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American Society of Consultant Pharmacists

Policy Document: ASCP Recommendations to Health Insurance Plans and Pharmacy Benefit Managers (PBMs)

The American Society of Consultant Pharmacists (ASCP) hereby provides the following policy recommendations to insurance plans and pharmacy benefit managers to establish sustainable reimbursement practices for medications with a Maximum Fair Price (MFP) negotiated by the Centers for Medicare and Medicaid Services (CMS) under the Medicare Drug Price Negotiation Program (MDPNP.)

ASCP is the only international professional society devoted to optimal medication management and improved health outcomes for older adults. ASCP represents the nation's 1,800 long-term care (LTC) pharmacies and 5,000 pharmacist members who manage medications and improve the quality of life of older adult and medically complex patients and others living in various settings, including sub-acute and long-term care facilities (LTCF), skilled nursing facilities (SNFs), assisted living communities, psychiatric hospitals, hospice programs, correctional facilities, home and community-based care.

Provisions of the *Inflation Reduction Act* (*IRA*) of 2022 have and will continue to significantly impact long-term care pharmacies by introducing changes to Medicare reimbursement, drug pricing, and payment models, creating both opportunities and challenges. The *IRA*'s provisions, such as the Medicare Drug Price Negotiation Program and inflation rebates, aim to lower prescription drug costs for individuals covered by Medicare. However, the long-term care pharmacies who serve these beneficiaries, are facing financial pressures from reduced reimbursement (generally and specifically for medications with negotiated prices), pricing constraints from PBMs, and projected declines in operating margins tied to average wholesale prices that could end operational viability for most small to medium-sized LTC pharmacies which would reduce patient's access to care and competition within the LTC pharmacy sector. Additionally, the *Act*'s focus on high-cost, single-source drugs may alter formularies, requiring LTC pharmacies to adapt to new pricing structures and negotiate contracts strategically to maintain sustainability, while benefiting from enhanced data and compliance support to navigate these changes.

In today's world, many people use Artificial Intelligence (AI) to understand public policy and the impacts of public policy on industries. A search of artificial intelligence platforms reveals that much of the impact on long term care pharmacy is misconstrued. For example, artificial intelligence platforms report opportunities for long-term care pharmacies by "potentially improving medication adherence and increasing prescription volumes for LTC pharmacies". In both cases, this is flatly untrue.

What is a long-term care pharmacy?
Long-term care (LTC) pharmacies are highly specialized pharmacies that serve medically

complex individuals residing in multiple types of care settings, including skilled nursing facilities (SNFs) nursing homes, assisted living facilities, group homes for people with disabilities and at home; the complexity of their associated health conditions often requires ongoing medication management. The Nursing Home Reform Act of 1987 created the requirement for LTC pharmacy services for certain LTC facilities to emphasize the importance of specialized medication access in settings caring for vulnerable patients.

While all pharmacists take care to ensure appropriate and safe care, LTC pharmacies take additional dispensing steps in order to deliver medications in a manner while ensuring the right dose for the right patient at the right time, every time. LTC pharmacies dispense medications in specialized packaging, often specific to the patient or their care setting, to support medication adherence and management goals. LTC pharmacies also provide 24/7/365 pharmacist support, manage complex drug regimens, review drug utilization, conduct medication reconciliation during care transitions, ensure timely medication deliveries, and help prevent medication errors by working closely with health care providers. In total, CMS regulations within Chapter 5 of the State Operations Manual defines an LTC pharmacy based on its service to a long-term facility as well as its ability to deliver ten (10) specialized services that support high-quality patient care across settings, including high-acuity settings like skilled nursing facilities.

How does the *IRA* impact LTC pharmacies?

The *IRA* changes the way medications are reimbursed for eligible Medicare Part D beneficiaries while economic forces have shifted and will continue shifting prices. Long-term care pharmacies must now purchase medication at the usual cost (Wholesale Acquisition Cost – WAC) and then dispense that medication, being reimbursed only the Maximum Fair Price (MFP,) negotiated by CMS. Today, LTC pharmacies reimbursement associated with medications often includes more than just simply WAC given the increased cost of dispensing into LTC facilities and associated services with serving a LTC facility.

With the *IRA*, the difference in the purchase price (WAC) and the reimbursement from plans/PBMs (MFP), referred to by CMS as the Standard Default Refund Amount (SDRA), can be hundreds, even thousands of dollars; pharmaceutical manufacturers are to reimburse the difference between the cost paid by the pharmacy and the MFP reimbursement. The new, secondary transaction between the pharmacy and the primary pharmaceutical manufacturer will create a new transaction-based relationship between the two entities. However, the current guidelines from CMS allow manufacturers 14 days to make the SDRA payment on top of the 7 days allowed for PDE file processing by the PBM/insurer. In total, the new system means pharmacies will be floating the difference, likely thousands of dollars at time, for weeks.

Additionally, no provisions within the *IRA* or from CMS allow long-term care pharmacies to be made whole or ensure a fair and reasonable for their dispensing and associated professional services. Instead, current guidance creates a gray area to provide less than the cost of the medication's MFP, a critical challenge for LTC pharmacy as approximately 70 percent of prescriptions dispensed by LTC pharmacies are for MFP-eligible individuals.

It is estimated that the first ten (10) medications, set to enter the new pricing system 1/1/2026, will cause the typical long term care pharmacy to see a more than 27 percent decrease in revenue.[i] Surveys of long-term care pharmacies in advance of *IRA* implementation found that:

- 60% would be forced to close pharmacy locations,
- 91% would be forced to lay off pharmacy staff,
- 85% would be forced to limit essential services,
- 82% would be forced to shift costs to LTC customers, and
- 56% would be challenged to dispense certain medications.[ii]

Additionally, the time frames at work within this new MFP/SDRA reimbursement system is 21-35 days, more than twice what is currently typical in the LTC sector. The new model forces LTC pharmacies to float the SDRA for several weeks, even after the required, contractual payment to wholesalers. CMS recognized this reality in Section 40.4.2 of its final guidance and directed manufacturers to address these pharmacy cash flow challenges in their effectuation plan, specifically citing LTC pharmacies.[iii]

Recommendations:
To maintain continuity of care for highly vulnerable, long-term care patients, both the Plan/PBM and the manufacturer must consider the impact on LTC pharmacy and patients' access to care by providing sufficient reimbursement for the associated professional services, beyond the cost of the product.

ASCP, working with its pharmacies serving the LTC setting, has developed specific and critical strategies to guide plans and PBMs to ensure the sustainability of LTC pharmacies. Without such strategies many skilled nursing facilities, nursing homes, assisted living communities, group home patients and home-based patients would face access and safety issues immediately upon program implementation on January 1, 2026.

The list of critical steps plans and PBMs must take with LTC pharmacies to ensure sustainability:

- Payers must reimburse at no less than the negotiated MFP;
- Payers must pay a professional dispensing fee on prescriptions dispensed under the MDPNP program that is reasonable and adequate to provide the highly specialized and highly regulated services necessary to serve residents of long-term care facilities;
- While CMS allows 7-day for claims processing, many payers can and therefore should process claims as quickly possible to facilitate timely reimbursement from manufacturers; and
- Payers should not engage in the relationship between pharmacies and manufacturers, nor require any data or contractual information of the pharmacy-manufacturer relationship

Payers must reimburse at least the negotiated MFP

The *IRA* lacks sufficient guidance regarding the reimbursement mechanisms or formulas between the manufacturer and the pharmacy. IRA creates a transaction-based relationship between pharmacies and manufacturers while providing vague guidance statements regarding pricing formulas for the refunded amount determined from the acquisition cost and the MFP. It is likely that the total reimbursement of a medication governed by MFP will not be revenue nor operating margin neutral, resulting in significant financial hardship for the pharmacy. Considering the administrative cost of reconciling the complex reimbursement by transaction and the costs to extend credit to carry this program since the reimbursement for the manufacturers will delay payment by at least 21 days, pharmacies will dispense drugs under the MDPNP below cost. Given MDPNP medications represent a significant majority of LTC pharmacy dispensing, it is, therefore, critical that the plans/PBMs reimburse LTC pharmacies MFP for the ingredient cost.

Payers must pay a professional dispensing fee on prescriptions dispensed under the program

Since the reimbursement for the product will be significantly less for LTC pharmacies, payment for the services rendered by the pharmacy must be ***reasonable and adequate***. **We recommend a $30 additional payment, per dispensed MFP product**, until the current LTC reimbursement model is modified to ensure continued access for patients residing in LTC facilities.

The Centers for Medicare & Medicaid Services (CMS) defines the professional dispensing fee for pharmacies as an amount paid to cover the costs of dispensing a prescription to a Medicaid or Medicare beneficiary, encompassing professional services and overhead costs, such as mixing drugs, delivery, and patient counseling. For Medicare Part D, CMS encourages plans to pay professional dispensing fees that account for the complexity of services, particularly for specialized settings like long-term care (LTC) facilities.

A recent study published by CliftonLarsonAllen LLC found that the average LTC pharmacy dispensing cost was $14.54 (median) and $15.41 (average) in 2023[i]. Additionally, research has found that a dispensing fee, for LTC pharmacies, would range from $16.95-$17.65 and be adjusted for inflation over time.[iv] If the SDRA is not implemented and discounts also go away for brand dispensing, LTC pharmacies will need a $30 dispensing fee for MFP drugs to maintain status quo of their operations.[v]

Payers can and therefore, should process claims as quickly as possible to facilitate timely reimbursement from manufacturers

As described, *IRA* implementation will be achieved with a new Medicare Transaction Facilitator (MTF) Data Module (MTF DM) that collects a transition for a Medicare beneficiary, presents that transaction to the payer and, once, verified by the payers, presents the transaction to the manufacturer for payment to the pharmacy, via an X12 835 claim. This process can delay payment to the pharmacy by 21 days causing the pharmacy to endure cash flow shortages. In CMS' recent *Draft Guidance on the Medicare Drug Price Negotiation Program*, CMS stated that that following types of pharmacies can self-identify to manufacturers as having cash flow concerns:

> "For example, CMS expects dispensing entities of the types that have raised material concerns about cashflow related to the effectuation of MFP—such as sole proprietor rural and urban pharmacies with high volume of Medicare Part D prescriptions dispensed, pharmacies who predominantly rely on prescription revenue to maintain business operations, **long-term care pharmacies**, 340B covered entities with in-house pharmacies, and Indian Health Service, Tribal, and Urban Indian (I/T/U) pharmacies—may self-identify through this process[vi]."

While this guidance directs manufacturers to assist in cash flow mitigation for pharmacies, plans and PBMs, thanks to investments and advances in technology, can and therefore should process claims immediately to help shorten the time from services to payment. Speedy adjunction of the claim by the PBM/payer will help mitigate the material cashflow challenges that LTC pharmacies will face under the *IRA*.

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[i] https://www.mcknights.com/news/60-percent-of-ltc-pharmacies-warn-of-closure-amid-major-drug-pricing-changes/
[ii] https://seniorcarepharmacies.org/new-scpc-member-survey-shows-more-than-half-of-americas-ltc-pharmacies-may-close-locations-without-congressional-action/
[iii] https://www.cms.gov/files/document/medicare-drug-price-negotiation-final-guidance-ipay-2027-and-manufacturer-effectuation-mfp-2026-2027.pdf
[iv] https://seniorcarepharmacies.org/wp-content/uploads/CLA_Long-Term_Care_Pharmacy_Cost_Analysis.pdf
[v] https://seniorcarepharmacies.org/scpc-releases-statement-in-support-of-government-accountability-office-gao-report-on-the-inflation-reduction-act/
[vi] https://www.cms.gov/files/document/ipay-2028-draft-guidance.pdf