreens 10352 McCain
17	Stuttgart	Dean's #2
18	Texarkana	College Hill
19	Wynne	Delta Community Pharmacy

2023 (21)

No.	City	Pharmacy
1	Arkadelphia	Allcare
2	Arkadelphia	Brookshire #96
3	Barling	Health Depot #2
4	Benton	Smith Caldwell
5	Calico Rock	Triple S
6	Camden	Super One #651
7	El Dorado	Brookshire #40
8	El Dorado	Brookshire #48
9	Forrest City	Walgreens 11344

10	Fort Smith	Health Depot #1 271
11	Fort Smith	Stonewood Village
12	Greenwood	Health Depot #3
13	Greenwood	Health-Wise
14	Harrison	Nikki's HT
15	Hope	Super One #619
16	Hot Springs	Hometown
17	Hot Springs	Lakeside
18	Magnolia	Brookshire #81
19	Malvern	Malvern Family
20	Mansfield	Health-Wise
21	Mena	Medi Shop