JULY 2024

SENIOR CARE PHARMACY COALITION

The Impact of Drug Price Negotiations on Seniors in Long-Term Care

It's Time for a Sustainable Payment Model for Long-Term Care Pharmacies

Executive Summary

For decades, long-term care (LTC) pharmacies have been the backbone of pharmacy services for the nation's most vulnerable patients. These specialized pharmacies provide hundreds of millions of medications and treatments to seniors and people with disabilities in LTC facilities every year. Unlike retail pharmacies that offer consumers convenience items in addition to pharmacy services, LTC pharmacies are closed-door operations with no revenue sources other than dispensing prescription drugs.

LTC pharmacies provide 24/7/365 access to prescription drugs and related services, including pharmacist services to advise on medication use and specialized services to ensure that prescription drugs are administered safely and effectively. Although these LTC pharmacies typically provide these services to residents in skilled nursing facilities or assisted living facilities, most Americans who need LTC live in community settings like group homes for people with disabilities or private homes. LTC pharmacy services increasingly serve patients across all settings.

Although LTC pharmacies serve vulnerable patients with complex care needs, the LTC pharmacy payment model does not provide reimbursement that covers the cost of LTC pharmacy services. Instead, insurance companies and pharmacy benefit managers (PBMs) insist on a payment model that forces LTC pharmacies to depend on high-cost brand-name drugs to subsidize the cost of providing essential and legally required services. Against this backdrop, policy-driven drug price cuts will put substantial financial pressure on LTC pharmacies and threaten access to LTC pharmacy services for many Medicare beneficiaries.

This brief report examines the people LTC pharmacies serve, the LTC pharmacy value proposition, and the urgent need for a sustainable LTC pharmacy payment model, given the instability of the current market environment and the growing impact of policy-driven changes in drug prices on the prescription drug supply chain.

The LTC Pharmacy Patient Population

About 1,200 LTC pharmacies serve more than two million residents of LTC facilities[1] and others with LTC needs every day nationwide. Most are women, most are age 75 or older (25% are 75-84, and 42% are over 85). Most are medically complex, with 77% suffering from multiple chronic conditions like diabetes, high blood pressure, heart disease, and depression. Seventy-five percent have impairments in at least three of the six activities of daily living, which include walking, dressing, bathing, transferring, toileting, and eating. More than half suffer from Alzheimer's disease or dementia.[2]

The LTC patient population relies heavily on prescription drugs for their health and quality of life. **The average patient in an LTC facility takes 13 prescription drugs** to manage multiple conditions or health issues and typically requires assistance to take these medications properly.

LTC PHARMACY BY THE NUMBERS

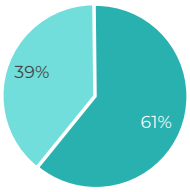
200 Million – annual number of Rx meds LTC pharmacies dispense to Part D patients
1,200 - number of LTC pharmacies serving 2 million LTC residents nationwide
13 - average number of Rx medications prescribed to patients in LTC settings
75% - percentage of LTC pharmacy revenues from Medicare Part D
$15 - average COST for LTC pharmacy services to dispense one prescription
$4 - average Part D Plan PAYMENT to reimburse LTC pharmacies to dispense one Rx

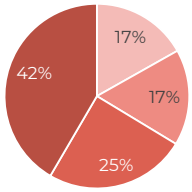
From the inception of the Medicare and Medicaid programs in 1965 until the mid-1990s, federal and state LTC focused on individuals living in skilled nursing facilities (SNFs), nursing facilities (NFs), and intermediate care facilities (ICFs) (collectively, nursing facilities), primarily because these programs only paid for LTC services in these facilities.3 Roughly 1.2 million Americans live in these nursing facilities.[3]

As policymakers worked to "rebalance" Medicaid LTC between facility-based and community-based services and as individuals with private resources sought alternatives to nursing homes, assisted living communities grew, such that **more than 800,000 Americans now reside in assisted living facilities (ALFs)**.[4]

The care needs of residents in ALFs increasingly mirror those of residents in SNFs, NFs, and ICFs. Not surprisingly, residents in ALFs increasingly need LTC pharmacy services, and LTC pharmacies now serve many of these residents. A comparison of patient characteristics in each setting underscores the common need regardless of setting:

Residents in Nursing Facilities or Assisted Living: Demographic, Clinical, and Functional Profile





Male Female

<65 65-74 75-84 85+

87% Difficulty Bathing	79% Difficulty Dressing	73% Difficulty Toileting	68% Difficulty with Chair Transfers	67% Difficulty Walking	53% Difficulty Eating
80% HaveHighBlood Pressure	52% Have Alzheimer's Disease or Dementia	50% Have Depression	41% Have HeartDisease	39% HaveDiabetes	

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Analysis represents individuals with Medicare residing in nursing facilities or assisted living in 2021, excluding residents without Medicare. Note: Chronic conditions represent diagnosed conditions defined by CMS CCW 30 chronic conditions algorithms. Conditions are only analyzed among people with sufficient claims and with at least 12 months of Medicare FFS during the year.
Source: ATI Advisory analysis of the 2021 MCBS linked to Medicare FFS claims

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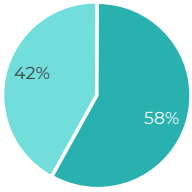
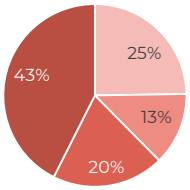
Assisted Living Residents: Demographic, Clinical, and Functional Profile





Male Female

<65 65-74 75-84 85+

71% Difficulty Bathing	57% Difficulty Dressing	46% Difficulty Toileting	38% Difficulty with Chair Transfers	39% Difficulty Walking	26% Difficulty Eating
63% HaveHighBlood Pressure	32% Have Alzheimer's Disease or Dementia	33% Have Depression	25% Have HeartDisease	23% HaveDiabetes	

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Analysis represents individuals with Medicare residing in assisted living in 2021, excluding residents without Medicare.
Note: Chronic conditions represent diagnosed conditions defined by CMS CCW 30 chronic conditions algorithms. Conditions are only analyzed among people with sufficient claims and with at least 12 months of Medicare FFS during the year.
Source: ATI Advisory analysis of the 2021 MCBS linked to Medicare FFS claims

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LTC Pharmacy 101

Medicare Part D: The Core of LTC Pharmacy

LTC pharmacies emerged in the 1980s in response to pharmacy service requirements that Congress imposed on skilled nursing facilities (SNFs) under Medicare and on nursing facilities (NFs) and intermediate care facilities (ICFs) under Medicaid.[5] These pharmacy services requirements specify that SNFs, NFs, and ICFs either provide such services directly, or contract with pharmacies capable of doing so.

In 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act (MMA), which added a voluntary, outpatient prescription drug benefit to Medicare, and which the Centers for Medicare and Medicaid Services (CMS) implemented in 2006 as Medicare Part D. As of October 2023, the Medicare Part D program served 50.5 million Medicare beneficiaries.[6] The MMA reshaped the LTC pharmacy market, with Part D now accounting for 75% of LTC pharmacy revenues.[7]

CMS administers the Part D program through regulations and guidance.[8] The Medicare Prescription Drug Benefit Manual (Part D Manual) compiles this guidance, which focuses on the standards Part D Plan Sponsors must meet to offer Part D Plans (PDPs) to Medicare beneficiaries. PDPs must demonstrate that they have a network of LTC pharmacies adequate to assure that PDP enrollees residing in LTC facilities receive access to more extensive services than retail or mail order pharmacies provide. These services mirror and elaborate on the pharmacy services requirements Medicare and Medicaid impose on SNFs, NFs, and ICFs, and must include:

- Routine and emergency access to prescription medications.
- Timely access to prescription drugs in as little as two hours after receipt of a prescription.
- Specialized and patient-specific packaging to minimize medication errors.
- 24/7/365 delivery of prescription drugs.
- Consultant pharmacist services such as patient advice, care planning, and medication management.
- Controlled substances tracking.[9]

Given the similar patient needs across all settings, LTC pharmacies routinely extend these services to all patients served, including those residing in ALFs or private homes.

The LTC Pharmacy Payment Model

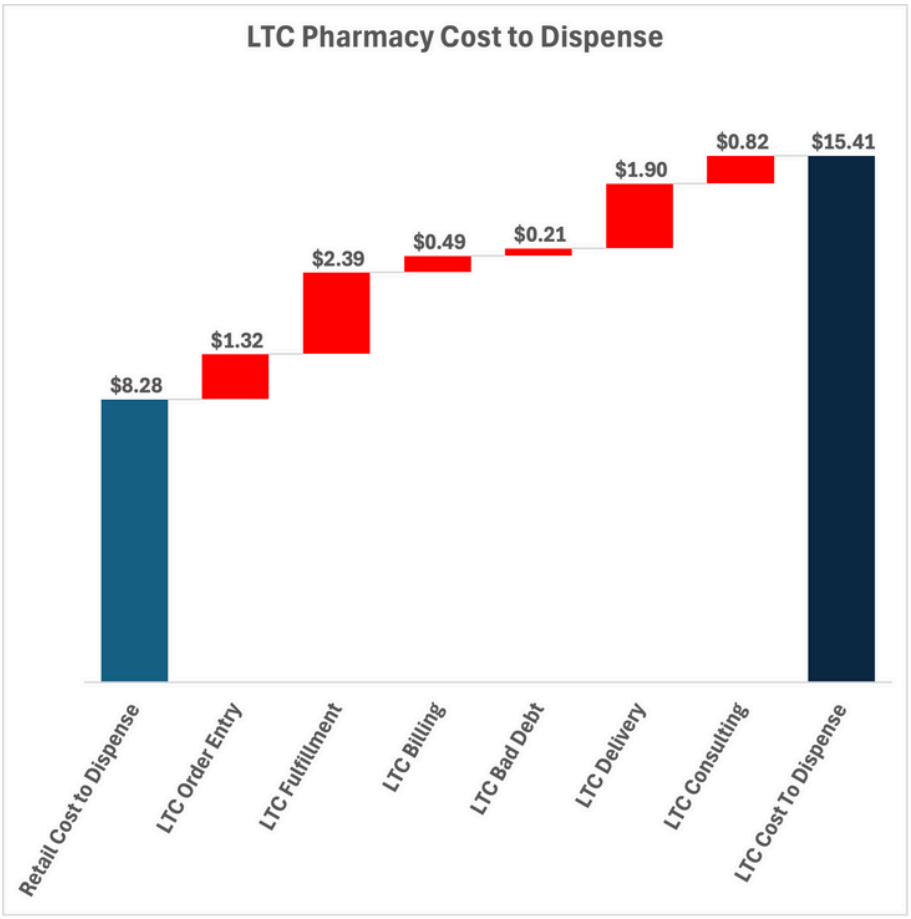
LTC pharmacies incur costs to: (1) purchase either brand or generic drugs (known as "ingredient cost" or "acquisition cost") and (2) dispense prescription drugs and provide required services that LTC patients need and the law requires (known as "dispensing costs"). **LTC pharmacies rely on third-party payers such as health plans and prescription drug plans for most of their revenues, with payment for ingredient costs and dispensing cost subject to negotiation with payers or their intermediaries.** The payers have disproportionately greater market power than LTC pharmacies or their negotiating proxies. As a result, payers effectively "reimbursement shift," providing greater compensation for ingredient costs – particularly ingredient costs for branded drugs – to offset compensation for dispensing fees substantially below LTC pharmacy dispensing costs.

Pharmacy benefit managers (PBMs) are the intermediaries most payers – Part D Plans, Medicaid managed care organizations, TRICARE, the Federal Employee Health Benefits Plan (FEHB), and commercial plans – use to negotiate contracts with LTC pharmacies or the Pharmacy Services Administrative Organizations (PSAOs) that negotiate Part D contracts on behalf of most LTC pharmacies. PBMs design drug formularies, which has given them extraordinary market power. The Federal Trade Commission recently concluded that PBMs wield disproportionate and anticompetitive market power, such that LTC pharmacies cannot negotiate fair contracts.[10]

PBM behavior with respect to Part D is especially pernicious since Part D accounts for 75% of LTC pharmacy revenues.[11] The combination of PBM financial incentives and disproportionate market power has resulted in a warped reimbursement model.

LTC pharmacies receive two payments regardless of payer: "ingredient cost" reimbursement and "dispensing fees". Payers – particularly PDPs – routinely reimburse only a fraction of true LTC pharmacy dispensing costs, preferring instead to set reimbursement for ingredient costs – particularly for brand name drugs – that force LTC pharmacies to subsidize losses on dispensing costs with margin on ingredient costs. PBMs follow this practice because their ability to manipulate formularies maximizes their revenues from manufacturer rebates on branded drugs and ownership interests in market-dominant generic drug purchasing groups.

While the dispensing fee shortfall is a problem for all pharmacies, it is an acute problem for LTC pharmacies because their costs are far higher costs than retail pharmacies due to the additional services LTC pharmacies must provide. A recent analysis by CliftonLarsonAllen LLP (CLA) shows that the cost to dispense one prescription in compliance with Medicare and Medicaid requirements is approximately $15.41.



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A recent ATI Advisory analysis of SCPC member pharmacy reimbursement data estimated that the average PDP dispensing fee for these LTC pharmacies is $3.90, a gap of more than $11 per prescription. **Given that LTC pharmacies dispense nearly 200 million prescriptions a year to Medicare Part D beneficiaries, this suggests that PDPs pay over $2 billion less each year in dispensing fees than the LTC pharmacies' actual cost of dispensing.**

More than 90% of the prescriptions LTC pharmacies dispense are for generics which are low cost, low margin drugs. While LTC pharmacies, on average, earn a modest margin on generic drug ingredient cost reimbursement, the gap between dispensing costs and dispensing fees more than eliminates this margin. Most LTC pharmacies lose money on the vast majority of most of the prescriptions they dispense. **LTC pharmacies remain viable businesses only because the margin on branded drugs ingredient cost compensates for inadequate dispensing fees across all prescriptions, whether brand or generic.**

Example Branded Eliquis and Generic Drug

	Brand -Eliquis	Generic - Famotidine
Revenue (Ingredient Cost + Dispense Fee)	$618 ($614 IC + $4 DF)	$11 ($7 IC + $4 DF)
Drug Acquisition Cost	$550	$4
Product-Level Margin	$64	$3
Cost to Fill	$16	$16
Dispense Fee Margin	($12)	($12)
Operating Margin	**$52**	**($9)**

Financial incentives for payers – particularly PDPs and their affiliated PBMs – have warped the LTC payment model, and LTC pharmacies lack the market power to control their own destiny. The result is a perverse, precarious, and crumbling foundation susceptible to significant disruption from policy changes designed to reduce drug prices.

Policy Driven Reductions in Drug Prices

Congress recently enacted two laws designed to lower drug prices for consumers. In 2021, Congress enacted the American Rescue Plan, which changed the formula for calculating rebates manufacturers must pay to state Medicaid programs when drug price increases outstrip inflation. As a result, manufacturers cut insulin prices by 70% in 2024, and are expected to do the same for respiratory inhalers in 2025. While this has lowered ingredient costs for LTC pharmacies, it also has reduced the margin on payment for ingredient costs, which limits the ability to subsidize losses on inadequate dispensing fees. Physicians frequently prescribe insulin and inhalers for LTC patients.

In 2022, Congress enacted the Inflation Reduction Act (IRA), which requires CMS to negotiate drug prices with manufacturers for certain Medicare Part B and Part D drugs to reduce out-of-pocket drug costs for Medicare enrollees. CMS must identify a specified number of the branded drugs on which Medicare spends the most each year and must negotiate Medicare prices for the identified drugs pursuant to criteria established in the statute. The program is set to launch in January 2026, and CMS is already negotiating Medicare prices (known as "Maximum Fair Price" or "MFP") for 10 specific Part D drugs.11 CMS will negotiate prices for Part B drugs starting in 2028.

While the IRA will no doubt reduce drug prices for seniors, the law inadvertently eliminates *any* margin for LTC pharmacies on MFP drugs, requiring pharmacies to purchase MFP drugs at the MFP price and to sell those drugs at the very same price. Given that dispensing fees are inadequate, LTC pharmacies may lose significant amounts for every MFP drug they dispense. Physicians frequently prescribe eight of the 10 MFP drugs for 2026 to LTC patients.

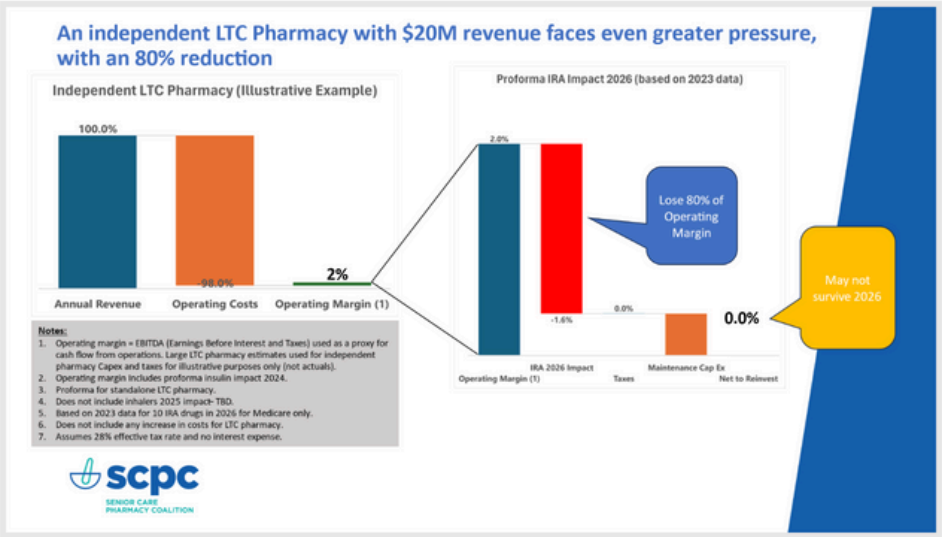
The economic impact of these policy-driven reductions in drug prices will disproportionately and adversely impact LTC pharmacies, since LTC pharmacies rely heavily on reimbursement from Medicare Part D and, unlike retail pharmacies, do not sell convenience items to offset losses from dispensing prescription drugs. The chart on the following page illustrates the likely impact on branded reimbursement, as compared to the earlier chart illustrating the current situation.

Example Eliquis 2023 vs. post IRA

	'23 Brand	Post IRA
Revenue (Ingredient Cost + Dispense Fee)	$618 ($614 IC + $4 DF)	$350 ($346 IC + $4 DF)
Drug Acquisition Cost	$550	$346
Product-Level Margin	$64	$0
Cost to Fill	$16	$16
Dispense Fee Margin	($12)	($12)
Operating Margin	**$52**	**($12)**

Lost Ingredient cost margin on Brand IRA d rug s

The impact on LTC pharmacies and the vulnerable patients they serve could be catastrophic. LTC pharmacies largely are small businesses. There are about 1,200 LTC pharmacies in America. More than 1,100 have annual revenues of less than $100 million, with most less than $20 million. Most have average operating margins – revenues net of expenses ***before*** paying taxes, servicing debt, and repairing and replacing capital equipment – of less than 2%. By the end of 2026, these smaller LTC pharmacies will have negative operating margins:



LTC facility residents in rural or medically underserved areas likely will face immediate access issues. Small LTC pharmacies in these areas are likely to close their doors, and larger LTC pharmacies often do not serve such communities. If LTC facilities cannot access LTC pharmacy services, they must cease operations as well. Residents who need LTC facility services will be forced to relocate elsewhere, often long distances from family and local community.[13]

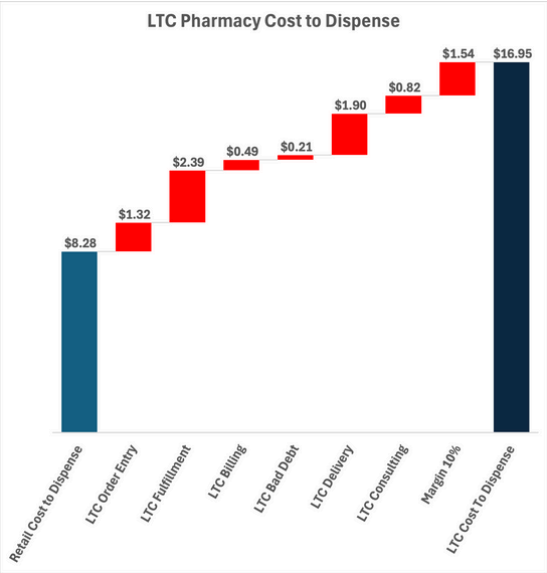
In other areas, LTC facilities will face higher pharmacy costs. For SNFs, which are responsible for prescription drug costs for Medicare beneficiaries during a Part A stay, LTC pharmacies will be forced to charge higher fees or charge a la carte fees for services currently included in broader contract pricing. SNFs already face increasing costs due to labor shortages and recently adopted minimum staffing requirements.[14] ALFs or their residents will face the Hobson's choice of higher costs for LTC pharmacy services or reduction in access to those services.

The LTC pharmacy market will change substantially, with fewer LTC pharmacies and more consolidation not only within the LTC pharmacy sector but across related markets. Increasingly, policymakers recognize that health care consolidation within markets and across adjoining markets has only benefited the conglomerates by enabling exploitation of unaffiliated competitors, to the detriment of patients and providers.[15]

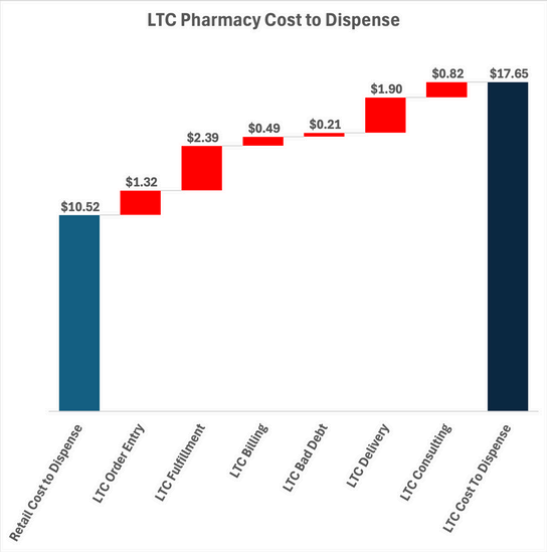
Solutions

Congress should take two steps to solve this problem before January 1, 2026, the date that MFP pricing will begin. First, Congress should require that Part D Plans pay LTC pharmacy dispensing fees that cover the costs of the LTC pharmacy services Medicare and Medicaid provide. A sustainable payment model, however, must recognize that costs increase over time, such that dispensing fees must increase over time to account for inflation and other cost increases. A sustainable payment model also must recognize that LTC pharmacies – like any business – must earn a margin above costs to remain viable operations. LTC pharmacies must have the resources to reinvest in capital expenditures (e.g., technology), pay taxes, and grow their businesses.

Assuming that dispensing fees should include a 10% margin to account for business needs, then a fair and reasonable dispensing fee would be $16.95:



This dispensing fee is consistent with dispensing fees for LTC pharmacies calculated by using retail pharmacy dispensing costs based on state Medicaid program cost studies and adding the costs specific to LTC pharmacy services based on the CLA study, which results in a LTC pharmacy cost to dispense of $17.65:



The CLA study found that the 75% percentile for the costs of LTC pharmacy services is $16.85, which provides further validation for a fair and reasonable LTC pharmacy dispensing fee in the $ $17.00 per prescription range.

Congress should require that CMS conduct LTC pharmacy cost surveys and establish minimum LTC pharmacy dispensing fees for Part D Plans that cover the costs of legally required LTC pharmacy services, include margin to allow LTC pharmacies to operate effectively, and increase over time in response to cost increases.

Second, Congress should empower CMS to establish fair and adequate terms and conditions that Part D Plans must include in contracts with LTC pharmacies to level the playing field between the PBMs negotiating contracts on behalf of Part D Plans and LTC pharmacies. Legislation should assure that CMS has the authority and responsibility to compel PBMs and Part D Plans to offer fair and reasonable contracts to LTC pharmacies.

Conclusion

Lower drug prices are good for consumers. Congress certainly did not intend lower prices to harm LTC pharmacies, much less threaten access to LTC pharmacy care and services LTC patients. But now Congress must act promptly to avoid these unintended consequences.

The solution discussed in this paper would correct the warped LTC pharmacy payment model PBMs have created, would address the unintended impact of policy-driven price cuts on LTC pharmacies, and would establish a sustainable payment model for LTC pharmacies that would protect Medicare beneficiaries who need LTC.

Congress should change Part D payment policy to protect LTC pharmacies and the millions of Medicare beneficiaries they serve, and should do so before January 1, 2026, when the first negotiated Medicare drug prices take effect.

Citations

[1] Long-term care (LTC) facilities participating in Medicare and Medicaid must provide pharmacy services to all facility residents. Medicare requires that skilled nursing facilities (SNFs), and Medicaid requires that nursing facilities (NFs) and intermediate care facilities (ICFs) provide "pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident." 42 U.S.C. § 1395i-3 (pertaining to SNFs participating in the Medicare program) and 42 U.S.C. § 1396r(b)(4)(a)(iii) (pertaining to NFs participating in the Medicaid program). The term "LTC facilities" as used in this analysis encompasses not only SNFs, NFs, and ICFs, but also assisted living facilities and other congregate care settings in which individuals who need LTC services reside.

[2] See ATI Advisory & Senior Care Pharmacy Coalition, "Functional and Clinical Complexity of Medicare Beneficiaries Living in Nursing Facilities and Assisted Living Communities," (June 21, 2024). ATI-SCPC-Nursing-Facility-and-Assisted-Living-Facts-2021-20240712.pdf . The ATI/SCPC July 2024 Report). See also ATI Advisory & Senior Care Pharmacy Coalition, "Medicare Beneficiaries with Long-Term Care Needs by Setting," (May 19, 2023) (the May 2023 ATI/SCPC Report), & ATI Advisory & Senior Care Pharmacy Coalition, "Understanding the Long-Term Care Needs of the Medicare Population and the Role of Long-Term Care Pharmacies in Addressing this Need," (July 2021) (the July 2021 ATI/SCPC Report). Hyperlinks to these reports on the SCPC website should be added.

[3] https://www.ahcancal.org/Assisted-Living/Facts-and-Figures/Pages/default.aspx

[4] https://www.ahcancal.org/Assisted-Living/Facts-and-Figures/Pages/default.aspx

[5] 42 U.S.C. 1395i-3.

[6] Approximately 4.2 million Medicare beneficiaries have impairments in two or more activities of daily living (ADLs), which is a commonly accepted definition of the need for LTC. Only 25% live in LTC facilities [including SNFs, NFs, ICFs, and assisted living facilities (ALFs)], while 75% live in the community. See July 2021 ATI/SCPC Report.

[7] Medicare Part A accounts for roughly 20% of LTC pharmacy revenues. Part A offers limited LTC coverage for Medicare enrollees who require skilled nursing facility care. Part A payments to SNFs include payment for prescription drugs and LTC pharmacy services. SNFs contract directly with LTC pharmacies to provide prescription drugs and LTC pharmacy services to residents on Part A stays. Other payers – Medicaid, TRICARE, the Federal Employee Health Benefits Program, commercial insurance, and patients – account for the remaining 5% of revenues.

[8] 42 C.F.R. § 423.100, et seq.

[9] Medicare Prescription Program Drug Manual, Chapter 5, Section 50.2.

[10] See, FTC, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, Interim Report (July 2024), "(the Interim FTC Market Report)." available at: https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf.

[10] Medicare Part D accounts for roughly 75% of LTC pharmacy revenues. Medicare Part A accounts for roughly 25% of LTC pharmacy revenues. Medicaid fee-for-service, Medicaid managed care, TRICARE, the FEHB program, commercial insurance, and patient out-of-pocket payments account for the remaining 5%. Medicare beneficiaries who require skilled nursing care are eligible for coverage under Medicare Part A for stays in SNFs. Medicare Part A pays SNFs using a "patient-driven payment model (PDPM)," which provides a bundled payment that includes compensation for prescription drugs and related LTC pharmacy services. LTC facilities and LTC pharmacies contract for the prescription drugs and LTC pharmacy services Part A residents require, such that the facility reimburses the pharmacy directly. Since assisted living residents are not eligible for the skilled nursing benefit, LTC pharmacies primarily serving ALF residents have greater revenues from Medicare Part D, commercial insurance plans, and patient out-of-pocket payments than LTC pharmacies primarily serving SNFs and NFs. Residents in ICFs have lower percentages of Part D coverage and higher percentages of Medicaid coverage, such that both Medicare Part A and Part D represent lower percentages of revenues for pharmacies primarily serving residents in ICFs.

[11] The CLA analysis estimates the retail pharmacy cost to dispense by calculating total LTC pharmacy cost to dispense based on data gathered from SCPC member pharmacies, then subtracts costs specifically associated with required services LTC pharmacies provide that retail pharmacies do not provide. This results in an imperfect estimate of retail pharmacy dispensing costs. By contract, state Medicaid programs routinely conduct surveys of retail pharmacy costs to establish dispensing fees for Medicaid fee-for-service drug coverage. The most recent state surveys estimate retail dispensing costs to be $10.52 per prescription. When the additional costs of required LTC pharmacy services are added to this base, the LTC pharmacy cost per prescription is $17.65.

[12] The 10 drugs selected for the first round of negotiations include treatments for several medical conditions, including diabetes (Farxiga, Fiasp/NovoLog, Januvia, Jardiance), blood clots (Eliquis, Xarelto), heart failure (Entresto, Farxiga), psoriasis (Stelara, Enbrel), rheumatoid arthritis (Enbrel), Crohn's disease (Stelara), and blood cancers (Imbruvica). Cubanski, "Facts about the Inflation Reduction Act's Medicare Drug Price Negotiation Program," KFF (January 31, 2024).

[13] More than one thousand nursing and long-term care facilities across the country have closed since 2015. Leaving 44,459 residents displaced, and the figures continue to increase. See https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/SNF-Closures-Report.pdf. Many residents experience "relocation stress syndrome" as a result. See https://emancipatorysciences.ucsf.edu/eslabblog/nursing-home-residents-transfer-trauma-or-relocation-stress-syndrome#:~:text=Research%20has%20shown%20that%20nursing,more%20vulnerable%20to%20transfer%20trauma.

[14] The estimated annual costs to implement the new staffing mandate range from CMS' estimate of $3.65 billion per year, 89 Fed. Reg. 40876, 40956 (May 10, 2024) to more than $6 billion per year, see also https://www.claconnect.com/en/resources/articles/24/cla-estimates-6-billion-annual-cost-for-nursing-home-staffing-mandate (CLA estimate of $6 billion nursing home staffing compliance costs).

[15] See, e.g., Interim FTC Market Report, Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies (July 2024), available at https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf

About Senior Care Pharmacy Coalition

The Senior Care Pharmacy Coalition (SCPC) is the only national organization exclusively representing the interests of LTC pharmacies, representing 75% of the sector overall. Its members operate in all 50 states and serve one million patients daily in skilled nursing and assisted living facilities across the country. Visit seniorcarepharmacies.org to learn more. Learn more at www.seniorcarepharmacies.org.

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