June 9, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Ave SW
Washington, DC 20201

Dear Dr. Oz:

We are writing to request that the Centers for Medicare & Medicaid Services (CMS) take action to protect Medicare beneficiaries' access to necessary treatments now that Part D benefit redesign enacted under the Inflation Reduction Act are now in effect. With the expanded use of utilization management (UM) tools in Medicare Part D, we remain concerned that CMS needs to take steps to better protect beneficiaries by improving transparency around the impact of these changes in their Part D plan choices and institute additional guardrails to ensure that beneficiaries have appropriate and timely access to treatment.

Effective this year Medicare Part D plans are responsible for 60% of costs in the catastrophic phase, up from 15% in 2023. This higher level of cost sharing creates incentives for plans to increase their use of UM tools such as step therapy, fill limits, formulary changes, non-medical switching, and prior authorization requirements. While UM is intended to lower drug expenditures, and can be appropriate in some circumstances, restrictive cost-control measures can delay or prevent beneficiaries from accessing necessary treatments. This can have significant clinical consequences, especially for the populations served by the Part D program.

We are already seeing the expanded UM in Part D. The Medicare Payment Advisory Commission (MedPAC) reports that the use of UM tools such as quantity limits, step therapy, and prior authorization in Part D has grown.[1] Meanwhile, more Part D formularies are shifting from copayments to coinsurance, which often lead to higher and less predictable out-of-pocket costs for beneficiaries.[2]

In your testimony to the Senate Finance Committee in March, you highlighted the fact that UM tools in Medicare Part D impact beneficiary access and place significant burden on providers. Physicians and their care teams must navigate complex and often inconsistent UM requirements across plans, including time-consuming prior authorizations, appeals, and documentation processes. These administrative demands divert valuable time and resources away from direct patient care, contributing to clinician burnout and ultimately impacting the quality and timeliness of care delivered to Medicare beneficiaries. We agree that this issue deserves greater attention and action from CMS and appreciate you highlighting this issue in your recent testimony.

While the agency previously indicated that it is monitoring changes in formulary design, there are a number of additional, commonsense steps that CMS can take to better support beneficiaries in response to our UM concerns. For example, CMS should outline clear expectations around the use of UM tools in Part D to ensure their appropriate use by plan sponsors. We also urge CMS to

increase transparency around plans' use of UM, such as by incorporating relevant information into the Medicare Plan Finder. Enhanced beneficiary education also can help Part D enrollees be more informed about how their care may be affected by UM tools and, therefore, more empowered in their decision making as it relates to selecting the prescription drug coverage that will best meet their needs.

We appreciate your attention on the implementation and impact of the Part D benefit redesign on our nation's patients and the increasing use of UM. We look forward to working with you to support the success of the Part D program and protect beneficiaries' access to treatment. Thank you for your attention to this matter.

Sincerely,

ADAP Advocacy Association
Alliance for Aging Research
Alliance for Patient Access
Alpha-1 Foundation
ALS Association
American Academy of Physical Medicine and Rehabilitation
American Association of Colleges of Pharmacy
American Association of Senior Citizens
American Association on Health and Disability
American College of Allergy, Asthma, and Immunology
American College of Clinical Pharmacy
American Society of Consultant Pharmacists
Association of Black Cardiologists
Barth Syndrome Foundation
Cancer Support Community
Caregiver Action Network
CaringKind, the Heart of Alzheimer's Caregiving
Clinical Neurological Society of America
CLL Society
Color of Gastrointestinal Illnesses
Community Liver Alliance
COPD Foundation
Crohn's and Colitis Foundation
Diabetes Leadership Council
Diabetes Patient Advocacy Coalition
EveryLife Foundation for Rare Diseases
FORCE: Facing Our Risk of Cancer Empowered
Genetic Alliance
Gerontological Society of America
Global Coalition on Aging Alliance for Health Innovation
Global Liver Institute
GO2 for Lung Cancer
Haystack Project
HealthHIV
HealthyWomen
HIV+Hepatitis Policy Institute
Hydrocephalus Association
ICAN, International Cancer Advocacy Network
International Pemphigus & Pemphigoid Foundation
Lakeshore Foundation
Let my Doctors Decide Action Netowrk
Lupus and Allied Disease Foundation
Mental Health America
National Association for Continence
National Black Nurses Association, Inc.
National Consumers League
National Eczema Association
National Hispanic Health Association
National Organization for Rare Disorders
National Patient Advocate Foundation
Neuropathy Action Foundation (NAF)
Nevada Chronic Care Collaborative
PAN Foundation
Partnership to Fight Chronic Disease
Patients Rising
PlusInc
Prevent Blindness

Second Wind Dreams, Inc.
Spondylitis Association of America
60 Plus Association
StopAfib.org
Tigerlily Foundation
Triage Cancer
TSC Alliance

[1] MedPAC. *March 2025 Report to the Congress: Medicare Payment Policy.* Mar 2025. https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/

[2] Avalere Health. *2025 Part D Formularies Shift to More Coinsurance and UM.* Oct 2024. https://advisory.avalerehealth.com/insights/2025-part-d-formularies-shift-to-more-coinsurance-and-um

Cc: Stephanie Carlton, Deputy Administrator and Chief of Staff

John Brooks, Deputy Administrator and Chief Policy and Regulatory Officer