NATIONAL HEALTH COUNCIL

July 20, 2026

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

RE: Request for Information: Pharmacy Benefit Manager Compensation and Data Collection [CMS-4218-NC]

Submitted electronically via regulations.gov

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to provide comments in response to the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on Pharmacy Benefit Manager Compensation and Data Collection.

Created by and for patient organizations more than 100 years ago, the NHC convenes organizations from across the health ecosystem to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, comprehensive, accessible, and sustainable health care. Made up of nearly 200 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

The NHC appreciates CMS' effort to gather technical input to inform implementation of section 6224 of the Consolidated Appropriations Act, 2026, including restrictions on pharmacy benefit manager (PBM) and PBM-affiliate remuneration in connection with covered Part D drugs and annual data reporting requirements beginning in 2028. Although many of the RFI's questions involve technical contracting, payment, and reporting arrangements, the issues raised have direct implications for Medicare beneficiaries. Patients do not experience Part D supply-chain terminology, but rather through whether their medications are covered, whether they can afford them at the pharmacy counter, whether prior authorization or step therapy delays access, whether pharmacies remain available in their communities, and whether benefit design supports continuity of care.

The NHC recognizes that PBMs can play an important role in the prescription drug supply chain, including by supporting claims administration, formulary management, pharmacy network contracting, and negotiations intended to reduce prescription drug spending. PBM compensation arrangements, affiliate relationships, and delegated administrative functions can affect whether savings are visible to patients, whether plan sponsors and regulators can evaluate the reasonableness of compensation, and whether beneficiaries encounter access

barriers at the pharmacy counter. Accordingly, PBM-related disclosures should follow a clear, consistent format that allows stakeholders to understand compensation sources and assess how those arrangements may interact with formulary design, utilization management, pharmacy access, and patient cost-sharing obligations.[1,2]

The NHC therefore supports implementation of section 6224 in a manner that increases transparency, supports meaningful oversight, and evaluates PBM and affiliate compensation arrangements based on their effects on patient access, affordability, and continuity of care. Such an approach can recognize the legitimate role of Part D sponsors and PBMs in administering prescription drug benefits while ensuring that beneficiaries, including those with chronic, disabling, rare, complex, or high-cost conditions, can obtain clinically appropriate medications in a timely, predictable, and affordable manner. The NHC's comments focus on the patient-centered principles that should guide future rulemaking and implementation, while recognizing that many of the RFI's questions will also require technical input from Part D sponsors, PBMs, pharmacies, manufacturers, and other entities with direct experience in contracting and reporting.

Summary of Recommendations

The NHC recommends that implementation of section 6224:

1. Reflect the range of PBM and affiliate functions involved in modern Part D benefit administration, including vertically integrated and contractually delegated arrangements that can affect formulary design, utilization management, pharmacy access, point-of-sale adjudication, and beneficiary costs.
2. Apply bona fide service fee and fair market value standards in a way that prevents compensation from being directly or indirectly tied to drug price, rebate value, formulary placement, utilization volume, referral volume, or other methodologies that may create incentives that could undermine patient access.
3. Establish PBM and affiliate data reporting that is standardized, auditable, and usable by CMS, Part D sponsors, patient organizations, pharmacies, researchers, and other stakeholders to evaluate patient access and affordability.
4. Include patient-relevant data elements on formulary placement, exclusions, tiering, prior authorization, step therapy, exceptions, appeals, point-of-sale cost sharing, pharmacy network access, specialty pharmacy requirements, mail-order requirements or incentives, medication abandonment, and midyear formulary or utilization management changes.
5. Evaluate implementation based on both compliance with technical statutory requirements for reported compensation and the extent to which the Part D program remains accessible, affordable, understandable, and responsive to beneficiaries with chronic, disabling, rare, complex, or high-cost conditions.

---

[1] National Health Council, "NHC Comments to the FTC on PBM Business Practices and the Impact on Independent Pharmacies and Consumers," May 26, 2022, https://nationalhealthcouncil.org/letters-comments/nhc-comments-to-the-ftc-on-pbm-business-practices-and-the-impact-on-independent-pharmacies-and-consumers/.

[2] National Health Council, "NHC Comments on Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure," April 15, 2026, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-improving-transparency-into-pharmacy-benefit-manager-fee-disclosure/.

PBM and Affiliate Definitions Should Reflect the Full Range of Functions Affecting Patient Experience

From the patient perspective, PBM functions extend beyond claims processing or rebate negotiation to encompass a wide range of policies and processes that determine whether a prescribed therapy is available, affordable, and accessible in a timely manner. These include formulary design, tier placement, prior authorization, step therapy, quantity limits, pharmacy networks, specialty pharmacy requirements, mail-order rules, point-of-sale adjudication, exceptions and appeals processes, and communications about coverage and cost sharing. The NHC recommends that CMS implement the definition of "pharmacy benefit manager" in a manner that reflects the full range of activities that shape beneficiaries' access to covered Part D drugs, because such a definition will better position CMS to understand how PBM and PBM-related functions operate across the Part D benefit and how those functions may affect access for beneficiaries with chronic, disabling, rare, complex, or high-cost conditions.

From the patient perspective, PBM functions extend beyond claims processing or rebate negotiation to encompass a wide range of policies and processes that determine whether a prescribed therapy is available, affordable, and accessible in a timely manner. These include formulary design, tier placement, prior authorization, step therapy, quantity limits, pharmacy networks, specialty pharmacy requirements, mail-order rules, point-of-sale adjudication, exceptions and appeals processes, and communications about coverage and cost sharing. The NHC recommends that CMS implement the definition of "pharmacy benefit manager" in a manner that reflects the full range of activities that shape beneficiaries' access to covered Part D drugs, because such a definition will better position CMS to understand how PBM and PBM-related functions operate across the Part D benefit and how those functions may affect access for beneficiaries with chronic, disabling, rare, complex, or high-cost conditions.
Accordingly, the NHC also recommends that CMS clarify that "related services" include services and activities that materially affect coverage, access, cost sharing, or pharmacy access for covered Part D drugs, such as formulary development, formulary management, tier placement, formulary exclusions, utilization management design, coverage determinations, exceptions and appeals, pharmacy network design, rebate aggregation, manufacturer contracting, claims adjudication, benefit-design consulting, and delegated or intermediary functions that may affect beneficiary access, cost sharing, or continuity of care. It will also be important for CMS to recognize that entities not identified as PBMs in contracts or corporate materials may nonetheless perform PBM-like functions, including rebate aggregators, group purchasing organizations, claims processors, specialty pharmacy entities, mail-order pharmacies, data vendors, pharmacy benefit consultants, payment facilitators, and others involved in administering pharmacy benefits.[3,4] A functional approach would help ensure that CMS' implementation of the definition accounts for the full range of activities affecting the Part D benefit, regardless of the type of entity performing them.

---

[3] National Health Council, "NHC Comments on Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure."

[4] National Health Council, "NHC Comments on Response to the Medicare Program Request for Information on Medicare Advantage Data," May 29, 2024, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-response-to-the-medicare-program-request-for-information-on-medicare-advantage-data/.

Narrow definitions focused on entity labels alone could make it more difficult for CMS to understand whether compensation structures are affecting formulary placement, utilization management, pharmacy access, or beneficiary costs, and could increase the risk that PBM functions or compensation are shifted across affiliates, intermediaries, or contractors in ways that limit visibility into the incentives affecting the Part D benefit. The NHC therefore urges CMS to adopt definitions that focus on function and effect, which would support transparency and oversight without presuming that any particular entity type or contracting model is inappropriate.

The NHC also encourages CMS to interpret the term "affiliate" in a manner that captures ownership, control, contractual, agency, and other relationships that can affect Part D drug utilization, cost sharing, pharmacy access, or PBM compensation. Patients experience Part D benefit as a single coverage system, not as a series of decisions made by separate corporate entities. A beneficiary may be unable to fill a medication at a local pharmacy, be required to use a specialty-pharmacy, encounter an unexpected prior authorization, or pay cost sharing based on a price that does not reflect negotiated concessions without knowing which entity is responsible. For that reason, affiliate reporting should be designed to help CMS understand the relationships among Part D sponsors, PBMs, rebate aggregators, pharmacies, wholesalers, data vendors, consultants, and other entities that may influence formulary design, utilization management, pharmacy network design, pharmacy reimbursement, or beneficiary cost sharing.

The NHC recommends that PBMs and Part D sponsors report sufficient ownership, control, contractual, and payment-flow information to allow the agency to determine whether an entity is functioning as an affiliate and whether compensation arrangements comply with statutory requirements. This reporting should help CMS understand how related entities or delegated functions interact with the Part D benefit without presuming that any particular arrangement is inappropriate or that all affiliated relationships have the same implications for patients. The purpose of this reporting should be to ensure that CMS has the information needed to evaluate whether an arrangement supports patient access, affordability, and program integrity.[5,6,7]

Bona Fide Service Fee and Fair Market Value Standards Should Support Patient Access While Preserving Legitimate Plan and PBM Functions

For patients, a core issue is whether compensation arrangements create incentives that support timely access to clinically appropriate care. The NHC therefore supports the statutory requirement that bona fide service fees reflect fair market value for a bona fide, itemized service actually performed and not be directly or indirectly based on drug price, rebates, formulary placement, referral volume, or other prohibited methodologies. Such an

---

[5] National Health Council, "NHC Comments on Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure."

[6] D. Patrick Durham et al., "Pharmacy Benefit Managers: Transparency, Accountability, and Impact on Patient Care," Journal of Managed Care & Specialty Pharmacy 27, no. 7 (2021): 903–907, https://doi.org/10.18553/jmcp.2021.27.7.903.

[7] Timothy J. Mattingly II et al., "Pharmacy Benefit Managers: History, Business Practices, Economics, and Policy," JAMA Health Forum 4, no. 11 (2023): e233822, https://doi.org/10.1001/jamahealthforum.2023.3822.

implementation of the bona fide service fee would distinguish between legitimate service-based compensation from arrangements that may continue to operate as price-based, rebate-based, volume-based, formulary-based, or channel-based compensation. This distinction is important because PBMs and affiliates may perform legitimate services for Part D sponsors and other entities, while compensation arrangements that are not clearly tied to bona fide services may make it more difficult to evaluate whether the Part D benefit is being administered in a manner that supports patient access and affordability.

A durable oversight framework would include sufficient documentation to demonstrate the service performed, the entity for whom the service was performed, the methodology used to determine compensation, and the reason the payment is not directly or indirectly tied to prohibited factors, while preserving flexibility for reasonable service-based arrangements where PBMs and affiliates are performing legitimate services for Part D sponsors and other entities. Preserving that flexibility will require sufficient information for CMS to determine whether remuneration varies based on drug price benchmarks, rebate amounts, formulary placement, preferred status, utilization management placement, prescription volume, referral volume, product selection, or use of a particular pharmacy channel. The NHC supports an approach that allows legitimate administrative and benefit-management functions to continue while giving CMS the information needed to identify arrangements that may create incentives misaligned with patient access.

The NHC recommends careful treatment of incentive payments deemed bona fide service fees under the statute, recognizing that incentive payments may be appropriate where they reward demonstrable performance that benefits beneficiaries, such as accurate point-of-sale adjudication, timely resolution of errors, improved access to needed medications, reduced inappropriate administrative burden, improved formulary accuracy, or better patient-facing communications. Those payments should be structured so they do not create indirect incentives to limit access to clinically appropriate therapies, increase administrative burden, or reduce pharmacy choice in ways that affect beneficiaries. To support patient-centered implementation, incentive payments should reward performance that improves the functioning of the benefit for beneficiaries. They should not reward practices that merely shifts costs, limits access, or makes the system more difficult for patients and caregivers to navigate.

The NHC also urges CMS to define fair market value in a manner that is objective, auditable, and resistant to manipulation in markets where related entities may perform multiple functions across the prescription drug supply chain. Internal transfer prices or affiliate contracts should not be treated as sufficient evidence of fair market value without documentation showing that the compensation is reasonable for the actual service performed market value determinations would be most useful if supported by clear documentation explaining the specific service performed, the methodology used to calculate the fee, the comparators used, whether the arrangement involves affiliated entities, and whether the compensation varies directly or indirectly based on drug price, utilization, rebate value, formulary status, pharmacy channel, or product selection.[8,9] Such

[8] National Health Council, Policy Recommendations for Reducing Health Care Costs, updated September 2021, https://nationalhealthcouncil.org/wp-content/uploads/2021/09/NHC-Health-Care-Costs-2021-Recommendations.pdf.

[9] Mattingly et al., “Pharmacy Benefit Managers: History, Business Practices, Economics, and Policy.”

documentation would help CMS evaluate whether the compensation reflects the value of a bona fide service or instead depends on factors that may affect patient access, affordability, or continuity of care.

The NHC recognizes that CMS will need to evaluate compliance with the statutory requirements based on administrable standards that can be applied across a wide range of PBM, affiliate, and Part D sponsor arrangements. Technical compliance alone may be insufficient if the practical effect of a compensation arrangement is to increase patient costs, reduce access, or make benefit design less transparent, which is why evaluation of bona fide service fee and fair market value standards should consider whether they improve transparency, support appropriate oversight, and help ensure that beneficiaries receive the intended value of prescription drug benefit administration. This patient-centered evaluation would allow CMS to implement the statute in a manner that preserves legitimate plan and PBM functions while maintaining focus on how compensation arrangements affect the beneficiaries who rely on Part D coverage.[10]

Pharmacy Payment Policies and Network Arrangements Should Be Monitored for Downstream Effects on Patient Access

The RFI asks about pharmacy payment or compensation arrangements that are preserved under the statutory provision related to flat dispensing fees, ingredient-cost reimbursement, and existing pharmacy payment requirements. The NHC encourages implementation of the statute in a way that preserves legitimate pharmacy reimbursement while allowing CMS to monitor whether PBM compensation reforms affect pharmacy access for beneficiaries, particularly because pharmacy access is often inseparable from medication access for people with chronic, disabling, rare, complex, or high-cost conditions. This monitoring should be grounded in the patient experience and should consider how payment, network, and point-of-sale arrangements affect whether beneficiaries can obtain needed medications in a timely and reliable manner.

Beneficiaries with chronic conditions, disabilities, limited transportation, cognitive impairment, language-access needs, rural residence, or complex medication regimens may rely on specific pharmacy settings, including independent community pharmacies, long-term care pharmacies, specialty pharmacies, and pharmacies with particular care-management capabilities. Pharmacists and pharmacies often play a critical role in helping patients understand their medications, identify affordability issues, navigate coverage barriers, and maintain adherence, and, for many beneficiaries, particularly those in rural or underserved communities, a local pharmacy may be one of the most accessible points of contact in the health care system.[11,12] Because of this role, changes in PBM compensation, pharmacy reimbursement, pharmacy network participation, or point-of-sale processes can have practical consequences for whether beneficiaries are able to fill prescriptions, maintain adherence, and avoid gaps in therapy.

---

[10] National Health Council, Policy Recommendations for Reducing Health Care Costs.

[11] American Pharmacists Association, “APhA Advocacy Issues,” accessed June 17, 2026, https://www.pharmacist.com/Advocacy/Issues.

[12] American Pharmacists Association, “DIR Fees Increase Costs for Patients and Pharmacies,” accessed June 17, 2026, https://aphanet.pharmacist.com/sites/default/files/audience/APhADIRHandout.pdf.

Monitoring efforts could assess the effects of section 6224 implementation on pharmacy network adequacy and beneficiary access to preferred and non-preferred pharmacies, independent community pharmacies, long-term care pharmacies, and specialty pharmacies. They could also track changes in mail-order requirements or incentives, prescription-fill delays, pharmacy network terminations, and beneficiary complaints related to pharmacy choice. That monitoring could also consider whether pharmacy reimbursement or pharmacy performance arrangements create incentives that affect access to medications used by beneficiaries with chronic, rare, disabling, complex, or high-cost conditions. The NHC does not recommend that CMS use this RFI to resolve broader pharmacy reimbursement policy questions outside the scope of the statute; however, implementation would be strengthened by safeguards that avoid unintentionally destabilizing pharmacy access or obscuring incentives that affect where and how beneficiaries can obtain needed medications.[13,14]

Input from independent community pharmacies, long-term care pharmacies, consultant pharmacists, and other pharmacy professionals would be valuable in understanding how PBM compensation, pharmacy reimbursement, network participation, and point-of-sale processes affect the patient experience.[15,16] That input should inform future rulemaking and implementation guidance, while the central measure of success should remain whether beneficiaries can obtain needed therapies in a timely, predictable, and affordable manner. This approach would allow CMS to recognize the role of pharmacy stakeholders in the Part D ecosystem without shifting the focus away from patients, caregivers, and beneficiaries who experience the consequences of benefit design and pharmacy access decisions.

Data Collection Should Be Patient-Relevant, Standardized, and Actionable

The RFI asks what additional data elements beyond those required by statute would help CMS implement and monitor section 6224, and the NHC strongly encourages CMS to ensure that PBM data collection is not limited to aggregate financial flows. While compensation and pricing data are essential, these reporting requirements should also capture data that allow CMS to assess whether PBM and affiliate arrangements are supporting patient access, affordability, and continuity of care. Data collection will be most valuable if it enables CMS to connect compensation arrangements with the practical

---

[13] National Health Council, “NHC Comments on Draft CY 2025 Part D Redesign Program Instructions,” March 1, 2024, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-draft-cy-2025-part-d-redesign-program-instructions/.

[14] National Health Council, “NHC Comments on Medicare Drug Price Negotiation Program Draft Guidance, Implementation of Sections 1191–1198 of the Social Security Act for Initial Price Applicability Year 2027 and Manufacturer Effectuation of the Maximum Fair Price in 2026 and 2027,” July 2, 2024, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-medicare-drug-price-negotiation-program-draft-guidance-implementation-of-sections-1191-1198-of-the-social-security-act-for-initial-price-applicability-year-2027-and-manufac/.

[15] American Society of Consultant Pharmacists, “ASCP Weighs in on CMS Guidance for Maximum Fair Price & Pharmacy Payments,” July 31, 2024, https://www.ascp.com/news/678747/ASCP-Weighs-in-on-CMS-Guidance-for-Maximum-Fair-Price--Pharmacy-Payments.htm.

[16] National Community Pharmacists Association, “NCPA Comments to the FTC on PBM Business Practices,” May 23, 2022, https://ncpa.org/sites/default/files/2022-05/5.23.2022-NCPAcommentFTCPBMsolicitation.pdf.

features of the Part D benefit that beneficiaries experience, including formulary placement, utilization management, pharmacy access, cost sharing, and point-of-sale adjudication.

Transparency alone does not guarantee improved patient outcomes. For transparency to be meaningful, data must be structured in a clear, consistent format that allows CMS, Part D sponsors, Congress, patient organizations, pharmacies, researchers, and other stakeholders to understand how PBM compensation arrangements interact with formulary design, utilization management, cost sharing, pharmacy access, and patient experience. Disclosure frameworks should be usable not only by entities with specialized pharmacy benefit expertise, but also by stakeholders who need to understand whether reported compensation is reasonable relative to the services provided and whether compensation structures may affect beneficiary access. The NHC encourages CMS to prioritize standardized definitions, reporting templates, and data elements that make reported information comparable across entities and meaningful for oversight.[17]

Data collection would be most useful if it includes plan- and drug-level data on formulary inclusion or exclusion, tier placement, preferred and non-preferred status, specialty-tier placement, therapeutic class, generic and biosimilar coverage, and midyear formulary changes, as well as information sufficient to show whether formulary placement is associated with rebates, fees, discounts, or other remuneration. These data would allow CMS to evaluate whether compensation reforms affect formulary breadth, beneficiary choice, or continuity of care. Because beneficiaries experience the Part D benefit in significant part through formulary design, understanding its relationship to compensation is central to evaluating whether the statute is achieving its intended purpose. Formulary and compensation data should therefore be considered together rather than in isolation.[18]

The NHC also recommends collecting data on prior authorization, step therapy, quantity limits, exceptions, appeals, and related utilization management outcomes, including if a drug is subject to utilization management, whether utilization management requirements changed during the plan year, the number and percentage of requests approved or denied, the timing of decisions, the frequency of appeals, the frequency of overturned denials, and the reasons for denial. Prior authorization and other utilization management tools can create substantial administrative and access burdens for patients with chronic conditions and disabilities, and prescription drugs often remain outside major prior authorization reform efforts. PBM data collection should therefore help CMS identify whether compensation arrangements are associated with increased use of utilization management or with delays in access, while also helping the agency understand whether those patterns are concentrated

[17] National Health Council, “NHC Comments on Improving Transparency Into Pharmacy Benefit Manager Fee Disclosure.”

[18] National Health Council, “NHC Comments on Draft CY 2025 Part D Redesign Program Instructions.”

in particular therapeutic areas, plan designs, pharmacy channels, or beneficiary populations.[19,20,21,22]

Patient cost-sharing and point-of-sale experience data should also be collected to allow CMS to understand what beneficiaries are asked to pay at the pharmacy counter, whether cost sharing reflects list price, negotiated price, net price, or another pricing basis, and whether rebates, discounts, or other price concessions affect beneficiary out-of-pocket costs. Such data would also enable CMS to capture information on rejected claims, reversed claims, claims requiring beneficiary or prescriber intervention, delayed fills, medication abandonment where available, and complaints related to unexpected cost sharing. Collecting these data is particularly important for beneficiaries with ongoing or high-cost medication needs, for whom even temporary disruptions can affect adherence, disease control, and overall health. A data collection framework that captures both financial and point-of-sale experience data would allow CMS to assess whether compensation arrangements are associated both aggregate program costs and also with the affordability and usability of the Part D benefit for beneficiaries.[23,24,25]

In order for CMS to evaluate whether PBM and affiliate compensation arrangements create incentives that affect pharmacy choice in ways that may not align with patient preference, clinical need, or practical access, pharmacy network and channel access data should also be included. These data would allow CMS to evaluate network composition, preferred and non-preferred pharmacy status, specialty pharmacy requirements, mail-order requirements or incentives, use of affiliated pharmacies, beneficiary access to community and independent pharmacies, access to long-term care and specialty pharmacies, and complaints or grievances related to pharmacy access or pharmacy choice. The NHC encourages CMS to consider how pharmacy network data, complaint data, and claims data can be used together to identify whether beneficiaries are experiencing delays, disruptions, or limitations in obtaining covered Part D drugs.

---

[19] National Health Council, Exploring the Burden of Prior Authorization on Patients with Chronic Disease, November 2023, https://nationalhealthcouncil.org/wp-content/uploads/2023/11/NHC-Report-Exploring-the-Burden-of-Prior-Authorization-on-Patients-with-Chronic-Disease.pdf.

[20] National Health Council, “NHC Comments on Interoperability and Prior Authorization Proposed Rule,” March 13, 2023, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-interoperability-and-prior-authorization-proposed-rule/.

[21] National Health Council, “NHC’s Comments on the CMS Proposed Rule on Interoperability and Prior Authorization,” June 2026, https://nationalhealthcouncil.org/letters-comments/nhcs-comments-on-the-cms-proposed-rule-on-interoperability-and-prior-authorization/.

[22] National Health Council, “NHC Final 2022 NBPP Comments,” December 30, 2020, https://nationalhealthcouncil.org/wp-content/uploads/2021/01/NHC-Final-2022-NBPP-Comments.pdf.

[23] National Health Council, “NHC Final 2022 NBPP Comments.”

[24] National Health Council, “NHC Comments on Draft CY 2025 Part D Redesign Program Instructions.”

[25] National Health Council, “NHC Comments on Medicare Drug Price Negotiation Program Draft Guidance.”

Financial and operational reporting would be strengthened by patient-relevant experience data, including beneficiary complaints, grievances, appeals, pharmacy-counter access problems, delays in obtaining covered Part D drugs, confusion related to cost sharing or formulary status, and disruptions related to midyear formulary or utilization management changes. Development of these measures would benefit from input from patient organizations, pharmacy stakeholders, Part D sponsors, and other affected parties, both to identify the most meaningful patient-centered measures and to interpret data in the context of real-world beneficiary experience. This input will be especially important where quantitative reporting may show that a coverage or pharmacy process technically occurred within required parameters, but patients still experienced confusion, delay, abandonment, or disruption in access to therapy.

Reporting Alignment Should Preserve Part D-Specific Oversight

The NHC supports CMS' interest in actionable data and encourages the agency to align section 6224 reporting with existing federal reporting frameworks where appropriate. Such alignment could reduce duplication and administrative burden, improve consistency, and make it easier to compare data across markets. At the same time, reporting must contain sufficient Part-D specific detail to identify to account for Medicare beneficiaries' unique needs and protections and allow CMS and stakeholders to monitor beneficiary access, cost sharing, formulary design, pharmacy access, and utilization management.

CMS could support consistent reporting and reduce interpretation variability though phased timelines, technical guidance, standardized templates, data dictionaries, and illustrative examples. The NHC also supports data validation and audit mechanisms to ensure accuracy and completeness, while avoiding unnecessary duplication or reporting burden where existing data sources can be used effectively. Together, these implementation tools would help CMS obtain data that are comparable, reliable, and useful for oversight without creating avoidable administrative burden for plans, PBMs, pharmacies, or other reporting entities.[26,27,28]

Appropriate Public Reporting Can Support Oversight and Accountability

The NHC recognizes that some PBM contracting information may raise confidentiality concerns, but public transparency remains essential to accountability. Aggregated, de-identified, and appropriately protected public reporting would allow patient organizations, researchers, policymakers, pharmacies, Part D sponsors, and other stakeholders to assess

---

[26] National Health Council, "NHC Comments on CY 2027 Policy & Technical Changes to Medicare Advantage and Medicare Part D," January 26, 2026, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-cy-2027-policy-technical-changes-to-medicare-advantage-and-medicare-part-d/.

[27] National Health Council, "NHC Submits Comments to CMS RE CY 2026 Policy & Technical Changes to MA and Part D Proposed Rule," January 27, 2025, https://nationalhealthcouncil.org/letters-comments/nhc-submits-comments-to-cms-re-cy-2026-policy-technical-changes-to-ma-and-part-d-proposed-rule/.

[28] National Health Council, "NHC Responds to CMS Information Collection Request on Drug Price Negotiation," August 29, 2025, https://nationalhealthcouncil.org/letters-comments/nhc-responds-to-cms-information-collection-request-on-drug-price-negotiation/.

whether Part D is meeting beneficiary needs. Public reporting does not need to disclose proprietary contracting terms to be useful, but it should provide enough information for stakeholders to understand trends in access, affordability, formulary design, pharmacy access, and utilization management. This distinction is important because CMS can preserve the confidentiality of sensitive contracting information while still ensuring that the public has access to information that shows whether program implementation is improving the beneficiary experience.

Public reporting should include information on formulary coverage trends, utilization management, appeals and overturns, pharmacy access, beneficiary cost sharing, and complaints or grievances, and CMS could also publish analytic reports that evaluate relationships between PBM compensation structures and access outcomes. Where CMS determines that certain data cannot be publicly released at a granular level, those data can still support oversight, enforcement, and policy development, while summary findings can help inform public understanding. This distinction between confidential oversight data and public-facing summary data would allow CMS to protect sensitive information while still giving beneficiaries, patient organizations, pharmacies, plans, and policymakers a clearer view of whether the Part D program is meeting patient needs.

Transparency should be actionable and should support accountability, patient understanding, and evidence-based oversight.[29,30,31] PBM reporting should not become a compliance exercise that produces data inaccessible to patients, patient organizations, pharmacies, plan sponsors, or policymakers, but should instead help stakeholders understand whether the Part D program is operating in a way that promotes access, affordability, pharmacy choice, and continuity of care. Public reporting that is designed with these goals in mind would help ensure that section 6224 implementation informs future policy development and supports meaningful oversight of the Part D benefit.[32,33]

---

[29] Arthritis Foundation, “HHS Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs,” July 16, 2018, https://www.arthritis.org/getmedia/19bdf068-aa60-4073-8219-0e541550959d/AF-Comments-on-Drug-Pricing-Blueprint-July-2018.pdf.

[30] Arthritis Foundation, “Accumulator Adjustment Program State Model Language,” February 2021, https://www.arthritis.org/getmedia/eb4d81c4-3201-419f-ae11-59757e60a3f7/Accumulator-Adjustment-Programs-Model-Language-FINAL-Feb-2021.pdf.

[31] PAN Foundation, “PAN Joins 200+ Healthcare Organizations Urging Congress to Include the Safe Step Act in Pharmacy Benefit Manager Reform Legislation,” November 2024, https://www.panfoundation.org/pan-joins-200-healthcare-organizations-urging-congress-to-include-the-safe-step-act-in-pharmacy-benefit-manager-reform-legislation/.

[32] National Health Council, Amplifying the Patient Voice: Roundtable and Recommendations on CMS Patient Engagement, March 2024, https://nationalhealthcouncil.org/wp-content/uploads/2025/05/Amplifying-the-Patient-Voice-Roundtable-and-Recommendations-on-CMS-Patient-Engagement-new-1.pdf.

[33] National Health Council, “NHC Comments on Response to the Medicare Program Request for Information on Medicare Advantage Data.”

Implementation Should Be Evaluated Based on Patient Access, Not Just Technical Compliance

The NHC appreciates that this RFI is focused on technical implementation of statutory compensation and reporting provisions; however, those requirements should ultimately be evaluated based on whether implementation improves transparency, accountability, affordability, and access for Medicare beneficiaries. This is particularly important in the Part D context, where changes in compensation, reporting, formulary design, utilization management, or pharmacy access may appear technical from an operational perspective but can have immediate consequences for beneficiaries attempting to obtain needed medications. The NHC encourages CMS to use the data collected under section 6224 to both assess compliance and understand whether implementation is improving the practical experience of beneficiaries who rely on Part D coverage.

To that end, monitoring efforts could assess whether implementation is associated with changes in beneficiary out-of-pocket spending, formulary breadth and stability, utilization management frequency and outcomes, appeals and exception approvals, prescription abandonment or delayed fills, pharmacy network access and pharmacy choice, use of affiliated pharmacies, and complaints or grievances. Particular attention is warranted for beneficiaries with chronic, rare, disabling, complex, or high-cost conditions, who are most likely to be affected by restrictive formularies, utilization management, pharmacy network limitations, and high out-of-pocket costs, and who may have fewer clinically appropriate alternatives if access to a prescribed therapy is delayed or disrupted. These measures would help CMS understand whether implementation is affecting patient access in ways that may not be apparent from compensation data alone.

CMS could also assess whether section 6224 data collection is sufficient to identify and respond to emerging access issues. If reporting does not provide sufficient information on the relationship between compensation and patient access, the agency could refine the reporting requirements through future rulemaking or subregulatory guidance. The process would also benefit from input from patient organizations, pharmacy stakeholders, Part D sponsors, and other affected parties on the usefulness of reported data and the real-world implications of PBM and affiliate compensation structures. Stakeholder feedback would help ensure that implementation remains grounded in beneficiary experience and that future policy refinements respond to practical access, affordability, and continuity-of-care concerns.

Conclusion

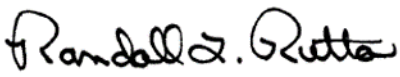
The NHC appreciates CMS' efforts to implement section 6224 of the Consolidated Appropriations Act, 2026, in a manner that improves transparency and accountability in Part D PBM compensation and data reporting. Although PBM arrangements are complex, the patient-centered objective remains straightforward: beneficiaries should be able to access clinically appropriate prescription drugs in a timely, affordable, predictable, and understandable manner. This objective should guide both the technical implementation of compensation and reporting requirements and the agency's evaluation of whether those requirements are improving the functioning of the Part D benefit for patients.

As CMS develops future rulemaking and guidance, the NHC urges the agency to define PBM and affiliate functions broadly enough to reflect modern market structures, implement bona fide service fee and fair market value standards that prevent compensation from being

tied directly or indirectly to access-restrictive incentives, and collect standardized, actionable, patient-relevant data on formulary design, utilization management, pharmacy access, cost sharing, and patient experience. These steps would help ensure that implementation of section 6224 supports transparency and accountability while remaining focused on the patients and beneficiaries who experience the practical effects of Part D benefit design, pharmacy access, and prescription drug affordability.

Thank you for the opportunity to provide comments. Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs, at kbeer@nhcouncil.org or Shion Chang, Assistant Vice President, Policy & Regulatory Affairs, at schang@nhcouncil.org if you or your staff would like to discuss these comments in greater detail.

Sincerely,



Randall L. Rutta
Chief Executive Officer