July 20, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via www.regulations.gov

Re: Request for Information: Pharmacy Benefit Manager Compensation and Data Collection, (CMS-4218-NC)

Dear Administrator Oz:

The Alliance of Community Health Plans (ACHP) has long supported pharmacy benefit manager (PBM) reforms that increase transparency and reduce hidden costs across the prescription drug supply chain. Comprehensive drug supply chain transparency requires visibility into manufacturer prices, wholesaler markups, pharmacy reimbursement and payments retained by group purchasing organizations and rebate aggregators in Medicare Part D. Addressing only one entity will not provide adequate oversight without visibility across the full drug pricing system. We appreciate the opportunity to provide comments on PBM compensation and data collection. ACHP support CMS' efforts to implement Section 6224 of the Consolidated Appropriations Act of 2026 in a manner that increases transparency, improves accountability and ensures PBM compensation is tied to bona fide services rather than drug prices, rebates, spread pricing or other misaligned incentives.

ACHP represents the nation's local, nonprofit health plans, providing high-quality coverage to tens of millions of Americans, including nearly four million Medicare Advantage consumers across the nation. ACHP is the only national organization advancing a unique partnership model of coverage and care that fosters a truly competitive market. We believe Americans deserve the highest-quality health care, and ACHP's provider-aligned health plans are delivering innovative, affordable coverage rooted in the communities they serve.

As CMS implements these requirements, it is imperative that the agency target the misaligned incentives associated with PBM compensation practices without inadvertently sweeping in nonprofit, provider-aligned health plans, integrated delivery systems or internal pharmacy administration functions that neither operate as third-party PBMs nor retain PBM-related revenue.

Definition of Pharmacy Benefit Manager

ACHP recommends CMS refine the PBM definition to be limited to entities that contract to administer or manage prescription drug benefits or otherwise materially affect the financial terms of prescription drug claims. This includes entities that may not identify as PBMs but influence prescription drug pricing, pharmacy reimbursement, manufacturer payments, rebate contracting and administration or beneficiary cost sharing. CMS should clarify that activities such as claims processing, utilization review, prior authorization, appeals adjudication, pharmacy network contracting and cost control should not, on their own, cause an integrated health care delivery system to be treated as a PBM. This is particularly true when those activities are performed for its own members and are not provided as a

separate compensable third-party PBM service. Further, CMS should focus oversight on the nature of the service performed and whether compensation is tied to drug price, rebate value, formulary placement, utilization, spread pricing or retained revenue rather than targeting any company that contracts with a PBM.

ACHP recommends preserving flexibility for intermediary and subcontracting relationships where entities provide discrete operational or administrative services to payers with appropriate transparency and accountability. PBMs may provide related services beyond the functions expressly listed in the statute, including formulary support, manufacturer contracting support and clinical or disease management programs. At the same time, CMS should recognize that PBMs are not the only entities that influence prescription drug costs and financial incentives. Manufacturer copay assistance programs, switch companies that administer those programs and wholesalers operating brand preference programs also affect prescription drug spending and financial flows.

Definition of Affiliate

ACHP recommends CMS apply the affiliate definition based on common ownership, shared control or performance of PBM functions on behalf of a PBM or PDP sponsor. CMS should distinguish entities that support care delivery, pharmacy access or administrative operations from entities that participate in PBM revenue generation or receive remuneration tied to Part D drug utilization, rebate value, wholesale acquisition cost (WAC), average wholesale price (AWP), formulary placement, pharmacy channel, product selection, spread pricing or retained revenue. CMS should apply greater scrutiny to entities that receive or retain payments through these channels including group purchasing organizations and rebate aggregators. To the extent feasible, CMS should align with existing federal and state concepts of ownership and control to reduce unnecessary compliance complexity.

Definition of Bona Fide Service Fee

ACHP supports limiting PBM compensation to flat-dollar, fair-market-value fees for bona fide, itemized services performed. This approach is consistent with a transparent, fee-based PBM model and reduces incentives for PBMs to favor higher-cost drugs, higher rebates or utilization patterns that increase retained revenue.

ACHP recommends CMS prohibit compensation methodologies tied directly or indirectly to drug price, wholesale acquisition cost (WAC), average wholesale price (AWP), rebate value, formulary placement, utilization volume, referral volume, pharmacy channel, product selection, spread pricing or retained revenue. CMS should preserve objective performance-based incentive payments that are tied to measurable operational, quality or service-level outcomes rather than drug price, rebate value or formulary placement.

Additionally, CMS should preserve flexibility for performance-based arrangements that improve service quality and operational performance. Appropriate performance measures may include medication therapy management performance, Star Ratings support, call center performance, claims payment accuracy and other objective service metrics.

We recommend CMS apply the statutory standard to require that all bona fide service fees correspond to identifiable services that the paying entity would otherwise perform or contract for in the absence of the arrangement.

Determination of Fair Market Value

ACHP recommends CMS define fair market value through a flexible, facts-and-circumstances standard rather than a single national methodology or standardized fee schedule. Fair market value may vary based on contract scope, service complexity, plan size, delegated functions, operational scale and entity type. CMS should not equate fair market value with a nationally standardized bona fide service fee. Benchmarking may be useful but may not fully account for differences in plan size, service scope, contract structure or organizational model. CMS should also consider how PBM market concentration may limit the availability of transparent, comparable market benchmarks.

It is imperative that CMS accept multiple forms of documentation to demonstrate fair market value, including market benchmarking, itemized bids, cost accounting, independent valuation reports, actuarial certification, internal cost studies, service-level pricing and contract comparability analyses. This flexibility should maintain requiring sufficient documentation to support oversight while preserving flexibility for different organizational structures, contracting models and service arrangements.

Pharmacy Payment

ACHP requests CMS clearly distinguish pharmacy reimbursement from PBM compensation. Section 6224 should not be implemented in a manner that unintentionally disrupts pharmacy payment arrangements, pharmacy network design or value-based pharmacy reimbursement models. CMS should ensure the requirements do not disadvantage smaller pharmacies or enable steering toward PBM-favored pharmacies, so community health plan members can maintain access to the pharmacies that best meet their needs.

Pharmacy reimbursement arrangements, including acquisition-cost-based reimbursement, dispensing fees and pharmacy performance arrangements are distinct from PBM compensation when they compensate pharmacies for dispensing services or pharmacy performance. CMS should clarify that vaccine administration fees and other distinct clinical service payments are also outside the scope of PBM compensation restrictions.

ACHP opposes codifying a single pharmacy reimbursement methodology given the continued evolution of pharmacy payment arrangements, including movement toward acquisition-cost-based approaches such as NADAC plus a dispensing fee.

Data Collection

ACHP recommends CMS require standardized PBM reporting with a clear data dictionary to ensure consistent reporting across PBMs. Reporting should give CMS and plan sponsors visibility into payments retained by PBMs, subsidiaries, affiliates, subcontractors, group purchasing organizations and rebate aggregators. CMS should require PBMs to disclose monetary amounts paid, directly or indirectly, in fees, rebates or other compensation to brokers and consultants. CMS should also require PBMs to disclose the acquisition cost of drugs and any additional dollars received through the PBM structure.

ACHP recommends that CMS place primary reporting responsibility on the entities that control the underlying data. Plan sponsors should receive sufficient information to validate utilization, dispensing activity, drug cost, pricing, enrollee cost sharing, direct and indirect remuneration, pharmacy reimbursement, plan spending, PBM-retained revenue and affiliate-retained revenue.

Implementation Considerations

ACHP encourages CMS to implement Section 6224 with clear operational guidance that preserves flexibility for plan sponsors using integrated delivery system models. CMS should avoid applying traditional PBM requirements to nonprofit, provider-aligned health plans and integrated delivery systems that perform pharmacy benefit functions for their own members and do not operate as separate compensable third-party PBM intermediaries.

ACHP appreciates CMS' commitment to increase accountability, reduce hidden costs and improve visibility across the prescription drug supply chain. We remain committed to collaborating to advance these important goals and preserve flexibility for nonprofit, provider-aligned health plans, integrated delivery systems and legitimate pharmacy payment arrangements.

Please contact Carmen Witsken, Senior Manager of Pharmacy Policy, at cwitsken@achp.org for questions or follow-up discussion.

Sincerely,

Dan Jones

Dan Jones
Senior Vice President, Federal Affairs
Alliance of Community Health Plans