



September 20, 2023

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Deputy Administrator and Director of the Center for Medicare
Centers for Medicare and Medicaid Services
200 Independence Avenue SW
Washington, DC

Submitted via PartDPaymentPolicy@cms.hhs.gov

RE: Medicare Prescription Payment Plan Guidance

Dear Dr. Seshamani:

The MAPRx Coalition (MAPRx) appreciates the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with comments regarding the implementation of the Medicare Prescription Payment Plan program set to take effect for Contract Year (CY) 2025 per the Memorandum ***Maximum Monthly Cap on Cost-Sharing Payments Under Prescription Drug Plans: Draft Part One Guidance on Select Topics, Implementation of Section 1860D-2 of the Social Security Act for 2025, and Solicitation of Comments***, published on August 21, 2023.

Our group, MAPRx, is a national coalition of 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 undersigned members of the MAPRx Coalition are pleased to provide CMS with our official commentary in response to your efforts to implement the Maximum Monthly Cap on Cost-Sharing Payments Program.

MAPRx appreciates the opportunity to comment on how CMS intends to implement the Medicare Prescription Payment Plan, a program that will help ease beneficiary financial burdens for medications by making out-of-pocket (OOP) costs more manageable and predictable through monthly payments. When advocating for Congress to enact a true OOP cap in Medicare, MAPRx was consistently a strong proponent of this type of program. Given the critical role this program will play in alleviating financial burdens for beneficiaries, we want to

ensure that it is effective in smoothing payments and that CMS is effective in its outreach to beneficiaries who could benefit from the program. Specifically, MAPRx would like to address the following issues CMS raised in this first round of guidance:

- **Program Calculations**
- **Participant Billing and Billing Statement**
- **Claims Processing and Coordination of Benefits**
- **Enrollee Outreach**
- **Program Eligibility and Enrollment**
- **Voluntary and Involuntary Disenrollments**
- **Grace Periods and Notice Requirements**
- **Participant Disputes**

Program Calculations

MAPRx appreciates CMS offering detailed scenarios for the calculations to facilitate deeper understanding of the mechanics of the program. We concur that participants starting the program later in the year could have higher monthly bills, especially compared to those starting earlier in the year. Furthermore, we are concerned that beneficiaries starting later in the year (eg., October) may experience an increase in costs for December, which could be a surprising shock for them. Based on this possible challenge, we urge CMS to explore methodologies to prevent this scenario.

Additionally, given the complexity related to the calculations, MAPRx strongly supports educating beneficiaries at a high level regarding the program calculations, rather than overwhelming them with this the complicated approach contained in the guidance. Specifically, when educating beneficiaries on how the calculations work, we request that CMS offer language stating that the OOP costs may vary slightly from month to month, but that participant costs will never exceed \$2,000 OOP (or your actual OOP prescription costs). We also think it will be helpful to provide guidance to prospective and current participants that the higher your OOP cost, the higher your monthly cost. If CMS is considering providing program participants with detailed charts showing the remaining costs for the rest of the plan year, we recommend displaying only a column for patient OOP costs incurred and monthly OOP costs—thereby removing the maximum monthly cap amount in the draft guidance—to minimize confusion.

Participant Billing and Billing Statement

Overall, MAPRx appreciates CMS' commitment to afford flexibility for participants regarding payment options and to provide transparency for participants through the monthly billing statement. While we appreciate CMS encouraging plans to offer certain payment options, we urge CMS to **require** several different options (eg., electronic funds transfer, automated payments, paper bills, etc.). According to the 2023 ACI Speedpay Pulse Report, older Americans within the baby boomer generation prefer a wide range of payment options for bill payments, including automated clearing house (ACH) automated debit, paper check by mail, debit/credit card, website, or over the phone.¹ Given the diversity of preferences among the Medicare population, we believe requiring plans to offer a multitude of options will facilitate

¹ 2023 ACI Speedpay® Pulse Report: Billing and Payment Trends and Behaviors. ACI Worldwide.
<https://www.aciworldwide.com/wp-content/uploads/2023/08/2023-ACI-Speedpay-Pulse-Annual-Report.pdf>. Accessed September 13, 2023.

greater beneficiary participation in the program.

MAPRx also applauds CMS for requiring Part D plans to provide robust information within the billing statement. We especially appreciate CMS building awareness around financial assistance by including the language about the possible eligibility for the low-income subsidy (LIS). While we generally approve of including the information in the proposed billing statement, we respectfully offer several modifications. The first page of the statement should be reserved for only critically important information so beneficiaries can easily understand their OOP obligation and monthly responsibilities for the remainder of the plan year. We want to ensure the language/information is clear and actionable, therefore, below is the most crucial information we believe should be highlighted on the first page:

- Total, non-itemized OOP costs
- OOP costs expected on a monthly basis for the remainder of the plan year
- Statement reiterating that there will be changes to the monthly OOP costs if a beneficiary has a new prescription or discontinues an existing prescription

Additionally, while the proposed billing statement is robust, there may be some important information missing from it. To that end, MAPRx requests the following additions to the billing statement:

- Information on State Health Insurance Assistance Program (SHIP) counselors as we believe it is important for beneficiaries to have access to an impartial stakeholder to help prepare them for the program (ie., explaining the dynamic of making monthly payments) and answering questions
- Highly visible note/language focused on the impact of noncompliance
 - While beneficiaries may take different approaches regarding medical billing in other healthcare programs, there are consequences for late payments. We request that CMS highlight the imperative for beneficiaries to pay and pay on time
- Language that the beneficiary will not pay more than \$2,000 and informing the patient when that cap has been met, including the standard monthly payments through the end of the year after the cap has been met

Finally, we appreciate CMS' assurance that Part D sponsors and plans cannot seek debt collections against program participants.

Claims Processing and Coordination of Benefits

MAPRx appreciates the detail the agency has provided for the processing of claims and coordination of benefits. We do not have any additional feedback on this section, with the exception that we believe it is important to ensure that assistance provided by patient assistance programs, such as those offered by independent charitable foundations, be properly identified and continue to be included in the patient OOP calculation. Additionally, MAPRx seeks clarification from CMS on this dynamic. Specifically, we ask the agency to clarify whether the two-transaction pharmacy claims process allows for independent charitable assistance to be billed for the patient responsibility as a component of "Other Health Insurance" prior to application of any Medicare Prescription Payment Plan.

Enrollee Outreach

As the Medicare Prescription Payment Plan program will be new in 2025, MAPRx strongly supports a robust effort to educate via beneficiary outreach on this new program. Given the complexities and possible confusion among prospective beneficiaries, effective outreach and education are critical for the success of this program.

The targeted outreach will be a critical step in educating beneficiaries about the possible benefits of enrolling into the Maximum Monthly Cap on Cost-Sharing Payments Program. We strongly encourage CMS to move away from certain thresholds for conducting targeted beneficiary outreach. We caution the agency not to make assumptions about what is beneficial for beneficiaries. Specifically, beneficiaries may face deductibles or other OOP costs in other Medicare programs or have other expenses to consider and this maximum monthly cap could be beneficial even if they do not have a perceived high-cost medication in Part D. We respectfully request that CMS recall that the congressional intent for this specific benefit was to be widely applicable and open to all beneficiaries in Part D. Establishing thresholds for proactive outreach runs counter to that intent. To that end, we strongly advocate for not implementing a threshold for conducting targeted outreach.

As engagement with patient groups is critical for informing CMS's outreach strategy and tactics, we look forward to the opportunity in Part 2 of the guidance to comment on model language for beneficiary communications and plan marketing materials. As stakeholders continue to explore the best education and outreach efforts, we encourage CMS to include information on the program both in plan marketing materials and in materials created by the agency (eg., the Medicare & You handbook and the Medicare website). We specifically wanted to raise a widely utilized platform: the Medicare Plan Finder tool. The Medicare Plan Finder is an important tool for educating beneficiaries on important plan information, including this new program. Many beneficiaries and their caregivers use this tool when making enrollment decisions, and as such, it will be critically important to highlight this new program on Plan Finder. While CMS may offer more details on how it will provide information on Plan Finder in Part 2 of the guidance, we strongly support the development of a customizable analytical tool that could help enrollees determine if the new program would be beneficial.

In addition to our thoughts on educating beneficiaries directly, we also encourage CMS to educate other stakeholders who play a part in educating beneficiaries. As pharmacies will have a significant role at the point of sale (POS) in notifying beneficiaries who may benefit from the program, we hope that CMS will offer specific educational materials to be deployed by pharmacies for review in Part 2. We also believe strongly that educating healthcare providers and prescribers will be another important step to help beneficiaries understand the benefits of the program and how to enroll. We encourage CMS to educate providers and prescribers so they, in turn, can help educate beneficiaries.

MAPRx believes in consistently evaluating the effectiveness of the program outreach, especially by gaining feedback and insights from the stakeholders using and managing the program. We encourage CMS to explicitly provide additional opportunities for stakeholder, particularly patient and caregiver, input in the future. Additionally, collecting demographic data (eg., ethnicity, geography) could also help refine and better target outreach efforts in future plan years.

Program Eligibility and Enrollment

MAPRx appreciates CMS exploring various enrollment options into the program. While we generally agree with CMS' proposed eligibility requirements and election options before and

during the plan year, we have several concerns about the guidance related to enrollment at the point-of-sale (POS). Frankly, we are concerned that CMS is already conceding this as too challenging to implement for 2025, despite this specific enrollment option being critical for catching in real time the patients who may benefit from the program. Therefore, we strongly recommend the agency consider requiring plans and pharmacies to offer real-time or POS enrollment for 2025 as the agency already has reviewed a few feasible ideas. Our organizations are committed to working with CMS and other stakeholders to identify ways in which enrollment options at the POS can be implemented in 2025.

We also strongly support CMS requiring plans to process midyear elections within 24 hours. We fervently believe if there is a mechanism for plans to facilitate midyear elections within 24 hours, then there feasibly could be a mechanism for POS enrollment.

MAPRx also seeks clarification regarding a scenario in which a current participant changes Part D plans midyear (ie., due to a relocation or move). We ask the agency to explain what safeguards and processes will be in place to ensure the effective carryover from the program from one Part D plan to another without “waiting period” delays or loss of OOP “credit” towards the cap.

Voluntary and Involuntary Disenrollments

MAPRx appreciates CMS clearly stating that Part D sponsors may preclude an individual from opting into the plan in a subsequent year if the individual fails to pay the amount billed. However, the guidance is unclear if a plan may preclude enrollment for more than one year. Based on the statutory language, we respectfully recommend that CMS allow Part D plans to preclude affected individuals for only one year and not multiple years. We also recommend halting the preclusion once the beneficiary has made the outstanding payment.

MAPRx also seeks clarification in the event of the death of the beneficiary. If a patient dies, we are unaware of no other instance where CMS has a claim against a beneficiary’s estate. Based on this, we would assume that the Part D plan and/or CMS would absorb the cost. Otherwise, this may discourage beneficiaries from participating in the program.

Grace Periods and Notice Requirements

During consideration of the Inflation Reduction Act, MAPRx strongly supported a generous grace period for any type of smoothing benefit to prevent plans from disenrolling participants immediately following a late payment. We recommend CMS establish a 3-month grace period for late payments. We also strongly support CMS requiring Part D plans to communicate with beneficiaries within this time frame about the consequences of late payments and possible involuntary termination. Specifically, we recommend standardizing plan communications during this time frame. We look forward to providing our feedback on this model language in Part 2 of the guidance.

Participant Disputes

It is important for participants to have a mechanism to resolve disputes with Part D plans. Therefore, we appreciate CMS requiring Part D sponsors to apply their established Part D appeals procedures to any dispute made by a Medicare Prescription Payment Plan participant

about the amount of Part D cost-sharing owed by that participant for a covered Part D drug. However, we are concerned that there are no clear requirements regarding the timeframes associated with disputes. We strongly recommend that CMS require sponsors to resolve disputes within a 24-hour period, leveraging the expedited review process under the current appeals program.

Conclusion

Thank you for your consideration of comments on the Part 1 guidance of the implementation of the Maximum Monthly Cap on Cost-Sharing Payments Program. The undersigned members of MAPRx appreciate your leadership to improve beneficiaries' access and affordability in Medicare Part D. For questions related to MAPRx or the above comments, please contact Bonnie Hogue Duffy, Convener, MAPRx Coalition, at (202) 540-1070 or bduffy@nvgllc.com.

- Allergy & Asthma Network
- Alliance for Aging Research
- Alliance for Patient Access
- ALS Association
- American Association on Health and Disability
- American Cancer Society Cancer Action Network
- American Kidney Fund
- Arthritis Foundation
- Epilepsy Foundation
- GO2 for Lung Cancer
- HealthyWomen
- Infusion Access Foundation
- Lakeshore Foundation
- LUNGevery Foundation
- Lupus and Allied Diseases Association, Inc.
- Lupus Foundation of America
- Muscular Dystrophy Association
- National Council on Aging
- National Health Council
- National Infusion Center Association (NICA)
- National Kidney Foundation
- National Multiple Sclerosis Society
- Patient Access Network (PAN) Foundation
- The AIDS Institute
- The Assistance Fund
- The Leukemia & Lymphoma Society
- The Leukemia & Lymphoma Society
- Tourette Association of America
- Triage Cancer