January 26, 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: Contract Year (CY) 2027 Medicare Advantage and Part D Proposed Rule

Dear Administrator Oz,

The undersigned members of the MAPRx Coalition (MAPRx) appreciate the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) Contract Year (CY) 2027 Medicare Advantage and Part D proposed rule released on November 25, 2025.

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 appreciates the opportunity to provide feedback on the CY 2027 Medicare Advantage and Part D proposed rule. As detailed in our specific comments below, we advocate for CMS to implement robust, patient-centric processes that:

- **Ensure marketing and communications safeguards, including referring to State Health Insurance Assistance Programs (SHIPs) in the third-party marketing organization (TPMO) disclaimer.**
- **Protect beneficiary access and affordability in Medicare Part D benefit by including maintaining appropriate guardrails around the specialty-tier cost threshold.**
- **Improve transparency and accountability in CMS Part D formulary oversight and utilization management.**
- **Increase transparency of Medicare Advantage risk adjustment data and consider incorporating Part D encounter data into future risk adjustment approaches.**
- **Ensure that any streamlining of the Star Ratings program is paired with strong plan oversight and enforcement so quality improvements are sustained and**
- **Continue refinements to the Medicare Prescription Payment Plan program, which the proposed rule does not address.**

Ensure Beneficiary Protections in Marketing Materials

CMS proposes to relax several safeguards intended to limit steering and reduce beneficiary confusion, including allowing educational and marketing events back-to-back without a 12-hour waiting period, removing the 48-hour "cooling-off" period between collecting a Scope of Appointment (SOA) and holding a personal marketing appointment, and allowing SOAs to be collected at educational events. CMS also proposes adjusting the TPMO disclaimer by requiring it to be stated before discussing benefits, while removing SHIPs from the disclaimer and directing beneficiaries primarily to Medicare.gov and 1-800-MEDICARE.

MAPRx is concerned these changes, taken together, may increase the likelihood that beneficiaries experience confusion, high-pressure, or misleading interactions during plan selection. This risk is especially acute for beneficiaries with complex medication needs, limited health literacy, cognitive impairment, limited English proficiency, or those who rely on trusted local counseling resources.

SHIP counselors are uniquely positioned to provide unbiased, community-based assistance. Removing SHIPs from required marketing disclosures reduces visibility for a key neutral resource at the very moment beneficiaries are most vulnerable to steering.

MAPRx recommends that CMS:

- Retain SHIPs in the TPMO disclaimer and ensure beneficiaries are informed of independent counseling options in both verbal and written marketing materials, not only Medicare.gov and 1-800-MEDICARE.
- If CMS finalizes removal of SHIPs from the TPMO disclaimer, require TPMOs and plans to provide SHIP information through another enforceable mechanism (for example, a standardized written notice that includes the beneficiary's state or local SHIP contact information.)
- Maintain the existing separation between educational and marketing activities, or replace the removed timing guardrails with clear, enforceable standards that prevent immediate transitions from education to sales and ensure clear beneficiary consent before marketing begins.
- Strengthen monitoring and enforcement by using complaint data, call recording review, and targeted audits to identify steering and misleading comparative claims and publicly report enforcement actions and recurring deficiencies.

Medicare Part D Redesign: Specialty-Tier Cost Threshold

CMS proposes revising the specialty-tier cost threshold regulation to allow CMS to decrease the threshold under certain circumstances. While we recognize the intent to align policies with changing market dynamics, lowering the specialty-tier cost threshold would expand the number of drugs eligible for placement on the specialty tier and would exacerbate a specialty tier policy that already harms beneficiaries through high coinsurance and unpredictable out-of-pocket costs.

Beneficiaries should benefit from declining drug prices through lower out-of-pocket spending, not be moved into benefit designs that impose higher coinsurance and weaken patient protections. CMS should avoid policy changes that shift financial risk to beneficiaries or increase the likelihood of prescription abandonment for people with serious or complex conditions.

MAPRx recommends that CMS:

- Do not finalize the proposal to allow the specialty-tier cost threshold to decrease and instead maintain a stable threshold methodology that protects beneficiaries from inappropriate placement of drugs on the specialty tier.
- If CMS retains any authority to decrease the threshold in future years, establish clear guardrails, including beneficiary impact analysis, advance notice, and an opportunity for stakeholder input before any downward adjustment is implemented.
- Change the exceptions policy to allow for cost exceptions on the specialty tiers.
- Ensure that any specialty-tier policy changes are paired with strengthened affordability protections, so beneficiaries do not experience higher out-of-pocket spending as prices decline.

Improve transparency and accountability in CMS formulary oversight and utilization management

MAPRx supports CMS's proposal to require Part D sponsors to retain the original documentation used in coverage determinations and prior authorization decisions, including prior authorization forms, supporting clinical information, and call notes. This documentation will be critical to effective oversight and to ensure there is a robust record when beneficiaries challenge denials or delays in access.

At the same time, CMS's formulary oversight feels opaque to those of us outside the agency. Beneficiaries can see the consequences of restrictive formularies and utilization management, but stakeholders have limited insight into how CMS evaluates formulary submissions and utilization management criteria, how CMS applies actuarial checks, what deficiencies CMS identifies, and how CMS verifies ongoing compliance throughout the year.

As Part D benefit redesign is implemented and plan incentives shift, CMS must pair flexibility for plan design with meaningful transparency and proactive oversight to prevent inappropriate use of prior authorization, step therapy, and mid-year access barriers.

MAPRx recommends that CMS:

- Publish a plain-language annual summary of CMS's Part D formulary review and oversight process, including the criteria used to evaluate formularies and utilization management, and how CMS applies actuarial equivalence checks.
- Create a structured process for beneficiary and stakeholder input on formulary design and utilization management trends (including prior authorization, step therapy, quantity limits) and describe how CMS incorporates this input into oversight.
- Require standardized reporting and public transparency for key access indicators, such as prior authorization approval and denial rates, time-to-decision, appeals outcomes, and utilization management changes over the plan year.
- Use audit authorities to identify and address patterns of inappropriate denials or excessive hurdles and provide clearer standards for corrective action plans when sponsors are out of compliance.

Risk Adjustment: Support Transparency and Encourage Use of Part D Encounter Data

MAPRx applauds CMS's proposal to increase transparency and access to Medicare Advantage risk adjustment data, including encounter data, while maintaining appropriate safeguards for beneficiary privacy and commercially sensitive information. Greater access to these data can

support research, program integrity, and a clearer understanding of how Medicare Advantage plans perform for beneficiaries with complex clinical and medication needs.

MAPRx recommends that CMS:

- Finalize the proposal to broaden permissible use and release of Medicare Advantage risk adjustment data in a manner aligned with standards for fee-for-service claims data, while preserving privacy and security protections.
- For future risk adjustment approaches, consider incorporating Part D encounter data into both Part C and Part D risk adjustment models to better reflect the health risk associated with medication use, multimorbidity, and beneficiary complexity.

Star Ratings: Streamlining Must Be Paired with Oversight and Enforcement

MAPRx appreciates CMS's efforts to streamline the Star Ratings program and reduce burden by focusing on measures that meaningfully distinguish plan performance and reflect beneficiary-relevant outcomes. At the same time, any reduction in measurement or administrative requirements should be paired with renewed plan oversight and enforcement to ensure that quality improvements driven by the Star Ratings program are sustained.

MAPRx recommends that CMS:

- Maintain strong monitoring, validation, and audit activity alongside any measure removals, including targeted reviews where complaints, access barriers, or outcomes suggest deterioration in performance.
- Use enforcement tools consistently when plans fail to meet requirements and publicly report recurring deficiencies and corrective actions to reinforce accountability.
- Ensure that beneficiary experience, access, and medication-related quality indicators remain central, particularly for beneficiaries with complex chronic conditions and high medication needs.

Continue to Refine the Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a vital option for beneficiaries to manage out-of-pocket costs by smoothing payments over the year. However, early implementation has demonstrated that beneficiary awareness and understanding remain low, and many beneficiaries likely to benefit from the program remain unaware of it and have not enrolled. The CY 2027 rulemaking is an important opportunity for CMS to continue to bolster the program by promoting beneficiary awareness and simplifying election, including at the pharmacy counter.

In November 2025, MAPRx released recommendations to improve the Medicare Prescription Payment Plan based on early beneficiary experience and implementation challenges. The proposed rule does not include programmatic improvements or additional requirements that would promote consistent, beneficiary-friendly implementation across Part D sponsors.

MAPRx recommends that CMS:

- Expand "likely to benefit" point-of-sale outreach. Lower the pharmacy notification trigger from $600 for a single prescription to $400 or less and require sponsors to use cumulative out-of-pocket spending (not just a single fill) to identify beneficiaries likely to benefit.

- Require broad open enrollment notice for non-Extra Help beneficiaries. Provide standardized notice during open enrollment to all beneficiaries not eligible for the Low-Income Subsidy (Extra Help), not only those who reached the out-of-pocket cap in the prior year.
- Promote existing Medicare.gov and Medicare Plan Finder resources. Ensure beneficiaries and assisters can easily find fact sheets and the Plan Finder functionality that allows comparison of drug costs with and without the program.
- Require prominent plan communications. Require plans to display Medicare Prescription Payment Plan information prominently on plan websites and in beneficiary-facing materials that discuss drug costs and affordability options.
- Enable opt-in through Medicare.gov and Medicare Plan Finder. Allow beneficiaries to choose the program at the time of enrollment and when comparing expected costs, using the platforms they already rely on.
- Require development of a point-of-sale opt-in option by CY 2027. Work with pharmacies, plans, and system vendors to implement a point-of-sale election pathway so beneficiaries can choose smoothing when faced with high costs at the pharmacy counter, reducing prescription abandonment.
- Provide routine public reporting on program operations and uptake.
- Solicit beneficiary feedback and incorporate it into oversight. Conduct regular focus groups and structured listening sessions with beneficiaries and patient advocacy organizations to test whether outreach, election, billing, and customer support are meeting program objectives, and use findings to guide refinements.

Thank you for your consideration of these comments. MAPRx welcomes continued opportunities to work with CMS to strengthen beneficiary protections, ensure transparent and accountable oversight of Part D formularies and utilization management, and improve the Medicare Prescription Payment Plan so that it delivers on its promise of better affordability and predictability for beneficiaries.

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
Alliance for Patient Access
American Association on Health and Disability
American Cancer Society Cancer Action Network
American Kidney Fund
American Society of Consultant Pharmacists (ASCP)
Arthritis Foundation
Autoimmune Association
Blood Cancer United
Coalition of Skin Diseases
Derma Care Access Network

Eosinophilic & Rare Disease Cooperative
Epilepsy Foundation of America
Foundation for Sarcoidosis Research
GO2 for Lung Cancer
HealthyWomen
HIV+Hepatitis Policy Institute
Lakeshore Foundation
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of America
Muscular Dystrophy Association
National Alliance on Mental Illness (NAMI)
National Council on Aging
National Health Council
National Kidney Foundation
National Multiple Sclerosis Society
PAN Foundation
RetireSafe
Sjögren's Foundation, Inc.
The Mended Hearts, Inc.
Triage Cancer