Pharmacists United for Truth & Transparency

November 23, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4217-NC
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Request for Information; Medicare Part D Reasonable and Relevant Pharmacy Contracting Standards (CMS-4217-NC; Docket No. CMS-2026-3037)

Administrator Oz:

I write to you on behalf of the Board of Directors and members of Pharmacists United for Truth and Transparency (PUTT) in response to CMS's Request for Information on reasonable and relevant pharmacy contracting terms and conditions. We thank you and CMS staff for the opportunity to submit our feedback on this urgent matter.

Pharmacists United for Truth and Transparency was founded in 2011 in direct response to the anti-competitive business practices of the largest pharmacy benefit managers (PBMs). PUTT's mission is to bring awareness, backed by evidence, of the depth and breadth of negative impact these practices have on pharmacies' ability to provide patient access to care.

We submit the following recommendations for shaping Part D contract terms to be more reasonable and relevant to pharmacies in order that our nation's retail pharmacies, whether independently owned or part of a national retail chain, can remain open and accessible to patients and readily available patient care.

Reimbursement & Pricing (Section A)

The reality: Pharmacies are financing Part D: they're paid too little and too slowly to stay open.

We ask the following of CMS:

1. Reimbursement equal to NADAC + the state average dispensing fee + a percentage to offset the cost of floating plan payments. H.R. 6610, the Pharmacists Fight Back Act in the Federal Employees Health Benefit Plan, is similarly structured, with the offset percentage equal to 4% of ingredient cost capped at a maximum of $50. With a "floor" to prevent below-cost reimbursements that threaten a pharmacy's viability, and a "ceiling" ensuring the most Part D pays above NADAC is $50 plus a predictable dispensing fee, costs become manageable for the federal government. Pharmacies can dispense Part D medications without concern for under-

water reimbursement. CMS established NADAC more than a decade ago[1] and it is the most reliable price-predictor for medication cost. It should be used as the primary index for establishing a pharmacy's drug reimbursement.
2. Reduce the 14-day standard payment window to 3 business days, consistent with how most businesses conduct payment and fund transfers.
3. Require the same reimbursement for a drug regardless of the benefit phase the patient is in[2].
4. Ban regressive multi-year rate schedules[3].
5. End proprietary or private-label NDCs that let PBM-owned pharmacies be paid differently (often much more) for the same drug found in retail pharmacies.

Current Contracting Practices (Section B)

The reality: There is no actual negotiation in Part D contracting. Pharmacies are given take-it-or-leave-it terms, must sign an NDA to see their own contract, and experience their contract terms changed by faxed memo. The process should be rebuilt so both sides have equal weight and terms are transparent.

We ask the following:

1. As Part D is a government program, have one standard Part D pharmacy contract for every pharmacy.
2. Contracts should be relatively short (e.g. 3 pages) and focused on the service pharmacies are to provide to patients on behalf of the federal government. Current contracts exceed 40 pages and contain terms and conditions more concerned with limiting a pharmacy's ability to provide open, transparent patient care.
3. Eliminate the PBM practice of distributing contract changes through passive amendments. Pricing or contract terms should not be changed through provider manual updates, faxed bulletins, website postings, etc.
4. Deliver contracts and amendments through a trackable e-signature system like DocuSign, with at least 30 days to review and respond.
5. No terminating or dropping a pharmacy mid-plan-year without proof of fraud.
6. No all-or-nothing contracts, and no tying participation in one network to another (Medicare to Medicaid or vice versa).
7. Any term or protection offered to one pharmacy or chain must be offered to all.
8. Ban gag clauses outright. Pharmacies should be free to discuss medication cost or other relevant, non-HIPAA related information with patients and plan sponsors when necessary and relevant to the patient or plan sponsor's interests.[4]

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[1] Methodology for Calculating the National Average Drug Acquisition Cost (NADAC), December 2024 p. 4. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/prescription-drugs/ful-nadac-downloads/nadacmethodology.pdf Accessed 11/23/2026

[2] One of the "Big 3" PBMs charges $70 for a commonly-prescribed medication during the deductible phase, which the patient pays in full, then $6.16 once the plan is responsible. This unfairly shifts the payment burden to the patient.

[3] One of the "Big 3" PBMs had the following "step down" in reimbursement per year of the contract: AWP −20%, then −24%, then −28%. Pharmacies must accept the whole contract, knowing their own costs are increasing, while their reimbursements are decreasing.

[4] Pharmacies can tell patients the cash price vs. their copay. They can't tell a local employer, "I'm only getting paid $4 on Ozempic." A PUTT member was penalized by a "Big 3" PBM after telling a TRICARE patient she'd lose money filling the prescription; the patient complained to TRICARE and the pharmacist was threatened with network expulsion.

Pharmacy quality & performance measures (Section D)

The reality: Performance measures like EQuIPP penalize pharmacies for serving the sickest patients and for outcomes they can't control. They were built for plan Star Ratings, not to measure pharmacy quality.

We ask CMS to:

1. Eliminate the use of the Star Rating measures[5], which are meant to score Plan quality instead of provider quality, to score or justify clawing back payments from pharmacies.[6]
2. Measures must be risk-adjusted, within the pharmacy's control, and the same for every pharmacy.
3. Pharmacies are allowed to receive full access to their measures and data, plus a formal appeal process (plans can sue CMS over their ratings; pharmacies have no recourse).[7]
4. Exclude patients who are deceased, discontinued by their prescriber, clinically ineligible, moved into a facility, or filling elsewhere.
5. Quality oversight stays with state boards of pharmacy, not plans. Several Plans are overriding state boards of pharmacy, a states' rights issue.

Other Areas of Concern Not Necessarily Addressed in the RFI:

Auditing practices & clawbacks

The reality: A 10-year audit window is longer than the IRS requires, and PBMs already have point-of-sale edits and AI to catch problems up front. Audit and clawback powers should shrink to match.

We ask CMS to:

1. Shorten the audit lookback. Possible trade-off: if pharmacies are paid within 48 hours, allow audits up to 1 year after adjudication. If payment still takes 14 days, no audits after payment.
2. Allow clawbacks only for documented fraud, waste or abuse, not technical or paperwork errors.[8]
3. PBMs with concerns about a pharmacy should take them to the state board of pharmacy, which can open an investigation.
4. Extend the audit protections the chains have negotiated to every pharmacy.[9]

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[5] Several very large PBMs exploit the performance-network loophole.

[6] Pharmacies are penalized when: A doctor stops a medication ("you lost 80 pounds, you don't need this anymore"); a diabetic patient isn't on a statin, even if they're allergic or don't need one; A patient moves into a nursing home and switches pharmacies; patient dies; PUTT member pharmacies have been penalized for an expired patient's missed refills; a visiting patient from out of state fills once and returns to their home state.

[7] At least 14 Medicare Advantage insurers have sued CMS over 2027 Star Ratings, saying $4.1B in quality bonuses is at stake.

[8] From a PUTT member pharmacy: "We provided a service. We took care of a customer. They took the drug. There's no reason to claw it back unless I'm fraudulent."

[9] We know from a review of contracts that have been mistakenly sent to PUTT members that CVS and Walgreens contracts include audit protections independents aren't offered: Auditors can't review their signature logs. They don't have to return unclaimed prescriptions to stock within 10 days; items can sit for months.

Forced arbitration

The reality: Mandatory arbitration clauses mean pharmacies effectively can't hold PBMs accountable for contract violations when needed.

We ask CMS to:

1. Restore pharmacies' right to sue, individually or as a class. Contracts require arbitration and block class actions; pharmacies with the same problem must each file separately.
2. Prohibit mandatory arbitration clauses in Part D pharmacy contracts. PBM mandatory arbitration is set up to favor the PBM. PUTT members and their attorneys have reported to us that arbitration requires 3 arbitrators, each with 10+ years of experience and pharmacy expertise. Cost is roughly $250,000 minimum per pharmacy and travel is required to arbitrate in the PBM's home state or jurisdiction (e.g. Express Scripts in Missouri, Caremark in Arizona, etc)
3. Where arbitration is used, hold it in the pharmacy's home state, cap costs, and publish outcomes so a precedent may be set for other pharmacies facing similar or identical complaints. Currently a win doesn't set precedent and can't be made public.

Preferred networks, steering & formularies

The reality: Preferred pharmacy networks steer patients away from the pharmacy they choose, and in rural areas that can mean a 30–50 mile drive. Every network pharmacy should be treated the same.

We ask CMS to:

1. Eliminate preferred and restricted pharmacy networks in Part D. They only benefit the PBM and its owned/affiliated pharmacies but create obstacles to care for patients who want to work with the pharmacy of their choice.
2. Allow any pharmacy willing to accept standard terms to participate on equal footing, specialty drugs included.
3. Abolish mid-year formulary changes, or, alternatively, allow pharmacies the same flexibility as Part D plans.[10]

PBM "Transaction Fees"

The reality: PBMs charge pharmacies to use the only claims system they're allowed to use. That passes a PBM's own business costs onto small businesses, and state bans can't reach federal plans. PBMs additionally charge "accreditation" and "credentialing" fees to be part of the PBM's pharmacy network, and often require pharmacies to adhere to standards higher than the pharmacy's State Board of Pharmacy.

We ask CMS to:

1. Ban claim transaction fees in Part D. Electronic submission is the only option: PBMs won't accept paper Universal Claim Forms, then charge pharmacies to use their system

[10] Formularies change every year, and often include seemingly random mid-year changes. When Part D formularies change mid-year, pharmacies don't have enough time to adjust accordingly. Example: Farxiga had a generic this year but stayed on the brand-name program.

2. Ban PBM accreditation or credentialing fees for pharmacies in good standing with their state board of pharmacy.
3. Require PBMs to use the data pharmacies already report to NCPDP instead of requiring separate, paid credentialing.

Enforcement & implementation

The reality: New standards won't matter without enforcement. For decades, CMS's answer to pharmacy complaints has been "we don't get involved in contracts."

We ask the following:

1. Create a dedicated Part D enforcement unit with authority to investigate and assess meaningful fines on PBMs for violation of CMS contract terms and conditions and include admission of wrongdoing. Avoid inadvertently supporting the notion that PBMs are somehow "too big to fail" when the work of patient care is still falling on pharmacies.[11]
2. Penalties assessed on PBMs for violations of their contract with CMS are large enough to change behavior. PBMs convicted of fraud, waste or abuse should lose their contracts, just as a pharmacy would.

Unexplained Claims Rejections

The reality: Unnecessary or unexplained claim rejections delay patients' medications and generate more transaction fees.[12]

We ask CMS to:

1. Require that PBMs reject a claim only because the drug isn't covered or the refill is too soon.
2. Every rejection must use the existing NCPDP response fields to say why the claim was rejected and how to fix it. Example: "omeprazole is the preferred drug."[13]

Conclusion

Patients and pharmacies share a unique relationship built on trust and accessibility. When pharmacies can't sustain operations under the contract terms they're offered, patients lose access to care.

Pharmacies have carried much of the burden of keeping Part D working for beneficiaries, and yet, because of the way Part D contract terms are written and managed by PBM Part D administrators, pharmacies continue to close at an alarming rate.

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[11] PBMs pay fines without admitting wrongdoing and keep participating, even after court findings of fraud, waste and abuse. A pharmacy in the same position would lose its contracts. Fines run $1–1.5M per incident, adding up to tens or hundreds of millions a year. The initial Omnicare settlement was almost $1B.

[12] A "Big 3" PBM consistently rejects 30-day fills to push 90-day fills and requires pharmacy to add a code and resubmit. Each resubmission generates a pharmacy-paid transaction fee to the PBM.

[13] NCPDP built those fields, but PBMs never turned them on. Some PBMs do provide reasons for claims rejection but feedback is inconsistent.

Part D was built on the promise that competition among plans would lower costs, and we respectfully ask CMS to show where that promise has been kept, for beneficiaries at the pharmacy counter and for the taxpayers who fund the program. We are confident CMS will discover that the current system is tipped grossly, favorably toward PBM profitability rather than patient care.

A system increasingly shaped by the same companies it is meant to oversee has opened the door to profiteering at the expense of patients and the pharmacies that serve them. The "reasonable and relevant" standard was meant to protect beneficiaries and pharmacies from exactly this outcome, and we hope with our feedback and that of the thousands of individuals who have also commented, CMS can help shape the future of the Part D program to reflect a necessary, positive change.

Thank you for the opportunity to submit these comments on behalf of our pharmacies, their communities, and the millions of patients they collectively serve.

Respectfully,

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Executive Director
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TruthRx.org