Submitted electronically via www.regulations.gov

February 18, 2026

Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director
Parts C & D Actuarial Group
Office of the Actuary
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies [CMS-2026-0034]

Director Wuggazer Lazio,

The National Community Pharmacists Association (NCPA) appreciates the opportunity to provide feedback on CMS' *Advance Notice of Methodological Changes for Calendar Year (CY) 2027 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.*

NCPA represents America's community pharmacists, including 18,900 independent community pharmacies. Almost half of all community pharmacies provide long-term care services and play a critical role in ensuring patients have immediate access to medications in both community and long-term care (LTC) settings. Together, our members employ 205,000 individuals, and provide an expanding set of healthcare services to millions of patients every day. Our members are small business owners who are among America's most accessible healthcare providers.

Star Rating System Changes

NCPA appreciates the ongoing CMS commitment to transparency and improving the patient experience by continuing to evolve Star Ratings for Part D as well as the commitment to providing advance notice in making substantive changes to Star Ratings. According to the *2025 NCPA Digest*, approximately 80% of independent pharmacies offer MTM services in their pharmacies.[1] Collectively, nearly two-thirds of independent pharmacies serve populations fewer than 50,000.[2]

In the Advanced Notice, CMS stated that the MTM Program Completion Rate for Comprehensive Medication Review (CMR) measure will be removed beginning with the 2027 Star Ratings; it will be on the

[1] *NCPA Digest*, 2025.
[2] *NCPA Digest*, 2025.

display page for measurement years 2025 and 2026 and will return to the Star Ratings as a new measure beginning with the 2029 Star Ratings (measurement year 2027).

In the CMR process, pharmacists can identify gaps in therapy, inappropriate therapies, or potential duplicative therapies. Overall, this retirement of CMR completion rate as an MTM Star Ratings measure is not only a lost source of revenue for pharmacies, but also decreases pharmacies' influence on Star Ratings, and therefore their influence in negotiations with Part D plan sponsors. **NCPA recommends that if the measure of CMR completion is retired from the MTM program, the MTM program should implement other methods to modernize the program and recognize pharmacists' clinical impact as members of the health care team.**

Past studies have shown a national average CMR completion rate of 11%[3] prior to its inclusion as a measure in the Star Ratings program, and its participation is estimated by CMS to be closer to 50% of eligible beneficiaries participating to date.[4] CMRs have been shown to be key benefits for patients with complex medication regimens and may reduce healthcare expenditures.[5] The inclusion of the CMR completion rate as part of Star Ratings measures has driven MTM engagement in pharmacies and in other vendors, however, its retirement may create an opportunity to recognize pharmacists' clinical impact in other ways. Pharmacist-led MTM has been shown to improve patient adherence and reduce hospitalizations.[6] For example, **CMS may consider maintaining and expanding MTM criteria to prioritize clinical outcomes such as focusing on follow-ups, medication adjustments, and patient engagement.** These services could leverage Fee-for-Service Opportunities for Pharmacies within Value-Based Care. CPESN USA® could model these types of Fee-for-Service Opportunities as their clinically integrated network of pharmacies provide enhanced clinical services beyond traditional dispensing.

Should CMR completion rate be retired from the Star Ratings measures, **NCPA requests that there be a structured transition plan before removing the current measures**. Eliminating current incentives without a clear replacement could restrict pharmacy participation, lower health plan engagement, and reduce patient access to essential services.

Concurrent Use of Opioids and Benzodiazepines (COB) is a measure being added beginning with the 2027 Star Ratings.

[3] https://www.pharmacytimes.com/view/increasing-emphasis-on-cmr-completion-rates
[4] Federal Register, 2024
[5] DeZeeuw EA, Coleman AM, Nahata MC. Impact of telephonic comprehensive medication reviews on patient outcomes. Am J Manag Care. 2018 Feb 1;24(2):e54-e58. PMID: 29461851; https://www.cms.gov/priorities/innovation/files/x/mtm-evidencebase.pdf
[6] Joseph T, Hale GM, Eltaki SM, Prados Y, Jones R, Seamon MJ, Moreau C, Gernant SA. Integration Strategies of Pharmacists in Primary Care-Based Accountable Care Organizations: A Report from the Accountable Care Organization Research Network, Services, and Education. J Manag Care Spec Pharm. 2017 May;23(5):541-548. doi: 10.18553/jmcp.2017.23.5.541. PMID: 28448780; PMCID: PMC10397758; Schultz BG, Tilton J, Jun J, Scott-Horton T, Quach D, Touchette DR. Cost-Effectiveness Analysis of a Pharmacist-Led Medication Therapy Management Program: Hypertension Management. Value Health. 2021 Apr;24(4):522-529. doi: 10.1016/j.jval.2020.10.008. Epub 2021 Jan 24. PMID: 33840430.

Use of Opioids at High Dosage in Persons without Cancer (OHD) (Part D)

The PQA updated the OHD measure specifications in the draft 2026 PQA Measure Manual to revise the methodology for daily morphine milligram equivalent (MME) calculation. Daily MME is calculated for each opioid prescription claim with a date of service during each opioid episode for the OHD measure. The daily MME is calculated by the following equation as updated by the PQA: MME/day = (# of opioid dosage units per day) × (opioid strength per unit) × (MME conversion factor).

The number of opioid dosage units per day is equal to the claim quantity dispensed divided by the claim days' supply. The opioid strength per unit and MME conversion factor are provided for each NDC in the PQA's Value Set, Opioids. When applying this updated formula to transdermal fentanyl patches, the opioid dosage units per day should always be 1, regardless of the claim's quantity dispensed or days' supply. Additionally, the PQA's Value Set, Opioids expresses weight-based strengths in milligrams, while the Centers for Disease Control and Prevention (CDC) MME conversion factors are based on micrograms. Thus, the PQA uses an adjusted MME conversion factor of 2,400 for transdermal fentanyl patches reported in milligrams (conversion factor of 2.4 for transdermal fentanyl patches reported in micrograms). This conversion factor accounts for the change in unit compared to the CDC and should be applied directly in the PQA's formula for calculating daily MME. Finally, this methodology aligns with opioid MME calculation methodology used in the CMS Part D Opioid Drug Utilization Review (DUR) policy and Overutilization Monitoring System (OMS), described in the OMS technical guidance.

The PQA QMEP voted to approve these changes in 2025. CMS plans to incorporate the updated MME calculation methodology beginning with the 2026 measurement year (2028 display page) at the earliest.

NCPA supports the above opioid measures. NCPA opposes any factors that CMS and Part D plans take into consideration in Star Ratings that would have downstream effects that limit pharmacists' scope of practice or patients' clinical benefit. For example, pharmacists should be able to dispense both opioids and benzodiazepines where clinically appropriate, appropriately dosed and through communication with the beneficiary's doctor. Furthermore, some community pharmacies dispense a higher percentage of opioids due to their patient mix, or because they are located near pain clinics, and should not be penalized from high dispensing alone. Under proper management and monitoring by a pharmacist, drug combinations are less risky to the patient.

Antipsychotic Use in Persons with Dementia for Long-Term Nursing Home Residents (APD-LTNH) (Part D)/Antipsychotic Use in Persons with Dementia (APD) (Part D)

NCPA supports CMS' decision to retire antipsychotic use in person with dementia for long-term nursing home residents (APD-LTNH). Additionally, NCPA supports the removal of brexipiprazole from the Antipsychotic Use in Persons with Dementia (APD) (Part D) measure following the approved indication for the medication by the FDA.

NCPA applauds the agency for taking steps to ensure that patients who can benefit from appropriate use of antipsychotics medications have access without negatively impacting the Plan's star ratings. NCPA encourages the agency to examine other measures that inappropriately disadvantage healthcare settings

because of patient utilization of appropriate and FDA-approved medications. Specifically, NCPA reminds CMS that the Long-Stay Antipsychotic Quality Measure has repeatedly been highlighted, by the HHS OIG, to fail a determine medication appropriateness. We encourage the agency to utilize the same logic employed to retire the APD-LTNH measure and reform the APD measure when addressing this setting-specific quality measure in the forthcoming Skilled Nursing Facility P*rospective Payment System (SNF PPS*) proposed rule.

NCPA thanks CMS for the opportunity to provide feedback, and we stand ready to work with CMS to offer possible solutions and ideas. Should you have any questions or concerns, please feel free to contact me at steve.postal@ncpa.org or (703) 600-1178.

Sincerely,

Senior Director, Policy & Regulatory Affairs
National Community Pharmacists Association