July 18, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd
Baltimore, MD 21244

Submitted via regulations.gov

RE: Comments on CMS-4218-NC, Request for Information: Pharmacy Benefit Manager Compensation and Data Collection

Dear Administrator Oz,

The MAPRx Coalition (MAPRx) appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information on Pharmacy Benefit Manager (PBM) Compensation and Data Collection (CMS-4218-NC), published June 18, 2026.

MAPRx is a national coalition of more than 60 beneficiary, caregiver, and healthcare professional organizations committed to improving access to prescription medications and safeguarding the well-being of Medicare beneficiaries with chronic diseases and disabilities. The coalition has championed policies in Part D that improve the affordability of medications and beneficiary access to those medications, including provisions of the Inflation Reduction Act (IRA) that establish an out-of-pocket cap in Part D and the Medicare Prescription Payment Plan. We are committed to ensuring that the implementation of these and other elements of the IRA are informed by the experiences and needs of beneficiaries living with chronic diseases and conditions.

MAPRx is responding specifically to Section F of this RFI, which solicits input on data elements CMS should collect from PBMs beyond the minimum reporting requirements established in section 1860D-12(h)(1)(C) of the Social Security Act. The annual PBM report required under section 6224 of the Consolidated Appropriations Act, 2026 (CAA, 2026) represents a significant opportunity to build

visibility into whether PBM compensation arrangements are affecting beneficiary access to medications. We urge CMS to use that opportunity by requiring data that tracks the beneficiary experience alongside the financial flows between PBMs, plan sponsors, and manufacturers.

The Statutory Reporting Framework Should Be Complemented by Beneficiary-Facing Access Data

Section 1860D-12(h)(1)(C) requires PBMs to report annually on drug utilization and dispensing activity, drug costs and pricing, enrollee out-of-pocket spending, direct and indirect remuneration (DIR), pharmacy reimbursement, overall plan spending, and revenue retained by the PBM or its affiliates. This data will give CMS meaningful visibility into the financial architecture of PBM compensation. It will not, on its own, give CMS the visibility it needs into whether those compensation arrangements are shaping formulary design and access management in ways that harm beneficiaries.

We urge CMS to require PBMs to include the following additional data elements in their annual reports.

Recommended Additional Data Elements

- **Formulary Coverage Rates and Access to Lower-Cost Drug Alternatives by Drug Class**

CMS should require PBMs to report, by drug class and tier, the share of clinically available drugs covered under the formularies they administer, the distribution of drugs across tiers, and the formulary treatment of lower-WAC versions compared to higher-WAC equivalents within the same drug class. The statutory floor focuses primarily on financial data and drug-level dispensing and cost information. It does not require reporting on the macro-level structure of formulary design or on how coverage is distributed between lower-cost and higher-cost versions of equivalent drugs.

This gap matters for beneficiaries. When formularies are designed to favor higher-WAC drugs over clinically equivalent lower-WAC alternatives, including biosimilars and generics, beneficiaries may be directed toward costlier treatments not because of clinical evidence but because of how PBM compensation is structured.

CMS should collect data that would allow it to monitor whether this formulary design pattern is occurring across Part D and whether it is changing over time as new compensation standards take effect. Coverage rate and WAC-version treatment data by drug class would give CMS that baseline. CMS should also require reporting on formulary and utilization management changes that occur during the plan year, including any midyear reclassification of a drug's tier or coverage status, so that beneficiaries are not exposed to unanticipated cost or access changes after they have already enrolled based on a plan's published formulary.

- **Prior Authorization Volume, Denial Rates, and Appeal Outcomes by Drug Class**

CMS should require PBMs to report the total number of prior authorization requests processed, approval and denial rates, and appeal outcomes, broken down by drug class. The CAA, 2026

requires PBMs to report and justify instances where a generic or biosimilar drug faces utilization management that its reference brand-name drug does not. That requirement addresses a specific type of utilization management disparity. It does not require PBMs to report their overall PA volumes or denial rates across the formulary.

Collecting this data by drug class is essential for CMS to distinguish between PA and step therapy programs that function as intended clinical screens and those that function as systematic access barriers. MAPRx has consistently urged CMS to strengthen oversight of utilization management practices that delay or deny access to clinically appropriate medications. Reporting should also include the stated reason for each denial, categorized in a standardized format, so that CMS can distinguish between denials based on clinical criteria and denials based on formulary or administrative requirements. CMS should also require reporting on expedited prior authorization requests, including decision timelines and outcomes, as delays for individuals with rapidly progressive diseases may result in permanent and irreversible loss of function.

PA volume and outcome data at the drug class level would give CMS the foundation it needs to act on that oversight responsibility.

- **Non-Formulary Exception Request Rates and Outcomes**

CMS should require PBMs to report the volume of non-formulary exception requests processed, approval rates, and average time-to-decision, by drug class. When beneficiaries are unable to access the medication their clinician prescribed through standard formulary channels, they must request an exception. The volume and outcome of those requests are direct indicators of whether the formulary is functioning as designed or creating systematic gaps in access. High exception request rates and low approval rates in specific drug classes are early warning signals that formulary design problems may be connected to compensation incentives. This data would give CMS a mechanism for targeted monitoring and corrective action before access barriers become entrenched.

CMS should report median and average time-to-decision for exception requests and appeals, including expedited requests, to identify whether administrative processes create clinically meaningful delays in access.

- **Beneficiary Cost-Sharing Basis at the Pharmacy Counter**

CMS should require PBMs to report whether beneficiary cost sharing for a given drug is calculated based on list price, negotiated price, or net price, and to report the extent to which rebates, discounts, and other price concessions affect the amount beneficiaries pay at the point of sale. Data on the pricing basis PBMs currently use for beneficiary cost sharing would allow CMS to determine whether beneficiary out-of-pocket costs are consistently calculated using net prices or whether list-price-based calculations remain common across the PBM market.

- **Specialty Drug and Biologic Access Metrics**

CMS should consider public reporting of access metrics for specialty medications, including biologics and therapies used to treat rare and serious conditions, to better understand the impact of PBM compensation arrangements on beneficiary access.

Annual PBM Reports Should Be Made Publicly Available in a Standardized Format

The CAA, 2026 requires PBMs to submit their annual reports to the prescription drug plan sponsor and to the Secretary. There is no corresponding requirement that CMS make the substance of those reports publicly available. MAPRx urges CMS to publish a standardized summary of the annual PBM reports in a format accessible to beneficiaries, patient organizations, and researchers.

This recommendation does not require CMS to disclose proprietary contracting terms or other confidential business information. Aggregated and de-identified summary data can provide meaningful transparency for beneficiaries and patient organizations while preserving appropriate confidentiality protections for PBMs and plan sponsors.

Public reporting gives beneficiaries and the organizations that represent them the information they need to assess whether Part D is delivering the affordability and access protections Congress intended.

It also creates accountability incentives for PBMs and plan sponsors that internal reporting alone does not. Transparency is a condition of effective oversight, and the framework established under section 6224 of the CAA, 2026 will be stronger if its findings are visible to the public rather than held exclusively by the agency and the plans.

Conclusion

The undersigned members of the MAPRx Coalition urge CMS to treat the annual PBM reporting requirement as an opportunity to build the visibility into beneficiary access and affordability that effective Part D oversight requires. The data elements we have recommended would give CMS the information it needs to identify access barriers connected to PBM compensation arrangements and take corrective action where warranted. The public reporting recommendation would extend the value of that data beyond the agency and into the hands of the beneficiaries the program is designed to serve.

The MAPRx Coalition thanks you for the opportunity to comment. For questions related to MAPRx or these comments, please contact Bonnie Hogue Duffy, Convener, MAPRx Coalition, at (202) 540-1070 or bduffy@nvgllc.com.

Sincerely,

AiArthritis
Alliance for Aging Research
American Cancer Society Cancer Action Network (ACS CAN)
American Kidney Fund
Arthritis Foundation
Blood Cancer United

Caregiver Action Network
Davis Phinney Foundation for Parkinson's
Depression and Bipolar Support Alliance
Derma Care Access Network
Epilepsy Foundation of America
GO2 for Lung Cancer
HealthyWomen
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Lupus and Allied Diseases Association, Inc.
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