Testimony
of the
National Association of Specialty Pharmacy (NASP)
for the
Senate Finance Committee
"Lower Health Care Costs for Americans: Understanding the Benefits of the Inflation Reduction Act"
September 17, 2024

The National Association of Specialty Pharmacy (NASP) appreciates the opportunity to submit testimony for the record for the Senate Finance Committee Hearing titled "Lower Health Care Costs for Americans: Understanding the Benefits of the Inflation Reduction Act." NASP shares the Committee's priority of ensuring patients have affordable access to the medicines they need. With this priority, we also believe it is most important to ensure that implementation of the IRA law and the Centers for Medicare and Medicaid Services' (CMS') related regulations and guidance ensure that patients have continued access to the specialty pharmacy of their choice and to the pharmacy-related services that are essential to support patient medication adherence and management, improve health outcomes, and reduce patient, health system, and government costs. NASP represents the entire spectrum of the specialty pharmacy industry, which includes the Nation's leading specialty pharmacies and practicing pharmacists, pharmacy benefit managers (PBMs), pharmaceutical and biotechnology manufacturers of specialty drugs, group purchasing organizations, wholesalers, distributors, integrated delivery systems, health systems, and technology and data management companies, among others. NASP's pharmacy members include specialty pharmacies of all types, including independent (non-affiliated with plan sponsors/PBMs), chain, grocery store, hospital and health system, health plan owned, and home infusion.

NASP wants to be certain the Committee and CMS understands and considers the impact statutory and regulatory drug pricing reforms under the Inflation Reduction Act (IRA) will have on the entire pharmaceutical channel and is prepared to establish protections to support pharmacy businesses and patient access to their pharmacies. The Committee is already aware of the immense amount of pressure pharmacies are already under within the Medicare Part D program. It is essential that the implementation of the IRA's Part D provisions, particularly the effectuation of the Maximum Fair Price (MFP) for negotiated drugs, does not exacerbate the financial difficulties already faced by pharmacies.

For years, pharmacies have been subject to draconian payment reductions after the point-of-sale through pharmacy direct and indirect remuneration (DIR) and other cuts, and those cuts have persisted in 2024. Pharmacies have experienced even worse upfront cuts at the point-of-sale ("negotiated price") through proposed 2025 contract terms. Specialty pharmacies have faced significant financial uncertainty, resulting in many forced pharmacy acquisitions at an alarming rate. Today, Part D reimbursement across drugs dispensed is too often far less than a pharmacy's actual acquisition cost of the drugs, and pharmacy dispensing fees are not nearly adequate to buffer the payment reductions or to afford the cost of the requisite high-touch pharmacy services needed to cover plan and/or manufacturer requirements to support a patient on a specialty drug.

Some Part D sponsors and their PBMs initiated contract practices for 2024 and 2025 that pharmacies believe are in violation of the new 2024 Medicare Part D rules, and some Plans/PBMs continue to grossly undermine the Medicare Any Willing Pharmacy statute. The Senate Finance Committee has been working to address these concerns in legislation, but CMS also has it within its own authority to enforce existing law that is intended to ensure payments to pharmacies are reasonable. Doing so is critically important especially now, as CMS seeks to implement the IRA drug pricing reform provisions, which will most certainly result in significant additional Medicare Part D financial pressures on and processes for specialty pharmacies and the broader pharmacy community.

Providing Access to the MFP in 2026 and 2027

NASP urges the Committee to request that CMS interprets the MFP for the select drugs as equal to the "lowest possible reimbursement" definition of "negotiated price" as set forth in the final Part D regulation issued by CMS that went into effect in January 2024.[1] It is clear in the IRA statute that Congress directed manufacturers to provide pharmacies access to the MFP for the selected drugs and CMS, through its proposed guidance, is seeking to establish a process to ensure pharmacies pay no more than the MFP when acquiring a drug. It stands to reason that if Congress intended for pharmacies to have access to the MFP, that the MFP (plus dispensing fees) would also be considered the negotiated price at the point of sale. To permit a plan sponsor to apply further price concessions to a Medicare negotiated drug, reducing a pharmacy's point-of-sale reimbursement below the MFP would most certainly put a pharmacy underwater on the ingredient cost of the drug alone. Such unreasonable reimbursement would be in violation of the Any Willing Pharmacy statute,[2] and the Committee must ensure that CMS enforces the law to ensure payment to pharmacy is reasonable to permit a pharmacy to participate in network.

NASP urges the Committee to ensure CMS explicitly prohibits any post-sale pharmacy price concessions for select drugs with an MFP to safeguard pharmacies from further financial instability. Any post-sale concessions would fail to result in a reduction to a MFP-eligible individual's cost sharing, meaning that these individuals would never benefit from post-sale concessions applied to the selected drugs, and such post-sale concessions only serve to threaten the financial viability of pharmacies, their ability to dispense certain drugs, and their continued ability to participate in pharmacy networks. While reducing beneficiary out-of-pocket drug costs is a significant goal of the IRA reforms, in implementing the law, it is critically important that the Committee ensure that CMS also seeks to protect beneficiary access to their pharmacies, and as such, prohibit post-sale pharmacy price concessions (post-sale pharmacy DIR fees).

---

[1] Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS); Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency; published May 9, 2022.

[2] Section 1860D-4(b)(1)(A) of the Social Security Act.

The IRA statute is clear that pharmacies are to receive a dispensing fee[3] though it did not stipulate any amounts for such fees. However, as acknowledged repeatedly by CMS in the draft guidance, all pharmacies are expected to have an increase in their operating costs to manage the new MFP process, including but not limited to: management of inventory, any reporting and reconciliation of payments through the MTF, and potentially many different manufacturer payment process requirements, etc. **NASP requests that the Committee ensure that as part of its oversight responsibilities in implementing the IRA law, CMS monitor and audit Part D plan/MA-PD dispensing fee arrangements to ensure that Plans are recognizing and covering new pharmacy operating cost requirements associated with the MFP for select drugs in addition to respecting and affording dispensing costs specialty pharmacies incur compared to their retail pharmacy counterparts, due to the extensive patient service requirements both manufacturers and plans require from specialty pharmacies.**

Medicare Transaction Facilitator (MTF) Data Facilitation

The IRA statute mandates that Primary Manufacturers make the MFP for selected drugs available to both MFP-eligible individuals and pharmacies/dispensing entities. When a pharmacy/dispensing entity is not purchasing the selected drug at MFP, pharmacies/dispensing entities will need a refund from the Primary Manufacturer administered through a retroactive process. CMS acknowledges that the following data exchange elements be in place to administer such a process: 1) verification that the selected drug was dispensed to a MFP-eligible individual via certain claim-level data elements and identifying which pharmacy/dispensing entity dispensed the select drug; 2) to initiate the 14-day prompt MFP payment window for effectuating the MFP refund for each claim for each selected drug to each pharmacy/dispensing entity; and 3) to collect payment-related data for each claim for a selected drug from Primary Manufacturers to indicate when a refund was paid and the amount of the refund paid. These requirements necessitate the coordination and reconciliation of several disparate data elements, including, but not limited to:

- Part D Verification to determine patient and drug MFP eligibility;
- Identifying 340B transactions that would not be MFP-eligible;
- Calculating MFP refunds; and
- Determining total pharmacy payment across responsible entities: patients, Part D plans and manufacturers.

CMS has determined that it will engage a MTF to provide a myriad of services with some of these services being mandatory to allow for the exchange of data with manufacturers and for CMS to verify data from manufacturers to ensure compliance with the law. CMS states that a Primary Manufacturer may choose to contract with one or more third parties to perform the data exchange operations with the MTF. **NASP urges the Committee to impress upon CMS that they must require a single, standardized approach for data exchange and payment processes, regardless of the involvement of third parties, to streamline operations and reduce administrative burdens on pharmacies. Otherwise, pharmacies would have to configure their operations to meet the individual needs of several manufacturers as well as potentially multiple verification systems in order to ensure they are ultimately paid correctly**

[3] Defined in section 1198(b)(3)(D) of the Inflation Reduction Act.

for the MFP. Effectuating the MFP should not be directly or indirectly left to the pharmacies to figure out and manage, diverting pharmacy time and resources away from serving its patients and adding significant financial and administrative burden to pharmacies that, as mentioned, are already facing numerous financial pressures within the Part D program in the absence of sufficient financial support to cover their business costs.

While NASP is pleased that CMS has stated in guidance its intention to prohibit manufacturers and any manufacturer-contracted partner from charging pharmacies fees for the retrospective MFP data/payment processes, this does not fully insulate pharmacy risk, nor does this account for the potential costs and significant burden of the many ancillary activities pharmacies may have to perform to support manufacturers with MFP effectuation outside of a required data exchange process managed by the MTF. CMS states in the guidance that it "intends to leverage existing Part D claims data in this data exchange and does not envision dispensing entities separately transmitting claims data to Primary Manufacturers." NASP requests that the Committee ensure that CMS formally establishes requirements and protections for pharmacies to ensure the burden of this data exchange process is not in any way placed on pharmacies. Pharmacies cannot be placed at any financial risk in order for the IRA law's requirements to be carried out. Congress clearly did not intend for pharmacies to shoulder the burden of MFP effectuation.

CMS states in its proposed guidance that requiring Primary Manufacturers to exchange data with the MTF will be necessary to administer a uniform approach to the start of the 14-day prompt MFP payment window for each claim to a pharmacy/dispensing entity and to the MTF for verification purposes, saying that any failure to meet this process will be considered a violation and risk the Primary Manufacturer being subjected to civil monetary penalties (CMPs) as permitted by the statute. **CMS does not address what happens to effectuation of the MFP for a pharmacy/dispensing entity should this occur, and the Primary Manufacturer is (or opts to be) subjected to CMPs instead of participating and carrying through the data exchange process. NASP must reiterate that pharmacies cannot be left at financial risk if manufacturers do not follow through on the requirement to effectuate the MFP. Pharmacies must receive assurance and commitment from CMS that in these circumstances, the MTF will work with CMS to leverage the existing Part D claims data process to effectuate the MFP for pharmacies.**

Data Transmission, Access and Timing – An Alternative Approach

NASP is providing comments on the process CMS has proposed to effectuate the MFP to pharmacies through its proposed guidance, but NASP strongly believes an alternative approach is likely needed in the absence of addressing pharmacies' concerns. NASP strongly encourages the Committee to ensure that CMS does not seek to "reinvent the wheel" in terms of designing a new process to ensure manufacturers are able to meet statutory MFP requirements, but rather follows to the greatest extent possible, the existing claims process system, requiring transparency for all parts of the pharmaceutical channel (all contracted entities) in the transfer of claims data for verification and payment.

The existing Part D claims management process, including the facilitation of the existing Coverage Gap Discount Process (CGDP) under Medicare Part D that largely seems to facilitate a data exchange

process that, with few alterations to better support increased transparency to pharmacies, could otherwise be mirrored to support manufacturer effectuation of the MFP as required under the IRA law. Indeed, NASP understands that Congress sought to model the MFP effectuation statutory requirement after the statute that established the CGDP[4] in an effort to follow past precedent for a discount program under Part D.

CMS effectuates CGDP discounts through contracted third-party entities with the Part D plans serving as payment facilitators. In the CGDP, manufacturers are required to provide CGDP-eligible individuals discounted prices for drugs at the point of sale. Part D plans include the manufacturer-required discount amount as part of the Plan's payment obligation. The pharmacy knows its full compensation amount for related claims in real time and within the claims workflow, and payments are made within a 14-day prompt payment standard. Manufacturers repay Part D plans through the CGDP contractor. CMS, Part D plans, and manufacturers reconcile financial transactions independently without disrupting patient access or pharmacy economics.

CMS has indicated that the CGDP model will be used to operationalize the new Manufacturer Discount Program (MDP) that IRA law replaced it with, saying that the MDP will be effective under the new Part D benefit starting in 2025. CMS should strongly consider the potential overlapping needs and functions necessary to also effectuate the manufacturer MFP (drug discount) refund. Such a financing model would allow manufacturers to seamlessly pay MFP refund amounts to pharmacies at the point of sale.

In the absence of a CGDP-like pre-funded option, under the approach outlined by CMS in its guidance, NASP believes pharmacies will be essentially pre-funding retrospective MFP adjustments themselves and then having to pursue and track any and all MFP refund payments under potentially varied manufacturer approaches. This is unacceptable and not what Congress intended when passing the IRA law.

The Committee must understand that payment to pharmacies under a retroactive process could amount to MFP payment effectuation taking as long as 60 days or more for each claim for a dispensed selected drug. This despite the fact that the statute envisioned that pharmacies would be paid the MFP (plus dispensing fees) within a 14-day prompt payment period. This is because once claims data has been verified by the Part D plan sponsor, and the pharmacy has already received payment, CMS envisions having the plan sponsor submit complete prescription drug event (PDE) records to the Drug Data Processing System (DDPS) for secondary verification before that data is then sent to the MTF and then the MTF sends data information to the manufacturer for response. Today, in the absence of any MFP effectuation requirements, Part D plan sponsors have 30 days to submit complete PDE records to DDPS. This window of time is extremely unworkable if CMS is to require a secondary validation of Medicare Part D claims by the DDPS before data is made available to the MTF for the MTF to provide to manufacturers. **CMS has stated it is evaluating whether the current 30-day PDE data transfer window should be shortened to seven days to support pharmacies receiving timely MFP refunds. NASP impresses upon the Committee that is critically important that CMS shorten this window and would**

[4] 42 U.S. Code § 1395w–114a.

suggest the time window for submission of PDE records to the DDPS by plan sponsors be conducted in less than seven days.

Nonduplication with 340B Ceiling Price

The IRA law states that the Primary Manufacturer of a select drug is not required to provide access to the MFP for a select drug to MFP-eligible individuals who are eligible to be dispensed a drug subject to a 340B ceiling price under statute if the 340B ceiling price is lower than the select drug's MFP. Primary Manufacturers are required to provide access to the MFP to 340B covered entities in a nonduplicated amount to the 340B ceiling price if the MFP for the select drug is lower than the 340B ceiling price. The proposed guidance makes clear that CMS will not assume responsibility for "deduplicating" discounts and instead expects manufacturers to assume that responsibility themselves. Supplying claims data is to be voluntary by a dispensing entity while CMS works to establish a process to identify applicable 340B eligible claims through the reporting of payment elements to the MTF. **For those dispensing entities that opt to provide this information, NASP believes the effort would be immensely burdensome as dispensers seek to work with individual manufacturers through their separate data submission processes.** CMS proposes that when a 340B price is lower than MFP, 340B entities append a modifier on the claim to identify the claim as 340B, which CMS believes would allow the manufacturer to avoid making the default payment for those claims. Yet, CMS acknowledges that most covered entities and their contract pharmacies cannot identify 340B claims at the point of sale, and likely not until days later, after the claim is submitted. **NASP believes it would be unworkable to expect pharmacies to use a separate physical inventory of 340B drugs.**

NASP is concerned that contract pharmacies for 340B covered entities will be in a very difficult situation regarding MFP implementation. Many contract pharmacies use a replenishment model, receiving drugs from the covered entity after they have been validated as 340B eligible. This process can take over 20 days after a 340B-eligible drug has been dispensed.

CMS should develop a methodology that would enable covered entities to retrospectively submit 340B claims data to the MTF and require that the MTF use the data to identify 340B claims that should be withheld from being submitted to the manufacturer.

Absent CMS guidelines and criteria for the manufacturers' nonduplication plans, a manufacturer could require covered entities to submit large volumes of data to the manufacturer or its contractor in order to receive the 340B price or MFP as a refund. Indeed, this has already been requested by one manufacturer toward pharmacies since the MFPs on negotiated drugs were announced. As noted by the Health Resources and Services Administration in September 2024, this is at odds with the longstanding practice of covered entities accessing the 340B discount as a purchase price and is highly disruptive to how hospitals manage their 340B programs. HRSA has never fully authorized manufacturers to offer 340B discounts as refunds instead of purchase prices.

NASP strongly encourages the Committee to request that CMS work with stakeholders to find more viable alternatives to ensure covered entities can purchase drugs at the 340B price and support efforts

to address MFP refunds through a process that works with hospital and contract pharmacy processes to manage 340B drugs.

Retrospective Refund Amount to Effectuate the Maximum Fair Price (MFP)

NASP believes use of WAC as proposed by CMS would allow for a fair standard metric to approximate a pharmacy's acquisition costs as it is generally accepted that specialty drugs are acquired at this benchmark. NASP urges the Committee to encourage CMS to use this standardized metric across manufacturers for determining retrospective payments in order to allow for predictability and replication across the pharmaceutical channel to support the pharmacy refund amount. Since WAC and MFP are both publicly available data they would easily allow for an auditable MFP refund amount for all stakeholders, including pharmacies, manufacturers, and Medicare.

Permitting a variety of metrics for determining pharmacy acquisition costs would be administratively burdensome for pharmacies as pharmacies seek to reconcile their payments for selected drugs across many manufacturers. NASP also urges CMS to prohibit manufacturers from requiring pharmacies to individually report their acquisition costs, as there are likely thousands of different acquisition costs for the same drugs as each pharmacy in the United States has different contract terms with entities in pharmaceutical channel, and sharing such information would allow proprietary pharmacy acquisition costs to be shared with others in the channel that are not privy to this information. Allowing a multitude of refund formulas could also lead to the risk of unreasonable metrics that are falsely assumed to model pharmacy acquisition costs.

The Committee must understand that the use of unreasonable metrics to address pharmacy acquisition costs in the absence of any CMS guardrails and agency oversight being in place would only further undercut pharmacy reimbursement under Part D, contributing to the financial strain many pharmacies are already facing today.

Medicare Transaction Facilitator (MTF) Dispensing Entity Participation Requirements

In its proposed guidance, CMS states that the MTF will be required to be used by Primary Manufacturers for data exchange; however, use of the MTF for facilitation of retrospective refund payments is at the option of both Primary Manufacturers and pharmacies. If not utilized for payment facilitation, payments to pharmacies would be provided through a separate process agreed to by the Primary Manufacturers and pharmacies.

NASP wants the Committee to understand that it remains extremely concerned about the financial uncertainty and cash flow challenge pharmacies will face if the transaction process across all Primary Manufacturers of selected drugs and pharmacies is not uniform, standardized and seamless. Pharmacies having to manage a multitude of different payment systems among manufacturers would be untenable. CMS must require that a uniform payment transaction system be utilized regardless of whether it is administered by the MTF or administered by manufacturers and/or their contractors.

Compliance with Administrative Actions and Monitoring of the Drug Price Negotiation Program

CMS states in the guidance that it is required by the IRA law to establish a robust program for monitoring compliance with the Negotiation Program. However, **NASP is concerned that CMS states it "may" audit any data related to the Primary Manufacturer providing access to the MFP, including where the selected drug is provided by a Secondary Manufacturer. NASP wants to emphasize to the Committee the importance of CMS overseeing and requiring compliance with the process for data exchange to effectuate the MFP, and reiterate that CMS should go further to require standardization and uniformity around payments to pharmacies with CMS oversight and protections to ensure that pharmacies are not put at any financial risk for the requirements of the law addressing MFP payments. The process for the exchange of information between manufacturers and pharmacists must be part of a mandatory audit by CMS.**

Manufacturer Compliance and Oversight

Under the IRA statute Primary Manufacturers must provide pharmacies and other dispensing entities and MFP-eligible individuals access to the MFP, and this requirement applies to all sales of the selected drugs, including when there are Secondary Manufacturers. CMS states that if it determines through audits, investigations, and complaints from pharmacies or other market participants that Primary Manufacturers have not fulfilled their MFP obligations to make the MFP available within the 14-day prompt MFP payment window, CMS will first encourage payment discrepancies to be addressed and may then issue CMPs. **NASP would appreciate clarity from CMS on the frequency in which it will proactively audit manufacturer compliance and whether it will commit to interviewing participating pharmacies that are dispensing MFP drugs to understand concerns and options for how to address these concerns for pharmacies.**

NASP is extremely concerned about CMS' vague proposed oversight standard of a manufacturer being able to inform CMS as soon as practical of any planned change in its payment of the MFP. There is nothing in the CMS guidance that speaks to when a pharmacy/dispensing entity would be required to be informed of any change in the payment of the MFP, and manufacturers are given flexibility to report or not report any change to CMS. The lack of a standard for manufacturer reporting of changes in effectuating the MFP to CMS and no standard requirement for manufacturers to inform pharmacies of these changes could have significant negative consequences for pharmacies to raise a complaint, dispute or appeal lack of payment or incorrect payment amounts to either CMS or the manufacturers and to have these addressed and addressed in a timely manner.

Negotiation Program Complaints and Disputes

CMS states that it will establish a centralized intake system for receiving reports on complaints and disputes related to access to the MFP with respect to eligible individuals (beneficiaries) and pharmacies/dispensing entities that provide selected drugs to MFP-eligible individuals. It describes this process to have different tracks and to focus on technical issues and data matters, making clear that the MTF intake process for addressing such concerns will under no circumstances determine whether a

Primary Manufacturer has provided access to the MFP or met its legal obligations (e.g., payment to pharmacies within 14-days). CMS states that the agency itself would be responsible for these issues not the MTF, and that it is still exploring options for collecting appeals/complaints and addressing them. CMS specifically states that it is still exploring the limits on the scope of disputes and complaints that the agency may remediate in the context of otherwise private transactions between Primary Manufacturers and dispensing entities.

It is not acceptable or appropriate for CMS to question whether a complaint and disputes process is necessary to address financial transaction disputes between channel partners for effectuating the MFP. It is unclear how CMS would ever be able to comply with the law's requirements and impose CMPs on manufacturers that do not effectuate the MFP for eligible individuals or pharmacies/dispensing entities if it is not able to appropriately consider proactive financial-related complaints/disputes received or act on them. NASP would again reiterate to the Committee that the law needs to be actualized and enforced by CMS, and that a standardized and required process for payment under Medicare Part D, rather than an optional and private payment process, is essential to effectuating the MFP. The amount of pressure on the channel to accurately provide access to the MFP is immense, and to establish a free-for-all system where manufacturers have carte blanche to design their own payment systems will create chaos for pharmacies and significant errors. This would put both pharmacies and manufacturers at extreme financial risk – as there is no guarantee of payment to a pharmacy, and manufacturers, should CMS choose to investigate or act on non-compliance, issue CMPs. NASP again recommends that CMS reconsider the MFP effectuation process in line with the existing claims process and other payment processes to protect access to the MFP for pharmacies and other entities in the channel.

Failure of Manufacturer to Ensure Access to a Price Less Than or Equal to the MFP

CMS states that upon discovery and confirmation of a failure to make the MFP available, CMS will send the Primary Manufacturer Notice of Potential Noncompliance and establish an "informal" process allowing the Primary Manufacturer 10 business days to respond to the notice. CMS will then consider the materials and make a decision regarding manufacturer liability and any CMPs.

NASP is alarmed that such a process to assess compliance with the law's requirements is being presented as an informal process. The law requires that the MFP terms be met and met within a specifically defined window of 14-days. The Committee should understand that CMS' informal process as suggested, would allow for well over 10 days before any decision is reached on manufacturer compliance with effectuating the MFP. As this process rolls out, pharmacy payment remains non-existent, and CMS does not address what happens when the MFP is not effectuated, effectively leaving pharmacies to "hold the bag." This is a significant concern and must be addressed.

Part D Formulary Inclusion of Selected Drugs

CMS states that Medicare Part D plans must include each covered Part D drug that is a selected drug on Part D formularies during contract year 2026 (and 2027) if a MFP is in effect for that drug that year and

during each subsequent year that a MFP for the selected drug. However, CMS states it does not have sufficient information to determine whether changes to the formulary inclusion policies are warranted given that it does not yet have information on plan formularies for Contract Year 2025 nor for Contract Year 2026 – the first year the law goes into effect. CMS says it intends to monitor Part D plans' compliance with formulary requirements and treatment of selected drugs and may possibly address formulary policies in the future. CMS also says that it will not implement explicit tier placement or utilization management requirements at this time. CMS does express concern that Part D sponsors may be incentivized in certain circumstances to disadvantage selected drugs by placing selected drugs on less favorable tiers compared to non-selected drugs, or by applying utilization management that is not based on medical appropriateness to steer Part D beneficiaries away from selected drugs in favor of non-selected drugs.

NASP wants to impress upon the Committee its concern about specialty patient access to the selected drugs whether for new patients or for those on current selected drug therapies, where a change in drug formulary could be extremely detrimental to their treatment. Part D sponsors may make significant formulary changes as a result of the law, and the Committee must understand that CMS oversight and enforcement will be essential to protecting patient access to their needed specialty medications.

Conclusion

NASP looks forward to continued opportunities to work with the Committee to address these and other issues during implementation of the IRA. NASP asks that the Committee ensure protections are in place for pharmacies and the patients they serve. To address questions about this testimony or for further information, please contact Sheila Arquette, NASP President and CEO at Sheila.Arquette@naspnet.org or NASP's government affairs representative Julie Allen at Julie.Allen@powerslaw.com.